COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

IN THE MATTER OF:

ELECTRONIC APPLICATION OF TAYLOR COUNTY	)	
RURAL ELECTRIC COOPERATIVE CORPORATION	)	CASE NO.
FOR A GENERAL ADJUSTMENT OF RATES	)	2023-00147

RESPONSES TO COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION TO TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION DATED MAY 11, 2023

Filed: June 19, 2023

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF	)	
TAYLOR COUNTY RURAL ELECTRIC	)	**Case No. 2023-000147**
COOPERATIVE CORPORATION FOR	)	
A GENERAL ADJUSTMENT OF RATES	)	

VERIFICATION OF JEFFREY R. WILLIAMS

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF TAYLOR)

Jeffrey R. Williams, Chief Executive Officer of Taylor County Rural Electric Cooperative Corporation, being duly sworn, states that he has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above referenced case on behalf of Taylor County Rural Electric Cooperative Corporation, and that the matters and things set forth therein are true and accurate to the best of his knowledge, information and belief, formed after reasonable inquiry.

Jeffrey R. Williams

The foregoing Verification was signed, acknowledged and sworn to before me this 14 day of June, 2023, by Jeffrey R. Williams.

Jana Lynn Marcum
Commission expiration: 04/11/2026

JANA LYNN MARCUM
NOTARY
ID #KYNP48965
MY COMMISSION EXPIRES 04/11/2026
PUBLIC
STATE AT LARGE, KENTUCKY

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF	)	
TAYLOR COUNTY RURAL ELECTRIC	)	**Case No. 2023-000147**
COOPERATIVE CORPORATION FOR	)	
A GENERAL ADJUSTMENT OF RATES	)	

VERIFICATION OF PATSY WALTERS

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF TAYLOR)

Patsy Walters, Manager, Finance and Accounting of Taylor County Rural Electric Cooperative Corporation, being duly sworn, states that she has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above referenced case on behalf of Taylor County Rural Electric Cooperative Corporation, and that the matters and things set forth therein are true and accurate to the best of her knowledge, information and belief, formed after reasonable inquiry.

Patsy Walters

Patsy Walters

The foregoing Verification was signed, acknowledged and sworn to before me this 14th day of June, 2023, by Patsy Walters.

Jessica Figueroa

Commission expiration: 5-20-27

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF	)	
TAYLOR COUNTY RURAL ELECTRIC	)	**Case No. 2023-000147**
COOPERATIVE CORPORATION FOR	)	
A GENERAL ADJUSTMENT OF RATES	)	

VERIFICATION OF JOHN WOLFRAM

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JEFFERSON)

John Wolfram, Principal, Catalyst Consulting LLC, being duly sworn, states that he has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above referenced case on behalf of Taylor County Rural Electric Cooperative Corporation, and that the matters and things set forth therein are true and accurate to the best of his knowledge, information and belief, formed after reasonable inquiry.

John Wolfram

The foregoing Verification was signed, acknowledged and sworn to before me this 14th day of June, 2023, by John Wolfram.

Destiny Henson

Commission expiration: _____

DESTINY ANN HENSON
Notary Public - State at Large
Kentucky
My Commission Expires Oct. 25, 2026
Notary ID KYNP61142

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 1
RESPONSIBLE PARTY: Patsy Walters

Request 1. Provide the following expense account data:

a. A schedule, in comparative form, showing the operating expense account balance for the test year and each of the three most recent calendar years for each account or subaccount included in Taylor RECC'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 Taylor RECC 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 1a. Please see attached. The attachment is an Excel spreadsheet and is being uploaded into the Commission's electronic filing system separately.

Response 1b. Taylor County provides the following summary of significant activities, initiatives, or programs undertaken or continued since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities. While there were other activities, initiatives, and programs undertaken, it is not possible to reasonably estimate the dollar impact of such actions.

1. The Board voted in 2018 and the union agreed to change the employee health insurance from a "Cadillac" plan to a high deductible health plan. This resulted in estimated cost savings of $313,000 annually.
2. New ways for members to pay their electric bill have been introduced through our mobile app and website, controlling manning needs in our member service areas.
3. Two employees in our Meter Department retired and we opted not to fill those positions. This created an annual savings of approximately $195,000.
4. Prepaid Metering Program was implemented in 2021. The use of remote collars allowed for better staff efficiency, saving on both staff time and transportation costs. Estimated annual savings are $209,000.
5. Taylor County was approved for a Sample Meter Testing Program in 2021. The potential savings over an eight year period should be $691,707.
6. Taylor County applied for the SBA/PPP Loan in 2020 in the amount of $882,873.52. The loan was forgiven enabling the cooperative to recover up to 8 weeks of payroll costs including benefits.
7. Overall, Taylor County operates on a lean workforce for both inside and outside.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

PSC CASE NO. 2023-00147

RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23

REQUEST 2

RESPONSIBLE PARTY: Patsy Walters

Request 2. Provide the capital structure at the end of the five most recent calendar years and each of the other periods shown in Schedule A1 and Schedule A2.

Response 2. Please see attached. The attachments are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 3
RESPONSIBLE PARTY: Patsy Walters

Request 3. 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 B1.

b. An analysis of short-term debt as shown in Schedule B2 as of the end of the latest calendar year.

Response 3a. Please see attached schedules showing long-term debt for the latest calendar year and the test year. The attachments are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

Response 3b. Taylor County RECC did not have any short-term debt at the end of the latest calendar year. Please see attached schedule showing short-term debt for the test year.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 4
RESPONSIBLE PARTY: Patsy Walters

Request 4. Provide Taylor RECC's internal accounting manuals, directives, and policies and procedures.

Response 4. Please see attached RUS Bulletin 1717B-2 "Guide for Preparing Financial and Statistical Reports for Electric Distribution Borrowers". Also reference the Audited Financial Statements provided as Exhibit 17 to the Application for a summary of significant accounting policies.

UNITED STATES DEPARTMENT OF AGRICULTURE
Rural Utilities Service

BULLETIN 1717B-2

RD-GD-2002-45

SUBJECT: Guide for Preparing Financial and Statistical Reports for Electric Distribution Borrowers

TO: All Electric Distribution Borrowers

EFFECTIVE DATE: Date of approval.

OFFICE OF PRIMARY INTEREST: Assistant Administrator, Electric Program.

FILING INSTRUCTIONS: This bulletin replaces RUS Bulletin 1717B-2, "Guide for Preparing Financial and Statistical Reports for Electric Distribution Borrowers," dated December 31, 1993. Suggestion to borrowers: Distribute copies of this bulletin to all units responsible for elements of the report.

This Bulletin is also available on the RUS Data Collection System Website at http://dcs.usda.gov.

PURPOSE: To provide instructions to all electric distribution borrowers required to submit operating reports to RUS. These instructions implement reporting requirements in the borrower's loan contract with RUS and the laws and regulations that authorize RUS to collect this information. The guidance provided in this bulletin corresponds to the completion of a paper Form 7 and 7a. The RUS Data Collection System Website contains instructions for completion of the electronic form.

Blaine D. Stockton
Assistant Administrator
Electric Program

2/14/02
Date

INSTRUCTIONS FOR THE PREPARATION OF THE FINANCIAL AND STATISTICAL REPORT

TABLE OF CONTENTS

ACRONYMS

CBO	Certificates of Beneficial Ownership
CD	Certificate of Deposit
CFC	National Rural Utilities Cooperative Finance Corporation
CL	Capital Leases
CATS	Certificates of Accrual on Treasury Securities
CTC	Capital Term Certificates
DCS	Data Collection System
ERC	Energy Resources Conservation
FCSFAC	Farm Credit System Finance Assistance Corporation
FDIC	Federal Deposit Insurance Corporation

ACRONYMS
(continued)

FERC	Federal Energy Regulatory Commission
FFB	Federal Financing Bank
FICO	Financing Corporation
FHLB	Federal Home Loan Banks
FHLMC	Federal Home Loan Mortgage Corporation or Freddie Mac
FmHA	Farmers Home Administration
FNMA	Federal National Mortgage Association or Fannie Mae
G&T	Generation and Transmission borrower
GNMA	Government National Mortgage Association, Ginnie Mae, or Ginnies
GSA	General Services Administration
NOW	Negotiable Order of Withdrawal
NRUCFC	National Rural Utilities Cooperative Finance Corporation
REFCORP	Resolution Funding Corporation
REIT	Real Estate Investment Trusts
RUS	Rural Utilities Service
SBA	Small Business Administration
Sallie Mae	Student Loan Marketing Association
TIGERS	Training Investment Growth Receipts
TVA	Tennessee Valley Authority
WMATA	Washington Metropolitan Area Transit Authority

1. REQUIREMENTS

The Rural Utilities Service's (RUS) requirements regarding the submission of financial and statistical reports by electric distribution borrowers are contained in the loan contract. Also, RUS's reporting requirements are codified in 7 CFR Parts 1710 and 1717.

2. REPORTS

2.1 The preparation of a monthly financial and statistical report aids a borrower's management in effectively operating and controlling the business.

2.2 As an aid to borrowers in developing and submitting operating information on a uniform basis, RUS furnishes a prescribed report form to be used by electric distribution borrowers. An original and one copy of RUS Form 7, pages 1 through 5, and Form 7a, Pages 1 and 2, should be submitted to RUS annually by March 1 for the period ending December 31. Quarterly reports (RUS Form 7, pages 1 and 2) are requested when a deficit exists in the prior year's operations. In addition, individual borrowers may be requested by RUS to submit RUS Form 7 (pages 1 and 2) monthly.

2.3 If after the filing of RUS Form 7 and 7a for December 31, major adjustments in the accounts are made which significantly affect the operating statement for the year, the balance sheet, or key financial ratios, revised reports reflecting these adjustments should be submitted to RUS promptly.

2.4 Sample copies of the revised report forms are attached to this guide. A supply of these forms will be furnished to borrowers not using the Data Collection System (DCS) system, upon request.

2.5 Distribution borrowers having generating facilities shall continue to submit reports on the operation of such facilities in accordance with the current instructions set forth in RUS Bulletin 1717B-3, in addition to the RUS Form 7 and 7a.

2.6 Timely reporting not only permits RUS to fulfill its reporting obligations, but helps the borrower have data promptly for effective management. It is strongly urged that attention be given to organizing your operations so that required reports will be submitted on time.

3. GENERAL

The "Financial and Statistical Report" makes available to RUS information for analyses in connection with the security of Government loan funds. It is believed that this report, when supplemented by such additional information as may be desired by an individual borrower, will also be of great assistance to boards of directors and managers of the system in successfully coping with various management problems.

The report provides RUS with sufficient information to prepare an annual financial and statistical report of all RUS borrowers' electric operations. RUS provides the Federal Energy Regulatory Commission (FERC) with a copy of the RUS statistical report. Thus, most borrowers are not required to submit individual reports to FERC.

The reports prepared by borrowers must accurately reflect the financial data as shown by the books of account, and should be prepared in accordance with the detailed instructions contained in this manual. Maximum benefits can be derived from the monthly and annual report only when they are correctly prepared. Careful preparation of the report also eliminates additional correspondence. After the report has been prepared and typed, it should be carefully reviewed and verified for both clerical and/or typographical errors. Accounts referenced: RUS Uniform System of Accounts - Electric (7 CFR 1767, subpart B, and RUS Bulletin 1767B-1).

These instructions and report forms do not apply to power supply borrowers.

4. SPECIFIC INSTRUCTIONS

4.1 The "Financial and Statistical Report," RUS Form 7, Pages 1 through 5, and Form 7a, "Investments, Loan Guarantees and Loans - Distribution," are composed as follows:

Form 7

Part A. Statement of Operations
Part B. Data on Transmission and Distribution Plant
Part C. Balance Sheet
Part D. Notes to Financial Statements
Part E. Changes in Utility Plant
Part F. Materials and Supplies
Part G. Service Interruptions
Part H. Employee - Hour and Payroll Statistics
Part I. Patronage Capital
Part J. Due From Consumers for Electric Service
Part K. kWh Purchased and Total Cost
Part L. Long-Term Leases
Part M. Annual Meeting and Board Data
Part N. Long-Term Debt and Debt Service Requirements
Part O. Power Requirements Data Base – Annual Summary

Form 7a
Part I. Investments
Part II. Loan Guarantees
Part III. Ratio
Part IV. Loans

4.2 The following system is used in this guide for reference to items reported on RUS Forms 7 and 7a:

A capital letter designates the part, a number designates the item or line number, and a lower case letter designates the column. Example: A15d indicates Part A, Item 15, Column d.

4.3 "Red" (or negative) figures on the report should be indicated by enclosing the amount in parentheses (--). Do not use parentheses to indicate that an amount is to be deducted when the format provides for the deduction to be made. Example: The entry for Form 7 - C4 should not be enclosed with parentheses as Net Utility Plant is to be determined by subtracting line 4 from line 3.

4.4 A column for "Budget" has been provided on RUS Form 7, Page 1, Part A, "Statement of Operations," for the convenience of borrowers. When used, this should consist of the cumulative monthly figures taken from the previously prepared annual budget. A budget is a plan for future guidance of the business in which probable revenue and expense is estimated and allocated. If there is a substantial difference between the budget item and the actual, it would be appropriate to make an analysis of operations to determine if remedial action is needed. While reporting of the "Budget" information is optional, RUS may require borrowers to report budget information on a case-by-case basis.

4.5 Much care should be exercised in the insertion of the statistical data required by the report, particularly that which cannot be verified on the report.

4.6 Borrowers should report all amounts to the "nearest dollar" and eliminate the cents. All totals and subtotals should be the sums of the rounded figures used.

EXHIBIT A
SPECIFIC INSTRUCTIONS FOR RUS FORM 7
FINANCIAL AND STATISTICAL REPORT

PART A, STATEMENT OF OPERATIONS

Column

a **Last Year**
This column reflects cumulative annual totals through the month covered by the report, entries for which should be obtained from Column b of this same part (RUS Form 7, Part A) of the operating report for the corresponding month of the prior year.

b **This Year**
Cumulative annual totals are also reflected in this column, entries for which should be obtained from the year-to-date totals of the general ledger trial balance for the corresponding month.

c **Budget (Optional)**
Entries for this column should be obtained from the operating budget using cumulative annual totals for the corresponding month.

d **This Month**
Entries for this column should be obtained from the monthly totals of the general ledger trial balance of the appropriate accounts for the month involved.

Item No.

1 **Operating Revenue and Patronage Capital**
The entry for Column b is obtained by adding Part O, Items 12 and 13 of the "Total Year to Date" column.

2 **Power Production Expense**
Accounts 500 through 554

3 **Cost of Purchased Power**
Accounts 555, 556, and 557

4 **Transmission Expense**
Accounts 560 through 573

5 **Distribution Expense - Operation**
Accounts 580 through 589

Item No. (continued)

6 **Distribution Expense - Maintenance**
Accounts 590 through 598

7 **Customer Accounts Expense**
Accounts 901 through 905

8 **Customer Service and Informational Expense**
Accounts 907 through 910

9 **Sales Expense**
Accounts 911 through 916

10 **Administrative and General Expense**
Accounts 920 through 931 and 935

11 **Total Operation and Maintenance Expense**
Total of Items 2 through 10

12 **Depreciation and Amortization Expense**
Accounts 403.1 through 403.7 and 404 through 407 (including 407.3 & 407.4)

13 **Tax Expense - Property and Gross Receipts**
Account 408.1 and 408.6. Some States have enacted laws providing for payments in lieu of property taxes. These taxes should be reported as "Tax Expense - Property and Gross Receipts."

14 **Tax Expense - Other**
All subaccounts of Accounts 408, except 408.1 and 408.6 plus Accounts 409.1, 410.1, 411.1, 411.4 and 420

15 **Interest on Long-Term Debt**
Account 427. Do not include any interest earned on Balance of Advance Payments. It is non-operating income, item 21.

16 **Interest Charged to Construction - Credit**
Account 427.3

17 **Interest Expense - Other**
Account 431

18 **Other Deductions**
Accounts 409.2, 410.2, 411.2, 411.5, 411.6, 411.7, 411.8, 411.9, 425, 426.1 through 426.5, 428, 428.1, 429, 429.1 and 430

Item No. (continued)

19 **Total Cost of Electric Service**
Total of Items 11 through 18

20 **Patronage Capital and Operating Margins**
Item 1 minus Item 19

21 **Non-Operating Margins - Interest**
Account 419 and 432. Include interest earned on Balance of Advance Payments, if any.

22 **Allowance for Funds Used During Construction**
Account 419.1

23 **Income (Loss) from Equity Investment**
Account 418.1 plus the amounts recorded in Account 421 relating to the income or loss from investments recorded on the equity method of accounting for investments.

24 **Non-Operating Margins - Other**
Net total of Accounts 415, 417, 418, 421, 421.1, less Accounts 416, 417.1, 421.2, and 422

25 **Generation and Transmission Capital Credits**
Account 423

26 **Other Capital Credits and Patronage Dividends**
Account 424

27 **Extraordinary Items**
Net total of Accounts 409.3 plus 434 minus 435 plus or minus 435.1

28 **Patronage Capital or Margins**
Total of Items 20 through 27

PART B, DATA ON TRANSMISSION AND DISTRIBUTION PLANT

All entries for Column a should be obtained from Column b of this part of the Operating Report for the prior year.

Item No.

1 **New Services Connected**
In Column b insert the total of all new individual services connected this year to date. The data should include new construction and exclude connections to new consumers on previously connected services.

2 **Services Retired**
In Column b place the number of all individual service installations physically removed during the year.

3 **Total Services in Place**
In Column b insert the number of services as of the end of the reporting period. (Report all services in place whether or not they are in use.)

4 **Idle Services (Exclude Seasonals)**
The number of idle services in Column b should be the total number of delivery points to which service wires remain physically in place but for which no bill is being rendered. Seasonal consumers or patrons paying a nominal sum for the retention in place of idle facilities should be excluded from the count of idle services.

5 **Miles Transmission**
Mileage in Column b represents the total pole line miles of transmission line that have been energized. A transmission line is a line serving as a source of supply to a point where the voltage is transformed to a voltage used for distribution purposes.

6 **Miles Distribution - Overhead**
Mileage in Column b represents the present total overhead pole line miles that have been energized. Distribution lines are those which deliver electric energy from the substation or metering point to the point of attachment to the consumers' wiring and include primary, secondary, and service facilities.

7 **Miles Distribution - Underground**
Mileage in Column b represents the total underground line miles of distribution lines (primary, secondary, and services) that have been energized.

8 **Total Miles Energized**
Sum of Items 5, 6, and 7

Note: (1) Underbuild in overhead lines or joint runs in underground installations do not increase the number of line miles except for distribution underbuild on transmission poles. In such cases, distribution pole line miles would be increased by the number of underbuild miles involved.

PART C, BALANCE SHEET

Assets and Other Debits

Item No.

1 **Total Utility Plant in Service**
Accounts 101 (total of Accounts 301 through 399), 101.1, 102 through 106, 114, 116, 118, and 120.1 through 120.6

2 **Construction Work in Progress**
All subaccounts of Account 107

3 **Total Utility Plant**
Sum of Items 1 and 2

4 **Accumulated Provision for Depreciation and Amortization**
All subaccounts of Account 108, and Accounts 111, 115, and 119

5 **Net Utility Plant**
Item 3 less Item 4

6 **Non-Utility Property (Net)**
Account 121 less Account 122

7 **Investments in Subsidiary Companies**
Account 123.11

8 **Investments in Associated Organizations - Patronage Capital**
Account 123.1

9 **Investments in Associated Organizations - Other - General Funds**
The amount of the investments recorded in Accounts 123.22 and 123.23 as provided for in 7 CFR 1717, Subpart N, Investments, Loans, and Guarantees by Electric Borrowers.

Item No. (continued)

10 **Investments in Associated Organizations - Other - Nongeneral Funds**
The amount of the investments in Accounts 123.22 and 123.23. The following are classified as such investments:

(1) All National Rural Cooperative Finance Corporation (CFC) – Capital Term Certificates (CTC) except those purchased more than 24 months in advance of their due date.

(2) Investments which have been specifically excluded by the Administrator or his designated representative.

(Note: The above investments are nongeneral fund items regardless of the account in which they are reported. However, the only excludable investments to be reported, for Item 10 are those which are reported in Accounts 123.22 or 123.23. The sum of the amounts reported for Items 9 and 10 should equal the sum of the balances in Accounts 123.22 and 123.23.)

11 **Investments In Economic Development Projects**
Report investments in Economic Development Projects recorded in accounts 123, Investments in Associated Organizations, and 124, Other Investments. (Note: These Economic Development investment amounts should not be reported on any other line of the Balance Sheet.)

12 **Other Investments**
Report amount in Account 124 not related to Economic Development Projects included in Item 11.

13 **Special Funds**
Accounts 125 through 128

14 **Total Other Property and Investments**
Total of Items 6 through 13

15 **Cash - General Funds**
Accounts 131.1, 131.12, 131.13, 131.14, and 135. Item 46, "Accounts Payable," should be utilized for checks written and not paid as of the date of this report.

16 **Cash - Construction Funds - Trustee**
Accounts 131.2 and 131.3. Item 46, "Accounts Payable," must be credited for checks written and not paid as of the date of this report.

17 **Special Deposits**
Accounts 132 through 134

Item No. (continued)

18 **Temporary Investments**
Account 136

19 **Notes Receivable (Net)**
Account 141 and 145 less Account 141.1

20 **Accounts Receivable - Sales of Energy (Net)**
Account 142.1 less Account 144.1

21 **Accounts Receivable - Other (Net)**
Accounts 142.2, 143 and 146 less Accounts 144.2 through 144.4

22 **Materials and Supplies - Electric and Other**
Accounts 151 through 157, 158.1, 158.2 and 163

23 **Prepayments**
Accounts 165.1 and 165.2

24 **Other Current and Accrued Assets**
Accounts 171 through 174

25 **Total Current and Accrued Assets**
Total of Items 15 through 24

26 **Regulatory Assets**
Accounts 182.2 and 182.3

27 **Other Deferred Debits**
Accounts 181 through 190, except 182.2 and 182.3

28 **Total Assets and Other Debits**
Total of Items 5, 14, 25 through 27

Liabilities and Other Credits

Item No.

29 **Memberships**
Accounts 200.1 and 200.2

30 **Patronage Capital**
Accounts 201.1 and 201.2

Item No. (continued)

31 **Operating Margins - Prior Years**
Account 219.1 and Account 219.4 when it applies to operating margins.

32 **Operating Margins - Current Year**
Total of Items 20, 25, 26, and the portion of Line 27 that relates to operating margins of the current RUS Form 7, Part A, Column b less that portion of current year margins transferred from Account 219.1 to Account 201.2 and included in the amount reported for Line 28, "Patronage Capital or Margins."

33 **Non-Operating Margins**
Total of Account 219.2 plus Account 219.4 when it applies to non-operating margins, and Items 21, 22, 23, 24, and the portion of Line 27 that relates to non-operating margins, of the current RUS Form 7, Part A, Column b.

34 **Other Margins and Equities**
Total of Accounts 208, 211, 215, 216.1, 217, 218, and 219.3

35 **Total Margins and Equities**
Total of Items 29 through 34.

36 **Long-Term Debt - RUS (Net)**
Accounts 224.1, 224.3, 224.5, 224.7 and 224.9 less Accounts 224.2, 224.4, 224.6, 224.8, and 224.10; also enter the amount of Account 224.6 in the space for "Payments-Unapplied." Report only the long-term portion of the debt under this item. The current portion of the debt (due within one year) should be reported on item 48.

37 **Long-Term Debt - RUS - Economic Development (Net)**
Report amounts recorded in accounts 224.16, Long-Term Debt - Economic Development Notes Executed, less 224.17, RUS Notes Executed - Economic Development - Debit. Report only the long-term portion of the debt under this item. The current portion of the debt (due within one year) should be reported on item 49.

38 **Long-Term Debt – FFB – RUS Guaranteed**
Report amounts recorded in accounts 224.14 less 224.15 that relate to FFB loans. Report only the long-term portion of the debt under this item. The current portion of the debt (due within one year) should be reported on item 48.

39 **Long-Term Debt - Other - RUS Guaranteed**
Report amounts recorded in accounts 224.11, 224.12, 224.14, 225, 226 less Accounts 123.21, 224.13 and 224.15 pertaining to Non-FFB debt whose repayment is guaranteed by RUS. Report only the long-term portion of the debt under this item. The current portion of the debt (due within one year) should be reported on item 48.

Item No. (continued)

40 **Long-Term Debt - Other (Net)**
Report amounts in Accounts 221, 222, 223, 224.11, 224.12, 224.14, 225, 226 less 123.21, 224.13 and 224.15 pertaining to debt whose repayment is NOT guaranteed by RUS. Report only the long-term portion of the debt under this item. The current portion of the debt (due within one year) should be reported on item 48.

41 **Total Long-Term Debt**
Total of Items 36 through 40.

42 **Obligations Under Capital Leases - Noncurrent**
Account 227

43 **Accumulated Operating Provisions**
Accounts 228.1 through 228.4, and 229. Note: If the cumulative amount recorded in Account 228 is a debit balance, the amount should be reported on Line 12, Other Investments.

44 **Total Other Noncurrent Liabilities**
Sum of items 42 and 43

45 **Notes Payable**
Accounts 231 and 233

46 **Accounts Payable**
Accounts 232.1, 232.2, 232.3 and 234.

47 **Consumers Deposits**
Account 235

48 **Current Maturities Long-Term Debt**
Report amounts due within one year of the obligations reported on items 36, 38, 39 and 40.

49 **Current Maturities Long-Term Debt – Economic Development**
Report amounts due within one year of the obligations reported on item 37.

50 **Current Maturities – Capital Leases**
Account 243

51 **Other Current and Accrued Liabilities**
Accounts 236.1 through 236.7, 237, 238.1, 238.2, 239, 240, 241, and 242.1 through 242.5

52 **Total Current and Accrued Liabilities**
Total of Items 45 through 51

53 **Regulatory Liabilities**
Account 254

54 **Other Deferred Credits**
Accounts 252, 253, 253.1, 255, 256, 257, 281, 282, and 283

55 **Total Liabilities and Other Credits**
Total of Items 35, 41, 44, and 52 through 54

PARTS D, NOTES TO FINANCIAL STATEMENTS

Part D provides space for important disclosure notes to the financial statements not included in other parts of this form.

A partial checklist of these disclosure notes is as follows:

Prepaid or deferred charges that are being amortized for a period exceeding 12 months.

Capital leases for lessee; sales or financing leases for lessor.

Unbilled revenue -- Report of the amount not billed to consumers for which kWhs have been consumed. Please state if this amount is or is not included in Part C, line 20.

Accounting changes.

Contingent Assets and Liabilities

Deferred compensation\Pension plans -- employers.

Deferred Debits or Credits, and Extraordinary Items.

Margin Stabilization Plans.

Short-term obligations expected to be refinanced.

Deferred credits that are being amortized for a period exceeding 12 months.

Related party transactions.

PART E, CHANGES IN UTILITY PLANT

Item No.

1 **Distribution Plant**
Accounts 360 through 373

2 **General Plant**
Accounts 391 through 399.

3 **Headquarters Plant**
Accounts 389 through 390.

4 **Intangibles**
Accounts 301, 302, and 303

5 **Transmission Plant**
Accounts 350 through 359

6 **All Other Utility Plant**
Accounts 101.1, 102 through 106, 114, 116, 118, 120.1 through 120.6, and 310 through 346.

7 **Total Utility Plant in Service**
Total of Items 1 through 6. Amount in column e should agree with Part C, Item 1.

8 **Construction Work in Progress**
Account 107. Amount in column e should agree with Part C, Item 2.

9 **TOTAL UTILITY PLANT**
Total of Items 7 and 8. Amount in column e should agree with Part C, Item 3.

Column

a **Balance Beginning of Year**
The balances in this column for each item should be the same as shown in "Balance End of Year" column of the previous years' report.

Column (continued)

b **Additions**

This column should show the additions to plant during the year including any corrections for additions for the current or preceding year for each item. The amount of the additions should be net cost (gross cost less contributions in aid of construction credited to the plant accounts). Include in this column transfers involving Account 103, "Experimental Electric Plant Unclassified," Account 106, "Completed Construction Not Classified - Electric," and Account 107,"Construction Work in Progress - Electric," made to close the record for items in these accounts. A credit will be shown in this column for Accounts 103, 106, and 107 if the "Balance End of Year" in either Accounts 103, 106, or 107 is less than "Balance Beginning of Year." Any amount paid for electric plant purchased during the year should be shown in Column b.

c **Retirements**

This column should show the value of physical retirements for each item of plant made during the year including any corrections for retirements for the current or preceding year. Any amount received during the year for electric plant sold should be shown in Column c. Do not include contributions in aid of construction in this account. See instructions for Column b above.

d **Adjustments and Transfers**

Include in this column:

1. Transfers between utility plant purchased or sold and the utility plant in service accounts.

2. Transfers between utility plant in service accounts and utility plant leased to others.

3. Transfers between utility plant in service accounts and utility plant held for future use.

4. Reclassifications or transfers within the utility plant in service accounts.

Do not include corrections of additions and retirements for the current or preceding year in this column. (These should be shown in Column b or Column c, respectively.) Do not include transfers from Account 107 to 106, or 106 to the electric plant in service accounts. (These are to be shown in Column b.)

Ordinarily, this column should total to zero. However, when utility plant purchased is transferred to the utility plant in service accounts, a difference will occur because of the accumulated provision for depreciation. When the utility plant in service accounts are credited with utility plant sold, a difference will develop. This is because of the adjustment to the accumulated provision for depreciation and the gain or loss.

Column (continued)

e **Balance End of Year**
These balances should be determined at year-end directly from the accounts. Each item and column total should be verified to see that "Balance Beginning of Year" plus "Additions" minus "Retirements" and plus or minus "Adjustments and Transfers" equal "Balance End of Year." The amount for Item 8 should agree with RUS Form 7, Part C, Item 2. The amount for Item 9 should agree with RUS Form 7, Part C, Item 3.

PART F, MATERIALS AND SUPPLIES

Item No.

1 **Electric**

Column a: Enter the total of the balances in Accounts 151 through 154 and 163 at the end of the previous year.

Column b: Enter the total of materials purchased during the year and recorded in Accounts 151, 152, and 154, plus net additions to Accounts 153 and 163 excluding inventory adjustments which are to be reported in Column f.

Column c: Enter the amount of the materials returned to stores from retirement of plant during the year.

Column d: Enter the net amount of materials used during the year (materials charged out less materials returned to stores). Include stores expense assigned to those materials. Do not include credits for inventory adjustments that are to be reported in Column f.

Column e: Enter the amount of all materials and supplies sold during the year.

Column f: Enter the net amount of inventory adjustments (shortages, overages, and breakage) made during the year.

Column g: Enter the total of the balances in Accounts 151 through 154 and 163 as of the end of the year.

2 **Other**
Enter in Column a the total of Accounts 155, 156, 157, 158.1, and 158.2 at the end of the previous year. Enter in Column b the amount of other purchases (at cost) for the year. Enter in Column c any trade-in merchandise or other material put into stock. Enter in Column d any merchandise or other materials taken from stock for the cooperative's use. Enter in Column e all merchandise and other material sold during the year. Enter in Column f any adjustments (net) for shortages, overages, breakage, etc. Enter in

Column g the total of the balances in Accounts 155, 156, 157, 158.1, and 158.2 on December 31 (Note: Columns a plus b and c, less d and e, plus or minus f, as appropriate, equal Column g).

PART G, SERVICE INTERRUPTIONS

The importance and manner of measuring and reporting continuity of service is described in RUS Bulletin 161-1. This bulletin provides for coding of causes that fit the four classifications shown in this part.

Average hours interruptions per consumer are obtained by multiplying the time of each interruption by the number of consumers affected and dividing by the average number of consumers receiving service.

Column

a **Power Supplier**
Enter in this column the average interruption hours per consumer resulting from failure of the power supplier's facilities.

b **Extreme Storm**
It is intended that this column exclude common or expected weather conditions and include extreme weather conditions resulting in extraordinary interruption time and equipment damage. Usually there is a series of concurrent interruptions resulting from conditions that exceed design assumptions.

c **Prearranged**
This column includes service interruptions caused by a decision to de-energize all or part of the system.

d **All Other**
Include in this column all service interruptions not included in Columns a, b, and c.

e **Total**
This column represents the sum of all causes, and represents either the average interruption hours per consumer for the current year (Item 1), or the average for 5 years (Item 2).

Item No.

1 **Present Year**
Enter data for the current year in the appropriate column.

2 **Five Year Average**

Enter data for the most recent 5 years including the current year. In the event that statistics are not available for a full previous 5 years, use the best estimate possible until actual figures become available

PART H, EMPLOYEE - HOUR AND PAYROLL STATISTICS

The object of this part is to obtain statistics on all work performed for the borrower by the cooperative's employees based on payroll records.

Item No.

1 **Number of Full-Time Employees**
The number reported should be the number of employees hired full-time for normal operations of the system. It should not include employees added to do emergency work, employees added for seasonal employment, or for special assignments. If an employee works for the first 6 months of the year, quits in July, and is replaced immediately or later by another employee, these two employees should be reported as one full-time employee.

2 **Employee-Hours Worked - Regular Time**
Report the total number of employee-hours worked for which the employees received a regular rate of pay. Include all employees both salaried and those paid by the hour. All leave with pay is to be counted as hours worked. All leave without pay is not to be counted.

3 **Employee-Hours Worked - Overtime**
Report the total number of employee-hours worked for which a premium rate of pay was received by the employee.

4 **Payroll - Expensed**
Enter the amount of payroll that was charged to the operation and maintenance expense accounts (Accounts 500 through 598 and 901 through 931 and 935) during the year.

5 **Payroll - Capitalized**
Enter the amount of payroll that was used in construction and retirement work (all payroll charged to Accounts 107.1 through 107.3, 108.8, plus all payroll directly charged to the plant Accounts 301 through 399).

6 **Payroll - Other**
Enter the amount of payroll that was not included in Items 4 and 5.

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Exhibit A
Page 22

PART I, PATRONAGE CAPITAL

Item No.

1 Capital Credits Distributions

a. General Retirements

Column (a) - This Year
Enter the total of those retirements made during the current year that covered a specific period or a specific percentage of a period. See Item 1b(a) for additional instructions.

Column (b) - Cumulative
This entry should be determined in accordance with the instructions from Item la except that the period covered is from inception through and including the current year. It also may be determined by using the balance for this item for the prior year and adding the entry in Item 1a(a) for the current year.

b. Special Retirements

Column (a) - This Year
Enter the total of those retirements made during the current (reported) year, such as estate settlements (Note: The total of the entries in Items 1 and 2 in column a should equal total patronage capital retirements for the year).

Column (b) - Cumulative
The entry should be determined in accordance with the instructions for Item 2a except the period covered is from inception through and including the current year. It also may be determined by using the balances for this item for the prior year and adding the entry in Item 2a for the current year.

c. Total Retirements

Column (a) - This Year
Enter total of 1a and 2a

Column (b) - Cumulative
Enter total of 1b and 2b

2 Capital Credits Received

a. Cash Received From Retirement of Patronage Capital by Suppliers of Electric Power

Column (a) - This Year
Self-explanatory

b. Cash Received From Retirement of Patronage Capital by Lenders for Credit Extended to the Electric System
Column (a) - This Year
Self-explanatory

c. Total Cash Received
Column (a) - This Year
Enter total of 2a and 2b

PART J, DUE FROM CONSUMERS FOR ELECTRIC SERVICE

Item No.

1 Amount Due Over 60 Days
Include both connected and disconnected consumers.

2 Amount Written Off During Year
Include total charges during the current year to Account 144.1 representing the write-off of uncollectible accounts.

PART K, kWh PURCHASED AND TOTAL COST

Enter in Column a the name of each wholesale power supplier from which power was purchased for resale. Column b is for RUS use only. Enter in Column c the total kWh purchased from each supplier. Enter in Column d the total cost of power from each supplier. This shall include energy, demand, wheeling and other charges associated with the power purchased from each supplier. Enter in Column e the average cost per kWh purchased (in cents). This calculation is made by dividing Column d by Column c.

When the power bill includes charges or credits for items other than charges for demand and energy, such as fuel cost adjustments, wheeling, equipment rentals, taxes, etc., the amounts thereof should be determined and entered in Column f or g as appropriate.

PART L, LONG-TERM LEASES

Report in this part by lessor, the type of property, and the amount of rental for the year (accrued or paid) on all restricted property that the borrower holds under long-term lease from other parties.

Restricted Rentals as defined in 7 CFR Part 1718, Subpart B, “Mortgage for Distribution Borrowers,” shall mean all rentals required to be paid under finance leases and charged to income, exclusive of any amounts paid under any such lease (whether or not designated therein as rental or additional rental) for maintenance or repairs, insurance, taxes, assessments, water

rates or similar charges. For the purpose of this definition the term ‘‘finance lease’’ shall mean any lease having a rental term (including the term for which such lease may be renewed or extended at the option of the lessee) in excess of 3 years and covering property having an initial cost in excess of $250,000 other than aircraft, ships, barges, automobiles, trucks, trailers, rolling stock and vehicles; office, garage and warehouse space; office equipment and computers. Long-Term Lease as defined in 7 CFR Part 1718, Subpart B, “Mortgage for Distribution Borrowers,” shall mean a lease having an unexpired term (taking into account terms of renewal at the option of the lessor, whether or not such lease has previously been renewed) of more than 12 months.

General plant is not to be included in the data to be reported in this part. Leases accounted for as capital leases (CL), the cost of which is included in utility (or non-utility) plant, should also be disclosed here with proper additional information included in Part D, "Notes to Financial Statements," and Part N, "Long-Term Debt and Debt Service Requirements." Identify these leases by placing "(CL)" following the name of the lessor.

PART M, ANNUAL MEETING AND BOARD DATA

Item No.

1 Date of Last Annual Meeting
Use date scheduled even if no legal meeting was held. If such is the case, so state.

2 Total Number of Members
The number of members in the cooperative that are eligible to vote is to be reported in this block. This number is to be determined on the basis of one vote to one member. It will customarily be less than the number of billed consumers as usually some members are billed for more than one account. If exact figures are not available, enter best estimate and use asterisk (*) to show the figure is an estimate.

3 Number of Members Present at Meeting
Report number of members present in person as determined by registration or votes cast. Only report persons eligible to vote. Do not report total number of persons in attendance.

4 Was Quorum Present?
A "yes" or "no" answer is sufficient.

5 Number of Members Voting by Proxy or Mail
Report the number of absentee ballots cast. Include both proxy votes and absentee votes. If none, so state.

6 Total Number of Board Members
List number on board when all vacancies are filled.

Item No. (continued)

7 **Total Amount of Fees and Expenses for Board Members**
Include all fees, expenses, and per diem paid to board members for all purposes during the current year, including attendance at board meetings, training seminars, delegated board business, association meetings, amounts paid for insurance, and other expenses directly associated with individual board members.

8 **Does Manager Have Written Contract?**
A "yes" or "no" answer is requested.

PART N, LONG-TERM DEBT AND DEBT SERVICE REQUIREMENTS

This section is to be prepared by all borrowers that list an amount on line 36 through 40 plus line 42 of Part C, RUS Form 7. Report all loans made to the utility system here. Loans made by the reporting utility system to others (e.g., economic development loans to finance local projects) should not be reported in this part of the report. Part N, line 12a, Total, should match the sum of the amount reported on line 41, "Total Long-Term Debt," plus the sum of the amount reported on line 42, “Obligations Under Capital Leases - Noncurrent, Part C, Balance Sheet.

Item No.

1-11 Enter required data for each lender. List each lender separately. Include all types of long-term obligations including long-term lease obligations (capital) as reported on lines 36, 37, 38, 39, 40, and 42, Part C, Balance Sheet.

12 Enter the total of Items 1 through 11 for each column.

Column

a **Balance End of Year**
Enter the outstanding long-term debt balance for each lender.

b **Interest**
Enter the sum of the amount for current interest billed during the year by each lender. This amount includes interest charged to construction as well as interest charged to expense. Do not deduct the interest earned on Balance of Advance Payments accounts.

c **Principal**
Enter the sum of the amounts billed for principal during the year by each lender. If a portion of the principal amount is being refinanced (e.g., the proceeds from a RUS or RUS-guaranteed loan are used to pay off a CFC intermediate-term construction loan), that amount should not be included in this column as part of the principal billed. The

principal amount being refinanced, however, should be asterisked and the refinanced portion should be shown under Part D, "Notes to Financial Statements."

Do not include in Columns b and c amounts billed that are applicable to another year's transaction such as billings for past due accounts, note assumptions, etc.

Amounts reported in Columns b and c should include billings due for payment by the end of the year. If a billing was not received for such a payment, the amount that will be billed should be estimated and included as part of the amounts reported in these columns.

d **Total**
Enter the total of amounts in Columns b and c for each lender.

PART O. POWER REQUIREMENTS DATA BASE – ANNUAL SUMMARY

All revenue from operating electric plant including kWh sales, penalties, income from utility property, and miscellaneous items is to be reported in this part. Please note that if unbilled revenue is estimated (accrued) and reported in Form 7, Part A, Item 1, then the unbilled revenue must be included in the applicable classes on this form in Part O, also. It must be added to the billed revenue for Residential Sales, Residential Sales - Seasonal, etc. It should not be reported as Sales for Resales - Other.

Item No.

1 - 9 **Line a**
Number Consumers Served
Enter the number of consumers, by classification, having a current service connection in December in Column a. Enter the average number of consumers served based on the number of months that revenue is reported in Column b.

Special Circumstances for Number Consumers Served
Residential consumers (seasonal and non-seasonal) should be counted on the basis of the number of residences served. If one meter serves two residences, then two consumers should be counted. If a water heater is metered separately from other appliances on the same premises, do not count the water heater load as a separate consumer.

Security or safety lights, billed to a residential customer, should not be counted as an additional consumer, nor should they be included in the Public Street and Highway Lighting Classification.

Seasonal consumers expected to resume service during the next seasonal period should be counted during off-season periods as well.

A residence and commercial establishment on the same premises, receiving service through the same meter and being billed under the same rate schedule, would be classified as one consumer based on the rate schedule. If the same rate schedule applies to both the residential and the commercial class, the consumer should be classified according to principal use.

Consumers for Public Street and Highway Lighting should be counted by the number of billings, regardless of the number of lights per billing.

Installations erected for billboards or advertising purposes should be counted by billing and included in the appropriate commercial classification.

1 - 9 Line b
kWh Sold
Enter the number of kWh sold during the year for each consumer classification in Column c, Total Year to Date.

1 - 9 Line c
Revenue
Enter the dollar value of billings for the year for each consumer classification in Column c, Total Year to Date.

10 Total Number of Consumers
Enter the total of Lines 1a through 9a, Column a, December, and Column b, Average No. Consumers Served.

11 Total kWh Sold
Enter the total of Lines 1b through 9b, Column c, Total Year to Date.

12 Total Revenue Received from Sales of Electric Energy
Enter the total of Lines 1c through 9c, Column c, Total Year to Date.

13 Other Electric Revenue
Report amounts in accounts 412, 414, 449.1, 450, 451, and 453 through 456 less account 413. Enter the total in column c, Total Year to Date. Check: Line 12 total plus Line 13 total must agree with Part A, Line 1, Column b.

14 kWh - Own Use
Enter the total of the kWh consumed for corporate purposes in Column c, Total Year to Date. Show only kWh purchases under wholesale power contract for resale or self-generated and used for this purpose. Do not report energy purchased directly from a supplier solely for corporate purposes.

15 **Total kWh Purchased**
Enter the total of the kWh delivered by the power suppliers in the Column c, Total Year to Date. Transformer loss adjustments for low or high side delivery, if any, should be reported as kWh delivered.

16 **Total kWh Generated**
Enter the total of the net generation in Column c, Total Year to Date. Check: These figures should agree with those reported in RUS Form 12d, 12e, 12f, and 12g.

17 **Cost of Purchases and Generation**
Enter the total of Part A, Column b, Lines 2, 3, and 4, in Column c, Total Year to Date.

18 **Interchange - kWh - Net**
Energy flow between two electric systems, but not included in power billings is to be entered on this line. Energy received into the systems should be reported as a positive figure and energy delivered out of the system should be reported as a negative number. When the flow is both "in" and "out", the difference should be reported. Enter the total in Column c, Total Year to Date.

19 **Peak - Sum All kW Input (Metered)**
Please check the appropriate box indicating coincident or non-coincident peak.

Enter the highest monthly demand reported in Column c, Total Year to Date.

Include both generated and purchased power. For purchased power, use metered demand plus adjustments for transformer losses. Do not include adjustments made for billing purposes.

EXHIBIT B
SPECIFIC INSTRUCTIONS FOR RUS FORM 7a
INVESTMENTS, LOAN GUARANTEES AND LOANS - DISTRIBUTION

This form implements the reporting requirements placed on RUS borrowers in 7 CFR 1717, Subpart N.

General Instructions

1. RUS Form 7a, Investments, correspond to those reported in the Balance Sheet (RUS Form 7, Page 2, Part C, Balance Sheet). Also, all investment items summarized on the Balance Sheet are also reported here and classified as either included, that is subject to the 15% Rule*, or excluded.

*The 15 percent Rule states: "A Borrower in compliance with all provisions of its RUS mortgage, RUS loan contract, and any other agreements with RUS may, without prior written approval of the Administrator, invest its own funds or make loans or guarantees not in excess of 15 percent of its total utility plant without regard to any provisions contained in any RUS mortgage or RUS loan contract to the effect that the borrower must obtain prior approval from RUS, ..." [Reference 7 CFR 1717.654, "Transactions below the 15 percent level," 1717.655, "Exclusion of certain investments, loans, and guarantees," and 1717.656, "Exemption of certain borrowers from controls."]

2. Please cross check each item listed in PART I. INVESTMENTS, to ensure that the total of each category on the Form 7a (e.g., 1. Non-Utility Property (Net)) matches the balance sheet amount on Form 7.

3. Exhibit C of this bulletin classifies most investments as either Included or Excluded. In developing our guidelines, we referred to 7 CFR 1717.655, "Exclusion of certain investments, loans, and guarantees." If you need further clarification, contact your RUS Regional Division office for assistance. Exhibit D of this bulletin describes each type of investment in greater detail and classifies it as included or excluded.

4. Almost all investments must be reported separately, however, there are exceptions: Energy Resources Conservation (ERC) loans, and Loans to Employees, Officers, and Directors, each of these types of investments should be combined and reported as a total. A full description of each investment is needed by RUS to verify its proper classification as included or excluded.

5. Loan guarantees that a RUS borrower makes (e.g. member guarantees of its power supplier's loan from RUS) in conformance with the terms of a formal agreement with RUS are excludable.

6. If you need more space than the printed forms provide, please show the remainder of your investments, separately, on a continuation page with headings like the Form 7a, keyed to the report name, item name, and number. A continuation form is enclosed.

Please review the following material carefully.

ITEMS INCLUDED IN 15% RULE CALCULATION:

All items properly reported in the Balance Sheet, RUS Form 7, Part C. Balance Sheet, items: 6 through 13, 15, 17 through 19, plus 21 must be reported as Included, or Excluded items, as defined below. The sum of the Included items, plus the sum of the borrower's commitments to invest in the 12 months following the reporting period, plus the sum of loans (the balances of loans outstanding) which the borrower has guaranteed, except those amounts excluded, added together, may not exceed 15% of Total Utility Plant to comply with the 15% Rule. [Reference 7 CFR 1717.655, "Exclusion of certain investments, loans, and guarantees."]

EXCLUDED INVESTMENTS:

The following list includes nearly all Approved Exclusions [Reference 7 CFR 1717.655]

1. Patronage Capital allocated from a power supply cooperative of which the borrower is a member.

2. Loans, investments, security, obligations entered into prior to the date of the borrower's initial RUS Mortgage.

3. Securities or deposits issued, guaranteed or fully insured as to payment by the U.S. Government or any agency thereof. Though not an exhaustive list, this includes:

   (a) U.S. Savings Bonds
   (b) U.S. Treasury Bonds, Notes, Bills, Certificates
   (c) Checking, Savings, and Certificates of Deposit, up to the limit of the amount insured by an instrumentality of the U.S. Government. [However, the amount exceeding $100,000 (in any single institution) insured by the Federal Deposit Insurance Corporation (FDIC) should be reported on Form 7a, Part I, as an Included item.]
   (d) Securities issued by the following Federal agencies and guaranteed as to payment by the full faith and credit of the U.S. Government (payable from the U.S. Treasury):
   Farm Credit System Financial Assistance Corporation (FCSFAC),
   Farmers Home Administration (FmHA),
   Federal Financing Bank (FFB),
   General Services Administration (GSA),
   Government National Mortgage Assoc. (GNMA),
   Maritime Administration Guaranteed Ship Financing Bonds issued after 1972,
   Small Business Administration (SBA),
   Washington Metropolitan Area Transmit Authority (WMATA) Bonds.
   (e) Other securities or deposits issued, guaranteed or fully insured as to payment by any agency of the United States Government. Unlike those listed above, these instruments may not be guaranteed by the full faith and credit of the U.S. Government, but are excludable.

4. Capital term certificates, bank stock, or similar securities of the supplemental lender which have been purchased as a condition of membership in the supplemental lender, or as a condition of receiving financial assistance from such lender, i.e., subscription or loan related capital term certificates from CFC, or stock from CoBank or Banks for Cooperatives.

5. Capital Credits issued by the supplemental lender received as an outcome of receiving financial assistance from that lender.

6. CFC Commercial Paper, CoBank Cash Investment Service, and Surplus Funds Program (St. Paul Bank for Cooperatives).

7. Any other investment that has been given formal written approval by the Administrator of RUS as an exclusion from the 15% Rule should be shown in Excluded column. For clarity, footnote such investments, and explain their special exemptions, otherwise the reviewer will assume they are classified improperly.

8. Investments funding post-retirement benefits are an excluded investment. [Reference Financial Accounting Standards Board Statement 106]

9. Reserves, if required by Revenue Bond Agreement; or amounts set aside to ensure prompt payment of loans made, guaranteed, or secured by a lien accommodated by RUS are excluded. However, only funds required for payments due within a three-month period after the report date may be excluded unless the "Agreement" requires a larger fund.

PART I. INVESTMENTS

Report all items in the following Balance Sheet categories on Form 7, Part C:

1. Non-Utility Property (Net):
   Report items summarized as Balance Sheet item 6.

2. Investments in Associated Organizations:
   Report items summarized as Balance Sheet items 7, 8, 9 and 10.

3. Investments in Economic Development Projects:
   Report items summarized as Balance Sheet item 11.

4. Other Investments:
   Report items summarized as Balance Sheet item 12.

5. Special Funds:
   Report items summarized as Balance Sheet item 13.

6. Cash-General:
   Report items summarized as Balance Sheet item 15.

7. Special Deposits:
   Report items summarized as Balance Sheet item 17.

8. Temporary Investments:
   Report items summarized as Balance Sheet item 18.

9. Notes and Accounts Receivable (Net):
   Report items summarized as Balance Sheet item 19 and 21.

10. Commitments To Invest Within 12 Months:
    These items do not appear on the RUS Form 7, Part C, Balance Sheet. Report any legally binding commitments to invest within the 12 months following the reporting period.

Column headings:
Column (a), Investment Description, giving issuer's name e.g. C.D. 1st National Bank, Omaha NE, or US Treasury Certificates, other investments, giving the name, the city and state of their address, type of investment.

Column (b), Included Amount: See Exhibit C of this bulletin.

Column (c), Excluded Amount: See Exhibit C of this bulletin.

Column (d), Income or Loss: For each investment that is accounted for under the equity method of accounting and reported in Section 2, Investments in Associated Organizations, 3, Investments in Economic Development Projects, and 4, Other Investments, indicate the amount of income or loss recognized during the reporting period. If there were no investments to account for under the equity method of accounting, please enter zero. For each receivable reported in section 9, Accounts & Notes Receivable (Net), indicate the amounts, if any, charged to the provision for uncollectible notes receivable. If there were no charges for uncollectible notes receivable, please enter zero.

Column (e), Rural Development: Identify investments in rural economic development by placing an "X" in column e. Include investments in any/all types of projects or products that were made to improve the economy and/or quality of life in your area.

Examples of Rural Economic Development Investments include (but are not limited to): energy resources and conservation loans, rural development loans/grants, water/wastewater, satellite/cable TV, natural/propane gas, telephone/Internet, power quality, load management, agricultural services, housing, industrial parks/organizations, incubator buildings, public health/safety, financing/revolving loan funds, security services, etc.

PART II. LOAN GUARANTEES

In this part, the reporting RUS borrower should list each loan guarantee they have given. They should not list those they receive from RUS or any other source. For example, a reporting borrower's guarantee of a bank's loan to a local rural development project should be reported here. By contrast, a Federal Financing Bank loan to your organization, the reporting RUS borrower, the repayment of which is guaranteed by RUS, should not be reported here.

List each loan your organization has guaranteed. This includes but is not limited to guarantees of loans to rural development projects, subsidiary organizations, associated/nonassociated organizations, power supply organizations.

Excluded Guarantees: Guarantees that a borrower makes in conformance with the terms of a formal agreement with RUS are excludable. For example, if a reporting RUS borrower guarantees the repayment of a loan made by a bank to a subsidiary of the power supplier, but the terms of that loan were not specifically agreed to by RUS, the guarantee is Includable. By contrast, a member's guarantee of its power supplier's loan, made as required by RUS, is Excludable.

Column (a), Organization: Identify the legal person, or entity whose loan is guaranteed, giving the name, the city and state of their address.

Column (b), Maturity Date: This is the date when the final payment on the loan guarantee by your organization is payable. If the final date has been extended, the new final date payment should be furnished here.

Column (c), Original Amount: The original loan amount owed upon execution of the note, usually the face amount, or a portion thereof, if it is a partial guarantee.

Column (d), Loan Balance: The remaining balance of the original loan amount that is outstanding, or portion thereof if it is a partial guarantee.

Column (e), Rural Development: Identify loan guarantees in rural economic development by placing an "X" in column e. Include loan guarantees in any/all types of projects or products that were made to improve the economy and/or quality of life in your area.

Examples of Rural Economic Development Investments include (but are not limited to): energy resources and conservation loans, rural development loans/grants, water/wastewater, satellite/cable TV, natural/propane gas, telephone/Internet, power quality, load management, agricultural services, housing, industrial parks/organizations, incubator buildings, public health/safety, financing/revolving loan funds, security services, etc.

Line 4, Totals, report the totals of Original Amounts and Loan Balances for all guarantees.

Line 5, Total - Included Loan Guarantees, report the sums of the Original Amounts and remaining Loan Balances or portion of the loan balances (shown in column d) that your

organization guaranteed, which are not excludable, that is, those which are subject to the 15% Rule limitation.

PART III, RATIO OF INVESTMENTS AND LOAN GUARANTEES TO TOTAL UTILITY PLANT

Divide the sum of the Included Investments (Part I, item 11, Total of Investments, column (b)) plus Included Loan Guarantees (Part II, Totals, Column (d)) by the Total Utility Plant (Form 7, Part C, Balance Sheet, item 3). This percentage should be expressed as a whole number with one decimal digit, e.g. 12.9%. Note: the balance of the "Loans" Part IV is not included.

PART IV, LOANS

List each note receivable, draft, demand loan, time loan, and similar evidence of indebtedness for each loan made by your organization. However, loans to your Employees, Officers, and Directors, and Energy Resources Conservation Loans (both items printed on the form) should be reported as totals.

Column (a) Name of the debtor organization
Column (b) Final maturity date
Column (c) Original loan amount
Column (d) Outstanding loan balance, or carrying value
Column (e) "X" for loans made for Rural Development purposes

EXHIBIT C
INVESTMENTS UNDER THE 15 PERCENT RULE

Investments to be INCLUDED in the 15 Percent Calculation

Annuity-type investments
Asset management accounts
Brokerage Accounts (non-FDIC)
Cash and CD's* (uninsured part)
Commercial paper (except NRUCFC)
Common stock
Convertible certificates (bonds, debentures, preference stock)
Corporate bonds
Energy resources conservation loans
Futures contracts
Lines of credit (to others, including G&T's)
Loan guarantees NOT required by RUS
Loans - personal
Membership certificates
Money market mutual funds
Mortgage-backed securities (unless backed by full faith and credit of a U.S. Government Agency)
Municipal bonds
Mutual funds
Options (stock)
Patronage capital, other than that from power suppliers and supplemental lenders
Preferred stock
Real Estate Investment Trusts
Repurchase agreements
Unit investment trusts
Warrants
Zero coupon bonds

Investments to be EXCLUDED from 15 Percent Calculation

Capital term certificates, bank stocks, etc., purchases as condition of supplemental lender membership or financing
CoBank cash investment services certificates
Commercial paper issued by NRUCFC
Deferred compensation (including MINT)
Loan guarantees required by RUS
Mortgage backed securities backed by full faith and credit of a U.S. Government agency (e.g., Ginnies, FCSFAC, FmHA CBO's, Frannies, FFB, GSA, and TVA)
NRUCFC membership certificates
NRUCFC securities (debt)
Patronage capital, from power supply cooperative from supplemental lenders
Post Retirement Benefits - Funded
Revenue Bond (Debt Service) Reserves
Surplus Funds Program (St. Paul Bank for Cooperatives)
U.S. Savings Bonds
U.S. Treasury Bills
U.S. Treasury Bonds
U.S. Treasury Notes
U.S. Governments backed by full faith and credit, U.S. Treasury: e.g., Maritime Administration Guaranteed Ship Financing Bonds (issued after 1972)
Farm Credit System Financial Assistance Corporation
FmHA, SBA, and WMATA

Investments Which May Be EXCLUDED Within Certain Limits

* Several forms of investment may be excluded from the 15 percent calculation to the extent that they are insured by U.S. Government agencies, such as FDIC, etc. However, any such investments in excess of the insured amount (typically $100,000) are Included in the 15 percent calculation.

EXHIBIT D
INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Annuity	Provides regular, guaranteed income payments for life or set time period.	Includable
Asset Management Account	One-stop financial plan that included brokerage account, checking, debit and credit card, money market fund.	Includable
Brokerage Accounts	Stock Brokers, banks, other agents providing investment services	Includable
Capital term certificates, bank stock, or similar securities	Securities of the supplemental lender which have been purchased as a condition of membership in the supplemental lender, or as a condition of receiving financial assistance from such lender.	Excludable
Cash, Uninsured	See U.S. Government issued, guaranteed, or fully insured securities or deposits.	Includable
Certificate of Deposit (CD) (Less than $100,000) In FDIC Bank	Receipt for set sum of money left in bank for set period of time at an agreed-upon interest rate; at end of period, bank pays deposit plus interest.	Excludable
CoBank Cash Investment Services	Short-term unsecured notes sold by the CoBank.	Excludable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Commercial Paper	Short-term unsecured notes sold by large corporations.	Includable
Commercial Paper, NRUCFC	Short-term unsecured notes sold by NRUCFC.	Excludable
Common Stock	Security that represents ownership in a company.	Includable
Convertible	Bond, debenture, or preferred share of stock which may be exchanged by owner for common stock, usually of same company.	Includable
Corporate Bond	Debt obligation of corporation.	Includable
Debt Service Reserve	Cash set aside to ensure prompt payment of (1) Revenue Bonds, or (2) RUS: Loans, Guarantees, or RUS Lien Accommodated Loans	Excludable: AMT. DUE IN THE 3 MONTHS FOLLOWING REPORT DATE
Deferred Compensation	Periodic payments made to an employee after retire-ment, either for the employee's life or for a specified number of years, for specific duties performed during periods of active employment.	Excludable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Energy Resources Conservation (ERC) Loans	Loans made by RUS borrower to its consumers for the cost of labor and materials for the following energy conservation measures: 1. Caulking 2. Weather-stripping 3. Ceiling insulation 4. Wall insulation 5. Floor insulation 6. Duct insulation 7. Pipe insulation 8. Water heater insulation 9. Storm windows 10. Thermal windows 11. Storm or thermal doors 12. Clock thermostats 13. Attic ventilation fans	Includable
Futures contracts	Contracts covering sale of financial instruments or physical commodities for future delivery; includes agricultural products, metals, Treasury bills, foreign currencies, and stock index futures (i.e., Standard and Poor's 500).	Includable
Line of Credit	Bank's moral commitment to make loans to a company for a specific maximum amount for a given period of time, typically 1-year. There is usually no commitment fee charged on the unused line. However, a compensating balance requirement often exists.	Includable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Loan Guarantee	Guarantees for the payment of debt obligations of others; i.e., including but not limited to rural development projects, subsidiary organizations, associated/nonassociated organizations, power supply organizations, etc.	Includable Excludable if formally approved by RUS/ or required by RUS loan contract.
Loans - Employees, Directors, Officers, and Others	Agreement by which an owner of property (the lender) allows another party (the borrower) to use the property for a specified time period, and in return the borrower will pay the lender a payment (usually interest), and return the property (usually cash) at the end of the time period. A loan is usually evidenced by a Promissory Note. Loans to a power supply cooperative, G&T, of which the cooperative is a member, are excludable, if these loans have been given specific RUS approval for exclusion or are required by RUS.	Includable
Membership Certificate	Security that represents ownership in a company.	Includable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Money market deposit account (if FDIC insured and Under $100,000)	A type of money market fund at a bank or savings and loan association with limited checking privileges.	Excludable
Money market mutual fund	An investment company which buys short-term money market instruments.	Includable
Mortgage-backed securities	Securities representing a share ownership of mortgages guaranteed as to payment by an Agency of the Federal governments; includes Ginnie Maes, Fannie Maes, Freddie Macs, etc.	Excludable
Mortgage-Backed securities	Not guaranteed as to payment by an agency of the Federal Government.	Includable
Municipal bond	Debt obligation of state, city, town or their agencies.	Includable
Municipal bond Public Utility Cooperative (Municipalities)	Debt obligation of public utility cooperative that is required by law to obtain financing through bonds.	Includable
Mutual fund	Investment trust in which your dollars are pooled with those of hundreds of others and invested by professional managers in stocks or bonds.	Includable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
National Rural Utilities Cooperative Finance Corporation (NRUCFC) membership certificate	Security that represents ownership in NRUCFC.	Excludable
NRUCFC Patronage Capital	Amounts paid or payable by NRUCFC arising from its furnishing credit services to member cooperatives, i.e., the refund of excess of its charges over its actual cost of service.	Excludable
NRUCFC Securities, Other	All securities issued by NRUCFC, except patronage capital, are excludable investments.	Excludable
Negotiable order of withdrawal (NOW) account	NOW interest-bearing checking account.	Excludable if FDIC & under $100,000
Options	The right to buy (call) or sell (put) a stock at a given price (strike price) for a given period of time.	Includable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Patronage Capital, other than power suppliers and supplemental lenders	Amounts paid or payable by the other associated companies in connection with the furnishing of supplies, etc., which are in excess of the cost of service and all other amounts which the associated companies are obligated to credit to the cooperative as patronage capital.	Includable
Patronage Capital, G&T Power Suppliers	Amounts paid or payable by the cooperative in connection with the furnishing of electric energy which are in excess of the cost of service and all other amounts which the G&T power supplier is obligated to credit to the cooperative as patronage capital.	Excludable
Preferred stock	Stock sold with a fixed dividend; if company is liquidated, has priority over common stock.	Includable
Real estate investment trusts (REIT)	Corporation or trust that invests in or finances real estate: offices, shopping centers, apartments, hotels, etc.; sold as securities.	Includable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Repurchase Agreement	Short-term buy/sell deal involving any money market instruments (but usually Treasury bills, notes, and bonds) in which there is an agreement that securities will be resold to the seller on an agreed-upon date, often the next day. The money market fund holds the securities as collateral and charges interest for the loan.	Includable
Savings account	Account in which money deposited earns interest.	Excludable if FDIC insured & less than $100,000
SuperNOW account	Interest-bearing bank account.	Excludable if FDIC insured & less than $100,000
Surplus Funds Program, (St. Paul Bank for Cooperatives)	Short-term unsecured notes sold by the Banks of Cooperatives. (St. Paul, Springfield, and CoBank).	Excludable
Treasury bills	Short-term U.S. Treasury securities; maturities: 13, 26, 52 weeks.	Excludable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
Treasury bonds	Long-term U.S. Treasury securities; maturities: 10 years or more.	Excludable
Treasury notes	Medium-term securities of U.S. Treasury, maturities: not less than 1 year and not more than 10 years.	Excludable
Unit investment trust	Fixed portfolio of securities deposited with a trustee; offered to public in units; categories include municipal bonds, corporate bonds, public utility common stocks, etc.	Includable
U.S. Savings Bonds	Debt obligations of U.S. Treasury designed for small investor.	Excludable
U.S. Government issued, guaranteed, or fully insured, securities or deposits	Securities or deposits issued, guaranteed, or fully insured, as to payment by the U.S. Government, or any agency thereof.	Excludable
	Deposits are fully insured, up to a $100,000 limit, by the following agencies: 1. Federal Deposit Insurance Corporation (FDIC) 2. National Credit Union Share Insurance Fund	Excludable

INVESTMENT DESCRIPTIONS

Type of Investment	**Description**	**Includable or Excludable**
U.S. Government issued, guaranteed, or fully insured, securities or deposits (continued)	Securities fully backed with the full faith and credit of the U.S. Government are as follows: 1. Farm Credit System Financial Assistance Corporation (FCSFAC) 2. Farmers Home Administration (FmHA) Certificates of Beneficial Ownership (CBO) 3. Federal Financing Bank (FFB) 4. General Services Administration (GSA) 5. Government National Mortgage Association (GNMA), also known as Ginnie Mae 6. Maritime Administration Guaranteed Ship Financing Bonds, issued after 1972 7. Small Business Administration (SBA) 8. Washington Metropolitan Area Transit Authority (WMATA) Bonds	Excludable
	The following investments are securities backed by the full faith and credit of U.S. Government agencies and are Excludable Investments: 1. Farm Credit System 2. Federal Home Loan Banks (FHLB) 3. Federal Home Loan Mortgage Corporation (FHLMC) (Freddie Mac)	Excludable

U.S. Government issued, guaranteed, or fully insured, securities or deposits (continued)	4. Federal National Mortgage Association (FNMA) (Fannie Mae) 5. Financing Corporation (FICO) 6. Resolution Funding Corporation (REFCORP) 7. Student Loan Marketing Association (Sallie Mae) 8. Tennessee Valley Authority (TVA) 9. United States Postal Service	
Warrant	Gives holder right to purchase a given stock at a stipulated price over a fixed number of years.	Includable
Zero coupon bond	Debt instruments; sold at discount from face value with no annual interest paid out; capital appreciation realized upon maturity; includes Training Investment Growth Receipts (TIGERS), and Certificates of Accrual on Treasury Securities (CATS).	Includable

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 5
RESPONSIBLE PARTY: Patsy Walters

Request 5. Provide Taylor RECC's long-term construction planning program.

Response 5. Please see attached.

2023 - 2026 Construction Work Plan

Taylor County Rural Electric Cooperative Corporation

November 2022

Presented to:

Mike Skaggs, Engineering and Operations Manager
mskaggs@tcrecc.com

Taylor County Rural Electric Cooperative Corporation
625 W Main Street
Campbellsville, Kentucky 42718

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Exhibit F - Distribution Line Construction Recommendations & Cost Estimates

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Exhibit H - Voltage Regulator Recommendations & Cost Estimates

Exhibit I - Capacitor Recommendations & Cost Estimates

Exhibit J - Line Sectionalizing Device Recommendations

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Maps

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Supporting Data

Other information and data that substantiate the conclusions made in this report are available from Patterson & Dewar Engineers upon request.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 – 2026 CONSTRUCTION WORK PLAN (CWP)
(January 2023 – December 2026)

ENGINEERING CERTIFICATION

Upon completion of the construction proposed herein, the above indicated electric distribution system can provide adequate and dependable service to approximately 27,948 customers with residential using a monthly average of 1,100 kilowatt-hours per consumer. The peak demand is estimated to be approximately 174,000 kW for the winter of 2026/27.

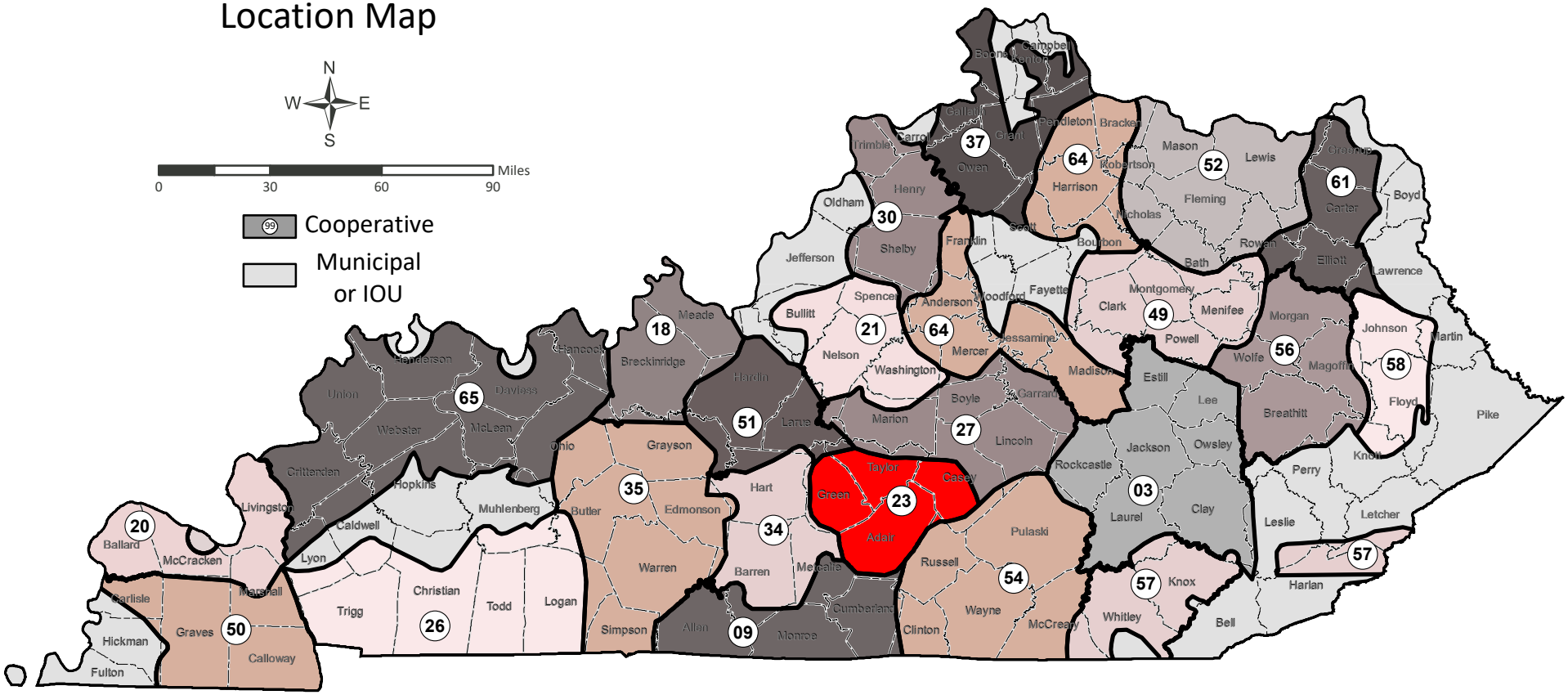
I certify that this 2023-2026 Construction Work Plan was prepared by me or under my direct supervision, and that I am a duly registered professional engineer under the laws of the State of Kentucky.

Patterson & Dewar Engineers, Inc.

John Daniel Bush
Kentucky P.E. No. 38177

11/8/2022

Kentucky Cooperative Location Map



3 Jackson EC - McKee
18 Meade County RECC - Brandenburg
20 Jackson Purchase EC - Paducah
21 Salt River ECC - Bardstown
23 Taylor County RECC - Campbellsville
26 Pennyrile Electric - Hopkinsville
27 Inter-County Energy CC - Danville
30 Shelby EC - Shelbyville
34 Farmers RECC - Glasgow
35 Warren RECC - Bowling Green
37 Owen EC - Owenton
49 Clark EC - Winchester
50 West Kentucky RECC - Mayfield
51 Nolin RECC - Elizabethtown
52 Fleming-Mason EC - Flemingsburg
54 South Kentucky RECC - Somerset
56 Licking Valley RECC - West Liberty
57 Cumberland Valley Electric - Gray
58 Big Sandy RECC - Paintsville
61 Grayson RECC - Grayson
64 Blue Grass Energy ECC - Nicholasville
65 Kenergy Corp - Henderson

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I. Executive Summary

A. Purpose, Results and General Basis of Study

This report documents the system engineering analysis and proposed construction for Taylor County Rural Electric Cooperative Corporation's (TCRECC) electric distribution system for the four-year period of January 1, 2023 through December 31, 2026.

The proposed construction program is to be financed by the Rural Utilities Service (RUS) and/or a supplemental lender. This report provides engineering support in the form of descriptions, costs, and the justification of required new facilities, as required for an RUS loan application.

Upon construction completion of the proposed facilities, the TCRECC distribution system can provide adequate and dependable service to approximately 27,948 consumers with the residential consumers using an average of 1,100 kWh per month.

The 2026 projected number of consumers and total peak system load were taken directly from the Cooperative's 2020 Load Forecast Report (LF) as approved by RUS. The 10% probability winter extreme highest kW demand was used for the loading conditions for the next four years. This loading level was agreed to by TCRECC management and the RUS General Field Representative (GFR).

A review of TCRECC's 2011 Long Range System Study (LRSS), finds the load projections and recommendations to be adequate for the four-year planning period.

One new delivery point (Contown Substation) was added during the previous Construction Work Plan (CWP) period. A one ownership (or substation justification) study was completed and approved for this project, and East Kentucky Power Cooperative (EKPC) completed the construction. No new delivery points are required during this new four-year construction work plan.

The cooperative's Operations and Maintenance Survey, was completed on March 8, 2022. Several maintenance items were identified for improvements, but no items were marked as needing corrective action.

An analysis of thermal loading, voltage drops, physical conditions and reliability, has been performed on all substations, distribution lines, and major equipment of the existing system. The existing base system model has been grown to the projected winter 2026/27 loading to develop a future system model. The basis of the system analysis is the RUS guidelines and TCRECC's system design guidelines.

The analyses indicated above utilized the WindMil© software package by Milsoft Utility Solutions©, and the results were used as the basis for determining the capital needs for TCRECC's electric distribution system.

B. Service Area, Distribution System and Power Supply

The corporate office of TCRECC is located in Campbellsville, Kentucky. The cooperative provides electric service to a portion of the central most part of Kentucky. The service area encompasses generally the rural areas around the small towns of Campbellsville, Columbia, and Greensburg. TCRECC provides electric service to rural homes, farms, and small commercial and industrial consumers in Adair, Casey, Green and Taylor counties.

The area generally consists of rolling hills, some rocky, rough terrain and grazing lands along small streams and tributaries. The chief sources of income are from general farming, timber and paper products, dairy operations, nurseries and varied small industries. Steady growth is being experienced around the small cities and towns with modest growth in the remaining rural areas.

The following data was taken, or derived, from TCRECC's December 2021 RUS Form 7:

Number of Consumers (Avg)	=	27,254
KWh Purchased	=	612,802,087
KWh Sold	=	583,874,807
KWh Used by Company	=	329,966
KWh Unaccounted for	=	28,597,314
KWh losses (%)	=	4.7%
Max. NCP kW Demand	=	128,421
Total Utility Plant	=	$102,838,792
Miles of Distribution	=	3,334
Consumers per Mile	=	8.17
Annual Load Factor	=	54.5%

Service is currently provided to TCRECC members through 16 delivery points. The engineering analysis reveals that no new delivery points will be required during this CWP period.

TCRECC's power supplier is EKPC, an RUS financed generation and transmission cooperative. EKPC's main office is in Winchester, Kentucky. As power supplier, EKPC accommodates all the generation, transmission, and substation requirements of TCRECC and other cooperatives located in the central and eastern half of Kentucky.

TCRECC takes delivery from EKPC at the distribution voltage of 7,200/12,470 volts.

C. System Organization and Operation

TCRECC's main office is located near the geographic center of the system. All engineering and management decisions come through this office. The system is operated and maintained under the leadership of an engineer and construction superintendent. Additional support staff of technicians, administrators, and aides compliments the system operations.

TCRECC utilizes contractor construction crews for large system improvement projects.

TCRECC's service territory is firmly established by Kentucky statutes. Consumers locating within TCRECC's territorial boundaries are set to be served by TCRECC.

D. Status of Previous Work Plan Projects

The current status of the previous work plan site-specific projects is presented in Exhibit C. The status of each project is identified as follows: COM – Complete; CPC – Complete Pending Closeout; DEL – Deleted; NP – No Progress; IP – In Progress.

E. Summary of Construction Program and Costs

The costs of the recommended construction program over the next four years have been projected as follows:

2023 -	$6,707,668
2024 -	$6,538,920
2025 -	$8,829,633
2026 -	$9,944,396
Total -	$32,020,617

The annual totals for distribution plant additions and replacements during the four previous years are as follows:

2018 -	$3,662,034
2019 -	$3,402,956
2020 -	$4,451,528
2021 -	$4,541,211
Total -	$16,057,729

This data noted above was taken from TCRECC's four previous year-end RUS Form 7's. Capital expenditures projected for this CWP have increased over past plant expenditures due to material price increases and system improvement increases; however, they remain reasonable.

A further breakdown of the construction program cost is summarized as follows:

	2023	2024	2025	2026	Totals
New Construction:	$3,398,984	$3,569,268	$5,178,888	$5,362,854	$17,509,994
System Improvements:	$3,308,684	$2,969,652	$3,650,745	$4,581,542	$14,510,623
Total Capital Needed:	$6,707,668	$6,538,920	$8,829,633	$9,944,396	$32,020,617

The total amount above is eligible for RUS loan funds. Each capital item recommended herein was reviewed with engineering and management staff prior to inclusion in this CWP. Approximately 55% of the total capital is for new construction, leaving approximately 45% for system improvements.

II. Basis of Study and Proposed Construction

A. Design and Operational Criteria

Exhibit L presents TCRECC's System Design Guidelines (SDG). On July 12, 2022, the Kentucky RUS GFR reviewed and concurred with TCRECC's criteria. The proposed construction as outlined in this 2023-2026 CWP is necessary for meeting the minimum standards set forth in the SDG.

The criteria presented are for use in design and operations only. System conditions may result in a breach of a specific criterion. Such occurrences are considered only temporary and not for long term operations.

B. Historical Line and Equipment Costs

Exhibit B presents the historical and projected unit cost averages for new services and new construction. The cost calculations utilize data encompassing a 24-month period ending December 31, 2021.

Line construction projects are grouped by project type, and the averages are expressed on a cost per mile basis. Several of the projected costs do not have a historical cost to reference. These estimates are tabulated, but the cost utilized is based on other system experiences.

C. Analysis of Current System Studies

1. 2020 Load Forecast

The 2020 Load Forecast Report was reviewed and approved by TCRECC. The report was prepared by EKPC in cooperation with Taylor County RECC's management and staff. The report utilized statistical models to forecast future energy and demand requirements. EKPC provided the economic, demographic, and weather information. Taylor County personnel provided historical information, system specific assumptions, and large commercial and industrial projections. The EKPC staff developed the LF database and forecasting models and produced the final report.

The LF projected kilowatt-hour sales as well as non-coincident peak kW demands for the period 2020-2040. The projected winter peak for the winter of 26/27 at the 20% probability was 169.0 MW (182 MW if Saloma was included). The system load factor is expected to change very little during the CWP period. In recent years the annual load factor has ranged from approximately 44% to 54% and is driven primarily by weather conditions in a given year. The load forecast offers various projection scenarios for planning purposes and they are as follows:

Peaks

Mild
Normal
Extreme*

*With projections of 20%, 10% and 3% probability of occurrence.

Generally, the normal and mild weather LF scenarios mentioned above are used in the preparation of rate studies and financial forecasts to determine realistic revenue projections. The extreme weather scenarios are used for system capacity planning. This is to assure that adequate capital expenditures are identified for system capacity in order to provide reliable and quality service to the customer. The extreme winter scenario with a 20% probability of occurrence was used in this work plan for the future system loading conditions. In discussion with the RUS GFR and TCRECC, it was decided to use 174,000 kW (excluding Saloma) as the design load for this CWP. This represents the 10% probability extreme loading scenario.

2. 2011 Long Range System Study (LRSS)

Patterson & Dewar Engineers, Inc. completed a LRSS for Taylor County RECC's distribution system in February 2011. The system configuration and the loads for January 2010 form the basis for the LRSS.

The LRSS used a projected load of 250 MW for the winter of 2035/36 in order to stress the system. The preferred plan included the possibility of six new substations. Due to load growth in the area around Phil Substation in Casey County, one new substation (Contown Substation) was energized during the previous CWP period. Based on current load projections, no other new substations are required for this CWP period.

Because of the abundance of 69 kV transmission line and the reasonable costs to build new delivery points, TCRECC service voltage will remain 7.2 / 12.47 kV over the study period.

The LRSS also recommended TCRECC standardize on three-phase line construction using primarily 1/0 ACSR, 336 kcmil and 477 kcmil ACSR conductor sizes. Exhibit N provides a summary of the Economical Conductor Analysis that agrees with the recommendations of the LRSS.

3. 2022 Operations and Maintenance Survey (RUS Form 300)

The cooperative's Operations and Maintenance Survey (Review Rating Summary - RUS Form 300), was completed on March 8, 2022. Several maintenance items were identified for improvements but no recommendations requiring capital funds were listed, and no items were marked as needing corrective action. A recommendation for the cooperative was made to continue to monitor issues related to joint use with telephone and cable TV companies.

D. Historical and Projected System Data

1. Annual Consumer, Load and Losses Data

Exhibit A tabulates the annual system data for consumers, system peak demand, losses, and annual load factor. The exhibit provides both data and graphs for the actual conditions for 2012 through 2021 and for the projected years of 2022 through 2031. The projected and historical customer count and kW demand comes from the most recent EKPC LF for TCRECC. The projected net distribution plant is estimated based on historic expenditures and cost estimates for the coming years.

The 2020 LF states that over the last 20 years the cooperatives sales have grown at a rate of approximately 2.5% per year, and the next 20 years is forecasted to grow at approximately 1.3% per year. The next 5 years are projected to grow at a rate of approximately 1.9% per year, and the 4-year CWP is included in this time frame.

The system is experiencing an annual 0.6 percent growth in consumers. There were 25,728 consumers in 2012, increasing to 27,254 in 2021. The projection for 2026 is 27,948 total consumers. This growth rate is expected to continue for the duration of the study period.

The highest total non-coincidence peak was 166 MW in the 2014/15 winter season. This included the Saloma Substation, which is an EKPC direct served load. The peak at that same time without Saloma was 158.1 MW, which represents the true distribution system peak.

TCRECC's load factor varies significantly from year to year and is very dependent on weather conditions. The distribution system load factor has ranged from a low of 35.3 percent to a high of 54.5 percent over the last 10 years, depending on the severity of the summer and winter peaks. A load factor of approximately 39.6 percent was used in the load forecast in 2026 to approximate the future probable loads at normal weather conditions.

The annual system distribution losses over the last 5 years have ranged from 5.61% to 5.90%. The 2020 LF projects losses of 5.6 percent for the TCRECC system for the next few years.

2. Special Loads

Care was taken to account for the unique loading conditions at Phil Substation. Tarter Industries is the predominant load in the area, resulting in one feeder that carries most of the load. Loading in this area was based on field measurements from TCRECC.

3. Substation Load Data

Exhibit O summarizes the substation loading and capacities for both existing and projected system peak conditions, with and without improvements. The exhibit identifies each substation, its voltage levels, winding capacity, percent of full load, percent power factor, and total peak demand. The loading is given in percent of full load rating of the substation transformer as provided by EKPC. All substations are owned and operated by EKPC.

The Taylor County RECC SDG establishes that a substation's current loading condition is not to exceed 95 percent of its full nameplate kVA capacity without plans for upgrade. This criterion also matches EKPC's policy. Currently none of TCRECC's substations are loaded over this level.

4. Circuit Loading and Voltage Conditions

The January 2022 non-coincident winter distribution peak for TCRECC was 135,756 kW. The corresponding peak kWh consumer billing data was used to develop the base system model for the winter 2021/22 conditions. During January 2022 the system served approximately 27,254 consumers.

Map 1 is a circuit diagram of TCRECC's primary electric system illustrating the loading and voltage conditions of the January 2022 system. The map also displays the CWP system recommended improvements.

Map 2 is a circuit diagram of the system configuration after the completion of work presented in this CWP.

Through the use of line voltage regulators and capacitors, adequate system voltages are being maintained for current system conditions. In anticipation of future system loading conditions, some line voltage regulator and capacitor changes will be necessary to maintain adequate voltage. See Exhibits H and I for a full listing of voltage regulator and capacitor recommendations.

5. System Outages and Reliability

TCRECC maintains daily outage reports and prepares monthly and annual summaries. A periodic review of those summaries reveals areas requiring system changes or right-of-way maintenance. Exhibit M presents a summary of the consumer outage hours for the five previous years.

The five year consumer outage average is 122.84 minutes per consumer per year which is below RUS's guideline of not exceeding 200 minutes per consumer per year.

III. Required Construction Items

A. Service to New Consumers

During the 24 month period ending December 31, 2021, TCRECC added 200 underground services and 716 overhead services for new consumers. The average line extension cost in 2021 for each new service was approximately $5,923 for underground and $4,246 for overhead services. It is estimated that 460 new underground and 1,400 new overhead services will be built over the next four years. Using projected per unit costs for this period, it is estimated that over the next four years $9,801,400 (or $2,450,350 per year) in capital will be required to construct these new lines.

Exhibit B summarizes the historical data used in projecting the required capital for the new services. Transformer, meter, and security light quantities and costs are also given in this exhibit. Exhibit D summarizes the costs on an annual basis. Approximately 31 percent of the capital required for this work plan is estimated to be for new consumer services.

B. Service Changes to Existing Customers

For the 24 month period ending December 31, 2021, TCRECC increased the service wire capacity of 37 consumers. TCRECC is expected to upgrade 100 services during the next four years. The average cost for each service upgrade is approximately $1,407. The capital requirement for the CWP period is approximately $140,725.

C. Distribution Lines – Additions and Changes

The recommended CWP line changes and improvements are generally for the following reasons:

- Excessive Voltage Drops
- Excessive Load Currents (or Overloaded Conductor)
- Poor Service Reliability

Increasing primary line voltage, increasing conductor size, increasing the number of phases, reducing distances of feed, and installing voltage regulators and capacitors are the primary methods of correction for excessive voltage drops. Excessive load current is an undesirable situation normally corrected by the same methods used for excessive voltage drop; however, system improvement projects may also be recommended to assure proper coordination of line reclosers or sectionalizing devices.

Right-of-way clearing often results in improved service reliability. However, if specific line components are causing outages, then priority is given to rebuilding the line to replace old and worn-out equipment. Rebuilding a line may include conductor, pole or crossarm replacement, replacing defective insulators, etc. Also, the construction of tie lines may improve service reliability. Tie lines shorten the circuit feed distance thereby reducing line exposure and providing loop feed capability. The loop feed capability is beneficial during outages and line maintenance.

The four year CWP distribution line construction estimate for Code 300 items is $5,616,720 including line conversions and changes. No tie-lines are recommended or required.

Each recommendation of the CWP has been carefully reviewed with the TCRECC engineering staff prior to inclusion in this report. Exhibit F presents a summary of the distribution line construction recommendations. Please note the following explanation for the construction RUS reference numbers:

XYY.ZZ	=	Construction Item Number
X	=	RUS Reference Prefix (2 for tie lines; 3 for line conversions)
YY	=	TCRECC Substation Number
ZZ	=	Consecutive Number Under Each Substation

Construction justification codes are presented for each recommendation. Exhibit Q further details the justification for each project.

D. Substation and Meter Point Additions and Changes

The System Design Guidelines establish that a substation's projected future loading condition is not to exceed 95 percent of its full nameplate KVA capacity without plans for upgrade. This criterion also agrees with EKPC's loading policy.

E. Capacitor Equipment – Additions and Changes

Exhibit I presents the capacitor recommendations for this CWP. They are also included in Map 1 and 2. Recommendations are included to comply with EKPC power factor policy of no less than 90 percent at peak for each cooperative delivery point. Recommendations have been included to maintain approximately 95% or higher during the peak conditions.

TCRECC is encouraged to enforce their power factor penalty clause in their C&I service contract, to further encourage C&I to install both fixed and switched capacitor banks. If, however, this effort is unsuccessful, TCRECC

should install capacitors on their system to eliminate the penalty charges from EKPC. The dollars received from penalizing the C&I customers should be adequate to cover the cost for the capacitor installations.

EKPC furnishes capacitors to TCRECC and other member cooperatives at no cost to the cooperatives. The cost to TCRECC is insignificant, therefore, no costs are included in the CWP for capacitor costs for TCRECC.

All capacitor recommendations are based on engineering modeling and input from the engineering staff at TCRECC. Capacitor locations and kVAR bank size recommendations were based on circuit loading, minimizing line loss, and improving voltage.

F. Sectionalizing Equipment - Additions and Changes

A thorough sectionalizing and coordination study was conducted in 2019. A sectionalizing review will be conducted for protective devices in 2023. The review includes an evaluation of device ratings against available load current and fault current and general sectionalizing recommendations. EKPC provided TCRECC low-side source impedance data so that available fault currents at each substation and delivery point can be determined. Also, any device overload conditions and line configuration changes resulting from the system improvements and revisions included in the work plan are to be included in the review.

The preliminary estimate for RUS Code 603, sectionalizing equipment, is $400,000 for the CWP period. This is based on historical data and estimates from TCRECC.

G. Line Regulators - Additions and Changes

Exhibit H and Maps 1 and 2 present the line voltage regulator recommendations. The cost of line regulators is categorized by RUS reference Code 604.

Exhibit H presents the location of the new regulators, and TCRECC is encouraged to add the regulators only as system problems are field measured and verified. The cost estimate for voltage regulators is $202,500 over the four year CWP period (average annual cost of $50,625).

H. Pole Replacements

The physical condition of TCRECC's electric plant is satisfactory according to work order inspections by Patterson & Dewar Engineers, Inc. Many system improvements have been made in recent years. However, following the experience of severe storms, persistent efforts to locate and replace old and depreciated poles is recommended.

Taylor County's distribution system consists of approximately 64,000 wood poles systemwide (3,228 miles of overhead line at approximately 20 poles per mile average). RUS recommends an annual inspection of at least 10 percent of a system's total poles. Taylor County should therefore have a pole inspection program that includes approximately 6,400 poles annually.

Current estimates for pole replacements can be found in Exhibit B. The projected number of pole replacements for the CWP period is 1,648 for a total cost of $3,839,428. The average cost per pole over the next 4 years is estimated to be $2,330.

I. Other Distribution Items

TCRECC currently has approximately 76 miles of single phase and 10 miles of three phase old copper conductor on their system. There are also small amounts of old, deteriorated 4 ACSR on the system. This work plan recommends replacing 20 miles of deteriorated lines over the CWP period. Exhibit K summarizes the plan for

deteriorated line replacement. A total of $1,160,000 has been allocated in this CWP under code 608 for the old conductor change-out. This represents approximately $58,000 per mile of line.

TCRECC plans to undertake an AMI replacement project that is expected to begin in 2025 and take approximately four years to complete. Half of the total estimated expense for the project has been included in this CWP. $2,800,000 has been included under code 601 for meter replacement and an additional $1,200,000 has been included in code 705 for necessary AMI equipment.

TCRECC included a pre-pay metering project within the last CWP. Further pre-pay meters will be required during the next four years. This CWP includes a total of $200,000 under code 601 for pre-pay meters.

The GIS project, which includes the field inventory, hardware and software, is shown under Code 707. This will include gathering detailed GIS data for the entire TCRECC system. It is estimated that data for approximately 100,000 points will be collected. The entire cost for the software and hardware is being included in the CWP; however, only 75% of the field inventory is being included for financing purposes. 75% of the field inventory cost is estimated at $700,000. Therefore, a total of $700,000 will be shown in Code 707 in this CWP.

IV. Conclusion

The recommendations set forth in this construction work plan will enable Taylor County Rural Electric Cooperative Corporation to serve the projected 2026-2027 peak winter conditions. The construction recommendations are in accordance with RUS prescribed guidelines and other economic criteria established by TCRECC's Long Range System Study, and related power supply studies. Any questions or comments regarding this report should be directed to the engineering staff of Taylor County RECC or Patterson & Dewar Engineers, Inc.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 - 2026 CONSTRUCTION WORK PLAN
System Statistical Data *

Year	Total Consumers (Annual Average) Actual	Total Consumers (Annual Average) Projected	kWh per Consumer Residential (Monthly Average) Actual	kWh per Consumer Residential (Monthly Average) Projected	Net Distribution Plant (millions of dollars) Actual	Net Distribution Plant (millions of dollars) Projected	Annual System Losses Total System Actual	Annual System Losses Total System Projected	Annual System Losses Distribution Only + Actual	Annual System Losses Distribution Only + Projected	Annual Load Factor Total System Actual	Annual Load Factor Total System Projected	Total Non-Coincident Peak Demand Historical Peak Demand	Total Non-Coincident Peak Demand Summer Normal Weather	Total Non-Coincident Peak Demand Winter Normal Weather	Total Non-Coincident Peak Demand Winter Extreme 20%
2012	25,728		1,057		69.75		5.64%		5.67%		45.6%		117,421			
2013	25,888		1,086		72.66		5.59%		5.62%		45.9%		119,887			
2014	25,958		1,154		75.45		5.20%		5.54%		37.5%		163,001			
2015	26,104		1,101		77.83		5.34%		5.65%		35.3%		166,000			
2016	26,290		1,061		80.58		4.74%		5.48%		47.0%		134,840			
2017	26,418		1,020		83.48		4.67%		5.64%		45.3%		141,488			
2018	26,521		1,015		86.72		4.73%		5.61%		43.8%		159,783			
2019	26,649		962		89.46		4.82%		5.80%		48.1%		137,244			
2020	26,883		922		93.36		4.85%		5.90%		51.3%		128,134			
2021	27,254		978		97.04		4.67%		5.66%		54.5%		128,421			
2022		27,188		1,108		102.38		5.11%		5.60%		38.6%		124,000	166,000	177,000
2023		27,375		1,106		107.72		5.11%		5.60%		39.2%		126,000	168,000	178,000
2024		27,554		1,104		113.13		5.11%		5.60%		39.2%		127,000	169,000	179,000
2025		27,739		1,098		118.70		5.11%		5.60%		39.5%		127,000	169,000	180,000
2026		27,948		1,100		124.52		5.11%		5.60%		39.6%		128,000	170,000	181,000
2027		28,159		1,107		129.87		5.11%		5.60%		39.7%		129,000	172,000	182,000
2028		28,359		1,120		135.40		5.11%		5.60%		39.7%		130,000	174,000	185,000
2029		28,548		1,124		140.93		5.11%		5.60%		40.0%		131,000	175,000	186,000
2030		28,732		1,125		146.45		5.11%		5.60%		40.2%		132,000	175,000	186,000
2031		28,907		1,124		151.98		5.11%		5.60%		40.4%		132,000	176,000	186,000

Note: All non-coincidental peak demands shown include the load for TGP-Saloma
* Projections are taken from the 2020 Load Forecast
\+ Excludes the direct serve load TGP - Saloma

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Historical Cost Data Ending 12/31/21

DISTRIBUTION	12 Months Ending 12/31/20	12 Months Ending 12/31/21	Estimated For 2023	Estimated For 2024	Estimated For 2025	Estimated For 2026	CWP Total
100 - NEW SERVICES							
101 - Underground							
Number Services	92	108	120	120	110	110	460
Total Lineal Feet	21,832	29,275	30,480	30,480	27,940	27,940	116,840
Average Feet Per Service	237	271	254	254	254	254	254
Total Cost	$423,454	$639,706	$746,280	$783,600	$754,270	$792,000	$3,076,150
Average Cost Per Service	$4,603	$5,923	$6,219	$6,530	$6,857	$7,200	$6,687
102 - Overhead							
Number Services	370	346	350	350	350	350	1,400
Total Lineal Feet	60,400	66,295	62,300	62,300	62,300	62,300	249,200
Average Feet Per Service	163	192	178	178	178	178	178
Total Cost	$1,178,831	$1,469,088	$1,560,300	$1,638,350	$1,720,250	$1,806,350	$6,725,250
Average Cost Per Service	$3,186	$4,246	$4,458	$4,681	$4,915	$5,161	$4,804
200 - NEW CONSTRUCTION AND TIE LINES (None Required)	NA	NA	$0	$0	$0	$0	$0
300 - LINE CONVERSIONS & CHANGES	NA	NA	$957,165	$1,272,012	$1,253,787	$2,133,756	$5,616,720
600 - MISCELLANEOUS DISTRIBUTION EQUIPMENT							
601 - Transformers and Meters							
Underground Transformers							
Number of Transformers	41	51	60	60	60	60	240
Total Cost of Transformers	$134,866	$155,494	$192,060	$201,660	$211,740	$222,300	$827,760
Average Cost of Trans.	$3,289.41	$3,048.90	$3,201	$3,361	$3,529	$3,705	$3,449
Overhead Transformers							
Number of Transformers	333	325	350	350	350	350	1,400
Total Cost of Transformers	$416,226	$467,789	$528,850	$555,450	$583,100	$612,150	$2,279,550
Average Cost of Trans.	$1,249.93	$1,439.35	$1,511	$1,587	$1,666	$1,749	$1,628

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Historical Cost Data Ending 12/31/21

DISTRIBUTION (continued)

600 - MISCELLANEOUS DISTRIBUTION EQUIPMENT (continued)

	12 Months Ending 12/31/20	12 Months Ending 12/31/21	Estimated For 2023	Estimated For 2024	Estimated For 2025	Estimated For 2026	Total for all Four Years
601 - Transformers and Meters (continued)							
Number of Meters (New members)	1,081	584	600	600	600	600	2,400
Total Cost of Meters	$278,761	$125,212	$139,800	$147,000	$154,200	$162,000	$603,000
Average Cost of Meters	$257.87	$214.40	$233	$245	$257	$270	$251
602 - Service Wires for Increased Capacity							
Number Work Orders	18	19	25	25	25	25	100
Total Cost	$14,337	$23,642	$32,650	$34,275	$36,000	$37,800	$140,725
Average Cost	$797	$1,244	$1,306	$1,371	$1,440	$1,512	$1,407
603 - Sectionalizing Equipment							
Number	6	1					
Total Cost	$68,452	$21,397	$100,000	$100,000	$100,000	$100,000	$400,000
Average Cost	$11,409	$21,397					
604 - Line Regulators *1							
Number Work Orders	0	1	~	~	~	~	~
Total Cost		$15,385	$50,625	$50,625	$50,625	$50,625	$202,500
Average Cost		$15,385	~	~	~	~	~
605 - Capacitors *2							
Number Work Orders	0	0	~	~	~	~	~
Total Cost			$0	$0	$0	$0	$0
Average Cost			~	~	~	~	~

*1 See notes under Exhibit H
*2 See notes under Exhibit I

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Historical Cost Data Ending 12/31/21

DISTRIBUTION (continued)

600 - MISCELLANEOUS DISTRIBUTION EQUIPMENT (continued)

	12 Months Ending 12/31/20	12 Months Ending 12/31/21	Estimated For 2023	Estimated For 2024	Estimated For 2025	Estimated For 2026	Total for all Four Years
606 - Pole Replacement							
Number of Poles Replaced	480	344	412	412	412	412	1,648
Total Cost	$892,032	$708,135	$890,744	$935,240	$982,208	$1,031,236	$3,839,428
Average Cost per Pole	$1,858	$2,059	$2,162	$2,270	$2,384	$2,503	$2,330
607 - Miscellaneous Replacements (new item)	N/A	N/A	$100,000	$100,000	$100,000	$100,000	$400,000
608 - Conductor Replacement (non site specific)							
Number Miles of Line	13	12	5	5	5	5	20
Total Cost	$47,043	$16,400	$290,000	$290,000	$290,000	$290,000	$1,160,000
Average Cost per Mile	$3,619	$1,367	$58,000	$58,000	$58,000	$58,000	$58,000

700 - OTHER DISTRIBUTION

702 - Outdoor Lights							
Number Work Orders	190	213	202	202	202	202	808
Total Cost	$117,216	$232,543	$231,694	$243,208	$255,328	$268,054	$998,284
Average Cost	$617	$1,092	$1,147	$1,204	$1,264	$1,327	$1,236

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Status of Previous CWP Projects

Code & Status Legend

COM = Completed IP/CO = In Progress/Carry-Over
DEL = Deleted NP/CO = No Progress/Carry-Over
CPC = Complete Pending Closeout

Project Number	Substation	Line Section or Location	Existing Construction	Proposed Construction	CWP Miles	CWP Cost	Actual Cost	% Actual-CWP Costs	Status
New Construction and Tie Lines (Code 200 Items)									
There were no 200 codes in previous Construction Work Plan.									
Line Conversions and Changes (Code 300 Items)									
301.01	Mile Lane	PC-292685 to PC-306722	1ø 2 URD	1ø 1/0 URD	0.80	$200,000	-	-	NP/CO
302.01	Greensburg	PC-21257 to PC-21258	3ø 3/0 ACSR DC	3ø 336 ACSR DC	0.50	$105,000	$156,722	149%	COM
303.01	Summersville	substation feeder exits	mixed - old	3ø 336 ACSR	1.10	$149,600	$174,202	116%	COM
304.01	McKinney Corner	substation feeder exits	mixed - old	3ø 336 ACSR	0.75	$102,000	$66,310	65%	COM
309.01	Phil	PC-306736 to PC-17651	3ø 4 ACSR	3ø 336 ACSR	1.00	$136,000	$177,587	131%	COM
309.02	Phil	sub to PC-14237	3ø 397 ACSR	3ø 477 ACSR DC	3.70	$832,500	-	-	NP/CO
313.01	Garlin	PC-3930 to PC-2653	1ø 4 ACSR	3ø 1/0 ACSR	1.05	$94,500	-	-	IP/CO
313.02	Garlin	PC-1581 to PC-133423	1ø & 2ø 4 ACSR	3ø 1/0 ACSR	0.50	$45,000	-	-	IP/CO
314.01	Contown	sub to PC-20653	1ø 4 ACSR	3ø 336 ACSR DC	1.50	$315,000	$391,028	124%	COM
314.02	Contown	sub to PC-9388	1ø 4 ACSR	3ø 336 ACSR DC	0.54	$113,400	$140,152	124%	COM

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Summary of Cost Estimates

			Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Total CWP Costs
740c REF 100:	**Line Construction for New Services**	=	$2,306,580	$2,421,950	$2,474,520	$2,598,350	$9,801,400
740c REF 200:	**New Construction and Tie Lines**	=	$0	$0	$0	$0	$0
740c REF 300:	**Line Conversions and Line Changes**	=	$957,165	$1,272,012	$1,253,787	$2,133,756	$5,616,720
740c REF 400:	**New Substations, Switching Stations, Meter Points, etc.**	=	$0	$0	$0	$0	$0
740c REF 500:	**Substation and Meter Point Changes**	=	$0	$0	$0	$0	$0
740c REF 600:	**Miscellaneous Distribution Equipment**						
1. Code 601 -	Transformers and Meters	=	$860,710	$904,110	$2,449,040	$2,496,450	$6,710,310
2. Code 602 -	Sets of Service Wires For Increased Service Capacity	=	$32,650	$34,275	$36,000	$37,800	$140,725
3. Code 603 -	Sectionalizing Equipment	=	$100,000	$100,000	$100,000	$100,000	$400,000
4. Code 604 -	Line Voltage Regulators	=	$50,625	$50,625	$50,625	$50,625	$202,500
5. Code 605 -	Line Capacitors	=	$0	$0	$50,625	$50,625	$101,250
6. Code 606 -	Pole Replacements	=	$890,744	$935,240	$982,208	$1,031,236	$3,839,428
7. Code 607 -	Miscellaneous Replacements	=	$100,000	$100,000	$100,000	$100,000	$400,000
8. Code 608 -	Conductor Replacement	=	$290,000	$290,000	$290,000	$290,000	$1,160,000
740c REF 700:	**Other Distribution Items**						
1. Code 702 -	Outdoor Lights	=	$231,694	$243,208	$255,328	$268,054	$998,284
2. Code 704 -	Load Management/SCADA	=	$187,500	$187,500	$187,500	$187,500	$750,000
3. Code 705 -	AMI Equipment	=	$0	$0	$600,000	$600,000	$1,200,000
4. Code 707 -	GIS	=	$700,000	$0	$0	$0	$700,000
	Total Estimated Distribution Requirements	=	**$6,707,668**	**$6,538,920**	**$8,829,633**	**$9,944,396**	**$32,020,617**

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Cost Estimate Breakdown For Loan Application and Financial Forecast
(RUS Form 740c Format)

1. DISTRIBUTION

a. 740c Ref. Code 100 - New Services	**Cost Year A 2023**	**Cost Year B 2024**	**Cost Year C 2025**	**Cost Year D 2026**	**Total CWP Costs**
101 - Underground - 460 Total Consumers (22.1 miles)	$746,280	$783,600	$754,270	$792,000	$3,076,150
102 - Overhead - 1,400 Total Consumers (47.2 miles)	$1,560,300	$1,638,350	$1,720,250	$1,806,350	$6,725,250
CODE 100 SUBTOTALS =	$2,306,580	$2,421,950	$2,474,520	$2,598,350	$9,801,400

TOTAL LOAN CODE 100 COSTS = $9,801,400
Total miles of line in Code 100 = 69.3 miles

b. 740c Ref Code 200: New Construction and Tie Lines

Project Number	Priority Year	Miles	Existing Construction	Proposed Construction	$ / Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026
			No Construction						
				CODE 200 SUBTOTALS =		$0	$0	$0	$0

TOTAL LOAN CODE 200 COSTS = $0

c. 740c Ref Code 300: Line Conversions and Changes (See Exhibit F for further details)

Project Number	Priority Year	Miles	Existing Construction	Proposed Construction	$ / Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026
300.01	D	2.06	3ph 3/0 & 4/0 ACSR	3ph 477 ACSR	$198,450				$408,807
300.02	C	1.30	3ph 1/0 & 3/0 ACSR	3ph 336 ACSR DC	$283,500			$368,550	
301.01*	B	0.84	1ph 2 URD	1ph 1/0 URD	$337,500		$283,500		
302.01	A	1.16	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$140,940			
302.02	A	0.38	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$46,170			
302.03	A	1.00	Mixed - old	5X 3ph 500 MCM URD	$150,000	$150,000			
304.01	D	1.42	3ph 1/0 ACSR	3ph 336 ACSR	$183,600				$260,712
305.01	D	1.36	3ph 3/0 ACSR	3ph 477 ACSR	$198,450				$269,892
305.02	A	1.20	3ph 1/0 ACSR	3ph 336 ACSR	$183,600	$220,320			
306.01	A	1.51	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$183,465			
306.02	B	1.00	Mixed - old	6X 3ph 500 MCM URD	$150,000		$150,000		
306.03	A	1.33	1ph 6 CU & 4 ACSR	3ph 1/0 ACSR	$121,500	$161,595			
309.01	B	1.89	1ph 4 ACSR	3ph 1/0 ACSR	$121,500		$229,635		
309.02*	D	3.74	3ph 336 & 397 ACSR	3ph 477 ACSR DC	$303,750				$1,136,025
309.03	C	1.00	Mixed - old	5X 3ph 500 MCM URD	$150,000			$150,000	
310.01	B	2.79	1ph 4 ACSR	3ph 1/0 ACSR	$121,500		$338,985		
311.01	C	2.85	1ph 4 ACSR	3ph 1/0 ACSR	$121,500			$346,275	
311.02	B	1.47	3ph 4 ACSR	3ph 336 ACSR	$183,600		$269,892		
312.01	C	1.96	3ph 3/0 ACSR	3ph 477 ACSR	$198,450			$388,962	
313.01*	D	0.48	1ph 4 ACSR	3ph 1/0 ACSR	$121,500				$58,320
313.02*	A	0.45	1ph 2ph 4 ACSR	3ph 1/0 ACSR	$121,500	$54,675			
				CODE 300 SUBTOTALS =		$957,165	$1,272,012	$1,253,787	$2,133,756

TOTAL LOAN CODE 300 COSTS = $5,616,720

* Project carried over from previous CWP

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Cost Estimate Breakdown For Loan Application and Financial Forecast
(RUS Form 740c Format)

d. 740c Ref Code 400: New Substations. Switching Stations, Metering Points - (See Exhibit G for further details)

Project Number	Priority Year	Proposed Construction	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026
		None				
		CODE 400 SUBTOTALS =	$0	$0	$0	$0
		TOTAL LOAN CODE 400 COSTS =		**$0**		

e. 740c Ref Code 500: Substation, Switching Stations, Metering Point Changes - (See Exhibit G for further details)

Project Number	Priority Year	Proposed Construction	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026
		None				
		CODE 500 SUBTOTALS =	$0	$0	$0	$0
		TOTAL LOAN CODE 500 COSTS =		**$0**		

f. 740c Ref Code 600: Miscellaneous Distribution Equipment

		Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Total CWP Costs
601	Transformers and Meter					
	Transformers - Underground - 240 Total	$192,060	$201,660	$211,740	$222,300	$827,760
	Transformers - Overhead - 1,400 Total	$528,850	$555,450	$583,100	$612,150	$2,279,550
	New Meters - 2,400 Total	$139,800	$147,000	$154,200	$162,000	$603,000
	Pre-Pay Meters - 500 Total	$0	$0	$100,000	$100,000	$200,000
	AMI Meters - 13,000 Total	$0	$0	$1,400,000	$1,400,000	$2,800,000
	Subtotals =	$860,710	$904,110	$2,449,040	$2,496,450	$6,710,310
602	Service Wires for Increased Capacity					
	25 units per year =	$32,650	$34,275	$36,000	$37,800	$140,725
603	Sectionalizing Equipment =	$100,000	$100,000	$100,000	$100,000	$400,000
604	Line Voltage Regulators =	$50,625	$50,625	$50,625	$50,625	$202,500
605	Line Capacitors =	$0	$0	$50,625	$50,625	$101,250
606	Pole Replacements =	$890,744	$935,240	$982,208	$1,031,236	$3,839,428
607	Miscellaneous Replacements	$100,000	$100,000	$100,000	$100,000	$400,000
608	Conductor Replacement (20 mi)	$290,000	$290,000	$290,000	$290,000	$1,160,000
	CODE 600 Totals =	**$2,324,729**	**$2,414,250**	**$4,058,498**	**$4,156,736**	**$12,954,213**

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Cost Estimate Breakdown For Loan Application and Financial Forecast
(RUS Form 740c Format)

g. 740c Ref Code 700: Other Distribution

		Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Total CWP Costs
702	Outdoor Lights - 202 units per year	$231,694	$243,208	$255,328	$268,054	$998,284
704	Load Management/SCADA	$187,500	$187,500	$187,500	$187,500	$750,000
705	AMI Equipment	$0	$0	$600,000	$600,000	$1,200,000
707	GIS	$700,000	$0	$0	$0	$700,000
	CODE 700 Totals =	**$1,119,194**	**$430,708**	**$1,042,828**	**$1,055,554**	**$3,648,284**
	Total Distribution =	**$6,707,668**	**$6,538,920**	**$8,829,633**	**$9,944,396**	**$32,020,617**

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Cost Estimate Breakdown For Loan Application and Financial Forecast
(RUS Form 740c Format)

		Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	TOTALS
NEW CONSTRUCTION						
100	Line Extensions	$2,306,580	$2,421,950	$2,474,520	$2,598,350	$9,801,400
601	Transformers and Meters	$860,710	$904,110	$2,449,040	$2,496,450	$6,710,310
702	Outdoor Lights	$231,694	$243,208	$255,328	$268,054	$998,284
	Total New Construction =	**$3,398,984**	**$3,569,268**	**$5,178,888**	**$5,362,854**	**$17,509,994**
						55%
SYSTEM IMPROVEMENTS						
200	New Tie Lines	$0	$0	$0	$0	$0
300	Conversions (Code 300)	$957,165	$1,272,012	$1,253,787	$2,133,756	$5,616,720
400	New Substations (Code 400)	$0	$0	$0	$0	$0
500	Substation Changes (Code 500)	$0	$0	$0	$0	$0
602	Service Wires Uprated	$32,650	$34,275	$36,000	$37,800	$140,725
603	Sectionalizing Equipment	$100,000	$100,000	$100,000	$100,000	$400,000
604	Line Regulators	$50,625	$50,625	$50,625	$50,625	$202,500
605	Line Capacitors	$0	$0	$50,625	$50,625	$101,250
606	Pole Replacements	$890,744	$935,240	$982,208	$1,031,236	$3,839,428
607	Miscellaneous Replacements	$100,000	$100,000	$100,000	$100,000	$400,000
608	Conductor Replacement	$290,000	$290,000	$290,000	$290,000	$1,160,000
704	Load Management/SCADA	$187,500	$187,500	$187,500	$187,500	$750,000
705	AMI Equipment	$0	$0	$600,000	$600,000	$1,200,000
707	GIS	$700,000	$0	$0	$0	$700,000
	Total System Improvements =	**$3,308,684**	**$2,969,652**	**$3,650,745**	**$4,581,542**	**$14,510,623**
						45%
	CWP Total =	**$6,707,668**	**$6,538,920**	**$8,829,633**	**$9,944,396**	**$32,020,617**

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Distribution Line Construction Recommendations and Cost Estimates

Construction Justification Codes

1. Overload Single Phase Line
2. Overload Multi-phase Line
3. Excessive Voltage Drop
4. Balance Phase Loading
5. Improve Service Reliability
6. New Feeders (New or Existing Sub)
7. New Load Development
8. Area Voltage Conversion
9. Eliminate 2-way Feed to Open Delta Bank
10. Establish or Strengthen Main Tie Between Sub/Circuit
11. Highway Relocation Project
12. Economical Conductor Loading
13. Old/Aging Conductor Replacement

Project Number	Priority Year	Line Sections	Miles	Existing Construction	Proposed Construction	$/Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Construction Justification Codes
Substation 1 - Campbellsville											
300.01	D	PC-10881 - PC-9450	2.06	3ph 3/0 & 4/0 ACSR	3ph 477 ACSR	$198,450				$408,807	2, 3, 5
300.02	C	PC-1102 - PC-8830	1.30	3ph 1/0 & 3/0 ACSR	3ph 336 ACSR DC	$283,500			$368,550		2, 3, 5
						Subtotal =	**$0**	**$0**	**$368,550**	**$408,807**	
Substation 10 - Mile Lane											
301.01*	B	PC-24652 - PC-25582	0.84	1ph 2 URD	1ph 1/0 URD	$337,500		$283,500			5, 13
		& PC-24650 - PC-19461				**Subtotal =**	**$0**	**$283,500**	**$0**	**$0**	
Substation 20 - Greensburg											
302.01	A	PC-3910 - PC-17263	1.16	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$140,940				1, 3, 5
302.02	A	PC-1222 - PC-4117	0.38	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$46,170				1, 5
302.03	A	Substation feeder exits	1.00	Mixed - old	5X 3ph 500 MCM URD	$150,000	$150,000				6
						Subtotal =	**$337,110**	**$0**	**$0**	**$0**	
Substation 30 - Summersville											
No Construction											
Substation 40 - Mckinney Corner											
304.01	D	PC-1194 - PC-18494	1.42	3ph 1/0 ACSR	3ph 336 ACSR	$183,600				$260,712	2, 3, 5
						Subtotal =	**$0**	**$0**	**$0**	**$260,712**	

* Project carried over from previous CWP

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Distribution Line Construction Recommendations and Cost Estimates

Construction Justification Codes

1. Overload Single Phase Line
2. Overload Multi-phase Line
3. Excessive Voltage Drop
4. Balance Phase Loading
5. Improve Service Reliability
6. New Feeders (New or Existing Sub)
7. New Load Development
8. Area Voltage Conversion
9. Eliminate 2-way Feed to Open Delta Bank
10. Establish or Strengthen Main Tie Between Sub/Circuit
11. Highway Relocation Project
12. Economical Conductor Loading
13. Old/Aging Conductor Replacement

Project Number	Priority Year	Line Sections	Miles	Existing Construction	Proposed Construction	$/Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Construction Justification Codes
Substation 50 - Coburg											
305.01	D	PC-9833 - PC-12566	1.36	3ph 3/0 ACSR	3ph 477 ACSR	$198,450				$269,892	2, 5
305.02	A	PC-16989 - PC-7458	1.20	3ph 1/0 ACSR	3ph 336 ACSR	$183,600	$220,320				3, 5, 10
						Subtotal =	**$220,320**	**$0**	**$0**	**$269,892**	
Substation 60 - Columbia											
306.01	A	PC-3995 - PC-23699	1.51	1ph 4 ACSR	3ph 1/0 ACSR	$121,500	$183,465				1, 3, 5
306.02	B	Substation feeder exits	1.00	Mixed - old	6X 3ph 500 MCM URD	$150,000		$150,000			6
306.03	A	PC-9811 - PC-17592	1.33	1ph 6 CU & 4 ACSR	3ph 1/0 ACSR	$121,500	$161,595				1, 5
						Subtotal =	**$345,060**	**$150,000**	**$0**	**$0**	
Substation 70 - Green River Plaza											
No Construction											
Substation 80 - Bass											
No Construction											

* Project carried over from previous CWP

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Distribution Line Construction Recommendations and Cost Estimates

Construction Justification Codes

1. Overload Single Phase Line
2. Overload Multi-phase Line
3. Excessive Voltage Drop
4. Balance Phase Loading
5. Improve Service Reliability
6. New Feeders (New or Existing Sub)
7. New Load Development
8. Area Voltage Conversion
9. Eliminate 2-way Feed to Open Delta Bank
10. Establish or Strengthen Main Tie Between Sub/Circuit
11. Highway Relocation Project
12. Economical Conductor Loading
13. Old/Aging Conductor Replacement

Project Number	Priority Year	Line Sections	Miles	Existing Construction	Proposed Construction	$/Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Construction Justification Codes
Substation 90 - Phil											
309.01	B	PC-12617 - PC-8219	1.89	1ph 4 ACSR	3ph 1/0 ACSR	$121,500		$229,635			2, 3, 5
309.02*	D	PC-12540 - PC-27271	3.74	3ph 336 & 397 ACSR	3ph 477 ACSR DC	$303,750				$1,136,025	1, 3, 5
309.03	C	Substation feeder exits	1.00	Mixed - old	5X 3ph 500 MCM URD	$150,000			$150,000		6
						Subtotal =	**$0**	**$229,635**	**$150,000**	**$1,136,025**	
Substation 100 - West Columbia											
310.01	B	PC-6531 - PC-4585	2.79	1ph 4 ACSR	3ph 1/0 ACSR	$121,500		$338,985			1, 3, 5
						Subtotal =	**$0**	**$338,985**	**$0**	**$0**	
Substation 110 - Creston											
311.01	C	PC-14006 - PC-26092	2.85	1ph 4 ACSR	3ph 1/0 ACSR	$121,500			$346,275		1, 3, 5
311.02	B	PC-3363 - PC-12961	1.47	3ph 4 ACSR	3ph 336 ACSR	$183,600		$269,892			3, 5, 10
						Subtotal =	**$0**	**$269,892**	**$346,275**	**$0**	
Substation 120 - East Campbellsville											
312.01	C	PC-17918 - PC-4811	1.96	3ph 3/0 ACSR	3ph 477 ACSR	$198,450			$388,962		2, 3, 5
						Subtotal =	**$0**	**$0**	**$388,962**	**$0**	

* Project carried over from previous CWP

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Distribution Line Construction Recommendations and Cost Estimates

Construction Justification Codes

1. Overload Single Phase Line
2. Overload Multi-phase Line
3. Excessive Voltage Drop
4. Balance Phase Loading
5. Improve Service Reliability
6. New Feeders (New or Existing Sub)
7. New Load Development
8. Area Voltage Conversion
9. Eliminate 2-way Feed to Open Delta Bank
10. Establish or Strengthen Main Tie Between Sub/Circuit
11. Highway Relocation Project
12. Economical Conductor Loading
13. Old/Aging Conductor Replacement

Project Number	Priority Year	Line Sections	Miles	Existing Construction	Proposed Construction	$/Mile	Cost Year A 2023	Cost Year B 2024	Cost Year C 2025	Cost Year D 2026	Construction Justification Codes
Substation 130 - Garlin											
313.01*	D	PC-3600 - PC-2421	0.48	1ph 4 ACSR	3ph 1/0 ACSR	$121,500				$58,320	1, 5
313.02*	A	PC-1428 - PC-22826	0.45	1ph 2ph 4 ACSR	3ph 1/0 ACSR	$121,500	$54,675				1, 5
					Subtotal =		**$54,675**	**$0**	**$0**	**$58,320**	
Substation 140 - Contown											
No Construction											
					Subtotal for New Construction and Tie Lines (Code 200 Items) =		**$0**	**$0**	**$0**	**$0**	
					Subtotal for Line Conversions and Changes (Code 300 Items) =		**$957,165**	**$1,272,012**	**$1,253,787**	**$2,133,756**	
					Total Distribution Line Construction Per Year =		**$957,165**	**$1,272,012**	**$1,253,787**	**$2,133,756**	
					Total New Construction and Tie Lines (Code 200 Items) =		**$0**				
					Total Line Conversions and Changes (Code 300 Items) =		**$5,616,720**				
					Total Distribution Line Construction =		**$5,616,720**				

* Project carried over from previous CWP

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Substation and Meter Point Recommendations and Cost Estimates

NEW SUBSTATIONS AND METER POINTS (Ref. Code 400):

None

SUBSTATION AND METER POINT CHANGES (Ref. Code 500):

None

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Voltage Regulator Recommendations and Cost Estimates

A - Seasonal Load
B - Overloaded
C - Improved Circuit Regulation
G - Open Point Change
D - Excessive Voltage Drop
E - Unneeded
F - Switching Capacity
ASI - After System Improvements

NOTE: All regulators are 7.2 kV unless otherwise noted

Substation/Circuit	Upline Line Section	Existing	Recommendations	Projected 2026 Load Current - ASI	Remarks
Substation 1 - Campbellsville	(None)				
Substation 10 - Mile Lane					
Circuit 10-3	PC-20223	3-150a	-	71	-
Circuit 10-4	PC-15291	-	Add 1-100a	43	D
Substation 20 - Greensburg					
Circuit 20-5	PC-6270	-	Add 3-150a	79	D
Substation 30 - Summersville					
Circuit 30-1	PC-22027	3-150a	-	102	-
Circuit 30-4	PC-3414	3-328a	-	191	-
Circuit 30-4	PC-7192	-	Add 1-100a	54	D
Substation 40 - McKinney Corner					
Circuit 40-1	PC-7191	-	Add 1-100a	50	D
Circuit 40-1	PC-22025	3-150a	-	132	-
Circuit 40-2	PC-27254	3-150a	-	62	-
Substation 50 - Coburg					
Circuit 50-1	PC-22574	3-100a	-	56	-
Circuit 50-3	PC-24402	3-219a	-	170	-
Substation 60 - Columbia					
Circuit 60-2	PC-3246	3-219a	-	148	-
Circuit 60-5	PC-16125	3-150a	-	84	-
Substation 70 - Green River Plaza	(None)				

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Voltage Regulator Recommendations and Cost Estimates

A - Seasonal Load
B - Overloaded
C - Improved Circuit Regulation
G - Open Point Change
D - Excessive Voltage Drop
E - Unneeded
F - Switching Capacity
ASI - After System Improvements

NOTE: All regulators are 7.2 kV unless otherwise noted

Substation/Circuit	Upline Line Section	Existing	Recommendations	Projected 2026 Load Current - ASI	Remarks
Substation 80 - Bass					
Circuit 80-2	PC-22726	-	Add 3-100a	39	D
Circuit 80-2	PC-4435	3-150a	-	72	-
Circuit 80-3	PC-25211	3-219a	-	153	-
Substation 90 - Phil					
Circuit 90-3	PC-25127	3-150a	-	78	-
Circuit 90-3	PC-25129	3-328a	-	158	-
Circuit 90-4	PC-6284	-	Add 3-100a	61	D
Circuit 90-5	PC-27270	3-100a	-	23	-
Substation 100 - West Columbia					
Circuit 100-2	PC-16675	3-150a	-	99	-
Circuit 100-2	PC-4384	3-219a	-	181	-
Circuit 100-3	PC-8548	3-150a	-	106	-
Substation 110 - Creston					
Circuit 110-3	PC-13902	3-150a	Move to PC-20506	88	ASI
Circuit 110-3	PC-22004	1-100a	-	57	-
Substation 120 - East Campbellsville					
Circuit 120-1	PC-10306	3-219a	-	118	-
Substation 130 - Garlin					
Circuit 130-3	PC-8182	3-219a	-	174	-
Circuit 130-5	PC-22029	3-150a	-	114	-
Substation 140- Contown					
Circuit 140-1	PC-3412	3-150a	-	75	-

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Voltage Regulator Recommendations and Cost Estimates

COST SUMMARY

Regulators	Removed	Added	Surplus	Required
100a	0	9	0	9
150a	0	3	0	3
219a	0	0	0	0
328a	0	0	0	0

9 - 100 Amp Regulators @ $16,500/each = $148,500

3 - 150 Amp Regulators @ $18,000/each = $54,000

0 - 219 Amp Regulators @ $14,000/each = $0

0 - 328 Amp Regulators @ $16,000/each = $0

Total = $202,500

Total per year (4 year period) = $50,625

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Capacitor Recommendations and Cost Estimates

SUMMARY AND COST ESTIMATES

EKPC furnishes capacitors to TCRECC and other member cooperatives at no cost to the cooperatives. The cost to TCRECC is insignificant, therefore, no costs are included in the CWP for capacitor costs for TCRECC. Shown below are capacitor recommendations for this CWP period. Refer to CWP maps for capacitor location recommendations.

Substation	Recommendations
Campbellsville	Add a 300 kVAR capacitor bank at the end of Section PC-23913.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Sectionalizing Summary and Cost Estimates

A sectionalizing review will be conducted for protective devices in 2023.

For the purpose of this work plan, it is estimated that $400,000 will be needed during the four year CWP period for sectionalizing. This figure is based partially on historical data and also on new sectionalizing improvements that TCRECC is planning.

2023	=	$100,000
2024	=	$100,000
2025	=	$100,000
2026	=	$100,000
		$400,000

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Conductor Replacement Summary

PLAN:
1. Replace all single phase (1ph) deteriorated lines that are causing consistent line outages.
2. Two and three phase (2ph & 3ph) deteriorated lines are to be replaced as needed due to feeder loading conditions or maintenance issues.
3. Lines will be replaced based on circuit reliability and loading conditions.
4. New single phase lines are to be built either 4 ACSR or larger depending on the likelihood that the line will require three-phase construction in the near future.
5. Any deteriorated 4 ACSR and 6 or 8 copper lines will be replaced as needed.
6. Taylor County RECC's goal for this CWP is to replace approximately 5 miles per year.

Total Miles of Copper Conductor on System

No.	Substation	1ph Miles	2ph Miles	3ph Miles
1	Campbellsville	2.6	0.0	1.1
10	Mile Lane	1.8	0.0	0.0
20	Greensburg	7.7	0.0	0.0
30	Summersville	10.5	0.0	0.0
40	McKinney Corner	8.0	0.0	0.0
50	Coburg	9.2	0.0	0.4
60	Columbia	7.0	0.0	0.0
70	Green River Plaza	0.2	0.0	0.0
80	Bass	0.3	0.0	3.4
90	Phil	4.6	0.0	0.0
100	West Columbia	4.5	0.0	0.0
110	Creston	8.8	0.0	1.4
120	East Campbellsville	2.2	0.0	3.3
130	Garlin	8.5	0.0	0.0
140	Contown	4.5	0.0	0.0
		_____	_____	_____
	Totals =	75.9	0.0	9.7
	Previous CWP Totals =	80.1	0.0	9.7
	Difference =	4.2	0.0	0.0

Approximately 4.2 miles of copper line were replaced with ACSR during the last work plan period.

Cost Estimate for 2023-2026

Miles	Construction Type	Cost / Mile	Extended Costs
20.0	1ph Cu to 1ph 4 or 1/0 ACSR	$58,000	$1,160,000

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 - 2026 CONSTRUCTION WORK PLAN (CWP)
System Design Guidelines

Each of the criteria items listed below was reviewed and concurred by the engineering staff at Taylor County RECC and the RUS General Field Representative.

Construction proposed in this construction work plan is required to meet the following minimum standards of adequacy for voltages, thermal loading, safety, and reliability on the system.

1) The maximum voltage drop from the substation on primary distribution lines is not to exceed 8 volts unregulated, 16 volts with one set of line voltage regulators, and 24 volts with two sets of line voltage regulators. Ordinarily, lines will be limited to one bank of line regulators.

2) The following equipment will be flagged for review if thermal loading exceeds the percentage shown below of the nameplate rating.

Power Transformers:	95%	summer rating / 95% winter rating
Voltage Regulators:	100%	at 10% buck or boost; 160% at 5% boost or buck.
Oil Circuit Reclosers:	100%	
Line Fuses:	80%	

3) Primary conductors are considered for replacement when loaded to 65% of the thermal rating.

4) Poles and crossarms are to be replaced if found to be physically deteriorated by inspection.

5) Conductors are to be replaced as needed.

6) New lines and line conversions are to be built according to the standard primary voltage levels as recommended in the Long Range System Study.

7) New primary conductor sizes are to be determined on a case by case basis using the Economic Conductor sizing computer program. A minimum of 1/0 ACSR is to be used on main lines, and a minimum of 4 ACSR is to be used on tap lines.

8) All new primary construction is to be overhead except where underground is required to comply with governmental or environmental regulations, local restrictions, or favorable economics.

9) All new distribution lines are to be designed and built according to RUS standard construction specifications and guidelines.

10) A single-phase tap will be considered for multi-phasing if any of the following conditions are present:
    a) Serves more than 60 customers,
    b) Load current over 35 amps,
    c) Serves an area that is growing.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN

Five Year Consumer Outage Report
(Outage minutes per consumer per year)

Outage Cause (Including Major Events and Power Supplier)

Year	Power Supplier	Major Event	Planned	All Other	Annual Total
2017	18.09	38.45	4.14	65.56	126.24
2018	2.85	62.59	2.61	54.30	122.35
2019	0.00	61.05	0.94	48.99	110.98
2020	18.95	43.83	1.11	48.89	112.78
2021	14.67	66.65	0.06	60.46	141.84
Five Year Average =	10.91	54.51	1.77	55.64	122.84

Outage Cause (Excluding Major Events and Power Supplier)

Year	Power Supplier	Major Event	Planned	All Other	Annual Total
2017	-	-	4.14	65.56	69.70
2018	-	-	2.61	54.30	56.91
2019	-	-	0.94	48.99	49.93
2020	-	-	1.11	48.89	50.00
2021	-	-	0.06	60.46	60.52
Five Year Average =	0.00	0.00	1.77	55.64	57.41

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Conductor Life Cycle Analysis
(New Construction Legend & Input Values)

0.00%	TOTAL	Total fixed cost. This is an optional replacement for O & M + TAX + DEP + INS.
4.70%	O & M	Operations and Maintenance Expense as a percentage of Average Net Distribution Plant calculated using RUS Bulletin 1724D-101A ***Electric System Long-Range Planning Guide*** based on *RUS Fixed Charge Calculation Guide*
0.00%	TAX	Property tax: annual Form 7, last year Part A, line 13(b) Plant the taxes were paid on: annual Form 7, 2 years ago, Part C, line 5 + line 22 Tax Rate: (Property tax / Plant) x 100, or estimated future tax rate
3.00%	DEP	Most Owners use straight-line depreciation where the depreciation rate is the reciprocal of the asset's life. Use annual rate for Coop, for classes of plant Depreciation rate on RUS Form 7 Part E Lines 5(f) and line 6(f)
0.00%	INS	Insurance as a percentage of Net Distribution Plant. Calculating the cost of insurance as a percentage of investment is difficult, and the result makes little difference, therefore, it can be ignored for most applications.
3.00%	INF	The annual inflation rate.
30	m	The loan amortization period in years.
7.2	KV	Line to ground voltage in kV.
99.00%	PF	Peak month power factor.
2.30%	INT	Cost of Capital (Calculated using *RUS Fixed Charge Guide*) used for Present Worth Calculation
1.90%	LGR	The annual rate of growth projected for the peak demand. (Use latest PRS)
30	ULC	Useful Life of Conductor
$0.00	$/KW	Monthly demand charge in dollars per kW per month. If $/KW is zero the following dependant inputs will also be zero:
0.00%	KWI	Demand charge inflation rate.
0.00%	CF	Coincidence factor - This factor represents the coincidence between the non coindedent peak for the line and billing demand.
0.000	RMO	The number of months the metered demand exceeds the minimum biling demand.
0.000	RAT	The annual demand ratchet expressed as a decimal.
0.000	N	The ratio of the average of the squares of the monthly kW demands for the months when the metered demand exceeds the minimum billing demand to the square of the peak month demand.
$0.0633	$/KWH	Energy charge in dollars per kWH per month.
3.00%	KWHI	Energy charge inflation rate.
54.50%	LF	Annual load factor.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Conductor Life Cycle Analysis
(7.2 kV Summary)

	Initial Loading					Future Loading based on a 1.90% LGR for 30 Years	
For loads below	1,893	kW use			1/0 ACSR	3,329	kW
For loads between	1,893	kW and	2,524	kW use	336 ACSR	3,329	kW
For loads above	2,524	kW use			477 ACSR	4,439	kW

Construction Costs

Conductor	Cost Per Mile	Ohms Per Mile	Conductor Operating Capacity* 50%	100%	
3 Ø 1/0 ACSR	$90,000	0.888	2,587	5,175	kW
3 Ø 336 ACSR	$136,000	0.278	5,549	11,098	kW
3 Ø 477 ACSR	$147,000	0.196	6,907	13,814	kW

* Operating Capacity is defined as the manufacturer's rating at a maximum recommended continuous operating temperature of 75° C (167° F), with a 25° C (77° F) ambient temperature and a 2 ft./sec wind.

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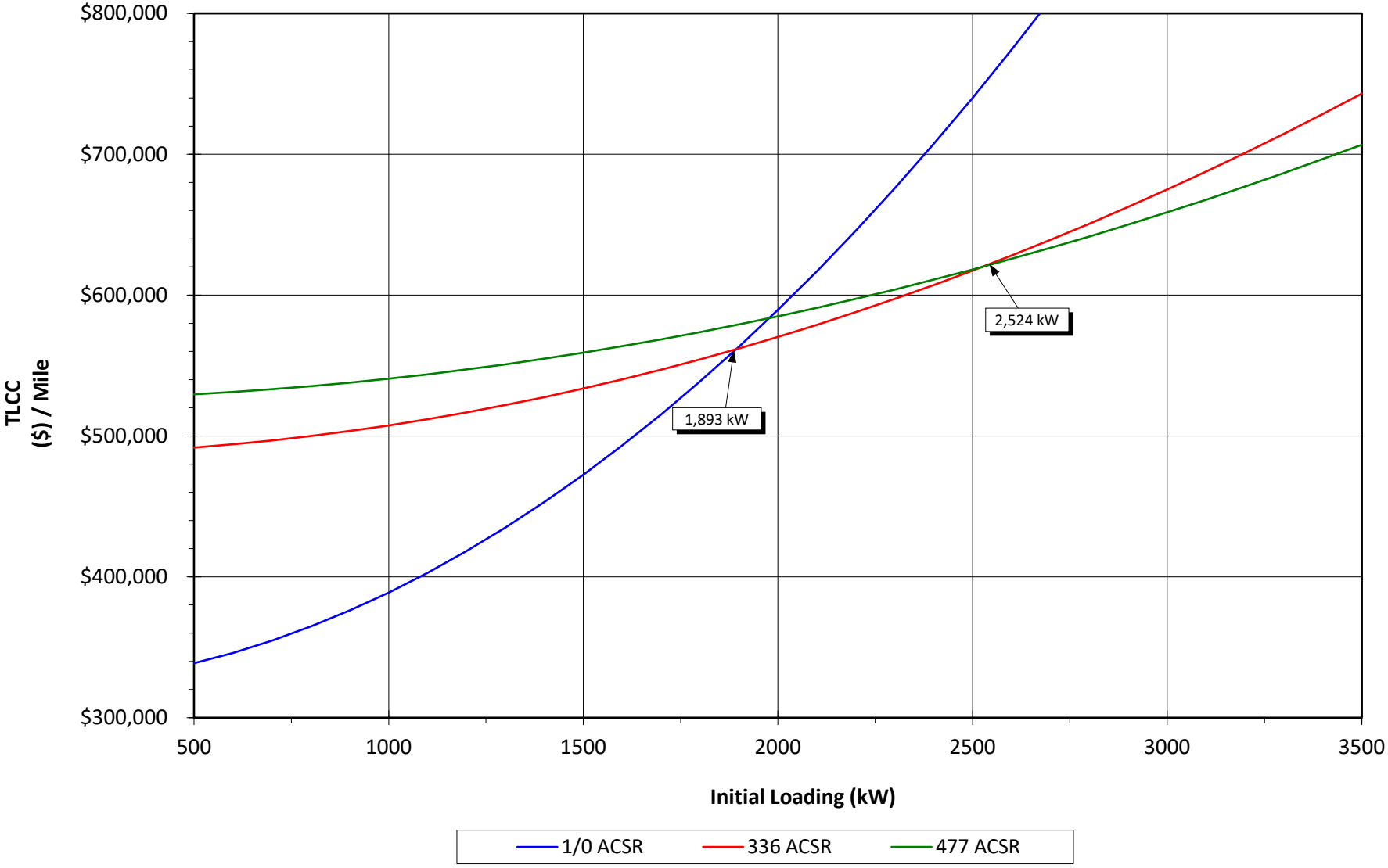
TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Conductor Life Cycle Analysis
Total Life Cycle Cost - Three Phase 7.2 kV



TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Substation Load Data
Winter 2021/2022 System

No.	Substation Name	Voltage KV	EKPC Capacity Base (KVA)	EKPC Capacity Summer (KVA)	EKPC Capacity Winter (KVA)	January 2022 Peak (KW)	Power Factor	(KVAR)	(KVA)	% Loading
1	Campbellsville #1	69-12.47	11,200	13,620	18,140	6,077	81.7%	4,283	7,434	41%
1	Campbellsville #2	69-12.47	11,200	13,620	18,140	8,573	99.7%	690	8,600	47%
10	Mile Lane	69-12.47	10,000	13,620	18,140	11,489	99.8%	777	11,515	63%
20	Greensburg	69-12.47	11,200	9,800	15,100	7,658	99.8%	-452	7,671	51%
30	Summersville	69-12.47	10,000	13,840	17,900	9,286	99.5%	891	9,329	52%
40	McKinney Corner	69-12.47	5,000	6,260	8,340	6,794	99.6%	643	6,824	82%
50	Coburg	69-12.47	11,200	13,840	17,900	11,651	99.7%	871	11,683	65%
60	Columbia	69-12.47	10,000	13,620	18,140	8,893	99.8%	519	8,909	49%
70	Green River Plaza	69-12.47	11,200	13,840	17,900	5,669	99.6%	536	5,694	32%
80	Bass	69-12.47	11,200	9,800	15,100	7,661	99.5%	803	7,703	51%
90	Phil	69-12.47	11,200	13,620	18,140	9,706	96.1%	2,797	10,101	56%
100	West Columbia	69-12.47	11,200	13,620	18,140	9,743	99.2%	1,223	9,819	54%
110	Creston	69-12.47	11,200	13,620	17,900	8,908	100.0%	274	8,912	50%
120	East Campbellsville	69-12.47	11,200	13,620	17,900	9,426	99.1%	1,309	9,517	53%
130	Garlin	69-13.2	11,200	9,800	15,100	9,903	99.8%	639	9,924	66%
140	Contown	69-12.47	11,200	13,620	18,140	4,320	99.3%	-516	4,351	24%
200	TGP - Saloma *									
					Distribution System Totals =	135,756			135,756	

* TGP - Saloma is an EKPC substation located in the KY23 service territory but not affilliated with KY23.
For this reason it is excluded from distribution system totals.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Substation Load Data
2026/27 Winter Peak - Projected Loading

No.	Substation Name	Voltage KV	EKPC Capacity Base (KVA)	EKPC Capacity Summer (KVA)	EKPC Capacity Winter (KVA)	Winter 2026/27 Peak without Improvements (KW)	Power Factor	(KVA)	% Loading	Winter 2026/27 Peak with Improvements (KW)	Power Factor	(KVA)	% Loading
1	Campbellsville #1	69-12.47	11,200	13,620	18,140	7,830	94.2%	8,315	46%	7,830	95.1%	8,231	45%
1	Campbellsville #2	69-12.47	11,200	13,620	18,140	11,045	94.2%	11,730	65%	10,915	95.1%	11,477	63%
10	Mile Lane	69-12.47	11,200	15,900	20,400	14,803	99.7%	14,848	73%	14,797	99.7%	14,842	73%
20	Greensburg	69-12.47	11,200	9,800	15,100	9,491	100.0%	9,492	63%	9,706	100.0%	9,707	64%
30	Summersville	69-12.47	10,000	13,840	17,900	11,509	99.4%	11,582	65%	11,507	99.4%	11,579	65%
40	McKinney Corner	69-12.47	11,200	9,800	11,600	8,420	99.4%	8,473	73%	8,341	99.4%	8,393	72%
50	Coburg	69-12.47	11,200	13,840	17,900	15,304	99.5%	15,379	86%	15,000	99.6%	15,066	84%
60	Columbia	69-12.47	10,000	13,620	18,140	11,459	99.5%	11,521	64%	11,419	99.5%	11,481	63%
70	Green River Plaza	69-12.47	11,200	13,840	17,900	7,304	99.0%	7,375	41%	7,302	99.0%	7,373	41%
80	Bass	69-12.47	11,200	9,800	15,100	9,495	99.4%	9,555	63%	9,255	99.4%	9,314	62%
90	Phil	69-12.47	11,200	13,620	18,140	12,996	95.3%	13,644	75%	12,733	96.3%	13,222	73%
100	West Columbia	69-12.47	11,200	13,620	18,140	13,046	98.9%	13,190	73%	13,019	98.9%	13,163	73%
110	Creston	69-12.47	11,200	13,620	17,900	11,040	100.0%	11,043	62%	10,943	100.0%	10,946	61%
120	East Campbellsville	69-12.47	11,200	13,620	17,900	12,145	97.9%	12,403	69%	12,243	98.1%	12,482	70%
130	Garlin	69-13.2	11,200	9,800	15,100	12,759	99.5%	12,819	85%	12,747	99.5%	12,807	85%
140	Contown	69-12.47	11,200	13,620	18,140	5,354	99.7%	5,371	30%	5,350	99.7%	5,366	30%
200	TGP - Saloma *												
				Distribution System Totals =		174,000		171,369		173,105		175,450	

Note:
1. 158 kW will be transferred on the same circuit at Greensburg.
2. 116 kW will be transferred on the same crcuit at Mckinney Corner.
3. 71 kW will be transferred on the same circuit at Mckinney Corner.
4. 192 kW will be transferred from Coburg to Greensburg.
5. 148 kW will be transferred on the same circuit at Coburg.
6. 65 kW will be transferred on the same circuit at Columbia.
7. 209 kW will be transferred from Bass to East Campbellsville.
8. 323 kW will be transferred on the same circuit at East Campbellsville.

* TGP - Saloma is an EKPC substation located in the KY23 service territory but not affilliated with KY23.
For this reason it is excluded from distribution system totals.

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TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023-2026 CONSTRUCTION WORK PLAN
Distribution Line Open Changes

LEGEND
ASAP - Change open as soon as possible
ASI - Change open after system improvement
* - See CWP Maps for general locations

No.	Substation Area	Line Section * Close	Line Section * Open	Priority	Sub Load Transfer	Transferred Load (kW)
1	Campbellsville	-	-	-	-	-
10	Mile Lane	-	-	-	-	-
20	Greensburg	PC-9529	PC-17378	ASI - 302.01	-	158
30	Summersville	-	-	-	-	-
40	McKinney Corner	PC-21379	PC-6750	ASAP	-	116
		PC-3967	PC-10955	ASAP	-	71
50	Coburg	PC-5257	PC-18932	ASAP	to Greensburg	192
		PC-21924	PC-11793	ASAP	-	148
60	Columbia	PC-16478	PC-3226	ASI - 306.03	-	65
70	Green River Plaza	-	-	-	-	-
80	Bass	PC-15695	PC-18395	ASAP	to East Campbellsville	209
90	Phil	-	-	-	-	-
100	West Columbia	-	-	-	-	-
110	Creston	-	-	-	-	-
120	East Campbellsville	PC-22273	PC-662	ASAP	-	323
130	Garlin	-	-	-	-	-
140	Contown	-	-	-	-	-

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TAYLOR COUNTT RURAL COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 - 2026 CONSTRUCTION WORK PLAN (CWP)
Distribution Line Construction Project Review

Project Number	Project Description and Justification	Project Mileage	Cost
300.01	Replace 2.06 miles of three phase 3/0 and 4/0 ACSR conductor with three phase 477 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	2.06	$408,807
300.02	Replace 1.30 miles of three phase 1/0 and 3/0 ACSR conductor with double circuit three phase 336 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.30	$368,550
301.01*	Replace 0.84 miles of single phase 2 URD conductor with single phase 1/0 conductor. The purpose of this project is to increase service reliability and replace aging underground conductor which serves the Forest Hills subdivision This is a carry-over project from the previously approved 2018 CWP.	0.84	$283,500
302.01	Replace 1.16 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.16	$140,940
302.02	Replace 0.38 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line and increase service reliability. Alternatives: There are no viable alternatives to this project.	0.38	$46,170
302.03	EKPC is upgrading the EKPC owned Greensburg Substation. To accommodate this, TCRECC must to rebuild the existing distribution feeders with five circuits of 500 MCM underground conductor. Alternatives: There are no viable alternatives to this project.	1.00	$150,000
304.01	Replace 1.42 miles of three phase 1/0 ACSR conductor with three phase 336 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.42	$260,712

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TAYLOR COUNTT RURAL COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 - 2026 CONSTRUCTION WORK PLAN (CWP)
Distribution Line Construction Project Review

Project Number	Project Description and Justification	Project Mileage	Cost
305.01	Replace 1.36 miles of three phase 3/0 ACSR conductor with three phase 477 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line and increase service reliability. Alternatives: There are no viable alternatives to this project.	1.36	$269,892
305.02	Replace 1.20 miles of three phase 1/0 ACSR conductor with three phase 336 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to increase service reliability, reduce excessive voltage drop, and strengthen the inter-circuit connection at Coburg Substation. Alternatives: There are no viable alternatives to this project.	1.20	$220,320
306.01	Replace 1.51 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.51	$183,465
306.02	EKPC is upgrading the EKPC owned Columbia Substation. To accommodate this, TCRECC must to rebuild the existing distribution feeders with six circuits of 500 MCM underground conductor. Alternatives: There are no viable alternatives to this project.	1.00	$150,000
306.03	Replace 1.33 miles of single phase 6 CU and 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line and increase service reliability. Alternatives: There are no viable alternatives to this project.	1.33	$161,595
309.01	Replace 1.89 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.89	$229,635
309.02*	Replace 3.74 miles of three phase 336 and 397 ACSR conductor with double circuit three phase 477 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line, increase service reliability, and reduce excessive voltage drop due to an expansion at manufacturing facilities in the Dunville, KY area. This is a carry-over project from the previously approved 2018 CWP.	3.74	$1,136,025
309.03	EKPC is upgrading the EKPC owned Phil Substation. To accommodate this, TCRECC must to rebuild the existing distribution feeders with five circuits of 500 MCM underground conductor. Alternatives: There are no viable alternatives to this project.	1.00	$150,000

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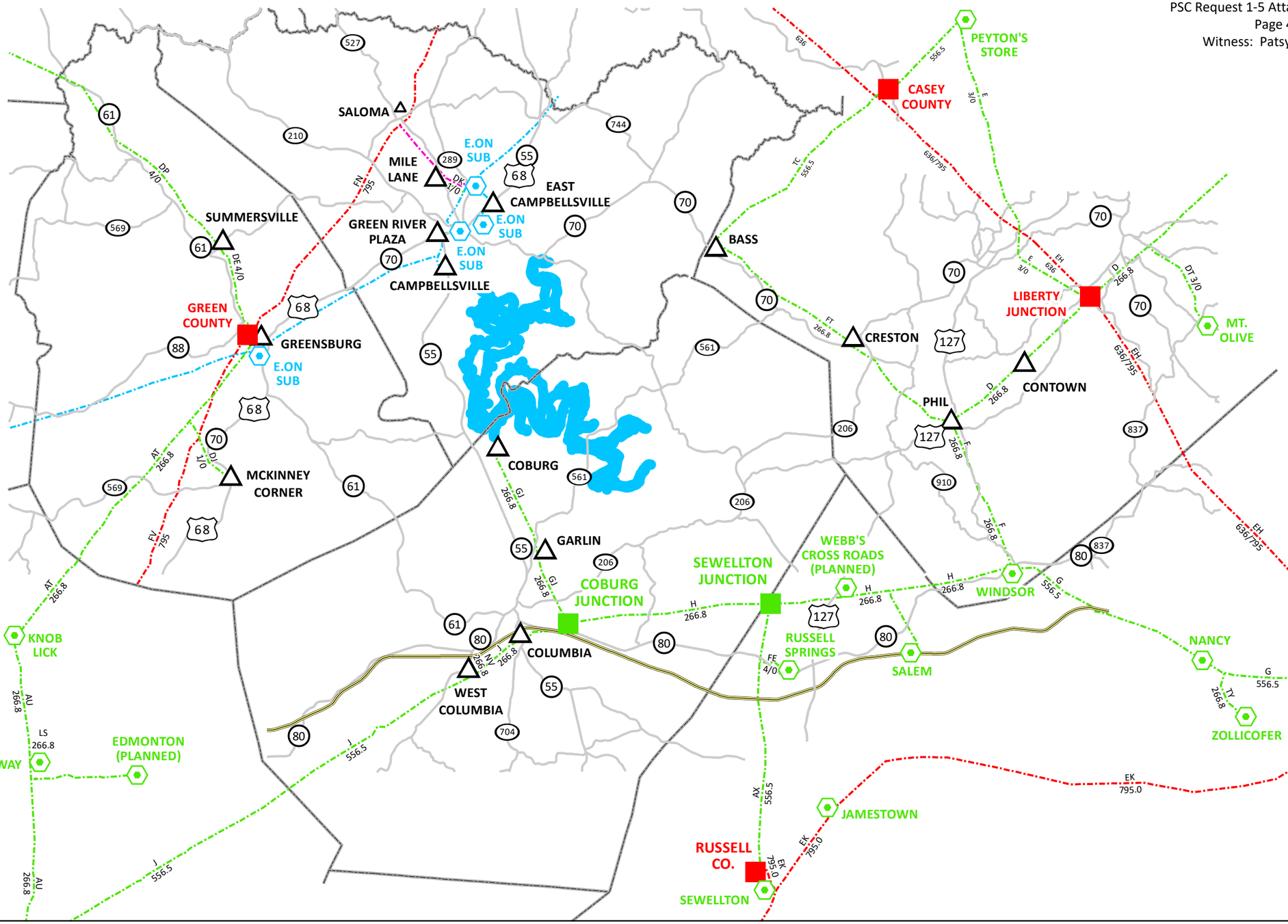
TAYLOR COUNTT RURAL COOPERATIVE CORPORATION
Kentucky 23 Taylor
Campbellsville, Kentucky

2023 - 2026 CONSTRUCTION WORK PLAN (CWP)
Distribution Line Construction Project Review

Project Number	Project Description and Justification	Project Mileage	Cost
310.01	Replace 2.79 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	2.79	$338,985
311.01	Replace 2.85 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	2.85	$346,275
311.02	Replace 1.47 miles of three phase 4 ACSR conductor with three phase 336 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to increase service reliability, reduce excessive voltage drop, and strengthen the inter-circuit connection between Bass and Creston Substations. Alternatives: There are no viable alternatives to this project.	1.47	$269,892
312.01	Replace 1.96 miles of three phase 3/0 ACSR conductor with three phase 477 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded three-phase line, increase service reliability, and reduce excessive voltage drop. Alternatives: There are no viable alternatives to this project.	1.96	$388,962
313.01*	Replace 0.48 miles of single phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line and increase service reliability. Alternatives: There are no viable alternatives to this project.	0.48	$58,320
313.02*	Replace 0.45 miles of single phase and two phase 4 ACSR conductor with three phase 1/0 ACSR conductor. Replace poles and equipment as necessary. The purpose of this project is to relieve an overloaded single-phase line and increase service reliability. Alternatives: There are no viable alternatives to this project.	0.45	$54,675

LEGEND

- TAYLOR COUNTY EXISTING SUBSTATION
- TAYLOR COUNTY PROPOSED SUBSTATION
- E.ON DISTRIBUTION SUBSTATION
- OFF SYSTEM DISTRIBUTION SUBSTATION
- EKPC 69KV TRANSMISSION SUBSTATION
- EKPC 161KV TRANSMISSION SUBSTATION
- EKPC 161KV TRANSMISSION LINE
- EKPC 69KV TRANSMISSION LINE
- LG & E 161KV TRANSMISSION LINE
- LG & E 69KV TRANSMISSION LINE
- COUNTY LINE
- FEDERAL HIGHWAY
- STATE HIGHWAY
- COUNTY ROAD



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pdengineers.com

0 2 4 8 12 16 Miles

N W E S

2023 - 2026 CONSTRUCTION WORK PLAN
TRANSMISSION LINE MAP

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
CAMPBELLSVILLE, KENTUCKY
KENTUCKY 23 TAYLOR

MAP
TRANSMISSION
EXHIBIT R

DWN BY: LJ | ENGRS FILE: KY23.2023.CWP.TRANSMISSION | DATE: 8/11/2022

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 6
RESPONSIBLE PARTY: Patsy Walters

Request 6. Concerning Taylor RECC;s construction projects, for each project started during the last five calendar years, provide the information requested in the format contained in Schedule C. For each project, include the amount of any cost variance and delay encountered, and explain in detail the reasons for such variances and delays.

Response 6. Please see attached. The attachment is an Excel spreadsheet and is being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 7
RESPONSIBLE PARTY: Patsy Walters

Request 7. Provide the information shown in Schedule D for each construction project in progress, or planned to be in progress, during the 12 months preceding the test year.

Response 7. All planned projects were complete during the 12 months preceding the historical test year and during the historical test year.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 8
RESPONSIBLE PARTY: Patsy Walters

Request 8. Provide, in the format provided in Schedule E, an analysis of Taylor RECC's Construction Work in Progress (CWP) as defined in the Uniform System of Accounts for each project identified in Schedule D.

Response 8. Please see response to Request 7 above. There were no active projects during the 12 months preceding the test year.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 9
RESPONSIBLE PARTY: Patsy Walters

Request 9. 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 9. Taylor County does not typically record capitalized interest as projects are typically short-term in nature.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 10
RESPONSIBLE PARTY: Patsy Walters

Request 10. Provide the following monthly account balances for the test year for the total company and Kentucky jurisdiction operations:

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;
j. Balance in accounts payable applicable to amounts included in plant under construction; and
k. Balance in accounts payable applicable to prepayments by major category or subaccount.

Response 10 (a) through (g) and (i) through (k). Taylor County does not operate in jurisdictions other than Kentucky. Please see attachments for (a) through (g). There were no

balances applicable to question (i), (j), or (k). The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

Response 10h. Minimum cash requirement is adjusted on a daily and weekly basis depending upon the needs of the cooperative. Taylor County utilizes its lines-of-credit with CoBank and CFC for liquidity purposes. The typical cash balance is usually between $2 and $3 million.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 11
RESPONSIBLE PARTY: Patsy Walters

Request 11. Provide a reconciliation and detailed explanation of each difference, if any, in Taylor RECC's capitalization and net investment rate base for the test year.

Response 11. Please see attached. Please note, Taylor County's revenue requirements are based on a times interest earned (TIER) measurement, not return on rate base or capitalization. The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 12
RESPONSIBLE PARTY: Patsy Walters

Request 12. 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 or each item of utility plant, the amortization period, and the unamortized balance at the end of the test year.

Response 12. No acquisitions of an operating unit or system have occurred since our last rate case.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 13
RESPONSIBLE PARTY: Patsy Walters

Request 13. Provide a copy of Taylor RECC's most recent depreciation study. If no such study exists, provide a copy of Taylor RECC'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 of schedule was last updated.

Response 13. Please see Mr. Williams' response in Exhibit 20 of Taylor County's Application.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 14
RESPONSIBLE PARTY: Patsy Walters

Request 14. Provide Taylor RECC's cash account balances at the beginning of the test year and at the end of each month during the test year for total company and Kentucky jurisdictional operations.

Response 14. Taylor County does not operate in any jurisdictions other than Kentucky. This response includes Taylor County's total company/Kentucky jurisdictional operations. Please see attached. The attachments are Excel spreadsheets and are being uploaded separately into the Commission's electronic filing system.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 15
RESPONSIBLE PARTY: Patsy Walters

Request 15. Provide the average number of customers on Taylor RECC's system by rate schedule for the test year and two most recent calendar years.

Response 15. Please see attached. The attachment is an Excel spreadsheet and is being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 16
RESPONSIBLE PARTY: Patsy Walters

Request 16. Provide a schedule, in the format provided in Schedule F, of electric operations net income, per kWh sold, per company books for the test year and three calendar years preceding the test year.

Response 16. Please see attached. The attachments are Excel spreadsheets and are being uploaded separately into the Commission's electronic filing system.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 17
RESPONSIBLE PARTY: Patsy Walters

Request 17. Provide the comparative operating statistics as shown in Schedule G.

Response 17. Please see attached. The attachments are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 18
RESPONSIBLE PARTY: Patsy Walters

Request 18. Provide the information requested in Schedule H1 for budgeted and actual numbers of full- and part-time employees by employee group, by month, and by year; and regular wages, overtime wages, and total wages by employee group, my month, for the test year and three most recent calendar years preceding the test year. Explain any variance exceeding 5 percent. Complete the information requested in Schedule H2. Provide a reconciliation and detailed explanation of each difference, if any, in Taylor RECC's capitalization and net investment rate base for the test year.

Response 18. Please see the attached Schedule H1 and H2. The attachments are Excel spreadsheets that are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 19
RESPONSIBLE PARTY: Jeff Williams

Request 19. State whether Taylor RECC, 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 since Taylor RECC's last base rate case.

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.

Response 19. Taylor County has performed a study.

Response 19a. Please see attached. The attachment is being filed under seal pursuant to a Motion for Confidential Treatment.

ATTACHMENT FILED UNDER SEAL PURSUANT TO A MOTION FOR CONFIDENTIAL TREATMENT

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 20
RESPONSIBLE PARTY: Jeff Williams

Request 20. Provide the most recent wage, compensation, and employee benefits studies, analyses, or surveys conducted since Taylor RECC's last base rate case or that are currently utilized by Taylor RECC.

Response 20. Please see the response to Response 20 above.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 21
RESPONSIBLE PARTY: Patsy Walters

Request 21. For each employee group, state the amount, percentage increase, and effective dates for general wage increases and, separately, for merit increases granted in the past three calendar years.

Response 21. The Bargaining Group received the following raises per union contract: 2020 totaling 2.00%, 2021 totaling 2.50% and 2022 totaling 9.72%. Merit increases for non-bargaining group received the following raises: 2020 totaling 2.64%, 2021 totaling 2.83% and 2022 totaling 12.52%.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 22
RESPONSIBLE PARTY: Patsy Walters

Request 22. Provide a schedule reflecting the salaries and other compensation of each executive officer for the test year and three most recent calendar years. Include the percentage annual increase and the effective date of each increase, the job title, duty and responsibility of each officer, the number of employees who report to each officer, and to whom each officer reports. For employees elected to executive office status since the test year in Taylor RECC's most recent rate case, provide the salaries for the persons they replaced.

Response 22. Please see attached. The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 23
RESPONSIBLE PARTY: Patsy Walters

Request 23. 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, Non0Exempt, Union, and Non-Union Hourly employees (e.g., single, family). 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 23. Please see attached. The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 24
RESPONSIBLE PARTY: Patsy Walters

Request 24. Provide all current labor contracts and the most recent labor contracts previously in effect.

Response 24. Please see attached.

AGREEMENT

BETWEEN

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

AND

LOCAL UNION NO. 89
GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS
AFFILIATED WITH
INTERNATIONAL BROTHERHOOD OF
TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

(Construction and Maintenance)

Effective December 1, 2020 through November 30, 2025

TABLE OF CONTENTS

ARTICLE I

This Agreement is made and entered into this 1st day of December, 2020, by and between Taylor County Rural Electric Cooperative Corporation, hereinafter referred to as the Cooperative, and Local Union No. 89, General Drivers, Warehousemen and Helpers, affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America, hereinafter called the Union.

ARTICLE II

PREAMBLE

Statement of Principles and Union Responsibilities

The Union recognizes its responsibilities as the exclusive bargaining agent for the employees covered by this Agreement, and realizes that in order to provide maximum opportunities for continuing employment, good working conditions and good wages, the Cooperative must be in a strong marketing position, which means that it must produce quality services and products and be able to sell them at the lowest possible costs and otherwise be able to operate its business efficiently, economically and competitively. The Union therefore agrees that it will support the Cooperative's efforts to assure a fair day's work by the employees for a fair day's pay. The Union will support the Cooperative in its efforts to improve services, preserve equipment, prevent accidents and strengthen good will between the Cooperative and its employees, as well as with its suppliers and customers. The Union further recognizes that the Cooperative has certain definite and stringent obligations and responsibilities to its customers, suppliers, Public Service Commission and Rural Utilities Service ("RUS") and the Union agrees that it will fully cooperate with the Cooperative in the performance and discharge of these obligations and responsibilities.

ARTICLE III

Recognition

The Cooperative recognizes the Union as the exclusive bargaining representative for all construction and maintenance employees employed from and at its Campbellsville, Kentucky, location, including mechanics, tree trimmers, laborers, linemen, instrument men, staking engineer helper, servicemen, groundmen, maintenance men, right-of-way helpers, warehousemen, truck drivers and tractor drivers, but excluding all office clerical employees, professional employees, guards and supervisors as defined in the Act, as amended. It is the intention of the parties hereto that the bargaining unit covered by this Agreement shall be as established by the National Labor Relations Board in its "Certification of Representative" dated November 14, 1978, in Case No. 9-RC-12607, and this Article is included herein solely for the purpose of discharging the Cooperative's obligation under the law to recognize the Union.

In the event the Cooperative is sold to a private investor notice of such sale will be given to the Union not later than the day of the closing of such sale.

ARTICLE IV

Management Prerogatives

The operation, control and management of the Cooperative's facilities and operations, and all business and activities of the Cooperative in connection therewith which are covered or affected by this Agreement, and the supervision and direction of the working forces at such facilities, operations and business are and shall continue to be solely and exclusively the functions and prerogatives of the management of the Cooperative.

All of the rights, functions and prerogatives of management which the Cooperative had prior to entering into this Agreement with the Union are reserved and retained exclusively to the

Cooperative, unless changed or modified by one or more explicit provisions of this Agreement. Specifically but without limiting or affecting the generality of the foregoing, it is distinctly understood and agreed that the Cooperative has the sole right to: Determine the nature and extent of the business to be carried on by the Cooperative, determine the suppliers and customers with whom it will deal, and the prices at which and terms upon which its materials, equipment and supplies will be purchased, leased or otherwise acquired and its services and products will be sold; determine the size and composition of the working force covered by this Agreement, and assignment of work, and policies affecting the hiring of new employees; layoff, discipline and discharge employees for cause; and determine the qualifications of employees, including the right to terminate the services of employees without limitation during their probationary period; establish and enforce quality, production, construction, and service standards for its employees, services and products; establish new departments; discontinue existing departments; introduce new and improved equipment, facilities and service methods; change, combine, establish or discontinue jobs or operations; determine when and if vacancies in the working force shall be filled; determine the means and methods by which production and services will be made; determine the hours of operation, discontinue temporarily or permanently, in whole or in part, any operations of the business of the Cooperative covered or affected by this Agreement.

The Cooperative shall also have the right from time to time to make and enforce such reasonable rules, procedures and regulations applicable to employees covered by this Agreement for the purpose of maintaining order, safety, effective operations and control; to enforce, change, abolish or modify such existing rules, procedures and regulations applicable to employees covered by this Agreement, as it may from time to time deem necessary or advisable, after advance notice thereof to the Union and employees, which shall be subject to the grievance and

arbitration procedure of this Agreement. The Cooperative shall also have the right to require compliance with such rules, procedures and regulations by employees until an Arbitrator sets aside the rule, procedure or regulation as a result of the grievance and arbitration procedure or the parties mutually agree to set aside the rule, regulation or procedure without arbitration.

ARTICLE V

Subcontracting

It is understood by the Cooperative and the Union that for the Cooperative to satisfy the demands of its customers and to successfully operate the business, contracting and/or subcontracting of work is necessary from time to time. It is therefore agreed by the Union that the Cooperative may, within its exclusive discretion, engage contractors for all construction, manufacturing, service and operations functions, and any and all other functions which it, in its exclusive discretion, deems necessary and desirable. The Cooperative will not subcontract work under this provision that would cause the layoff of employees.

ARTICLE VI

Supervisory and Other Excluded Personnel

Notwithstanding any of the provisions of this Agreement, there shall be no limitation or restriction upon the nature, extent and kind of work which Supervisory and Management personnel may perform, nor shall there be any limitation or restriction as to the times or occasions on which Supervisory and Management personnel may perform such work. The Cooperative will not utilize this Article in such a way as to displace any employee covered by this Agreement.

ARTICLE VII

Discipline and Discharge

SECTION 1.

The Cooperative shall have the right to discharge employees during their probationary period without cause and without recourse by the Union or by such probationary employee to the grievance procedure of this Agreement.

SECTION 2.

The Cooperative shall have the right to discipline or discharge employees for "just cause". While it is the policy of the Cooperative to warn employees for minor infractions before taking disciplinary action or discharging them, it is distinctly understood and agreed that certain offenses, such as, but not by any means limited to the following, shall be considered "just cause" and cause for immediate discharge, without warning: Dishonesty; insubordination; fighting while on the Cooperative's premises or on duty; smoking in fuel pump areas; failure or refusal to wear or utilize any safety equipment provided and required by the Cooperative or to follow any safety procedure prescribed by the Cooperative; horseplay of such a nature as to be capable of causing personal injury or property damage; drinking alcoholic beverages or being under the influence of alcoholic beverages while on the Cooperative's premises or on duty; being in possession of or using or being under the influence of narcotics (unless prescribed by the employee's physician and the employee is following the physician's directions on dosages, etc.), marijuana or hallucinatory drugs; proven falsification of the Cooperative's records or reports; willful damage to tools, equipment or other Cooperative property; failure to immediately report involvement in an accident while on duty or on the Cooperative's premises; or participation in any activity prohibited by the Article of this Agreement entitled "No Strike No Lockout".

SECTION 3.

It is understood and agreed that employees have a responsibility to be regular and punctual in their work attendance and that habitual or repeated tardiness or absenteeism or failure to report to work promptly, and other minor offenses will be cause for disciplinary action, including discharge. The procedure will be as follows: (1) first offense: verbal warning; (2) second offense: written warning; (3) third offense: three (3) day suspension; and (4) fourth offense: subject to discharge.

It is expressly agreed (a) that the Cooperative, in its discretion, may decide not to discharge an employee for the fourth (4th) offense, and (b) that the Cooperative's failure in any case or cases to strictly enforce the above procedure, shall not be a precedent and shall not constitute a waiver of the Cooperative's right to enforce such procedure in any other case.

SECTION 4.

It is agreed that in the event an employee is given any disciplinary action, including a warning notice, a copy of the warning notice will be given to the employee, one (1) copy to the Union and one (1) copy will be retained in the employee's personnel file. A warning notice or notices for any cause may constitute a basis for discharge for any subsequent infraction and it is understood and recognized by the parties hereto that the infractions specified in Section 2 of this Article shall be cause for immediate discharge without warning. It is further understood and recognized that in any event it shall be cause for discharge if an employee is given four (4) warning notices for any cause or combination of causes within a "rolling" twelve (12) month period. Disciplinary warnings outside this "rolling" twelve (12) month period will not be used for disciplinary purposes. All disciplinary warnings and discharges shall be subject to the grievance procedure.

ARTICLE VIII

Union Security and Checkoff

SECTION 1. Union Security.

It is recognized by the parties that the Commonwealth of Kentucky law prohibits union membership as a condition of employment. The Cooperative and the Union agree, in the event future legislation during the term of this Agreement provides for permitting a Union Shop in the Commonwealth of Kentucky, to negotiate with respect to inclusion of some form of a Union Security provision.

SECTION 2. Checkoff.

The Cooperative agrees to deduct each month, from the paychecks of all employees who are covered by this Agreement, all periodic dues and initiation fees owing to the Union by the employees, provided, however, that such employees shall have signed and submitted a written authorization for such action on the part of the Cooperative; such written authorization shall conform to and be in accordance with all applicable Federal and State laws.

All monies deducted by the Cooperative shall be forwarded to the Secretary-Treasurer of the Union.

It is understood and agreed that any monies collected by the Cooperative for the Union will be taken out of the paycheck for the first pay period of the month and remitted to the Union before the 30th day of the same month.

The Cooperative will recognize authorizations for deductions from wages, if in compliance with State and Federal law, to be transmitted to the Union. No such authorization shall be recognized if in violation of State or Federal law. No deduction shall be made which is

prohibited by applicable law. This provision is subject to whatever shop rule is promulgated by the Cooperative with respect to garnishments or other wage deductions.

SECTION 3.

In consideration of the adoption by the Cooperative of the Checkoff provisions, the Union agrees to indemnify and hold the Cooperative harmless from and against any and all liability or loss as a result of any action brought by any employee or employees on account of claimed illegal payments, suspension or discharge under the provisions of Article VIII of this Agreement, above described, including reasonable attorneys' fees and court costs.

SECTION 4.

If for any reason an employee does not work during the first pay period of any month in which the checkoff is made, the Cooperative shall make deductions for the above purpose from such employee's wages out of the next succeeding pay period in which he works.

ARTICLE IX

No Strike-No Lockout

The Union agrees that during the term of this Agreement neither the Union, its officers, agents or members shall authorize, instigate, aid, condone or engage in any work stoppage, strike of any kind or description, including so-called sympathy strikes, or otherwise interrupt, impede or restrict services of the Cooperative or engage in any activity which would tend to cause an interruption or delay in the accomplishment of the work and business of the Cooperative.

The Union further agrees that during the term of this Agreement the Union, its officers, agents or members will not honor or recognize any picket line or picketing in any form,

including recognition of picket lines or picketing out of so-called sympathy, by any union at the Cooperative, or any facility or operation of the Cooperative, regardless of where it is located.

Any employee who engages in any conduct prohibited by this Article, or who fails or refuses to comply with any provision of this Article, shall be subject to appropriate discipline, including discharge, without warning, by the Cooperative. In the event an employee is discharged for violation of the provisions of this Article, he may resort to the grievance and arbitration procedures set forth herein. The arbitrator shall, however, be limited to determining the single issue of whether or not the employee did, in fact, participate in or promote such action and the employee(s) affected will have the burden of conclusively showing his (their) non-participation in and not having promoted such actions. Further, the Cooperative shall be under no obligation to bargain with the Union concerning employees who are on strike or concerning the subject of any strike so long as the strike continues.

Neither the violation of any provision of this Agreement nor the commission of any act constituting an unfair labor practice or otherwise made unlawful by any federal, state or local law shall excuse the Union, its officers, agents or members from their obligations in the provisions of this Article.

The provisions of this Article shall not be appealable to the grievance procedure either for the purpose of assessing damages or securing a specific performance, such matters of law being determinable and enforceable only in the courts.

The Cooperative shall not lock out members of the Union during the term of this Agreement.

ARTICLE X

Probationary Employees

All new or rehired employees shall be placed on probation and shall be classified as temporary help during the first one hundred twenty (120) actual work days of their employment with the Cooperative. During such one hundred twenty (120) actual work day probationary period the Cooperative may discharge or otherwise discipline, lay off, transfer or assign such employees with or without cause, and such actions shall not be subject to the grievance procedure.

Probationary employees who complete their probationary period will be classed as regular employees and their date of hire shall be from the first day of hiring.

ARTICLE XI

Rates for New Job Classifications

Recognizing that during the term of this Agreement the Cooperative may install new equipment or change work methods resulting in the creation of new job classifications, the Cooperative shall establish rates for such new classifications in line with the Cooperative's wage scale for like work and notify the Union's representative in writing. If after ten (10) days neither party questions the rate established for the new classification, it shall become the established rate for the job; otherwise, the establishment of such rate shall be a matter for negotiation. If the parties negotiate and are unable to reach an agreement, the rate as established by the Cooperative shall stand until this Agreement expires if less than twelve (12) months until this Agreement expires and then shall be subject for renegotiation. If more than twelve (12) months from the expiration of this Agreement, then the dispute shall be subject to the Grievance-Arbitration Procedure set out elsewhere in this Agreement.

ARTICLE XII

Hours of Work and Overtime

SECTION 1.

An employee's regular work week shall be forty (40) hours and shall start at the beginning of his shift on Monday, subject to change by the Cooperative when requirements dictate, but shall not be less than eight (8) hours, excluding a one (1) hour lunch break. In addition, employees shall receive two (2) ten (10) minute breaks during a full eight (8) hour shift.

The work week shall begin at 12:01 a.m. Sunday and end at Midnight the following Saturday.

SECTION 2.

When overtime is required, the employees in the classification or who are assigned on the job where the overtime exists shall be required to work the overtime assigned.

SECTION 3.

Overtime at the rate of time and one-half (1-1/2) shall be paid for all hours actually worked in excess of forty (40) hours in any one work week. Time off for sick leave, actual hours served on Jury Duty under Article XVIII, and Holidays as set forth in Article XX, only shall be considered hours worked (8 hours per day) for purposes of this provision. Overtime under this Section shall be computed on a weekly basis.

SECTION 4.

No premium or overtime pay set out in this Agreement shall be pyramided.

SECTION 5.

An employee required, on a temporary basis, to report to a work place other than his regularly required work place, will not be required to travel on his own time for a period longer than the travel time to his regular reporting work place.

ARTICLE XIII

Reporting and Call-Out Pay

SECTION 1.

When an employee reports for work at his regular starting time on a scheduled work day, he will be guaranteed eight (8) hours straight time pay at his regular hourly rate of pay, provided, however, that this provision shall not apply in case of strikes or other work stoppages, disciplinary suspension of an employee, acts of God or any other cause beyond the Cooperative's control.

SECTION 2.

When an employee has completed his regular shift and left the Cooperative's premises, but is called in to work more than two (2) hours prior to the beginning of his next regularly scheduled shift, he will be guaranteed three (3) hours work at his regular straight-time hourly rate of pay. This guarantee shall only apply once each work day (24-hour period). Other hours actually worked on additional "call-outs" will be compensated at the employee's regular straight-time hourly rate.

Call-Out is mandatory and will be performed in the following way: One Serviceman will be on-call (the "On-Call Serviceman") for service calls from 12:01 a.m. Monday through Midnight Sunday (the "on-call week") for all counties in the Cooperative's service area. The

Servicemen will serve as the On-Call Serviceman on a rotating basis based on seniority, beginning with the most senior Serviceman.

The Cooperative will provide a dispatching service for purposes of call-out. The dispatcher will follow the steps below:

Step 1 – The dispatching service will call the Serviceman in the county where the outage or service is required. If the dispatcher cannot get in contact with that Serviceman immediately, then go to Step 2.

Step 2 – The dispatching service will contact the On-Call Serviceman for that on-call week. If the On-Call Serviceman can get another Serviceman or First Class Lineman who is closer to the outage or in the county where the outage exists, then that Serviceman or First Class Lineman will perform the work involved with the on-call lineman, as set out below or with a qualified employee. The On-Call Serviceman cannot use more than thirty (30) minutes in an effort to find such person who is closer or in the county where the outage exists.

Step 3 – If the outage is not covered by either Step 1 or Step 2, the On-Call Serviceman must perform the work himself with the on-call lineman or a qualified employee.

On all call-outs the On-Call Serviceman will be accompanied by a lineman or a qualified employee. Initially, the Cooperative will post a notice for linemen to volunteer to be called out. So long as there are no fewer than six (6) linemen on the volunteer list, this system will remain on a volunteer basis. The linemen on the volunteer list will be called on a rotation basis, with the lineman serving a full week beginning at 12:01 a.m. on Monday and ending at midnight on Sunday. Call-out for the linemen for the on-call week is mandatory.

If at any time the volunteer list for linemen to be called out falls below six (6), then all linemen in all classifications will be subject to call-out on a rotation basis and such call-out shall be mandatory.

The linemen call-out procedures set forth above will remain in effect unless the total number of linemen employed by the Cooperative is less than ten (10). If there are fewer than ten (10) linemen, then the application of the mandatory rotation of linemen shall end.

Only the On-Call Serviceman and On-Call lineman for each week will receive one (1) hour of pay at time and one-half (1-½) for each day served during the on-call week. If the On-Call Serviceman and On-Call lineman who are called to perform the work as set forth in Step 2, then the Serviceman or First Class Lineman and the On-Call lineman or a qualified employee who perform the work only, will receive the "guaranteed" three (3) hours straight time set forth above, unless the time to perform the work actually exceeds three (3) hours.

The On-Call Serviceman can trade his on-call week with another Serviceman and, in such case, the On-Call Serviceman must advise his immediate Supervisor or, in his absence, the Manager, of the replacement Serviceman at least one (1) regularly scheduled work day before the on-call week begins, except in the case of an emergency as determined by the Superintendent or, in his absence, the Manager on a particular day during the on-call week, less than such notice will be sufficient.

The On-Call lineman can trade his on-call week with another lineman and, in such case the On-Call lineman must advise his immediate supervisor or in his absence, the Manager of the replacement lineman at least one (1) regularly scheduled work day before the on-call week begins, except in the case of an emergency as determined by the Superintendent.

No employee shall be required to take time off to avoid the payment of overtime.

SECTION 3.

An employee on vacation who is "called-out" to work shall have the right to refuse such "call-out". If the employee on vacation reports for work, he shall be paid time and one-half (1-1/2) the regular hourly rate for hours actually worked in addition to his regular vacation pay.

SECTION 4.

If a Serviceman is on vacation and a First Class Lineman is called-out to replace him under Article XIII, Section 2, then such First Class Lineman will receive the Serviceman's hourly rate as set forth in Article XXVI, Section 4, or his "red circle" rate, whichever is higher. The call-out will be under the same terms and conditions as are set forth in Article XIII, Section 2.

ARTICLE XIV

Grievance Procedure

SECTION 1.

A grievance as referred to in this Agreement is a dispute arising from the interpretation or application of one or more specific provisions of this Agreement. Grievances shall be processed in accordance with the procedures set forth below.

STEP 1. The aggrieved employee shall present his grievance to his Supervisor within three (3) days after the cause of such grievance becomes known or could reasonably be expected to have been known. If he has been prevented from presenting the grievance within this time limit because of an excused absence, the days of excused absence shall be excluded in computing the time limit. The aggrieved employee may be accompanied by his Union Steward.

STEP 2. If the grievance is not settled in Step 1, it may be appealed by presenting the grievance in writing within five (5) days to the Superintendent, who shall meet with the aggrieved employee. The aggrieved employee may be accompanied by his Union Steward.

STEP 3. If the grievance is not settled in Step 2, it may be appealed by the Union within ten (10) days to the Manager (or the person acting in his capacity in the event of his absence) who shall arrange to meet with the Union's Assistant to the President and the aggrieved employee and his Union Steward.

STEP 4. If the grievance is not satisfactorily settled in Step 3 and if the grievance is otherwise arbitrable under this Agreement, it may be referred to arbitration in strict accordance with the provisions of this Agreement pertaining to arbitration, provided that if the Union fails to notify the Cooperative in writing by Registered Mail within ten (10) days after the Cooperative gives its answer in writing to a grievance at Step 3 of the grievance procedure of the Union's desire to arbitrate the grievance, then the Union shall be conclusively presumed to have accepted the Cooperative's answer and said grievance shall not thereafter be arbitrable.

SECTION 2.

The grievance procedure is subject to the following rules and conditions:

(a) A settlement satisfactory to the Union at any step in the grievance procedure shall be binding on it and the employee or employees making the complaint.

(b) Saturdays, Sundays and holidays are excluded in computing the time limits specified in this Article.

(c) All meetings conducted pursuant to the provisions of Step 1, Step 2, Step 3 and Step 4 of this Article, unless otherwise mutually agreed, shall be conducted at times when the aggrieved employee and others, including the Steward, are not regularly scheduled to work.

For employees in the Construction and Maintenance Unit, such meetings may also take place beginning at 4:30 p.m. or during the last one-half (1/2) hour of their shift, whichever is applicable. Neither party shall have more than a total of three (3) persons present, including the aggrieved employee, except, by mutual consent, the parties may agree to a greater number.

(d) Employees will not leave their work to investigate, present or discuss grievances without prior permission from their supervisor.

(e) This grievance procedure constitutes the sole and exclusive means of resolving controversies. Pending the raising, processing and/or settlement of a grievance, all employees will continue to work in a normal manner, and there shall be no slowdown, stoppage or other interference with work or plant operation as discussed and set forth elsewhere in this Agreement.

(f) Infrequently, due to the nature of the subject matter, the Cooperative or the Union may request that early steps of the grievance procedure be waived. In such cases certain steps of the grievance procedure may be waived provided there is mutual agreement by the Cooperative and the Union to do so.

(g) Any time the Cooperative offers a settlement with regard to any grievance, there will be a Union Official present. "Union Official" shall mean the employee's Steward or the Union's Assistant to the President. A settlement reached with the Steward will not set a precedent, unless the Union's Assistant to the President is aware of the settlement.

(h) Any grievance of any kind which has been presented under the grievance procedure set forth herein which is not appealed to the next step within the applicable time specified above and any grievance which has not been presented under the grievance procedure

set forth herein within the time period for presentation of grievances shall be considered settled and shall not be subject to further discussion or appeal.

SECTION 3.

The Cooperative shall not be required or obligated under the terms of this Agreement or otherwise to submit to arbitration any claim or cause of action which it may have or assert on account of any alleged violation of this Agreement by the Union or any employee or employees covered by this Agreement. The Cooperative shall have the right to sue at law or in equity in any court of competent jurisdiction, Federal or state, to enforce this Agreement and to recover for any breach or violation thereof.

SECTION 4.

No grievance shall be arbitrable unless it involves an allegation of the type set out in Section 1, which allegation shall be designated in writing by the Union to the Cooperative no later than the time such grievance is appealed to Step 2 of the grievance procedure set forth herein.

No grievance may be filed or considered which is based in whole or in part on an occurrence happening prior to or after the term of this Agreement.

SECTION 5.

The provisions of this Agreement covering grievance procedure and arbitration are completely unrelated to and independent of the provisions of the Article of this Agreement entitled "No Strike-No Lockout" clause. In the event the Cooperative claims that a grievance filed hereunder is not arbitrable, whether or not such claim be ultimately sustained, such claim shall not in any way affect or excuse the Union or any employee or employees covered by this

Agreement from the provisions of the Article entitled "No Strike-No Lockout" and their respective obligations and duties thereunder.

SECTION 6.

In the event any grievance which is otherwise arbitrable under the terms of this Agreement shall be arbitrated, selection of an arbitrator shall first be attempted by the Union and the Cooperative attempting to agree on an arbitrator, and, if they cannot agree upon a selection, the Federal Mediation and Conciliation Service shall be asked to furnish a panel consisting of at least seven (7) names of arbitrators. The Union and the Cooperative shall select a single arbitrator from the panel by alternately striking a name until such time as only one (1) name remains. The Cooperative and the Union will alternate in striking the first name from the list. The Cooperative will strike the first name in the first arbitration case and the Union will strike the first name in the second arbitration case, etc.

SECTION 7.

No more than one grievance shall be submitted to any one arbitrator unless the Cooperative and the Union agree otherwise in writing. The Arbitrators selected shall have power to receive relevant testimony from the parties to the dispute and hear such witnesses as they may desire to present. The parties may, if they so desire, be represented by counsel in all proceedings held before the Arbitrator. The Cooperative shall bear the costs of preparing and presenting its case to the Arbitrator and the Union shall bear the costs of preparing and presenting its case to the Arbitrator. All other expenses of arbitration, such as, but not limited to the Arbitrator's fee, and the hiring of a space in which the arbitration proceedings are held, shall be divided equally between the Cooperative and the Union.

SECTION 8.

The function of the Arbitrator shall be of a judicial, rather than a legislative, nature. The Arbitrator shall not have authority to add to, ignore or modify any of the terms or provisions of this Agreement. The Arbitrator shall not substitute his judgment for the Cooperative's judgment and where matters of judgment are involved he shall be limited to deciding whether or not the Cooperative acted arbitrarily, capriciously or in bad faith. The Arbitrator shall not decide issues which are not directly involved in the case submitted to him. In any discharge or disciplinary suspension case where the Arbitrator decides that the aggrieved employee should be awarded any back pay, the Cooperative shall be entitled to full credit on such awards for the employee's gross interim earnings, unemployment compensation benefits, worker's compensation benefits received or receivable and any other compensation he receives from any form of employment during the period he was not working for the Cooperative. Subject to the foregoing qualifications and limitations, the Arbitrator's award shall be final and binding upon the Cooperative, the Union and the aggrieved employee or employees.

SECTION 9.

Only the Union shall have the right to prosecute grievances under this Agreement and only the Union shall have the right to take to arbitration any grievance which is otherwise arbitrable under this Agreement. If the Union fails, refuses or declines to prosecute a grievance on behalf of an employee, or on behalf of a group of employees hereunder, such employee or employees who filed such grievance or on whose behalf it has been filed shall be conclusively bound thereby and both the Union and the aggrieved employee or employees shall thereafter be prohibited from reviving or further prosecuting said grievance.

ARTICLE XV

Access to Facilities and Properties of the Cooperative

An authorized officer or agent of the Union, the name of whom shall be furnished to the Cooperative in writing, shall have access to the Cooperative's establishment during working hours for the purpose of investigating grievances and for any other legitimate purpose in connection with the administration of this Agreement, provided he notifies the Manager of the Cooperative beforehand. The Union hereby agrees that its agents and representatives will not cause any interruption of the Cooperative's working schedule or interfere with the work of employees or otherwise abuse these visitation privileges when on its premises. In the event of a change of agents, the Cooperative will be immediately notified in writing.

ARTICLE XVI

Seniority

SECTION 1.

Seniority of employees covered by this Agreement shall be determined by the Cooperative on the basis of length of continuous service with the Cooperative from the last date of hire.

SECTION 2.

An employee's seniority, qualifications, physical condition, ability, skill and adaptability to perform the work involved, as determined by the Cooperative, shall apply in the case of layoff, recall from layoff, and promotions. It is agreed that in the case of layoff no employee, regardless of his seniority, may displace any other employee unless he is at that time able to satisfactorily perform the work of the employee being displaced. An employee who displaces

another employee pursuant to the provisions of this Section shall be paid at the hourly rate of pay for that job classification. When the working force is being increased after a layoff the Cooperative will apply the same standards as it originally applied for layoff when the employees are being recalled.

SECTION 3.

In the case of layoff, all probationary, seasonal, part-time and casual employees shall be laid off before any employees who have established seniority are affected.

SECTION 4.

The Cooperative will give employees one (1) week notice prior to layoff.

SECTION 5.

Seniority, qualifications, physical condition, ability, skill, adaptability to perform the work involved, as determined by the Cooperative, shall be the controlling factors in promotion of employees, and where in the Cooperative's judgment, these factors are relatively equal between two (2) or more employees, seniority will control.

SECTION 6.

All job vacancies in jobs which the Cooperative decides to fill will be posted for bid at least three (3) full working days, at all three (3) locations. Until the Cooperative has selected an employee to permanently fill such job vacancy the vacant job may be filled in any manner the Cooperative sees fit. The Cooperative will take final action with respect to all job openings within two (2) weeks after the posting is taken down. Employees shall be permitted to bid only on jobs which are higher than the job classification which they are in at the time and a successful job bidder shall not bid again for any posted job for six (6) months. If no employee in the unit

who bids on the job is selected, using the criteria set out in this Section 6, then the Cooperative may hire a new employee from outside the work force.

For purposes of bidding on positions in the Lineman classification (Groundman or Apprentice Lineman), it shall be a prerequisite that the employee(s) who is (are) awarded the job will be required as a condition of retaining the job to successfully complete a course of study in Electrical Theory previously approved by the Cooperative, if available. This course of study must be successfully completed within twelve (12) months of the award of the job. If the employee successfully completes the required course of study within the time limitations imposed, the Cooperative will reimburse the employee for the cost incurred for the course.

There will be no bidding within the Serviceman or Construction Department classifications.

The progression within the Lineman classification will be as follows:

Apprentice	Two (2) Years
Third Class Lineman	One (1) Year
Second Class Lineman	One (1) Year

Promotion within the Lineman classification will be at the discretion of the Cooperative.

For purposes of bidding on positions in the Meter Department classification, it shall be a prerequisite that the employee(s) who is (are) awarded the job will be required as a condition of retaining the job to be "certified" by the Public Service Commission, and other appropriate regulatory agencies, within ninety (90) days of the award of the job. If the employee successfully completes the required course of study within the time limitations imposed, the Cooperative will reimburse the employee for the cost incurred for the course.

An employee who bids on and is awarded a job and who, within ten (10) working days, voluntarily decides they do not desire to stay in that job shall be disqualified from bidding on another job for twelve (12) months.

SECTION 7.

An employee shall lose his seniority and his status as an employee shall cease for any of the following reasons:

(a) If an employee quits or is discharged.

(b) If an employee is in layoff status for more than eighteen (18) months.

(c) If an employee, after having been laid off, fails to report for work within three (3) working days when notified by the Cooperative by certified mail or telegram sent to the employee's last address appearing on the Cooperative's records.

(d) If an employee is absent from work for two (2) days without reporting to the supervisor.

(e) If an employee is retired.

SECTION 8.

Seasonal, temporary, part-time and casual employees are excluded from the bargaining unit covered by this Agreement and are not entitled to any of the benefits and privileges provided for in this Agreement. The Cooperative will give the Union notice when such employees are hired, but shall be under no further obligation with respect to the Union for these employees.

SECTION 9.

If, and when, employees in the bargaining unit covered by this Agreement are promoted or transferred to jobs outside the bargaining unit they will retain and accumulate seniority for a period of twelve (12) months, during which period such employees will have the right to return

to a job in the bargaining unit, provided they have the seniority therefor. At the end of said twelve (12) month period, if the employee remains in the job outside of the bargaining unit he will lose all seniority rights under this Agreement.

SECTION 10.

The seniority list shall be made up by the Cooperative within thirty (30) days after the date of this Agreement. A copy shall be furnished to the Assistant Business Agent or his representative and a copy posted on the Bulletin Board. This list shall be open for correction for a period of thirty (30) days thereafter and if an employee does not make a protest in writing to the Cooperative, with a copy to the Union within such thirty (30) day period after posting of such list, his seniority shall be as shown on the list. The seniority list shall be brought up-to-date on November 1 of each year thereafter.

SECTION 11.

In the event an employee becomes physically disabled from a work-related injury and can no longer perform the work in his classification (certified as such by his attending physician, and subject to confirmation by a physician selected by the Cooperative) he may request a transfer, if an opening exists at that time, to a lower classification of work, provided he is at that time able to satisfactorily perform the work of the lower classification. The employee will be paid at the rate of the classification to which he transfers. This provision shall only apply to employees with five (5) or more years of service with the Cooperative and only one (1) such transfer may be made.

In the event an employee is injured on the job and is eligible for workers compensation benefits, such employee must return to work and perform "light duty" as determined by the

Cooperative, in accordance with work restrictions placed on such employee by the attending physician.

SECTION 12.

For purposes of determining promotions the following shall apply:

1. Serviceman
   First Class Lineman

2. Apprentice Lineman
   Groundman
   Right-of-Way Crew
   Laborer
   Meter Department
   Garage
   Warehouse

3. Meter Department
   Staking Engineer
   Engineering Aid
   Right-of-Way Crew
   Laborer
   Groundman

4. Garage
   Right-of-Way Crew
   Laborer

5. Warehouse
   Right-of-Way Crew
   Laborer

SECTION 13.

In the event a job vacancy is posted in accordance with Section 6 of this Article and no employees bid on the job and the Cooperative decides not to fill the vacancy by hiring a new employee from outside the work force, then the Cooperative may assign employees to the position on a permanent basis, so long as the employees so assigned are not required to make a geographic move of their residences.

ARTICLE XVII

Leave Program

SECTION 1.

(a) "Leave," as the term is used in this Agreement, shall mean time off taken by an employee who has accumulated leave time for purposes of illness or maternity condition, and shall be used only for such purposes.

Each employee covered by this Agreement shall be entitled to receive one (1) day of leave for each full month of employment. Only leave actually earned prior to the date utilized may be compensable. Leave will not be earned and no entitlement shall be granted for periods of time an employee is not actually working, including time on leave. An employee may accumulate an unlimited amount of leave time. Pay shall only be provided for actual illness and only as set forth in this Agreement.

Medical leave shall be made available to employees following one (1) full year of employment and such leave will be in accordance with the provisions of and regulations issued in accordance with the Family and Medical Leave Act of 1993. Following exhaustion of all accumulated leave time, an employee on Family and Medical Leave will be required to use fifty percent (50%) of vacation entitlement (not including the one (1) week carry over) during such leave. Such vacation will be used beginning on the first day of leave under the Family and Medical Leave Act of 1993 and shall continue until fifty percent (50%) of such vacation entitlement has been paid.

(b) Gifting of sick days.

An employee with accumulated sick days may gift five (5) such days per calendar year to another employee. Sick days may be gifted only in a single 5 full day increment. The full days

contributed will be subtracted from the gifting employee's sick leave account at their regular hourly rate. No fractions of a day will be saved or recorded. No employee shall be entitled to more than 26 weeks of gifted leave.

The gifted sick days will be paid either at the regular hourly rate of the employee gifting the days, or the employee who receives the gifted days, whichever is less.

To be eligible to receive gifted sick days, the employee receiving the gifted sick days must qualify for FMLA Leave under the law, must have exhausted all of their own accumulated sick days and vacation days, and any other accumulated paid days, and must have exhausted an additional two (2) week waiting period.

SECTION 2.

(a) Illness of Employee. Pay will be provided to an employee who has accumulated leave for leave due to illness. In order to be entitled to pay for leave due to illness, an employee may be required, as a condition of such payment, to submit, for each day of absence, a written statement signed by his attending physician attesting to the illness of the employee and which shows his recommendation that the employee absent himself from work because of such illness. In addition, an employee must notify his immediate supervisor before his shift begins of the necessity for absence due to such illness, except in rare instances when the employee is completely physically unable to give the required notice. An employee who has been absent from work for a maximum of fifteen (15) days because of illness or other disability, must notify and advise his Superintendent regarding the anticipated duration of his absence.

(b) Illness of Employee's Spouse, Children or Step-Children. As of January 1 of each year of this Agreement, employees will be permitted to take up to forty (40) hours of their then accumulated sick leave per year for illness of the employee's spouse, children or minor

step-children living in the employee's home. The employee must present to the Cooperative a Physician's Statement certifying the illness of the employee's spouse, child or step-child living in the employee's home.

SECTION 3. Funerals.

An employee who has completed his probationary period will be permitted leave of absence with pay at his regular rate for regularly scheduled work hours lost to a maximum of three (3) regularly scheduled work days lost (to a maximum of eight (8) hours per day) in case of death in his immediate family (i.e., legal spouse, mother, father, son, daughter and step-children) provided such days fall on the employee's regularly scheduled work days and are taken during the period between the day of death and the day after the funeral or memorial service in lieu of funeral, and provided further that the employee is prepared to offer valid proof of death and relationship upon request. Under the same conditions, an employee will be permitted to take up to three (3) regularly scheduled work days for the employee's step-parents, mother-in-law, father-in-law, son-in-law and daughter-in-law, such days to be deducted from the employee's sick leave account. In addition, and subject to the same conditions, an employee will be permitted leave of absence with pay at his regular rate for regularly scheduled work hours lost for a maximum of one (1) regularly scheduled work day lost (to a maximum of eight (8) hours) in case of death of his sister, brother, grandchildren or grandparents. An employee may take an additional two (2) regularly scheduled work days off in the case of death of his sister, brother, grandchildren or grandparents, said days to be deducted from the employee's sick leave account. An employee may, under the same conditions as set forth above, take up to two (2) regularly scheduled work days off in the case of the death of the employee's brother-in-law and sister-in-law, said days to be deducted from the employee's sick leave account.

Only in the case of the death of one of the relatives set forth above whose funeral is more than 200 miles from the employee's regularly required work place will an employee be permitted to take such days off between the day of death and the day after the funeral.

SECTION 4.

Any employee found to have falsified the reasons for leave or who has abused the leave provision by falsification or misrepresentation shall thereupon be subject to disciplinary action, including discharge. In addition, such employee will restore to the Cooperative amounts paid to him to which he was not entitled unless otherwise mutually agreed upon between the Cooperative and the Union in the settlement of a grievance, or if an Arbitrator rules otherwise.

ARTICLE XVIII

Jury Duty

An employee who is required to serve and perform jury duty shall be compensated by the Cooperative in the amount of the difference between his regular rate for regularly scheduled work hours lost (to a maximum of eight (8) hours per day) and the amount received as juror's fees, provided he is prepared to offer valid proof of such jury duty and the amount received as juror's fees upon request by the Cooperative. An employee will be permitted to retain the "expense fee" received for serving Jury Duty. Whenever the employee is excused by the Court from such jury duty two (2) hours or more before his normal shift ends on a scheduled work day, he shall advise his immediate supervisor as promptly as possible and stand ready to report directly to work if requested by the Cooperative. The receipt of notice to report for jury duty must be reported immediately to his immediate supervisor.

In addition, and subject to the same conditions as stated above, an employee who is subpoenaed to appear in court and does appear as a defendant growing out of the Cooperative's business, a co-defendant with the Cooperative or as a witness on behalf of the Cooperative shall receive the difference between his regular rate for regular scheduled work hours lost and the amount received as a witness fee.

ARTICLE XIX

Military Service

Employees inducted into the Armed Forces of the United States shall be re-employed according to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. Any and all benefits under this Agreement which require working as a condition of earning such benefits and such other benefits as Health, Medical and other insurance and the retirement plan shall not be due such employees, unless specifically required by statute.

ARTICLE XX

Holidays

SECTION 1.

Members of the bargaining unit shall be paid eight (8) hours pay at their regular straight time rate for:

New Years Day	Labor Day
Good Friday	Thanksgiving Day
Memorial Day	Day After Thanksgiving Day
Independence Day (4th of July)	Christmas Eve
	Christmas Day

SECTION 2.

To receive holiday pay employees must have worked the full day immediately preceding the holiday and the full day immediately after the holiday. An employee will be considered to have worked the full day before the holiday if he is up to fifteen (15) minutes late reporting to work. The requirement that employees must have worked the full day immediately preceding and the full day immediately after the holiday shall be waived only when the absence is caused by being on scheduled vacation, jury duty, funeral leave, or injury sustained while working for the Cooperative and the injury is compensable under Worker's Compensation statutes and the injury occurred within thirty (30) days of the day for which eligibility is required. If an employee is on Sick Leave the day before or the day after a holiday, then such employee may receive Sick Leave under Article XVII, Leave Program, Sections 1 and 2, for the day of the holiday, but shall not receive holiday pay.

SECTION 3.

In addition to the above allowance, employees will be compensated for hours actually worked on the holidays at time and one-half (1-1/2) for hours actually worked between 8:00 a.m. and 5:00 p.m. and double time for hours actually worked before 8:00 a.m. and after 5:00 p.m.

SECTION 4.

Holidays falling on Saturday shall be recognized on Friday and holidays falling on Sunday shall be recognized on Monday.

SECTION 5.

If a holiday set forth in Section 1 falls within an employee's scheduled vacation, then the employee will receive an additional day of vacation, which will be at the employee's option added to the end of such scheduled vacation or at the beginning of such scheduled vacation.

ARTICLE XXI

Vacation

SECTION 1.

Employees shall receive paid vacations as follows:

After one (1) year of employment	-	One (1) week
After two (2) years of employment	-	Two (2) weeks
After ten (10) years of employment	-	Three (3) weeks
After twenty-one (21) years of employment	-	Three (3) weeks plus one (1) day
After twenty-two (22) years of employment	-	Three (3) weeks plus two (2) days
After twenty-three (23) years of employment	-	Three (3) weeks plus three (3) days
After twenty-four (24) years of employment	-	Three (3) weeks plus four (4) days
After twenty-five (25) years of employment	-	Four (4) weeks
After thirty (30) years of employment	-	Five (5) weeks

In computing length of employment for the purposes of vacation, the employee's length of employment with the Cooperative, including prior service, will be counted.

SECTION 2.

In order to be eligible for vacation as set forth above, an employee will be required to actually work the minimum number of hours set forth below during the twelve (12) month period immediately preceding the eligibility dates:

1,500 hours	100%
1,450 hours	75%
1,400 hours	50%
1,350 hours	25%
Less than 1,350 hours	0%

In order for an employee who retires before his anniversary date of employment to be eligible for vacation as set forth above, on a pro rata basis, he will be required to actually work the minimum number of hours set forth below during the period between his last anniversary date and his date of retirement.

80% of available hours--100% of pro rata vacation.

75% of available hours--75% of pro rata vacation.

70% of available hours--50% of pro rata vacation.

65% of available hours--25% of pro rata vacation.

Less than 65% of available hours--0%.

Actual hours spent on Jury Duty will be counted as hours "actually worked" for the purpose of meeting the minimum number of hours set forth above.

SECTION 3.

The Cooperative shall post vacation schedules on or before January 1 of each year. Each employee must designate his vacation period on such schedule not later than February 1 of each year. In the event two (2) or more employees designate the same vacation period on such schedule, then the employee with the longest period of continuous service from the last date of hire shall have preference. In designating the schedule of the periods in which vacations may be taken, such schedules shall be prepared in a manner consistent with the orderly and efficient operation of the Cooperative, as determined by it. If an employee who has designated a vacation period desires to change it, he may, if it is mutually agreed to by the Cooperative, change the period of vacation to a time when no other employee is scheduled or is otherwise convenient, as determined by the Cooperative.

In the instance of an employee with one (1) week of vacation, they may take such vacation in one (1) day increments. In the instance of employees with two (2) week vacation periods, they may take one (1) week in increments of one (1) full day or one-half (1/2) days. In the instance of employees with three (3), four (4) and five (5) week vacation periods, they may take one (1) week in increments of one (1) day and one (1) week in increments of one-half (1/2) days. If an employee chooses the option of taking vacation in one (1) day or one-half (1/2) day

increments as set forth, he must give at least two (2) days notice before each increment and must receive permission from his Department Head. If mutually convenient and agreeable between the Cooperative and the employee, the two (2) day notice may be waived.

SECTION 4.

Vacations are not cumulative and they shall be taken during the twelve (12) month period between January 1 and December 31 of each year. Vacation days earned, but not taken during such period, shall be forfeited by the employee and no pay will be provided to the employee for any days of vacation not taken, except employees shall be permitted to carry over one (1) week of vacation, but shall not in any one (1) year have more than six (6) weeks of vacation (earned and carried over). In the event an employee is off work because of a compensable injury under Worker's Compensation statutes, such employee will be given credit for service consistent with the yearly vacation entitlement set forth in Section 1. An employee who is off work because of a compensable injury under the Worker's Compensation Statute will be given credit for hours worked for earning vacation under Article XX1, Section 2, for up to seventy-five (75) working days (maximum of 600 hours) they are off work because of a compensable injury under the Worker's Compensation Statute.

An employee who voluntarily or involuntarily terminates employment with the Cooperative shall be paid for all accumulated vacation, on a prorated basis, as of the date of termination. Vacation days used in excess of the prorated accumulated days of entitlement before termination will be deducted from the employee's final pay at the time of termination.

ARTICLE XXII

Group Insurance

SECTION 1.

(a) The Cooperative agrees to provide health insurance for employees in accordance with the Anthem Plan provided to the Union during negotiations for this Agreement designated HSAE2E7 and make it available to regular full-time employees who have completed their probationary period. For employees hired on or before November 30, 2005 and who are actively employed on November 30, 2020, the Cooperative agrees to pay the full premium, including increases for family or single coverage, whichever is applicable.

(b) Employees hired on and after December 1, 2005 will have such health insurance provided to them on an employee-only basis. If such employee desires to add a spouse and/or dependents, then such employee will pay the difference in premium between the employee-only and the premium for adding a spouse and/or dependents.

(c) Further, such Employees hired on and after December 1, 2005 shall have no health insurance provided by the Cooperative when they retire.

(d) The Cooperative shall have the right to change insurance carriers for any of the group insurance programs as set forth in this Article at any time so long as the group insurance coverage is equivalent.

(e) The contracts between the Cooperative and insurance carriers will govern in all matters related to the insurance plans provided for herein. The exact coverage and the conditions for coverage of the aforesaid insurance will be determined by the terms and conditions of the policy or contract, and the Cooperative will not under any circumstances be liable as an insurer of any of the benefits to the employees.

SECTION 2.

Under the same conditions as set forth above in Section 1, the Cooperative will make available to employees a basic dental and vision plan. The full premium for such plans will be paid by the individual employees. The conditions established by the insurance company or companies involved will be met by the employees as a condition of providing such coverages including, but not limited to, minimum numbers of employees participation, duration, etc.

SECTION 3.

(a) For all current retirees and employees who were hired on or before November 30, 2005 who hereafter retire, in order for such insurance to be made available, a retiree or an eligible employee who retires from employment at the Cooperative in the future must have attained at least age sixty (60) and have at least thirty (30) years of service with the Cooperative.

(b) For all eligible employees described in paragraph (a) above, the Cooperative will provide the Humana Medicare Employer Plan designated Passive and Passive Waiver LPPO 079 064 with RX 127 presented to the Union during negotiations for this Agreement.

(c) For currently employed employees, who are eligible for health insurance under this Agreement, the Cooperative will create a Health Savings Account ("HSA") for each such employee and contribute the following amounts on the following dates to such HSA:

	Employee Coverage Only	Family Coverage Only
January 1, 2021	$3,300.00	$6,600.00
January 1, 2022	$3,300.00	$6,600.00
January 1, 2023	$3,300.00	$6,600.00
January 1, 2024	$3,300.00	$6,600.00
January 1, 2025	$3,300.00	$6,600.00

(d) When an eligible employee under this Section 3 becomes eligible for Medicare, that employee and spouse at the time of retirement from the Cooperative will submit proof of

enrollment and the amount paid for Medicare B and, thereafter on an annual basis provide to the Cooperative a certification of their continued participation; and the Cooperative will pay directly to the retiree, retroactively, on a quarterly basis, the amount paid for Medicare B.

(e) The insurance coverage referred to above shall only be made available for the life of the retired employee.

SECTION 4.

Under the same conditions as set forth above in Section 1, the Cooperative will make available for each employee a $50,000 life insurance plan. The full premium for such plan will be paid by the Cooperative for the duration of this Agreement. The conditions established by the insurance company or companies involved will be met by the employees as a condition of providing such coverage.

SECTION 5.

The Cooperative will provide to employees a long-term disability insurance plan with the following provisions:

(1) Sixty-six and two-thirds (66-2/3) pay

(2) Twenty-six (26) week waiting period

The contracts between the Cooperative and insurance carriers will govern in all matters related to the insurance plans provided for herein. The exact coverage and the conditions for coverage of the aforesaid insurance will be determined by the terms and conditions of the policy or contract, and the Cooperative will not under any circumstances be liable as an insurer of any of the benefits to the employees.

ARTICLE XXIII

Retirement Plan

SECTION 1.

Effective January 1, 1995, the Cooperative adopted and implemented the National Rural Electric Cooperative Association ("NRECA") Selectre Pension Plan (the "Plan") for the benefit of its employees. The Plan replaced the Taylor County RECC Employees' Retirement Savings Trust Fund (the "Trust Fund"). The Trust Fund was terminated.

The instruments composing the Plan will govern in all matters related to it. The exact terms and conditions for eligibility for coverage, eligibility for participation, eligibility for retirement, contribution rates, etc. will be determined by the terms and conditions of such instruments and the Cooperative will not under any circumstances be liable for any benefits, or otherwise, to the employees.

Employees who have reached the age of sixty (60) and have a minimum of thirty (30) years service with the Cooperative will be permitted to retire and, upon such retirement, the Cooperative will pay one hundred percent (100%) of the health insurance premium for such employee until they qualify for benefits provided by Medicare. At such time, the employee will be provided the Blue Cross–Blue Shield "carve out" supplemental plan provided for in Article XXII, Sections 3(c) and (d).

ARTICLE XXIV

Miscellaneous

SECTION 1. Stewards.

The Union shall have the right to designate from among the employees covered by this Agreement a Chief Steward at each of the three (3) places of work. The Union shall notify the

Cooperative in writing of the names of said Stewards so designated. The Cooperative shall have the right to recognize and deal with the Stewards, so designated, in the settlement of grievances and other matters pertaining to the administration of this Agreement. Stewards will not leave their work to investigate, present or discuss grievances unless given permission by their Supervisor. They will be permitted, however, to perform this business during scheduled breaks and scheduled meal periods and after their shift ends. In addition, Stewards will be permitted to transmit messages and information, which originates with, and are authorized by the Local Union or its officers, provided such messages and information have been reduced to writing. In the event of any change in Stewards, the Union shall notify the Cooperative in writing at the time the new Stewards assume their responsibilities.

SECTION 2. Bulletin Boards.

The Cooperative will provide suitable space on its bulletin boards at each location of work for the posting of official Union bulletins.

Nothing, however, shall be posted on such bulletin boards which is derogatory to any individual, or which is libelous or obscene, or which deals with any matter that is subject to the grievance-arbitration procedure set forth in this Agreement. Only official matters which relate directly to members of the bargaining unit at the Cooperative may be posted on such bulletin boards.

SECTION 3. Examinations.

Physical, mental or other examinations required by a government body, or the Cooperative, shall be promptly complied with by all applicants and employees, provided, however, the Cooperative shall pay for all such examinations. The Cooperative shall not pay for any time spent for such examinations, unless the examination is required to be taken by the

Cooperative. Employees may take sick leave for such time actually spent traveling to and from and at the place of examination. Examinations are not to exceed one (1) in any one (1) year, unless the employee has suffered an injury or illness during the year.

The employer reserves the right to select its own medical examiner or physician and the Union may, if it believes an injustice has been done an employee, have said employee reexamined at the Union's expense.

An employee who has been off work for illness or other disability for a period of more than two (2) weeks will be required to obtain a statement from his attending physician and specialist (if one) certifying the nature and extent of the employee's illness or other disability for the period of absence and certify that the employee is released to return to work with no restrictions on his ability to work and can perform all the duties of his job.

SECTION 4. Uniforms and Protective Clothing.

In the event the Cooperative requires employees to wear uniforms, the Cooperative shall supply and pay for the uniforms.

The Cooperative will provide all safety equipment required.

Lost, broken or stolen equipment will be replaced at the employee's cost, unless the employee can show that it was not because of his negligence or acts by him.

SECTION 5. Worker's Compensation.

The Cooperative agrees to use its best efforts to cause the insurance carrier to duly and promptly settle and pay just on-the-job injury claims, when such claims are due and owing. The Cooperative shall provide Worker's Compensation protection as required by law.

SECTION 6.

Retired employees shall continue to receive Co-op Hi-Lights in addition to being allowed to attend employee picnics and other recreational activities.

SECTION 7. Educational Assistance Program.

In order to actively encourage employees to take advantage of educational opportunities and to provide for individual growth and potential advancement, financial assistance will be made available under the following circumstances:

(1) Eligibility -- All regular full-time employees.

(2) Effective Date -- After completion of the probationary period provided for in this Agreement.

(3) Covered Educational Programs -- Courses which improve employee effectiveness under their present assignments and/or qualify an employee for promotion and such courses are taken on the employees' own time outside of regularly scheduled working hours.

(4) Expenses Eligible for Reimbursement -- Tuition for all approved courses completed with a grade "C" or better, or if the course is not graded on a letter basis but on a "pass-fail" basis, the employee receives a "pass" grade.

(5) Reimbursed Amount -- Fifty percent (50%) of the expenses for tuition after completion of the course and upon presentation to the Manager of proof of the grade and paid receipts for such tuition.

(6) Application Procedure --

(a) Employee must complete the application for course approval in sufficient time to obtain necessary approval prior to course registration and provide such application to his supervisor;

(b) Approval by the employee's immediate supervisor; and

(c) Final approval, in writing, by the Manager.

SECTION 8. DRIVE.

The Cooperative agrees during the first payroll period in December of each year of this Agreement that it will deduct from the paychecks of all employees who are covered by this Agreement a contribution in an amount designated by such employees, to DRIVE, the Union's political action committee, provided that such employees shall have signed and submitted a written authorization for such action on the part of the Cooperative; and, provided further, that such written authorization shall conform to and be in accordance with all applicable Federal and State laws. All monies deducted by the Cooperative shall be forwarded to the Secretary-Treasurer of the Union. The Cooperative will recognize authorizations for deductions from wages, if in compliance with State and Federal law, to be transmitted to the Union. No such authorization shall be recognized if in violation of State or Federal law. No deduction shall be made which is prohibited by applicable law. This provision is subject to whatever shop rule is promulgated by the Cooperative with respect to garnishments or other wage deductions.

In consideration of the adoption by the Cooperative of this DRIVE contribution, the Union agrees to indemnify and hold the Cooperative harmless from and against any and all liability or loss as a result of any action brought by any employee, employees or any other person on account of claimed illegal payments, including reasonable attorneys' fees and court costs.

If, for any reason, an employee does not work during the first payroll period in December of each year of this Agreement in which the DRIVE contribution is to be deducted, the Cooperative shall make deductions for the above purpose from such employee's wages out of the next succeeding pay period in which he works.

ARTICLE XXV

Non-discrimination

The Cooperative and the Union agree that the provisions of this Agreement shall be applied to all employees without discrimination on the basis of age (over 40), sex, religion, race, color, creed, national origin, or disability (as that term is defined and applied within the meaning of the Americans With Disabilities Act and its implementing regulations).

Whenever the words "he," "him" or "his" are used herein, those words shall be deemed to include the feminine gender as well.

ARTICLE XXVI

Wage Rates and Classifications

SECTION 1.

All employees in the bargaining unit receiving a "red circle" rate at the time this Agreement is executed, will continue to receive such "red circle" rate.

SECTION 2.

New employees hired by the Cooperative after the effective date of this Agreement shall begin their employment at eighty percent (80%) of the "classified rate;" after one (1) year of employment, such employees will be paid at the rate of ninety percent (90%) of the "classified rate"; after two (2) years of employment, such employees will be paid at the rate of one hundred percent (100%) of the "classified rate".

Employees who are promoted to higher rated positions after execution of this Agreement will be paid at the rate of the position to which they are promoted.

SECTION 3. Classified Rates.

Classification	Classified Rates					
	12/1/19	12/1/20	12/1/21	12/1/22	12/1/23	12/1/24
Serviceman	$ 29.93	$ 30.53	$ 31.29	$32.07	$32.87	$33.69
First Class Lineman	$ 29.33	$ 29.92	$30.67	$31.44	$32.23	$33.04
Second Class Lineman	$ 27.57	$28.12	$28.82	$29.54	$30.28	$31.04
Third Class Lineman	$ 24.37	$24.86	$25.48	$26.12	$26.77	$27.44
Apprentice Lineman	$ 23.06	$23.52	$24.11	$24.71	$25.33	$25.96
Right-of-Way Man	$ 25.21	$25.71	$26.35	$27.01	$27.69	$28.38
Right-of-Way Helper	$ 23.06	$23.52	$24.11	$24.71	$25.33	$25.96
Groundman	$ 23.06	$23.52	$24.11	$24.71	$25.33	$25.96
Laborer	$ 23.06	$23.52	$24.11	$24.71	$25.33	$25.96
Engineering Department						
Instrument Man	$ 28.15	$28.71	$29.43	$30.17	$30.92	$31.69
(Staking Engineer)	0.00	0.00	0.00	0.00	0.00	0.00
Engineering Aid	$ 26.97	$27.51	$28.20	$28.91	$29.63	$30.37
Staking Engineer Helper	$ 25.21	$25.71	$26.35	$27.01	$27.69	$28.38
Meter Department	0.00	0.00	0.00	0.00	0.00	0.00
Licensed Meter Man	$ 29.33	$29.92	$30.67	$31.44	$32.23	$33.04
Garage Department	0.00	0.00	0.00	0.00	0.00	0.00
Mechanic	$ 26.69	$27.22	$27.90	$28.60	$29.32	$30.05
Mechanic Helper	$ 24.90	$25.40	$26.04	$26.69	$27.36	$28.04
Warehouse Department	0.00	0.00	0.00	0.00	0.00	0.00
Warehouseman[1]	$ 25.21	$25.71	$26.35	$27.01	$27.69	$28.38

[1] When purchasing duties are assigned to the Warehouseman, the employee involved will receive a $1.00 per hour premium. Such premium shall be added to the Warehouseman's rate in effect at that time (e.g. Rate $15.00 per hour plus $1.00 per hour premium equals $16.00 per hour rate.)

SECTION 4.

The "Classified Rates" set forth above reflect the following increases to the rates in effect immediately prior to ratification of this Agreement: Effective December 1, 2020, a two percent (2%) per hour increase in wage rates; effective December 1, 2021, a two and one-half percent (2 ½%) per hour increase in wage rates; effective December 1, 2022 a two and one-half percent (2 ½%) per hour increase in wage rates; effective December 1, 2023, a two and one-half percent (2 ½%) per hour increase in wage rates; effective December 1, 2024, a two and one-half percent (2 ½%) per hour increase in wage rates.

ARTICLE XXVII

Effect of Law

All provisions of this Agreement shall be subordinate and subject to any statute or law that may be applicable, whether now in effect or hereinafter enacted. If any provision of this Agreement or application of this Agreement to any employee is contrary to law, then such provision or application shall not be deemed valid except to the extent permitted by law, but all other provisions or applications of this Agreement shall continue in full force and effect.

If any provisions of this Agreement or application of this Agreement to any employee is contrary to law, then the Cooperative and the Union shall meet and attempt in good faith to agree upon a suitable replacement. If the parties are unable with due diligence to agree, the issue in question shall be subject to collective bargaining negotiation when this Agreement expires.

ARTICLE XXVIII

Entire Agreement

SECTION 1.

This Agreement sets out the entire understanding between the Cooperative and the Union with respect to the unit of employees described in this Agreement. Neither party intends to be bound or obligated except to the extent that it has expressly so agreed herein and this Agreement shall be strictly construed. This Agreement applies only to the collective bargaining unit defined in this Agreement. None of the benefits, rights or privileges accorded by this Agreement to the Union or to any employee covered by this Agreement shall survive the expiration or termination of this Agreement.

SECTION 2.

It is distinctly understood and agreed by the Union that the Cooperative shall not be obligated, contractually or otherwise, to continue in effect any custom, practice or benefit unless it has contractually obligated itself to do so by clear and explicit language in this Agreement.

ARTICLE XXIX

Collective Bargaining

The Cooperative and the Union each acknowledge that this Agreement has been reached as a result of collective bargaining in good faith by both parties hereto, and that both parties hereto have had the unlimited opportunity during negotiations to submit and discuss proposals on all subjects which are bargainable matters. While it is the intent and purpose of the parties hereto that each of them shall fully perform all obligations by them to be performed in accordance with the terms of this Agreement, the Union agrees that the Cooperative shall not be obligated to bargain collectively with the Union during the term of this Agreement on any matter pertaining to rates of pay, wages, hours of employment, or other conditions of employment, unless an obligation to bargain is otherwise specifically provided for in another Article of this Agreement, and the Union hereby specifically waives any right which it might otherwise have to request or

demand such bargaining, except as provided in the Article entitled Effect of Law, and acknowledges that the Cooperative's obligations during the term of this Agreement shall be limited to the performance and discharge of its obligations under this Agreement.

ARTICLE XXX

Duration of Agreement

The effective date of this Agreement is December 1, 2020. This Agreement shall be in full force and effect for the entire period from December 1, 2020 through November 30, 2025, and from year to year thereafter, unless either party hereto shall at least sixty (60) days prior to November 30, 2025, or the 30th day of November in any year thereafter, notify the other party in writing of its intention and desire to terminate this Agreement. If proper notice is given and the parties, after negotiation, fail to reach agreement on the proposed changes, this Agreement may be terminated by either party upon ten (10) days' written notice delivered to the other at any time after the date upon which this Agreement would have otherwise terminated if no notice for termination had been given. Such ten (10) days' notice must be given before any lockout or strike may occur.

IN TESTIMONY WHEREOF, the Cooperative and the Union by their respective officers and representatives hereunto duly authorized, have signed this Agreement on the day, month and year first set forth above.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

President

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

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AGREEMENT

BETWEEN

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

AND

LOCAL UNION NO. 89
GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS
AFFILIATED WITH
INTERNATIONAL BROTHERHOOD OF
TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN AND HELPERS OF AMERICA

(Office Clerical)

Effective December 1, 2020 through November 30, 2025

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ARTICLE I

This Agreement is made and entered into this 1st day of December, 2020, by and between Taylor County Rural Electric Cooperative Corporation, hereinafter referred to as the Cooperative, and Local Union No. 89, General Drivers, Warehousemen and Helpers, affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America, hereinafter called the Union.

ARTICLE II

PREAMBLE

Statement of Principles and Union Responsibilities

The Union recognizes its responsibilities as the exclusive bargaining agent for the employees covered by this Agreement, and realizes that in order to provide maximum opportunities for continuing employment, good working conditions and good wages, the Cooperative must be in a strong marketing position, which means that it must produce quality services and products and be able to sell them at the lowest possible costs and otherwise be able to operate its business efficiently, economically and competitively. The Union therefore agrees that it will support the Cooperative's efforts to assure a fair day's work by the employees for a fair day's pay. The Union will support the Cooperative in its efforts to improve services, preserve equipment, prevent accidents and strengthen good will between the Cooperative and its employees, as well as with its suppliers and customers. The Union further recognizes that the Cooperative has certain definite and stringent obligations and responsibilities to its customers, suppliers, Public Service Commission and Rural Utilities Service ("RUS") and the Union agrees that it will fully cooperate with the Cooperative in the performance and discharge of these obligations and responsibilities.

ARTICLE III

Recognition

The Cooperative recognizes the Union as the exclusive bargaining representative for all office clerical employees employed at its Campbellsville, Kentucky, location, including the office janitor, but excluding all professional employees, guards, and supervisors as defined in the Act and all other employees. It is the intention of the parties hereto that the bargaining unit covered by this Agreement shall be as established by the National Labor Relations Board in its "Certification of Representative" dated November 14, 1978, in Case No. 9-RC-12614, and this Article is included herein solely for the purpose of discharging the Cooperative's obligation under the law to recognize the Union.

In the event the Cooperative is sold to a private investor, notice of such sale will be given to the Union not later than the day of the closing of such sale.

ARTICLE IV

Management Prerogatives

The operation, control and management of the Cooperative's facilities and operations, and all business and activities of the Cooperative in connection therewith which are covered or affected by this Agreement, and the supervision and direction of the working forces at such facilities, operations and business are and shall continue to be solely and exclusively the functions and prerogatives of the management of the Cooperative.

All of the rights, functions and prerogatives of management which the Cooperative had prior to entering into this Agreement with the Union are reserved and retained exclusively to the Cooperative, unless changed or modified by one or more explicit provisions of this Agreement. Specifically but without limiting or affecting the generality of the foregoing, it is distinctly

understood and agreed that the Cooperative has the sole right to: Determine the nature and extent of the business to be carried on by the Cooperative; determine the suppliers and customers with whom it will deal, and the prices at which and terms upon which its materials, equipment and supplies will be purchased, leased or otherwise acquired and its services and products will be sold; determine the size and composition of the working force covered by this Agreement, and assignment of work, and policies affecting the hiring of new employees, layoff, discipline and discharge of employees for cause; and determine the qualifications of employees, including the right to terminate the services of employees without limitation during their probationary period; establish and enforce quality, production, construction, and service standards for its employees, services and products; establish new departments; discontinue existing departments; introduce new and improved equipment, facilities and service methods; change, combine, establish or discontinue jobs or operations; determine when and if vacancies in the working force shall be filled; determine the means and methods by which production and services will be made; determine the hours of operation, discontinue temporarily or permanently, in whole or in part, any operations of the business of the Cooperative covered or affected by this Agreement.

The Cooperative shall also have the right from time to time to make and enforce such reasonable rules, procedures and regulations applicable to employees covered by this Agreement for the purpose of maintaining order, safety, effective operations and control; to enforce, change, abolish or modify such existing rules, procedures and regulations applicable to employees covered by this Agreement, as it may from time to time deem necessary or advisable, after advance notice thereof to the Union and employees, which shall be subject to the grievance and arbitration procedure of this Agreement. The Cooperative shall also have the right to require compliance with such rules, procedures and regulations by employees until an Arbitrator sets

aside the rule, procedure or regulation as a result of the grievance and arbitration procedure or the parties mutually agree to set aside the rule, regulation or procedure without arbitration.

ARTICLE V

Subcontracting

It is understood by the Cooperative and the Union that for the Cooperative to satisfy the demands of its customers and to successfully operate the business, contracting and/or subcontracting of work is necessary from time to time. It is therefore agreed by the Union that the Cooperative may, within its exclusive discretion, engage contractors for all construction, manufacturing, service and operations functions, and any and all other functions which it, in its exclusive discretion, deems necessary and desirable. The Cooperative will not subcontract work under this provision that would cause the layoff of employees.

ARTICLE VI

Supervisory and Other Excluded Personnel

Notwithstanding any of the provisions of this Agreement, there shall be no limitation or restriction upon the nature, extent and kind of work which Supervisory and Management personnel may perform, nor shall there be any limitation or restriction as to the times or occasions on which Supervisory and Management personnel may perform such work. The Cooperative will not utilize this Article in such a way as to displace any employee covered by this Agreement.

ARTICLE VII

Discipline and Discharge

SECTION 1.

The Cooperative shall have the right to discharge employees during their probationary period without cause and without recourse by the Union or by such probationary employee to the grievance procedure of this Agreement.

SECTION 2.

The Cooperative shall have the right to discipline or discharge employees for "just cause". While it is the policy of the Cooperative to warn employees for minor infractions before taking disciplinary action or discharging them, it is distinctly understood and agreed that certain offenses, such as, but not by any means limited to the following, shall be considered "just cause" and cause for immediate discharge, without warning: Dishonesty; insubordination; fighting while on the Cooperative's premises or on duty; smoking in fuel pump areas; failure or refusal to wear or utilize any safety equipment provided and required by the Cooperative or to follow any safety procedure prescribed by the Cooperative; horseplay of such a nature as to be capable of causing personal injury or property damage; drinking alcoholic beverages or being under the influence of alcoholic beverages while on the Cooperative's premises or on duty; being in possession of or using or being under the influence of narcotics (unless prescribed by the employee's physician and the employee is following the physician's directions on dosages, etc.), marijuana or hallucinatory drugs; proven falsification of the Cooperative's records or reports; willful damage to tools, equipment or other Cooperative property; failure to immediately report involvement in an accident while on duty or on the Cooperative's premises; or participation in any activity prohibited by the Article of this Agreement entitled "No Strike No Lockout".

SECTION 3.

It is understood and agreed that employees have a responsibility to be regular and punctual in their work attendance and that habitual or repeated tardiness or absenteeism or failure to report to work promptly, and other minor offenses will be cause for disciplinary action, including discharge. The procedure will be as follows: (1) first offense: verbal warning; (2) second offense: written warning; (3) third offense: three (3) day suspension; and (4) fourth offense: subject to discharge.

It is expressly agreed (a) that the Cooperative, in its discretion, may decide not to discharge an employee for the fourth (4th) offense, and (b) that the Cooperative's failure in any case or cases to strictly enforce the above procedure, shall not be a precedent and shall not constitute a waiver of the Cooperative's right to enforce such procedure in any other case.

SECTION 4.

It is agreed that in the event an employee is given any disciplinary action, including a warning notice, a copy of the warning notice will be given to the employee, one (1) copy to the Union and one (1) copy will be retained in the employee's personnel file. A warning notice or notices for any cause may constitute a basis for discharge for any subsequent infraction and it is understood and recognized by the parties hereto that the infractions specified in Section 2 of this Article shall be cause for immediate discharge without warning. It is further understood and recognized that in any event it shall be cause for discharge if an employee is given four (4) warning notices for any cause or combination of causes within a "rolling" twelve (12) month period. Disciplinary warnings outside this "rolling" twelve (12) month period will not be used for disciplinary purposes. All disciplinary warnings and discharges shall be subject to the grievance procedure.

ARTICLE VIII

Union Security and Checkoff

SECTION 1. Union Security.

It is recognized by the parties that the Commonwealth of Kentucky law prohibits union membership as a condition of employment. The Cooperative and the Union agree, in the event future legislation during the term of this Agreement provides for permitting a Union Shop in the Commonwealth of Kentucky, to negotiate with respect to inclusion of some form of a Union Security provision.

SECTION 2. Checkoff.

The Cooperative agrees to deduct each month, from the paychecks of all employees who are covered by this Agreement, all periodic dues and initiation fees owing to the Union by the employees, provided, however, that such employees shall have signed and submitted a written authorization for such action on the part of the Cooperative; such written authorization shall conform to and be in accordance with all applicable Federal and State laws.

All monies deducted by the Cooperative shall be forwarded to the Secretary-Treasurer of the Union.

It is understood and agreed that any monies collected by the Cooperative for the Union will be taken out of the paycheck for the first pay period of the month and remitted to the Union before the 30th day of the same month.

The Cooperative will recognize authorizations for deductions from wages, if in compliance with State and Federal law, to be transmitted to the Union. No such authorization shall be recognized if in violation of State or Federal law. No deduction shall be made which is

prohibited by applicable law. This provision is subject to whatever shop rule is promulgated by the Cooperative with respect to garnishments or other wage deductions.

SECTION 3.

In consideration of the adoption by the Cooperative of the Checkoff provisions, the Union agrees to indemnify and hold the Cooperative harmless from and against any and all liability or loss as a result of any action brought by any employee or employees on account of claimed illegal payments, suspension or discharge under the provisions of Article VIII of this Agreement, above described, including reasonable attorneys' fees and court costs.

SECTION 4.

If for any reason an employee does not work during the first pay period of any month in which the checkoff is made, the Cooperative shall make deductions for the above purpose from such employee's wages out of the next succeeding pay period in which he works.

ARTICLE IX

No Strike-No Lockout

The Union agrees that during the term of this Agreement neither the Union, its officers, agents or members shall authorize, instigate, aid, condone or engage in any work stoppage, strike of any kind or description, including so-called sympathy strikes, or otherwise interrupt, impede or restrict services of the Cooperative or engage in any activity which would tend to cause an interruption or delay in the accomplishment of the work and business of the Cooperative.

The Union further agrees that during the term of this Agreement the Union, its officers, agents or members will not honor or recognize any picket line or picketing in any form, including recognition of picket lines or picketing out of so-called sympathy, by any union at the Cooperative, or any facility or operation of the Cooperative, regardless of where it is located.

Any employee who engages in any conduct prohibited by this Article, or who fails or refuses to comply with any provision of this Article, shall be subject to appropriate discipline, including discharge, without warning, by the Cooperative. In the event an employee is discharged for violation of the provisions of this Article, he may resort to the grievance and arbitration procedures set forth herein. The arbitrator shall, however, be limited to determining the single issue of whether or not the employee did, in fact, participate in or promote such action and the employee(s) affected will have the burden of conclusively showing his (their) non-participation in and not having promoted such actions. Further, the Cooperative shall be under no obligation to bargain with the Union concerning employees who are on strike or concerning the subject of any strike so long as the strike continues.

Neither the violation of any provision of this Agreement nor the commission of any act constituting an unfair labor practice or otherwise made unlawful by any federal, state or local law shall excuse the Union, its officers, agents or members from their obligations in the provisions of this Article.

The provisions of this Article shall not be appealable to the grievance procedure either for the purpose of assessing damages or securing a specific performance, such matters of law being determinable and enforceable only in the courts.

The Cooperative shall not lock out members of the Union during the term of this Agreement.

ARTICLE X

Probationary Employees

All new or rehired employees shall be placed on probation and shall be classified as temporary help during the first one hundred twenty (120) work days of their employment with

the Cooperative. During such one hundred twenty (120) work day probationary period the Cooperative may discharge or otherwise discipline, lay off, transfer or assign such employees with or without cause, and such actions shall not be subject to the grievance procedure.

Probationary employees who complete their probationary period will be classed as regular employees and their date of hire shall be from the first day of hiring.

ARTICLE XI

Rates for New Job Classifications

Recognizing that during the term of this Agreement the Cooperative may install new equipment or change work methods resulting in the creation of new job classifications, the Cooperative shall establish rates for such new classifications in line with the Cooperative's wage scale for like work and notify the Union's representative in writing. If after ten (10) days neither party questions the rate established for the new classification, it shall become the established rate for the job; otherwise, the establishment of such rate shall be a matter for negotiation. If the parties negotiate and are unable to reach an agreement, the rate as established by the Cooperative shall stand until this Agreement expires if less than twelve (12) months until this Agreement expires and then shall be subject for renegotiation. If more than twelve (12) months from the expiration of this Agreement, then the dispute shall be subject to the Grievance-Arbitration Procedure set out elsewhere in this Agreement.

ARTICLE XII

Hours of Work and Overtime

SECTION 1.

An employee's regular work week shall be forty (40) hours and shall start at the beginning of his shift on Monday, subject to change by the Cooperative when requirements

dictate, but shall not be less than eight (8) hours, excluding a one (1) hour lunch break. In addition, employees shall receive two (2) ten (10) minute breaks during a full eight (8) hour shift.

The work week shall begin at 12:01 a.m. Sunday and end at Midnight the following Saturday.

SECTION 2.

When overtime is required, the employees in the classification or who are assigned on the job where the overtime exists shall be required to work the overtime assigned.

SECTION 3.

Overtime at the rate of time and one-half (1-1/2) shall be paid for all hours actually worked in excess of forty (40) hours in any one work week. Time off for sick leave, actual hours served on Jury Duty under Article XVIII, and Holidays as set forth in Article XX, only shall be considered hours worked (8 hours per day) for purposes of this provision. Overtime under this Section shall be computed on a weekly basis.

SECTION 4.

No premium or overtime pay set out in this Agreement shall be pyramided.

SECTION 5.

An employee required, on a temporary basis, to report to a work place other than his regularly required work place, will not be required to travel on his own time for a period longer than the travel time to his regular reporting work place.

ARTICLE XIII

Reporting and Call-Out Pay

SECTION 1.

When an employee reports for work at his regular starting time on a scheduled work day, he will be guaranteed eight (8) hours straight time pay at his regular hourly rate of pay, provided, however, that this provision shall not apply in case of strikes or other work stoppages, disciplinary suspension of an employee, acts of God or any other cause beyond the Cooperative's control.

SECTION 2.

When an employee has completed his regular shift and left the Cooperative's premises, but is called in to work more than two (2) hours prior to the beginning of his next regularly scheduled shift, he will be guaranteed three (3) hours work at his regular straight-time hourly rate of pay. This guarantee shall only apply once each work day (24-hour period). Other hours actually worked on additional "call-outs" will be compensated at the employee's regular straight-time hourly rate.

No employee shall be required to take time off to avoid the payment of overtime.

ARTICLE XIV

Grievance Procedure

SECTION 1.

A grievance as referred to in this Agreement is a dispute arising from the interpretation or application of one or more specific provisions of this Agreement. Grievances shall be processed in accordance with the procedures set forth below.

STEP 1. The aggrieved employee shall present his grievance to his Supervisor within three (3) days after the cause of such grievance becomes known or could reasonably be expected to have been known. If he has been prevented from presenting the grievance within this time limit because of an excused absence, the days of excused absence shall be excluded in computing the time limit. The aggrieved employee may be accompanied by his Union Steward.

STEP 2. If the grievance is not settled in Step 1, it may be appealed by presenting the grievance in writing within five (5) days to the Superintendent, who shall meet with the aggrieved employee. The aggrieved employee may be accompanied by his Union Steward.

STEP 3. If the grievance is not settled in Step 2, it may be appealed by the Union within ten (10) days to the Manager (or the person acting in his capacity in the event of his absence) who shall arrange to meet with the Union's Assistant to the President and the aggrieved employee and his Union Steward.

STEP 4. If the grievance is not satisfactorily settled in Step 3 and if the grievance is otherwise arbitrable under this Agreement, it may be referred to arbitration in strict accordance with the provisions of this Agreement pertaining to arbitration, provided that if the Union fails to notify the Cooperative in writing by Registered Mail within ten (10) days after the Cooperative gives its answer in writing to a grievance at Step 3 of the grievance procedure of the Union's desire to arbitrate the grievance, then the Union shall be conclusively presumed to have accepted the Cooperative's answer and said grievance shall not thereafter be arbitrable.

SECTION 2.

The grievance procedure is subject to the following rules and conditions:

(a) A settlement satisfactory to the Union at any step in the grievance procedure shall be binding on it and the employee or employees making the complaint.

(b) Saturdays, Sundays and holidays are excluded in computing the time limits specified in this Article.

(c) All meetings conducted pursuant to the provisions of Step 1, Step 2, Step 3 and Step 4 of this Article, unless otherwise mutually agreed, shall be conducted at times when the aggrieved employee and others, including the Steward, are not regularly scheduled to work. Neither party shall have more than a total of three (3) persons present, including the aggrieved employee, except, by mutual consent, the parties may agree to a greater number.

(d) Employees will not leave their work to investigate, present or discuss grievances without prior permission from their supervisor.

(e) This grievance procedure constitutes the sole and exclusive means of resolving controversies. Pending the raising, processing and/or settlement of a grievance, all employees will continue to work in a normal manner, and there shall be no slowdown, stoppage or other interference with work or plant operation as discussed and set forth elsewhere in this Agreement.

(f) Infrequently, due to the nature of the subject matter, the Cooperative or the Union may request that early steps of the grievance procedure be waived. In such cases certain steps of the grievance procedure may be waived provided there is mutual agreement by the Cooperative and the Union to do so.

(g) Any time the Cooperative offers a settlement with regard to any grievance, there will be a Union Official present. "Union Official" shall mean the employee's Steward or the Union's Assistant to the President. A settlement reached with the Steward will not set a precedent, unless the Union's Assistant to the President is aware of the settlement.

(h) Any grievance of any kind which has been presented under the grievance procedure set forth herein which is not appealed to the next step within the applicable time specified above and any grievance which has not been presented under the grievance procedure set forth herein within the time period for presentation of grievances shall be considered settled and shall not be subject to further discussion or appeal.

SECTION 3.

The Cooperative shall not be required or obligated under the terms of this Agreement or otherwise to submit to arbitration any claim or cause of action which it may have or assert on account of any alleged violation of this Agreement by the Union or any employee or employees covered by this Agreement. The Cooperative shall have the right to sue at law or in equity in any court of competent jurisdiction, Federal or State, to enforce this Agreement and to recover for any breach or violation thereof.

SECTION 4.

No grievance shall be arbitrable unless it involves an allegation of the type set out in Section 1, which allegation shall be designated in writing by the Union to the Cooperative no later than the time such grievance is appealed to Step 2 of the grievance procedure set forth herein.

No grievance may be filed or considered which is based in whole or in part on an occurrence happening prior to or after the term of this Agreement.

SECTION 5.

The provisions of this Agreement covering grievance procedure and arbitration are completely unrelated to and independent of the provisions of the Article of this Agreement entitled "No Strike-No Lockout" clause. In the event the Cooperative claims that a grievance

filed hereunder is not arbitrable, whether or not such claim be ultimately sustained, such claim shall not in any way affect or excuse the Union or any employee or employees covered by this Agreement from the provisions of the Article entitled "No Strike-No Lockout" and their respective obligations and duties thereunder.

SECTION 6.

In the event any grievance which is otherwise arbitrable under the terms of this Agreement shall be arbitrated, selection of an arbitrator shall first be attempted by the Union and the Cooperative attempting to agree on an arbitrator, and, if they cannot agree upon a selection, the Federal Mediation and Conciliation Service shall be asked to furnish a panel consisting of at least seven (7) names of arbitrators. The Union and the Cooperative shall select a single arbitrator from the panel by alternately striking a name until such time as only one (1) name remains. The Cooperative and the Union will alternate in striking the first name from the list. The Cooperative will strike the first name in the first arbitration case and the Union will strike the first name in the second arbitration case, etc.

SECTION 7.

No more than one grievance shall be submitted to any one arbitrator unless the Cooperative and the Union agree otherwise in writing. The Arbitrators selected shall have power to receive relevant testimony from the parties to the dispute and hear such witnesses as they may desire to present. The parties may, if they so desire, be represented by counsel in all proceedings held before the Arbitrator. The Cooperative shall bear the costs of preparing and presenting its case to the Arbitrator and the Union shall bear the costs of preparing and presenting its case to the Arbitrator. All other expenses of arbitration, such as, but not limited to the Arbitrator's fee,

and the hiring of a space in which the arbitration proceedings are held, shall be divided equally between the Cooperative and the Union.

SECTION 8.

The function of the Arbitrator shall be of a judicial, rather than a legislative, nature. The Arbitrator shall not have authority to add to, ignore or modify any of the terms or provisions of this Agreement. The Arbitrator shall not substitute his judgment for the Cooperative's judgment and where matters of judgment are involved he shall be limited to deciding whether or not the Cooperative acted arbitrarily, capriciously or in bad faith. The Arbitrator shall not decide issues which are not directly involved in the case submitted to him. In any discharge or disciplinary suspension case where the Arbitrator decides that the aggrieved employee should be awarded any back pay, the Cooperative shall be entitled to full credit on such awards for the employee's gross interim earnings, unemployment compensation benefits, worker's compensation benefits received or receivable and any other compensation he receives from any form of employment during the period he was not working for the Cooperative. Subject to the foregoing qualifications and limitations, the Arbitrator's award shall be final and binding upon the Cooperative, the Union and the aggrieved employee or employees.

SECTION 9.

Only the Union shall have the right to prosecute grievances under this Agreement and only the Union shall have the right to take to arbitration any grievance which is otherwise arbitrable under this Agreement. If the Union fails, refuses or declines to prosecute a grievance on behalf of an employee, or on behalf of a group of employees hereunder, such employee or employees who filed such grievance or on whose behalf it has been filed shall be conclusively

bound thereby and both the Union and the aggrieved employee or employees shall thereafter be prohibited from reviving or further prosecuting said grievance.

ARTICLE XV

Access to Facilities and Properties of the Cooperative

An authorized officer or agent of the Union, the name of whom shall be furnished to the Cooperative in writing, shall have access to the Cooperative's establishment during working hours for the purpose of investigating grievances and for any other legitimate purpose in connection with the administration of this Agreement, provided he notifies the Manager of the Cooperative beforehand. The Union hereby agrees that its agents and representatives will not cause any interruption of the Cooperative's working schedule or interfere with the work of employees or otherwise abuse these visitation privileges when on its premises. In the event of a change of agents, the Cooperative will be immediately notified in writing.

ARTICLE XVI

Seniority

SECTION 1.

Seniority of employees covered by this Agreement shall be determined by the Cooperative on the basis of length of continuous service with the Cooperative from the last date of hire.

SECTION 2.

An employee's seniority, qualifications, ability, skill and adaptability to perform the work involved, as determined by the Cooperative, shall apply in the case of layoff, recall from layoff, and promotions. It is agreed that in the case of layoff no employee, regardless of his seniority, may displace any other employee unless he is able, within two (2) weeks, to satisfactorily

perform the work of the employee being displaced, except this two (2) week period will not apply in the case of new and different kinds of equipment. In the event of layoff, the least senior, least qualified employee in the unit will be laid off. If the job opening created is to be filled and the layoff was created by elimination of a job of a more senior, qualified employee, then that employee will fill the job of the employee laid off. If the employee is not able to satisfactorily perform the work of the employee being displaced within the two (2) week period, then that employee will be laid off. If more than one (1) job opening is created and they are to be filled, then the same procedure applies with the most senior, qualified employee having first selection, the second most senior, qualified employee having second selection, etc. An employee who displaces another employee pursuant to the provisions of this Section shall be paid at the hourly rate of pay for that job classification. When the working force is being increased after a layoff the Cooperative will apply the same standards as it originally applied for layoff when employees are being recalled.

SECTION 3.

In the case of layoff, all probationary, seasonal, part-time and casual employees shall be laid off before any employees who have established seniority are affected.

SECTION 4.

The Cooperative will give employees one (1) week of notice prior to layoff.

SECTION 5.

Seniority, qualifications, ability, skill and adaptability to perform the work involved, as determined by the Cooperative shall be the controlling factors in promotion of employees, and where in the Cooperative's judgment, these factors are relatively equal between two (2) or more employees, seniority will control.

SECTION 6.

All job vacancies in jobs which the Cooperative decides to fill will be posted for bid at least three (3) full working days. Until the Cooperative has selected an employee to permanently fill such job vacancy the vacant job may be filled in any manner the Cooperative sees fit. The Cooperative will take final action with respect to all job openings within two (2) weeks after the posting is taken down. Employees shall be permitted to bid only on jobs which are higher than the job classification which they are in at the time and a successful job bidder shall not bid again for any posted job for six (6) months. If no employee in the unit who bids on the job is selected using the criteria set out in this Section, then the Cooperative may hire a new employee from outside the work force.

An employee who bids on and is awarded a job and who, within ten (10) working days, voluntarily decides they do not desire to stay in that job shall be disqualified from bidding on another job for twelve (12) months.

SECTION 7.

An employee shall lose his seniority and his status as an employee shall cease for any of the following reasons:

(a) If an employee quits or is discharged.

(b) If an employee is in layoff status for more than one (1) year.

(c) If an employee, after having been laid off, fails to report for work within three (3) working days when notified by the Cooperative by certified mail or telegram sent to the employee's last address appearing on the Cooperative's records.

(d) If an employee is absent from work for two (2) days without reporting to his supervisor.

(e) If an employee is retired.

SECTION 8.

Seasonal, temporary, part-time and casual employees are excluded from the bargaining unit covered by this Agreement, and are not entitled to any of the benefits and privileges provided for in this Agreement. The Cooperative will give the Union notice when such employees are hired, but shall be under no further obligation with respect to the Union for these employees.

SECTION 9.

If, and when, employees in the bargaining unit covered by this Agreement are promoted or transferred to jobs outside the bargaining unit they will retain and accumulate seniority for a period of twelve (12) months, during which period such employees will have the right to return to a job in the bargaining unit, provided they have the seniority therefor. At the end of said twelve (12) month period, if the employee remains in the job outside of the bargaining unit he will lose all seniority rights under this Agreement.

SECTION 10.

The seniority list shall be made up by the Cooperative within thirty (30) days after the date of this Agreement. A copy shall be furnished to the Assistant Business Agent or his representative and a copy posted on the Bulletin Board. This list shall be open for correction for a period of thirty (30) days thereafter and if an employee does not make a protest in writing to the Cooperative, with a copy to the Union within such thirty (30) day period after posting of such list, his seniority shall be as shown on the list. The seniority list shall be brought up-to-date on November 1 of each year thereafter.

SECTION 11.

In the event an employee becomes physically disabled from a work-related injury and can no longer perform the work in his classification (certified as such by his attending physician, and subject to confirmation by a physician selected by the Cooperative) he may request a transfer, if an opening exists at that time, to a lower classification of work, provided he is at that time able to satisfactorily perform the work of the lower classification to which he transfers. This provision shall only apply to employees with five (5) or more years of service with the Cooperative and only one (1) such transfer may be made.

In the event an employee is injured on the job and is eligible for workers compensation benefits, such employee must return to work and perform "light duty" as determined by the Cooperative, in accordance with work restrictions placed on such employee by the attending physician.

SECTION 12.

The following departments, I, II, III and IV, shall be utilized for the purpose of determining promotions, with Department I being the highest:

I Accounting Department

II Work Order Department

III Customer Services Department

IV Office Custodian

For purposes of bidding on jobs and promotion, the following will be used when jobs are open in the following departments:

Department III--Department IV employees

Department II--Departments III and IV employees

Department I--Departments II, III and IV employees

SECTION 13.

In the event a job vacancy is posted in accordance with Section 6 of this Article and no employees bid on the job and the Cooperative decides not to fill the vacancy by hiring a new employee from outside the work force, then the Cooperative may assign employees to the position on a permanent basis, so long as the employees so assigned are not required to make a geographic move of their residences.

ARTICLE XVII

Leave Program

SECTION 1.

(a) "Leave", as the term is used in this Agreement, shall mean time off taken by an employee who has accumulated leave time for purposes of illness or maternity condition, and shall be used only for such purposes.

Each employee covered by this Agreement shall be entitled to receive one (1) day of leave for each full month of employment. Only leave actually earned prior to the date utilized may be compensable. Leave will not be earned and no entitlement shall be granted for periods of time an employee is not actually working, including time on leave. An employee may accumulate an unlimited amount of leave time. Pay shall only be provided for actual illness and only as set forth in this Agreement.

Medical leave shall be made available to employees following one (1) full year of employment and such leave will be in accordance with the provisions of and regulations issued in accordance with the Family and Medical Leave Act of 1993. Following exhaustion of all accumulated leave time, an employee on Family and Medical Leave will be required to use fifty

percent (50%) of vacation entitlement (not including the one (1) week carry over) during such leave. Such vacation will be used beginning on the first day of leave under the Family and Medical Leave Act of 1993 and shall continue until fifty percent (50%) of such vacation entitlement has been paid.

(b) Gifting of sick days.

An employee with accumulated sick days may gift five (5) such days per calendar year to another employee. Sick days may be gifted only in a single 5 full day increment. The full days contributed will be subtracted from the gifting employee's sick leave account at their regular hourly rate. No fractions of a day will be saved or recorded. No employee shall be entitled to more than 26 weeks of gifted leave.

The gifted sick days will be paid either at the regular hourly rate of the employee gifting the days, or the employee who receives the gifted days, whichever is less.

To be eligible to receive gifted sick days, the employee receiving the gifted sick days must qualify for FMLA Leave under the law, must have exhausted all of their own accumulated sick days and vacation days, and any other accumulated paid days, and must have exhausted an additional two (2) week waiting period.

SECTION 2.

(a) Illness of Employee. Pay will be provided to an employee who has accumulated leave for leave due to illness. In order to be entitled to pay for leave due to illness, an employee may be required, as a condition of such payment, to submit, for each day of absence, a written statement signed by his attending physician attesting to the illness of the employee and which shows his recommendation that the employee absent himself from work because of such illness. In addition, an employee must notify his immediate supervisor before his shift begins of the

necessity for absence due to such illness, except in rare instances when the employee is completely physically unable to give the required notice. An employee who has been absent from work for a maximum of fifteen (15) days because of illness or other disability, must notify and advise his Superintendent regarding the anticipated duration of his absence.

(b) Illness of Employee's Spouse or Children. As of January 1 of each year of this Agreement, employees will be permitted to take up to forty (40) hours of their then accumulated sick leave per year for illness of the employee's spouse, children or minor step-children living in the employee's home. The employee must present to the Cooperative a Physician's Statement certifying the illness of the employee's spouse, child or step-child living in the employee's home.

SECTION 3.

Funerals. An employee who has completed his probationary period will be permitted leave of absence with pay at his regular rate for regularly scheduled work hours lost to a maximum of three (3) regularly scheduled work days lost (to a maximum of eight (8) hours per day) in case of death in his immediate family (i.e., legal spouse, mother, father, son, daughter and step-children) provided such days fall on the employee's regularly scheduled work days and are taken during the period between the day of death and the day after the funeral or memorial service in lieu of funeral, and provided further that the employee is prepared to offer valid proof of death and relationship upon request. Under the same conditions, an employee will be permitted to take up to three (3) regularly scheduled work days for the employee's step-parents, mother-in-law, father-in-law, son-in-law and daughter-in-law, such days to be deducted from the employee's sick leave account. In addition, and subject to the same conditions, an employee will be permitted leave of absence with pay at his regular rate for regularly scheduled work hours lost for a maximum of one (1) regularly scheduled work day lost (to a maximum of eight (8) hours)

in case of death of his sister, brother, grandchildren or grandparents. An employee may take an additional two (2) regularly scheduled work days off in the case of death of his sister, brother, grandchildren or grandparents, said days to be deducted from the employee's sick leave account. An employee may, under the same conditions as set forth above, take up to two (2) regularly scheduled work days off in the case of the death of the employee's brother-in-law and sister-in-law, said days to be deducted from the employee's sick leave account.

Only in the case of the death of one of the relatives set forth above whose funeral is more than 200 miles from the employee's regularly required work place will an employee be permitted to take such days off between the day of death and the day after the funeral.

SECTION 4.

Any employee found to have falsified the reasons for leave or who has abused the leave provision by falsification or misrepresentation shall thereupon be subject to disciplinary action, including discharge. In addition, such employee will restore to the Cooperative amounts paid to him to which he was not entitled unless otherwise mutually agreed upon between the Cooperative and the Union in the settlement of a grievance, or if an Arbitrator rules otherwise.

ARTICLE XVIII

Jury Duty

An employee who is required to serve and perform jury duty shall be compensated by the Cooperative in the amount of the difference between his regular rate for regularly scheduled work hours lost (to a maximum of eight (8) hours per day) and the amount received as juror's fees, provided he is prepared to offer valid proof of such jury duty and the amount received as juror's fees upon request by the Cooperative. Whenever the employee is excused by the Court from such jury duty two (2) hours or more before his normal shift ends on a scheduled work day,

he shall advise his immediate supervisor as promptly as possible and stand ready to report directly to work if requested by the Cooperative. The receipt of notice to report for jury duty must be reported immediately to his immediate supervisor.

In addition, and subject to the same conditions as stated above, an employee who is subpoenaed to appear in court and does appear as a defendant growing out of the Cooperative's business, a co-defendant with the Cooperative or as a witness on behalf of the Cooperative shall receive the difference between his regular rate for regular scheduled work hours lost and the amount received as a witness fee.

ARTICLE XIX

Military Service

Employees inducted into the Armed Forces of the United States shall be re-employed according to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. Any and all benefits under this Agreement which require working as a condition of earning such benefits and such other benefits as Health, Medical and other insurance and the retirement plan shall not be due such employees, unless specifically required by statute.

ARTICLE XX

Holidays

SECTION 1.

Members of the bargaining unit shall be paid eight (8) hours pay at their regular straight time rate for:

New Years Day	Labor Day
Good Friday	Thanksgiving Day
Memorial Day	Day After Thanksgiving Day

Independence Day
(4th of July)

Christmas Eve

Christmas Day

SECTION 2.

To receive holiday pay employees must have worked the full day immediately preceding the holiday and the full day immediately after the holiday. An employee will be considered to have worked the full day before the holiday if he is up to fifteen (15) minutes late reporting to work. The requirement that employees must have worked the full day immediately preceding and the full day immediately after the holiday shall be waived only when the absence is caused by being on scheduled vacation, jury duty, funeral leave, or injury sustained while working for the Cooperative and the injury is compensable under Worker's Compensation statutes and the injury occurred within thirty (30) days of the day for which eligibility is required. If an employee is on Sick Leave the day before or the day after a holiday, then such employee may receive Sick Leave under Article XVII, Leave Program, Sections 1 and 2, for the day of the holiday, but shall not receive holiday pay.

SECTION 3.

In addition to the above allowance, employees will be compensated for hours actually worked on the holidays at time and one-half (1-1/2) for hours actually worked between 8:00 a.m. and 5:00 p.m. and double time for hours actually worked before 8:00 a.m. and after 5:00 p.m.

SECTION 4.

Holidays falling on Saturday shall be recognized on Friday and holidays falling on Sunday shall be recognized on Monday.

SECTION 5.

If a holiday set forth in Section 1 falls within an employee's scheduled vacation, then the employee will receive an additional day of vacation, which will be, at the employee's option, added to the end of such scheduled vacation or at the beginning of such scheduled vacation.

ARTICLE XXI

Vacation

SECTION 1.

Employees shall receive paid vacations as follows:

After one (1) year of employment	-	One (1) week
After two (2) years of employment	-	Two (2) weeks
After ten (10) years of employment	-	Three (3) weeks
After twenty-one (21) years of employment	-	Three (3) weeks plus one (1) day
After twenty-two (22) years of employment	-	Three (3) weeks plus two (2) days
After twenty-three (23) years of employment	-	Three (3) weeks plus three (3) days
After twenty-four (24) years of employment	-	Three (3) weeks plus four (4) days
After twenty-five (25) years of employment	-	Four (4) weeks
After thirty (30) years of employment	-	Five (5) weeks

In computing length of employment for the purposes of vacation, the employee's length of employment with the Cooperative, including prior service, will be counted.

SECTION 2.

In order to be eligible for vacation as set forth above, an employee will be required to actually work the minimum number of hours set forth below during the twelve (12) month period immediately preceding the eligibility dates:

1,500 hours	100%
1,450 hours	75%
1,400 hours	50%
1,350 hours	25%
Less than 1,350 hours	0%

In order for an employee who retires before his anniversary date of employment to be eligible for vacation as set forth above on a pro rata basis, he will be required to actually work the minimum number of hours set forth below during the period between his last anniversary date and his date of retirement.

80% of available hours--100% of pro rata vacation.

75% of available hours--75% of pro rata vacation.

70% of available hours--50% of pro rata vacation.

65% of available hours--25% of pro rata vacation.

Less than 65% of available hours--0%

Actual hours spent on jury duty will be counted as hours "actually worked" for the purpose of meeting the minimum number of hours set forth above.

SECTION 3.

The Cooperative shall post vacation schedules on or before January 1 of each year. Each employee must designate his vacation period on such schedule not later than February 1 of each year. In the event two (2) or more employees designate the same vacation period on such schedule, then the employee with the longest period of continuous service from the last date of hire shall have preference. In designating the schedule of the periods in which vacations may be taken, such schedules shall be prepared in a manner consistent with the orderly and efficient operation of the Cooperative, as determined by it. If an employee who has designated a vacation period desires to change it, he may, if it is mutually agreed to by the Cooperative, change the period of vacation to a time when no other employee is scheduled or is otherwise convenient, as determined by the Cooperative.

In the instance of an employee with one (1) week of vacation, they may take such vacation in one (1) day increments. Employees will be permitted to take two (2) days of vacation entitlement per year in four (4) hour increments. Notice must be given by the employee to their immediate supervisor at least one (1) hour before each increment is taken.

In the instance of employees with two (2) week vacation periods, they may take one (1) week in increments of one (1) full day or one-half (1/2) days. In the instance of employees with three (3), four (4) and five (5) week vacation periods, they may take one (1) week in increments of one (1) day and one (1) week in increments of one-half (1/2) days. If an employee chooses the option of taking vacation in one (1) day or one-half (1/2) day increments as set forth, he must give at least two (2) days notice before each increment and must receive permission from his Department Head. If mutually convenient and agreeable between the Cooperative and the employee, the two (2) day notice may be waived.

SECTION 4.

Vacations are not cumulative and they shall be taken during the twelve (12) month period between January 1 and December 31 of each year. Vacation days earned, but not taken during such period, shall be forfeited by the employee and no pay will be provided to the employee for any days of vacation not taken, except employees shall be permitted to carry over one (1) week of vacation, but shall not in any one (1) year have more than six (6) weeks of vacation (earned and carried over). In the event and employee is off work because of a compensable injury under Worker's Compensation statutes, such employee will be given credit for service consistent with the yearly vacation entitlement set forth in Section 1. An employee who is off work because of a compensable injury under the Worker's Compensation Statute will be given credit for hours worked for earning vacation under Article XX1, Section 2, for up to seventy-five (75) working

days (maximum of 600 hours) they are off work because of a compensable injury under the Worker's Compensation Statute.

An employee who voluntarily or involuntarily terminates employment with the Cooperative shall be paid for all accumulated vacation, on a prorated basis, as of the date of termination. Vacation days used in excess of the prorated accumulated days of entitlement before termination will be deducted from the employee's final pay at the time of termination.

ARTICLE XXII

Group Insurance

SECTION 1.

(a) The Cooperative agrees to provide health insurance for employees in accordance with the Anthem Plan provided to the Union during negotiations for this Agreement designated HSAE2E7 and make it available to regular full-time employees who have completed their probationary period. For employees hired on or before November 30, 2005 and who are actively employed on November 30, 2020 the Cooperative agrees to pay the full premium, including increases for family or single coverage, whichever is applicable.

(b) Employees hired on and after December 1, 2005 will have such health insurance provided to them on an employee-only basis. If such employee desires to add a spouse and/or dependents, then such employee will pay the difference in premium between the employee-only and the premium for adding a spouse and/or dependents.

(c) Further, Employees hired on and after December 1, 2005 shall have no health insurance provided by the Cooperative when they retire.

(d) The Cooperative shall have the right to change insurance carriers for any of the group insurance programs as set forth in this Article at any time so long as the group insurance coverage is equivalent.

(e) The contracts between the Cooperative and insurance carriers will govern in all matters related to the insurance plans provided for herein. The exact coverage and the conditions for coverage of the aforesaid insurance will be determined by the terms and conditions of the policy or contract, and the Cooperative will not under any circumstances be liable as an insurer of any of the benefits to the employees.

SECTION 2.

Under the same conditions as set forth above in Section 1, the Cooperative will make available to employees a basic dental and vision plan. The full premium for such plans will be paid by the individual employees. The conditions established by the insurance company or companies will be met by the employees as a condition of providing such coverages including, but not limited to, minimum numbers of employees participation, duration, etc.

SECTION 3.

(a) For all current retirees and employees who were hired on or before November 30, 2005 who hereafter retire, in order for such insurance to be made available, a retiree or an eligible employee who retires from employment at the Cooperative in the future must have attained at least age sixty (60) and have at least thirty (30) years of service with the Cooperative.

(b) For all eligible employees described in paragraph (a) above, the Cooperative will provide the Humana Medicare Employer Plan designated Passive and Passive Waiver LPPO 079 064 with RX 127 presented to the Union during negotiations for this Agreement.

(c) For currently employed employees, who are eligible for health insurance under this Agreement, the Cooperative will create a Health Savings Account ("HSA") for each such employee and contribute the following amounts on the following dates to such HSA:

	Employee Coverage Only	Family Coverage Only
January 1, 2021	$3,300.00	$6,600.00
January 1, 2022	$3,300.00	$6,600.00
January 1, 2023	$3,300.00	$6,600.00
January 1, 2024	$3,300.00	$6,600.00
January 1, 2025	$3,300.00	$6,600.00

(d) When an eligible employee under this Section 3 becomes eligible for Medicare, that employee and spouse at the time of retirement from the Cooperative will submit proof of enrollment and the amount paid for Medicare B and, thereafter on an annual basis provide to the Cooperative a certification of their continued participation; and the Cooperative will pay directly to the retiree, retroactively, on a quarterly basis, the amount paid for Medicare B.

(e) The insurance coverage referred to above shall only be available for the life of the retired employee.

SECTION 4.

Under the same conditions as set forth above in Section 1, the Cooperative will make available for each employee a $50,000 life insurance plan. The full premium for such plan will be paid by the Cooperative for the duration of this Agreement. The conditions established by the insurance company or companies involved will be met by the employees as a condition of providing such coverage.

SECTION 5.

The Cooperative will provide to employees a long-term disability insurance plan with the following provisions:

(1) Sixty-six and two-thirds (66-2/3) pay

(2) Twenty-six (26) week waiting period

The contracts between the Cooperative and insurance carriers will govern in all matters related to the insurance plans provided for herein. The exact coverage and the conditions for coverage of the aforesaid insurance will be determined by the terms and conditions of the policy or contract and the Cooperative will not under any circumstances be liable as an insurer of any of the benefits to the employees.

ARTICLE XXIII

Retirement Plan

SECTION 1.

Effective January 1, 1995, the Cooperative adopted and implemented the National Rural Electric Cooperative Association ("NRECA") Selectre Pension Plan (the "Plan") for the benefit of its employees. The Plan replaced the Taylor County RECC Employees' Retirement Savings Trust Fund (the "Trust Fund"). The Trust Fund was terminated.

The instruments composing the Plan will govern in all matters related to it. The exact terms and conditions for eligibility for coverage, eligibility for participation, eligibility for retirement, contribution rates, etc. will be determined by the terms and conditions of such instruments and the Cooperative will not under any circumstances be liable for any benefits, or otherwise, to the employees.

Employees who have reached the age of sixty (60) and have a minimum of thirty (30) years service with the Cooperative will be permitted to retire and, upon such retirement, the Cooperative will pay one hundred percent (100%) of the health insurance premium for such employee until they qualify for benefits provided by Medicare. At such time, the employee will

be provided the Blue Access "carve out" supplemental plan provided for in Article XXII, Sections 3(c) and (d).

ARTICLE XXIV

Miscellaneous

SECTION 1. Stewards.

The Union shall have the right to designate from among the employees covered by this Agreement a Chief Steward. The Union shall notify the Cooperative in writing of the name of said Steward so designated. The Cooperative shall have the right to recognize and deal with the Steward so designated in the settlement of grievances and other matters pertaining to the administration of this Agreement. The Steward will not leave his work to investigate, present or discuss grievances unless given permission by his Supervisor. He will be permitted, however, to perform this business during scheduled breaks and scheduled meal periods and after his shift ends. In addition the Steward will be permitted to transmit messages and information, which originate with, and are authorized by the Local Union or its officers, provided such messages and information have been reduced to writing. In the event of any change in the Steward, the Union shall notify the Cooperative in writing at the time the new Steward assumes his responsibilities.

SECTION 2. Bulletin Boards.

The Cooperative will provide suitable space on its bulletin boards at each location of work for the posting of official Union bulletins.

Nothing, however, shall be posted on such bulletin boards which is derogatory to any individual, or which is libelous or obscene, or which deals with any matter that is subject to the grievance-arbitration procedure set forth in this Agreement. Only official matters which relate

directly to members of the bargaining unit at the Cooperative may be posted on such bulletin boards.

SECTION 3. Examinations.

Physical, mental or other examinations required by a government body, or the Cooperative, shall be promptly complied with by all applicants and employees, provided, however, the Cooperative shall pay for all such examinations. The Cooperative shall not pay for any time spent for such examinations, unless the examination is required to be taken by the Cooperative. Employees may take sick leave for such time actually spent traveling to and from and at the place of examination. Examinations are not to exceed one (1) in any one (1) year, unless the employee has suffered an injury or illness during the year.

The employer reserves the right to select its own medical examiner or physician and the Union may, if it believes an injustice has been done an employee, have said employee re-examined at the Union's expense.

An employee who has been off work for illness or other disability for a period of more than two (2) weeks will be required to obtain a statement from his attending physician and specialist (if one) certifying the nature and extent of the employee's illness or other disability for the period of absence and certify that the employee is released to return to work with no restrictions on his ability to work and can perform all the duties of his job.

SECTION 4. Uniforms and Protective Clothing.

In the event the Cooperative requires employees to wear uniforms, the Cooperative shall supply and pay for the uniforms.

The Cooperative will provide all safety equipment required.

Lost, broken or stolen equipment will be replaced at the employee's cost, unless the employee can show that it was not because of his negligence or acts by him.

SECTION 5. Worker's Compensation.

The Cooperative agrees to use its best efforts to cause the insurance carrier to duly and promptly settle and pay just on-the-job injury claims, when such claims are due and owing. The Cooperative shall provide Worker's Compensation protection as required by law.

SECTION 6.

Retired employees shall continue to receive Co-op HiLights in addition to being allowed to attend employee picnics and other recreational activities.

SECTION 7. Educational Assistance Program.

In order to actively encourage employees to take advantage of educational opportunities and to provide for individual growth and potential advancement, financial assistance will be made available under the following circumstances:

(1) Eligibility -- All regular full-time employees.

(2) Effective Date -- After completion of the probationary period provided for in this Agreement.

(3) Covered Educational Programs -- Courses which improve employee effectiveness under their present assignments and/or qualify an employee for promotion and such courses are taken on the employees' own time outside of regularly scheduled working hours.

(4) Expenses Eligible for Reimbursement -- Tuition for all approved courses completed with a grade "C" or better, or if the course is not graded on a letter basis but on a "pass-fail" basis, the employee receives a "pass" grade.

(5) Reimbursed Amount -- Fifty percent (50%) of the expenses for tuition after completion of the course and upon presentation to the Manager of proof of the grade and paid receipts for such tuition.

(6) Application Procedure --

(a) Employee must complete the application for course approval in sufficient time to obtain necessary approval prior to course registration and provide such application to his supervisor;

(b) Approval by the employee's immediate supervisor; and

(c) Final approval, in writing, by the Manager.

SECTION 8. DRIVE.

The Cooperative agrees during the first payroll period in December of each year of this Agreement that it will deduct from the paychecks of all employees who are covered by this Agreement a contribution in an amount designated by such employees, to DRIVE, the Union's political action committee, provided that such employees shall have signed and submitted a written authorization for such action on the part of the Cooperative; and, provided further, that such written authorization shall conform to and be in accordance with all applicable Federal and State laws.

All monies deducted by the Cooperative shall be forwarded to the Secretary-Treasurer of the Union.

The Cooperative will recognize authorizations for deductions from wages, if in compliance with State and Federal law, to be transmitted to the Union. No such authorization shall be recognized if in violation of State or Federal law. No deduction shall be made which is

prohibited by applicable law. This provision is subject to whatever shop rule is promulgated by the Cooperative with respect to garnishments or other wage deductions.

In consideration of the adoption by the Cooperative of this DRIVE contribution, the Union agrees to indemnify and hold the Cooperative harmless from and against any and all liability or loss as a result of any action brought by any employee, employees or any other person on account of claimed illegal payments, including reasonable attorneys' fees and court costs.

If, for any reason, an employee does not work during the first payroll period in December of each year of this Agreement in which the DRIVE contribution is to be deducted, the Cooperative shall make deductions for the above purpose from such employee's wages out of the next succeeding pay period in which he works.

ARTICLE XXV

Non-discrimination

The Cooperative and the Union agree that the provisions of this Agreement shall be applied to all employees without discrimination on the basis of age (over 40), sex, religion, race, color, creed, national origin, or disability (as that term is defined and applied within the meaning of the Americans With Disabilities Act and its implementing regulations).

Whenever the words "he", "him" or "his" are used herein, those words shall be deemed to include the feminine gender as well.

ARTICLE XXVI

Wage Rates and Classifications

SECTION 1.

All employees in the bargaining unit receiving a "red circle" rate at the time this Agreement is executed will continue to receive such "red circle" rate.

SECTION 2.

New employees hired by the Cooperative after the effective date of this Agreement shall begin their employment at eighty percent (80%) of the "classified rate"; after one (1) year of employment, such employees will be paid at the rate of ninety percent (90%) of the "classified rate"; after two (2) years of employment, such employees will be paid at one hundred percent (100%) of the "classified rate".

Employees who are promoted to higher rated positions after execution of this Agreement will be paid at the rate of the position to which they are promoted.

SECTION 3. Classified Rates.

	Classification	Classified Rates					
		12/1/19	**12/1/20**	**12/1/21**	**12/1/22**	**12/1/23**	**12/1/24**
I.	Accounting Department:						
	Bookkeeper	$ 26.12	$26.64	$27.31	$27.99	$28.69	$29.41
	Assistant Bookkeeper	$ 25.32	$25.83	$26.48	$27.14	$27.82	$28.52
	Payroll Clerk	$ 24.89	$25.39	$26.02	$26.67	$27.34	$28.02
II.	Work Order Department:						
	Work Order Clerk	$ 24.82	$25.32	$25.95	$26.60	$27.27	$27.95
	Assistant work Order Clerk	$ 24.28	$24.77	$25.39	$26.02	$26.67	$27.34
III.	Customer Services Department:						
	Clerks	$ 23.33	$23.80	$24.40	$25.01	$25.64	$26.28
	General Office Helpers	$ 21.81	$22.25	$22.81	$23.38	$23.96	$24.56
IV.	Office Custodian	$ 21.81	$22.25	$22.81	$23.38	$23.96	$24.56

SECTION 4.

The "Classified Rates" set forth above reflect the following increases to the rates in effect immediately prior to ratification of this Agreement: Effective December 1, 2020, a two percent (2%) per hour increase in wage rates; effective December 1, 2021, a two and one-half percent (2 ½%) per hour increase in wage rates; effective December 1, 2022 a two and one-half percent (2 ½%) per hour increase in wage rates; effective December 1, 2023, a two and one-half percent (2

½%) per hour increase in wage rates; effective December 1, 2024, a two and one-half percent (2 ½%) per hour increase in wage rates.

ARTICLE XXVII

Effect of Law

All provisions of this Agreement shall be subordinate and subject to any statute or law that may be applicable, whether now in effect or hereinafter enacted. If any provision of this Agreement or application of this Agreement to any employee is contrary to law, then such provision or application shall not be deemed valid except to the extent permitted by law, but all other provisions or applications of this Agreement shall continue in full force and effect.

If any provisions of this Agreement or application of this Agreement to any employee is contrary to law, then the Cooperative and the Union shall meet and attempt in good faith to agree upon a suitable replacement. If the parties are unable with due diligence to agree, the issue in question shall be subject to collective bargaining negotiation when this Agreement expires.

ARTICLE XXVIII

Entire Agreement

SECTION 1.

This Agreement sets out the entire understanding between the Cooperative and the Union with respect to the unit of employees described in this Agreement. Neither party intends to be bound or obligated except to the extent that it has expressly so agreed herein and this Agreement shall be strictly construed. This Agreement applies only to the collective bargaining unit defined in this Agreement. None of the benefits, rights or privileges accorded by this Agreement to the Union or to any employee covered by this Agreement shall survive the expiration or termination of this Agreement.

SECTION 2.

It is distinctly understood and agreed by the Union that the Cooperative shall not be obligated, contractually or otherwise, to continue in effect any custom, practice or benefit unless it has contractually obligated itself to do so by clear and explicit language in this Agreement.

ARTICLE XXIX

Collective Bargaining

The Cooperative and the Union each acknowledge that this Agreement has been reached as a result of collective bargaining in good faith by both parties hereto, and that both parties hereto have had the unlimited opportunity during negotiations to submit and discuss proposals on all subjects which are bargainable matters. While it is the intent and purpose of the parties hereto that each of them shall fully perform all obligations by them to be performed in accordance with the terms of this Agreement, the Union agrees that the Cooperative shall not be obligated to bargain collectively with the Union during the term of this Agreement on any matter pertaining to rates of pay, wages, hours of employment, or other conditions of employment, unless an obligation to bargain is otherwise specifically provided for in another Article of this Agreement, and the Union hereby specifically waives any right which it might otherwise have to request or demand such bargaining, except as provided in the Article entitled Effect of Law, and acknowledges that the Cooperative's obligations during the term of this Agreement shall be limited to the performance and discharge of its obligations under this Agreement.

ARTICLE XXX

Duration of Agreement

The effective date of this Agreement is December 1, 2020. This Agreement shall be in full force and effect for the entire period from December 1, 2020 through November 30, 2025, and from year to year thereafter, unless either party hereto shall at least sixty (60) days prior to November 30, 2025, or the 30th day of November in any year thereafter, notify the other party in writing of its intention and desire to terminate this Agreement. If proper notice is given and the parties, after negotiation, fail to reach agreement on the proposed changes, this Agreement may be terminated by either party upon ten (10) days' written notice delivered to the other at any time after the date upon which this Agreement would have otherwise terminated if no notice for termination had been given. Such ten (10) days' notice must be given before any lockout or strike may occur.

IN TESTIMONY WHEREOF, the Cooperative and the Union by their respective officers and representatives hereunto duly authorized, have signed this Agreement on the day, month and year first set forth above.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

President

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

0000HZ6.0737029 4839-1652-1192v1

EXHIBIT I.

	Current Pay Rate	Proposed Pay Increase	Pay Rate after Increase	Contract - 2.5% wage increase for each year		
				12/1/2022	12/1/2023	12/1/2024
Serviceman	31.29	2.00	33.29	34.12	34.98	35.85
1st Class Lineman	30.67	2.00	32.67	33.49	34.32	35.18
2nd Class Lineman	28.82	2.00	30.82	31.59	32.38	33.19

Bookkeeping/Payroll,

Per the Attached Addendum, the hourly rates above, take effect Sunday March 6, 2022.

Thanks

Barry L Nunnery.

3/4/2022

COPY

ADDENDUM

This Addendum is entered into by and between Taylor County Rural Electric Cooperative Corporation (the "Cooperative") and Local Union No. 89 General Drivers, Warehousemen and Helpers Affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America (the "Union") for the purpose of making certain limited modifications to the Construction and Maintenance Collective Bargaining Agreement (the "Agreement"), effective from December 1, 2020 – November 30, 2025.

In accordance with the Chart attached hereto as Exhibit 1. Article XXVI, Section 3 is to reflect negotiated changes to the wage rates for the classifications of Serviceman, First Class Lineman, and Second Class Lineman only. Such changes to the wage rates will be effected on the next regular payroll following the full execution of this Addendum. Such changes were proposed by the Cooperative at a meeting with the Union on February 23, 2022 and ratified by the Construction and Maintenance Bargaining Unit on March 1, 2022.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on March ____, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: _____

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: _____

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This Addendum is entered into by and between Taylor County Rural Electric Cooperative Corporation (the "Cooperative") and Local Union No. 89 General Drivers, Warehousemen and Helpers Affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America (the "Union") for the purpose of making certain limited modifications to the Construction and Maintenance Collective Bargaining Agreement (the "Agreement"), effective from December 1, 2020 – November 30, 2025.

In accordance with the Chart attached hereto as Exhibit 1, Article XXVI, Section 3 is amended to reflect agreed-upon changes to the wage rates for the classifications listed. Such changes to the wage rates will be effective at the start of the next payroll period following the full execution of this Addendum and will replace the previously agreed upon 2 ½ percent wage increase that was scheduled to take effect on December 1, 2022. Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Construction and Maintenance Bargaining Unit on September 27, 2022.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9-28-22

EXHIBIT 1

SECTION 3. Classified Rates.

Classification	Current Rate of Pay	Pay Rate After Increase	12/21/22	12/1/23	12/1/24
Serviceman	$33.29	$40.38	N/A	$41.39	$42.42
First Class Lineman	$32.67	$38.11	N/A	$39.06	$40.04
Second Class Lineman	$30.82	$35.33	N/A	$36.21	$37.12
Third Class Lineman	$25.48	$31.48	N/A	$32.27	$33.08
Apprentice Lineman	$24.11	$27.83	N/A	$28.53	$29.24
Right-of Way Man	$	$	N/A		
Right-of Way Helper	$	$	N/A		
Groundman	$	$	N/A		
Laborer	$24.11	$25.32	N/A	$25.95	$26.60
Engineering Department					
Instrument Man (Staking Engineer)	$29.43	$31.92	N/A	$32.72	$33.54
Engineering Aid	$28.20	$29.61	N/A	$30.35	$31.11
Staking Engineer Helper	$				
Meter Department					
Licensed Meter Man	$30.67	$32.50	N/A	$33.31	$34.14
Garage Department					
Mechanic	$27.90	$29.30	N/A	$30.03	$30.78
Mechanic Helper	$	$	N/A	$	$
Warehouse Department					
Warehouseman[1]	$	$	N/A	$	$

[1] When purchasing duties are assigned to the Warehouseman, the employee involved will receive a $1.00 per hour premium. Such premium shall be added to the Warehouseman's rate in effect at that time (e.g. Rate $15.00 per hour plus $1.00 per hour premium equals $16.00 per our rate.)

ADDENDUM

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Article XXII, Section 1(a) is amended to replace the existing language with the following language: "The Cooperative agrees to provide health insurance under Anthem Plan – Kentucky Rural Electric Cooperative Health Plan. During the period from October 1, 2022 until December 31, 2022, the Cooperative agrees to pay the full premium, including family or single coverage, whichever is applicable, for employees hired on or before November 30, 2005 and who are actively employed on November 30, 2020."

Article XXII, Section 1(b) is amended to replace the existing language with the following language: "During the period from October 1, 2022 until December 31, 2022, the Cooperative agrees to pay the health insurance premium for employees hired on and after December 1, 2005 for employee-only coverage, and if the employee desires to add a spouse and/or dependents, then such employee will pay the difference in premium between the employee-only and the premium for adding a spouse and/or dependents. Beginning January 1, 2023, the Cooperative will pay 95% of the full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire. Beginning January 1, 2024, the Cooperative will pay 90% of the full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire. Beginning January 1, 2025, the Cooperative will pay 88% of the

full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire."

Article XXII, Section 2 is amended to replace the existing language with the following language: "Under the same conditions as set forth above in Section 1, the Cooperative will make available to employees a basic dental and vision plan. Beginning October 2022, the Cooperative will pay 80% of the premium for the dental plan, regardless of the plan selected, for all employees who are actively employed on that date. The conditions established by the insurance company or companies involved will be met by the employees as a condition of providing such coverages including, but not limited to, minimum numbers of employees, participation, duration, etc."

Article XXII, Section 3(c) is amended to replace the existing amounts contributed by the Cooperative to a Health Savings Account for each employee with the following amounts:

	Employee Coverage Only	Family Coverage Only
January 1, 2023	$3,500	$7,000
January 1, 2024	$3,500	$7,000
January 1, 2025	$3,500	$7,000

Article XXII, Section 4 is amended to replace the existing language with the following language effective January 2023: "Under the same conditions as set forth above in Section 1, the Cooperative will make available for each employee a life insurance policy in an amount equal to twice the amount that the employee earned in base wages or base salary during the preceding calendar year; employees who were not employed during the previous year will have available a life insurance policy based on the annualized base salary or base wages in effect on their hire date. The full premium for such plan will be paid by the Cooperative for the duration of this Agreement.

The conditions established by the insurance company or companies involved will be met by the employee as a condition of providing such coverage."

Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Construction and Maintenance Bargaining Unit on September 27, 2022. Such changes shall take effect following ratification as noted in this Addendum.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9.28.22

ADDENDUM

This Addendum is entered into by and between Taylor County Rural Electric Cooperative Corporation (the "Cooperative") and Local Union No. 89 General Drivers, Warehousemen and Helpers Affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America (the "Union") for the purpose of making certain limited modifications to the Construction and Maintenance Collective Bargaining Agreement (the "Agreement"), effective from December 1, 2020 – November 30, 2025.

Article XVII, Section 1 is amended to add a new subsection (c) with the following language: "At the end of each calendar year, an employee who has accumulated 200 or more hours of unused sick leave can elect to exchange up to five days of the accumulated sick leave for pay. The employee shall notify the Cooperative in writing of the number of days the employee elects to exchange for pay as directed by the Accounting department in November-December of each year."

Article XVII, Section 2(b) is amended to replace the existing language with the following language: "As of January 1 of each year of this Agreement, employees will be permitted to take any or all of their then accumulated sick leave for illness of the employee's spouse, children or minor step-children living in the employee's home. The Cooperative may request that an employee present to the Cooperative a Physician's Statement certifying the illness of the employee's spouse, child or step-child living in the employee's home."

Article XX is amended to add Martin Luther King, Jr. to the list of paid holidays.

In accordance with the Chart attached hereto as Exhibit 1, Article XXI, Section 1 is amended to reflect agreed-upon changes to the number of vacation days awarded to employees.

Article XXI, Section 3 is amended to replace the existing second and third paragraphs with the following language: "Employees may take such vacation in increments of one (1) full day or

one-half (1/2) day. If an employee chooses the option of taking vacation in one (1) day or one-half (1/2) day increments, the employee must give at least two (2) days' notice before each increment and must receive permission from the employee's Department Head. If mutually convenient and agreeable between the Cooperative and the employee, the two (2) days' notice may be waived."

Article XXI, Section 4 is amended to increase the total number of earned but unused vacation days that an employee can carry over from one year to the next, as follows: at the end of each calendar year, an employee can carry over a maximum of the total amount of vacation days allotted to that employee during that calendar year, rather than a maximum of just (1) week.

Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Construction and Maintenance Bargaining Unit on September 27, 2022. Such changes shall take effect on the first day of the month following ratification, with the exception of vacation accrued, effective January 1, 2023.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9-28-22

ARTICLE XXI

Exhibit I

Vacation

SECTION 1.

Vacation Amount prior to Addendum

After one (1) year of employment	1 week
After two (2) years of employment	2 weeks
After ten (10) years of employment	3 weeks
After twenty-one (21) years of employment	3 weeks + 1 addl. day
After twenty-two (22) years of employment	3 weeks + 2 addl. days
After twenty-three (23) years of employment	3 weeks + 3 addl. days
After twenty-four (24) years of employment	3 weeks + 4 addl. days
After twenty-five (25) years of employment	4 weeks
After thirty (30) years of employment	5 weeks

Vacation Amount under Addendum

Year 0 hired in 2nd half of year	1 week
Year 0 hired in 1st half of year	2 weeks
Year 1 through 4	2 weeks
Year 5 through 9	3 weeks
Years 10 through 19	3 weeks + 1 addl. day a year
Year 20	5 weeks

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In accordance with the Chart attached hereto as Exhibit 1, Article XXVI, Section 3 is amended to reflect agreed-upon changes to the wage rates for the classifications listed. Such changes to the wage rates will go into effect on December 1, 2022 and will replace the previously agreed upon 2 ½ percent wage increase that was scheduled to take effect on December 1, 2022. Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Office Clerical Bargaining Unit on September 27, 2022.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9-28-22

EXHIBIT 1

SECTION 3. Classified Rates.

	Classification	Current Rate	12/1/22	12/1/23	12/1/24
I.	Accounting Department:				
	Bookkeeper	$27.31	$28.68	$29.40	$30.14
	Assistant Bookkeeper	$26.48	$27.80	$28.50	$29.21
	Payroll Clerk	$26.02	$27.32	$28.00	$28.70
II.	Work Order Department:				
	Work Order Clerk	$25.95	$27.25	$27.93	$28.63
	Assistant work Order Clerk	$25.39	$26.66	$27.33	$28.01
III.	Customer Services Department:				
	Clerks	$24.40	$25.62	$26.26	$26.92
	General Office Helpers	$22.81	$23.95	$24.55	$25.16
IV.	Office Custodian	$22.81	$23.95	$24.55	$25.16

ADDENDUM

This Addendum is entered into by and between Taylor County Rural Electric Cooperative Corporation (the "Cooperative") and Local Union No. 89 General Drivers, Warehousemen and Helpers Affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America (the "Union") for the purpose of making certain limited modifications to the Office Clerical Collective Bargaining Agreement (the "Agreement"), effective from December 1, 2020 – November 30, 2025.

Article XXII, Section 1(a) is amended to replace the existing language with the following language: ""The Cooperative agrees to provide health insurance under Anthem Plan – Kentucky Rural Electric Cooperative Health Plan. During the period from October 1, 2022 until December 31, 2022, the Cooperative agrees to pay the full premium, including family or single coverage, whichever is applicable, for employees hired on or before November 30, 2005 and who are actively employed on November 30, 2020."

Article XXII, Section 1(b) is amended to replace the existing language with the following language: "During the period from October 1, 2022 until December 31, 2022, the Cooperative agrees to pay the health insurance premium for employees hired on and after December 1, 2005 for employee-only coverage, and if the employee desires to add a spouse and/or dependents, then such employee will pay the difference in premium between the employee-only and the premium for adding a spouse and/or dependents. Beginning January 1, 2023, the Cooperative will pay 95% of the full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire. Beginning January 1, 2024, the Cooperative will pay 90% of the full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire. Beginning January 1, 2025, the Cooperative will pay 88% of the

full premium of each coverage level for all employees who are actively employed on that date, regardless of the date of hire."

Article XXII, Section 2 is amended to replace the existing language with the following language: "Under the same conditions as set forth above in Section 1, the Cooperative will make available to employees a basic dental and vision plan. Beginning October 2022, the Cooperative will pay 80% of the premium for the dental plan, regardless of the plan selected, for all employees who are actively employed on that date. The conditions established by the insurance company or companies involved will be met by the employees as a condition of providing such coverages including, but not limited to, minimum numbers of employees, participation, duration, etc."

Article XXII, Section 3(c) is amended to replace the existing amounts contributed by the Cooperative to a Health Savings Account for each employee with the following amounts:

	Employee Coverage Only	Family Coverage Only
January 1, 2023	$3,500	$7,000
January 1, 2024	$3,500	$7,000
January 1, 2025	$3,500	$7,000

Article XXII, Section 4 is amended to replace the existing language with the following language effective January 2023: "Under the same conditions as set forth above in Section 1, the Cooperative will make available for each employee a life insurance policy in an amount equal to twice the amount that the employee earned in base wages or base salary during the preceding calendar year; employees who were not employed during the previous year will have available a life insurance policy based on the annualized base salary or base wages in effect on their hire date. The full premium for such plan will be paid by the Cooperative for the duration of this Agreement.

The conditions established by the insurance company or companies involved will be met by the employee as a condition of providing such coverage."

Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Office Clerical Bargaining Unit on September 27, 2022. Such changes shall take effect as specified in this Addendum following ratification.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9-28-22

ADDENDUM

This Addendum is entered into by and between Taylor County Rural Electric Cooperative Corporation (the "Cooperative") and Local Union No. 89 General Drivers, Warehousemen and Helpers Affiliated with International Brotherhood of Teamsters, Chauffeurs, Warehousemen & Helpers of America (the "Union") for the purpose of making certain limited modifications to the Office Clerical Collective Bargaining Agreement (the "Agreement"), effective from December 1, 2020 – November 30, 2025.

Article XVII, Section 1 is amended to add a new subsection (c) with the following language: "At the end of each calendar year, an employee who has accumulated 200 or more hours of unused sick leave can elect to exchange up to five days of the accumulated sick leave for pay. The employee shall notify the Cooperative in writing of the number of days the employee elects to exchange for pay as directed by the Accounting department in November-December of each year."

Article XVII, Section 2(b) is amended to replace the existing language with the following language: "As of January 1 of each year of this Agreement, employees will be permitted to take any or all of their then accumulated sick leave for illness of the employee's spouse, children or minor step-children living in the employee's home. The Cooperative may request that an employee present to the Cooperative a Physician's Statement certifying the illness of the employee's spouse, child or step-child living in the employee's home."

Article XX is amended to add Martin Luther King, Jr. to the list of paid holidays.

In accordance with the Chart attached hereto as Exhibit 1, Article XXI, Section 1 is amended to reflect agreed-upon changes to the number of vacation days awarded to employees.

Article XXI, Section 3 is amended to replace the existing second and third paragraphs with the following language: "Employees may take such vacation in increments of one (1) full day or

one-half (1/2) day. If an employee chooses the option of taking vacation in one (1) day or one-half (1/2) day increments, the employee must give at least two (2) days' notice before each increment and must receive permission from the employee's Department Head. If mutually convenient and agreeable between the Cooperative and the employee, the two (2) days' notice may be waived."

Article XXI, Section 4 is amended to increase the total number of earned but unused vacation days that an employee can carry over from one year to the next, as follows: at the end of each calendar year, an employee can carry over a maximum of the total amount of vacation days allotted to that employee during that calendar year, rather than a maximum of just (1) week.

Such changes were proposed by the Cooperative at a meeting with the Union on September 8, 2022 and ratified by the Office Clerical Bargaining Unit on September 27, 2022. Such changes shall take effect on the first day of the month following ratification, with the exception of vacation accrued, effective January 1, 2023.

Being fully informed and in agreement, the Cooperative and the Union enter into this Addendum on September 28, 2022.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION

BY: _____

Date: 9-28-22

LOCAL UNION NO. 89, GENERAL DRIVERS, WAREHOUSEMEN AND HELPERS, AFFILIATED WITH INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN & HELPERS OF AMERICA

BY: _____

Date: 9-28-22

ARTICLE XXI

Exhibit I

Vacation

SECTION 1.

Vacation Amount prior to Addendum

After one (1) year of employment	1 week
After two (2) years of employment	2 weeks
After ten (10) years of employment	3 weeks
After twenty-one (21) years of employment	3 weeks + 1 addl. day
After twenty-two (22) years of employment	3 weeks + 2 addl. days
After twenty-three (23) years of employment	3 weeks + 3 addl. days
After twenty-four (24) years of employment	3 weeks + 4 addl. days
After twenty-five (25) years of employment	4 weeks
After thirty (30) years of employment	5 weeks

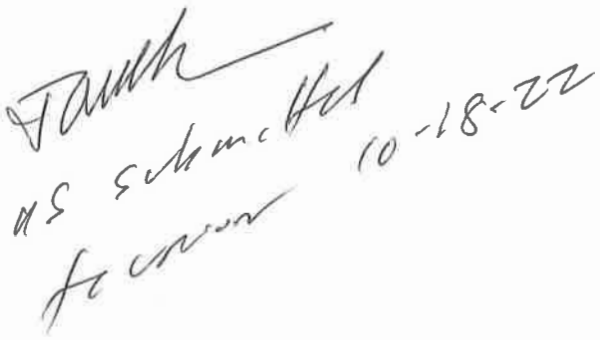
Vacation Amount under Addendum

Year 0 hired in 2nd half of year	1 week
Year 0 hired in 1st half of year	2 weeks
Year 1 through 4	2 weeks
Year 5 through 9	3 weeks
Years 10 through 19	3 weeks + 1 addl. day a year
Year 20	5 weeks

Engineering Department	Current Rate	12/1/22	12/1/23	12/1/24
Sr. Staking Engineer	$35.07	N/A	$35.95	$36.85

10-18-22
as submitted to Union

V. Operations Department	Current Rate	12/1/22	12/1/23	12/1/24
Dispatcher	$25.95	$27.25	$27.93	$28.63



TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 25
RESPONSIBLE PARTY: Patsy Walters

Request 25. Provide each medical insurance policy that Taylor RECC currently maintains.

Response 25. Please see attached.

Kentucky Rural Electric Cooperative

Kentucky Rural Electric Cooperative Employers Benefit Plan
Taylor County Rural Electric Cooperative Corporation
Summary Plan Description

Effective
January 1, 2023

TABLE OF CONTENTS

Commented [JCM1]: [To be updated in final draft]

SECTION I—INTRODUCTION

This document is a description of The Kentucky Rural Electric Cooperative Employers Benefit Plan (*Plan*). No oral interpretations can change this *Plan*. The *Plan* described is designed to protect *plan participants* against certain catastrophic health expenses. Terms which have special meanings when used in this *Plan* will be italicized. For a list of these terms and their meanings, please see the **Defined Terms** section of the summary plan description. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

The *employer* fully intends to maintain this *Plan* indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the *Plan* at any time and for any reason.

Changes in the *Plan* may occur in any or all parts of the *Plan* including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, defined terms, eligibility, and the like.

This *Plan* is not a 'grandfathered health plan' under the *Patient Protection and Affordable Care Act (PPACA)*, also known as Health Care Reform. Questions regarding the *Plan's* status can be directed to the *Plan Administrator*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit **www.dol.gov/ebsa/healthreform**.

Failure to follow the eligibility or enrollment requirements of this *Plan* may result in delay of coverage or no coverage at all. Reimbursement from the *Plan* can be reduced or denied because of certain provisions in the *Plan*, such as coordination of benefits, subrogation, exclusions, timeliness of Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims*, or lack of coverage. These provisions are explained in summary fashion in this document. Additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services, you need to understand what is covered and excluded under your benefit *Plan*, your cost sharing obligations, and the steps you can take to minimize your out-of-pocket costs. For complete terms of the *Plan* and information about benefits which are not outlined in this summary plan description, refer to your *Plan's* wrap document, which can be obtained from your Human Resources representative. If there is any conflict between this summary plan description and the *Plan's* wrap document, this plan document will control, unless otherwise specified.

This plan document does not determine rights under the *Plan*; the collective bargaining agreement always will remain the final authority. In the case of a dispute, the information in the union plan documents or collective bargaining agreement will control to the extent permitted by law. If you are a union *employee* covered under a collective bargaining agreement that provides benefits with the *employer*, you should contact your local Human Resources Representative to obtain a copy of the summary plan description that applies to you.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminates. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements. Refer to the Quick Reference Information Chart for contact information.

A. Quick Reference Information Chart

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator • Second-Level *Appeals* of *Pre-Service* and *Post-Service Claims*	Kentucky Rural Electric Cooperative 4775 Lexington Road Winchester, KY 40391 1-859-745-9672
Medical Claims Administrator/Third Party Administrator (Medical and Dialysis) • *Claim* Forms (Medical) • Medical *Claims* • First-Level *Appeals* of *Post-Service Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-844-209-0071 **www.MyAmeriBen.com**
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First-Level *Appeals* of *Pre-Service Claims*	AmeriBen Medical Management PO Box 7186 Boise, ID 83707 1-844-209-0071
PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory – see website	Anthem 1-833-835-2714 **www.anthem.com**
Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Specialty Pharmacy Program	**Retail** Navitus Health Solutions, LLC PO Box 999 Appleton, WI 54912 1-866-378-4755 **www.navitus.com** Fax: 1-920-735-5315 **Mail Order** Birdi P.O. Box 8004 Novi, MI 48376-8004

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

Kentucky Rural Electric Cooperative
4775 Lexington Road
Winchester, KY 40391
1-859-745-9672

The *Plan* is administered by the *Plan Administrator* within the purview of Employee Retirement Income Security Act of 1974 (ERISA), and in accordance with these provisions. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* shall administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care, and treatments are *experimental/investigational*), to decide disputes which may arise relative to a *plan participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan.* The decisions of the *Plan Administrator* as to the facts related to any *claim* for benefits and the meaning and intent of any provision of the *Plan*, or its application to any *claim*, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *plan participant* is entitled to them.

Service of legal process may be made upon the *Plan Administrator*.

D. Duties of the Plan Administrator

The duties of the *Plan Administrator* are to:

1. administer the *Plan* in accordance with its terms
2. interpret the *Plan*, including the right to remedy possible ambiguities, inconsistencies, or omissions
3. decide disputes that may arise relative to a *plan participant's* rights
4. prescribe procedures for filing a *claim* for benefits and to review *claim* denials
5. keep and maintain the plan documents and all other records pertaining to the *Plan*
6. appoint a *Third Party Administrator* to pay *claims*
7. perform all necessary reporting as required by ERISA
8. establish and communicate procedures to determine whether a *Medical Child Support Order* is qualified under ERISA Sec. 609
9. delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate

E. Amending and Terminating the Plan

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, as the settlor of the *Plan*, the *Plan Sponsor*, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan* or the Trust Agreement (if any).

Any such amendment, suspension, or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. *Notice* shall be provided as required by ERISA. In the event that either:

1. the *Plan Sponsor* is a different type of entity, then such amendment, suspension, or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents
2. the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in their own discretion

If the *Plan* is terminated, the rights of the *plan participant* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

F. Plan Administrator Compensation

The *Plan Administrator* serves without compensation; however, all expenses for *Plan* administration, including compensation for hired services, will be paid by the *Plan*.

G. Fiduciary Duties

A *fiduciary* must carry out their duties and responsibilities for the purpose of providing benefits to the *employees* and their *dependent(s)* and defraying *reasonable* expenses of administering the *Plan*. These are duties which must be carried out:

1. with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the *Plan* so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so
3. in accordance with the plan documents to the extent that they agree with ERISA

H. Type of Administration

The *Plan* is a self-funded group health plan, and the *claims* administration is provided through a *Third Party Administrator*. The *Plan* is not insured.

I. Employer Information

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

Kentucky Rural Electric Cooperative
4775 Lexington Road
Winchester, KY 40391
1-859-745-9672
EIN 61-0461919

J. Plan Name

The name of the *Plan* is the Kentucky Rural Electric Cooperative Employers Benefit Plan.

K. Plan Number

501

L. Type of Plan

The *Plan* is commonly known as an employee health benefit plan. The *Plan* has been adopted to provide *plan participants* certain benefits as described in this document. The Kentucky Rural Electric Cooperative Employers Benefit Plan is to be administered by the *Plan Administrator* in accordance with the provisions of ERISA Section 4(a).

M. Plan Year

The *plan year* is the twelve (12) month period beginning January 1 and ending December 31.

N. Plan Effective Date

January 1, 2023

O. Plan Sponsor

The *employer* is the *Plan Sponsor*.

P. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator* (*TPA*) to assist the *Plan Administrator* with *claims* adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-844-209-0071

A *Third Party Administrator* is **not** a *fiduciary* under the *Plan*, except to the extent otherwise agreed upon in writing or as required under ERISA.

Q. Employer's Right to Terminate

The *employer* reserves the right to amend or terminate this *Plan* at any time. Although the *employer* currently intends to continue this *Plan*, the *employer* is under absolutely no obligation to maintain the *Plan* for any given length of time. If the *Plan* is amended or terminated, an authorized officer of the *employer* will sign the documents with respect to such amendment or termination.

R. Agent for Service of Legal Process

The name of the person designated as agent for service of legal process and the address where a processor may serve legal process upon the *Plan* are:

Kentucky Rural Electric Cooperative Employers Benefit Plan
East Kentucky Power Cooperative
4775 Lexington Road
Winchester, KY 40391
1-859-744-4812

SECTION II—ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Commented [ALW2]: This section has been updated per eligibility requirements of each group. Groups will need to review this section for accuracy.

A. Eligibility

Eligible Classes of Employees

All *active* and retired *employees* of the *employer*.

Eligibility Requirements for Employee Coverage

A person is eligible for *employee* coverage from the first day that the *employee*:

1. is a full-time, *active employee* of the *employer*

   An *employee* is considered to be full-time if they normally work at least thirty (30) hours per week and are on the regular payroll of the *employer* for that work.

2. is in a class eligible for coverage, as shown above
3. completes the employment *waiting period* of sixty (60) consecutive days as an active *employee*

   A *waiting period* is the time between the first day of *active employment* and the first day of coverage under the *Plan*.

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* as of the first day of the calendar month following the date that the *employee* satisfies all of the following:

1. the eligibility requirement
2. the active *employee* requirement
3. the enrollment requirements of the *Plan*, as shown in the Enrollment subsection

Active Employee Requirement

An *employee* must be an active *employee* (as defined by this *Plan*) for this coverage to take effect.

Eligible Classes of Dependents

A *dependent* is any of the following persons:

1. a covered *employee's* spouse

   The term 'spouse' shall mean the person recognized as the covered *employee's* legally married husband or wife and does not include common law marriages. The *Plan Administrator* may require documentation proving a legal marital relationship.

2. a covered *employee's* child(ren)

   For the purposes of the *Plan*, an *employee's* child includes their:

   a. natural child or stepchild
   b. adopted child

   Unless otherwise specified, an *employee's* child will be an eligible *dependent* until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. To determine when coverage will end for a child who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

   The phrase 'placed for adoption' refers to a child whom a person intends to adopt, whether or not the adoption has become final, and who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term 'placed' means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

3. a covered *employee's* qualified *dependents*

   The term 'qualified *dependents*' shall include children for whom the *employee* is a *legal guardian*. To be eligible for *dependent* coverage under the *Plan*, a qualified *dependent* must be under the limiting age as

described herein. To determine when coverage will end for a qualified *dependent* who reaches the applicable limiting age, please refer to the When Dependent Coverage Terminates subsection.

Any child of a *plan participant* who is an *alternate recipient* under a *Qualified Medical Child Support Order* (*QMCSO*) or National Medical Support Notice shall be considered as having a right to *dependent* coverage under this *Plan*.

A *participant* of this *Plan* may obtain, without charge, a copy of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or covered qualified *dependent* who reaches the limiting age and is *totally disabled*, incapable of self-sustaining employment by reason of mental or physical disability, primarily dependent upon the covered *employee* for support and maintenance, and is unmarried

   The *Plan Administrator* may require, at reasonable intervals, continuing proof of the *total disability* and dependency.

   The *Plan Administrator* reserves the right to have such *dependent* examined by a *physician* of the *Plan Administrator's* choice, at the *Plan's* expense, to determine the existence of such incapacity.

Effective Date of Dependent Coverage

A *dependent's* coverage will take effect on the day that the eligibility requirements are met, the *employee* is covered under the *Plan*, and all enrollment requirements are met.

Ineligible Dependent(s)

Unless otherwise provided in this plan document, the following are not considered eligible *dependents*:

1. other individuals living in the covered *employee's* home, but who are not eligible as defined
2. the legally separated or divorced former spouse of the *employee*
3. any person who is on active duty in any military service of any country
4. a person who is covered as an *employee* under the *Plan*
5. any other person not defined above in the subsection entitled Eligible Classes of Dependents

Restrictions on Elections

If a *plan participant* changes status from *employee* to *dependent* or *dependent* to *employee*, and the person is covered continuously under this *Plan* before, during, and after the change in status, credit will be given for *deductibles,* and all amounts will be applied to maximums.

If two (2) *employees* (spouses) are covered under the *Plan,* and the *employee* who is covering the *dependent* children terminates coverage, the *dependent* coverage may be continued by the other covered *employee* with no *waiting period* as long as coverage has been continuous.

Accumulators will transfer if a *dependent* changes from coverage under one (1) parent *employee* to coverage under another parent *employee*.

Eligibility Requirements for Dependent Coverage

A *dependent* of an *employee* will become eligible for *dependent* coverage on the first day that the *employee* is eligible for *employee* coverage and the family member satisfies the requirements for *dependent* coverage.

At any time, the *Plan* may require proof that a spouse, qualified *dependent*, or a child qualifies or continues to qualify as a *dependent* as defined by this *Plan*.

B. Enrollment

Enrollment Requirements

An *employee* must enroll for coverage for themselves and/or their *dependents* by completing the enrollment process along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children

A newborn child will be automatically enrolled for thirty (30) days from birth. In order for coverage to continue, a covered *employee* must complete an enrollment application as shown in the Qualifying Events Chart subsection.

If the newborn child is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan* beyond the initial thirty (30) days from birth. The covered parent will be responsible for all further costs and will have to wait until the next *open enrollment period* to add the child as a *dependent*.

C. Timely Enrollment

The enrollment will be timely if the completed form is received by the *Plan Administrator* no later than thirty (30) days after the person initially becomes eligible for coverage, or as shown in the Qualifying Events Chart subsection for each type of special enrollment period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a special enrollment period. *Late enrollees* and their *dependents* who are not eligible to join the *Plan* during the special enrollment period may join only during the *open enrollment period*.

The time between the date a *late enrollee* first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*. Coverage begins January 1.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, or placement for adoption, there may be a right to enroll in this *Plan*. However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

E. Special Enrollment Periods

The *enrollment date* for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period*.

Individuals Losing Other Coverage, Creating a Special Enrollment Right

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if loss of eligibility for coverage meets any of the following conditions:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this *Plan* was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or *dependent* who had lost the coverage was under COBRA and the COBRA coverage was exhausted or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because *employer* contributions towards the coverage were terminated.
4. The *employee* or *dependent* requests enrollment in this *Plan* no later than as shown in the Qualifying Events Chart subsection after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of *employer* contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one (1) of the following occurs:

1. The *employee* or *dependent* has a loss of eligibility due to the *Plan* no longer offering any benefits to a class of similarly situated individuals (e.g., part-time *employees*).
2. The *employee* or *dependent* has a loss of eligibility as a result of legal separation, divorce, cessation of *dependent* status (such as attaining the maximum age to be eligible as a *dependent* child under the *Plan*), death, termination of employment, reduction in the number of hours of employment, or contributions towards the coverage were terminated.

Covered *employees* or *dependents* will not have a special enrollment right if the loss of other coverage results from either:

1. the *employee's* failure to pay premiums or required contributions
2. the *employee* or *dependent* making a fraudulent *claim* or an intentional misrepresentation of a material fact in connection with the *Plan*

Dependent Beneficiaries

If a *dependent* becomes eligible to enroll and the *employee* is not enrolled, the *employee* must enroll in order for the *dependent* to enroll.

If both of the following conditions are met, then the *dependent* (and if not otherwise enrolled, the *employee* and other eligible *dependents*) may be enrolled under this *Plan*:

1. The *employee* is a *plan participant* under this *Plan* (or has met the *waiting period* applicable to becoming a *plan participant* under this *Plan* and is eligible to be enrolled under this *Plan* but for a failure to enroll during a previous enrollment period).
2. A person becomes a *dependent* of the *employee* through marriage, birth, adoption, or placement for adoption.

In the case of the birth or adoption of a child, the spouse of the covered *employee* may be enrolled as a *dependent* of the covered *employee* if the spouse is otherwise eligible for coverage. If the *employee* is not enrolled at the time of the event, the *employee* must enroll under this special enrollment period in order for their eligible *dependents* to enroll.

The *dependent* special enrollment period is as shown in the Qualifying Events Chart subsection. To be eligible for this special enrollment, the *dependent* and/or *employee* must request enrollment during the timeframe specified as shown in the Qualifying Events Chart subsection.

F. Qualifying Events Chart

This chart is only a summary of some of the permitted health plan changes and is not all-inclusive.

Qualifying Event	Effective Date	Forms and Notification Must be Received Within:	You May Make the Following Changes(s)
Marriage	Date of event	thirty (30) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other newly acquired *dependents*
Divorce or annulment	Date of event	thirty (30) of the date of final divorce decree or annulment	Coverage will terminate for your spouse Enroll yourself and *dependent* child(ren) if you, or they, were previously enrolled in your spouse's plan
Birth of your child	Date of event	sixty (60) days of birth	Enroll yourself Enroll the newborn child
Adoption, placement for adoption, or legal guardianship of a child	Date of event	thirty (30) days of adoption	Enroll yourself Enroll the newly adopted child
Your *dependent* child reaches maximum age for coverage	Date of event	thirty (30) days of loss of eligibility	Coverage will terminate for the child who lost eligibility from your health coverage

Death of your spouse or *dependent* child	Date of event	thirty (30) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
A *change in employment status* (including a change from one *employment* classification to another, you or your spouse taking a qualified unpaid *leave of absence*, a strike or lockout, or a change in worksite)	Date of event	thirty (30) days of *change in employment status* classification	Enroll yourself, if your employment change results in you being eligible for a new set of benefits Enroll your spouse and other eligible *dependents* Drop health coverage Drop your spouse and other eligible *dependents* from your health coverage
Special requirements relating to the Family and Medical Leave Act	Date of event	thirty (30) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Spouse or covered *dependent* obtains coverage in another group health plan	Date of event	thirty (30) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	Date of event	thirty (30) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	Date of event	thirty (30) days of the date of loss of coverage	Enroll your spouse and eligible *dependent* children Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse's plan
Eligibility for government-sponsored plan, such as *Medicare* (excluding the government-sponsored Marketplace)	Date of event	thirty (30) days of eligibility date	Drop coverage for the person who became entitled to *Medicare*, Medicaid, or other eligible coverage
CHIP Special Enrollment – loss of eligibility for coverage under a state Medicaid or CHIP program, or eligibility for state premium assistance under Medicaid or CHIP	Date of event	sixty (60) days of loss of eligibility or eligibility date	Enroll yourself, if applicable Add the person who lost entitlement to CHIP Drop coverage for the person entitled to CHIP coverage
Qualified Medical Support Order affecting a *dependent* child's coverage	Date listed on the notice	thirty (30) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or *dependents* for cause, making a fraudulent *claim*, or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered *dependents* for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the *Plan's* discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written *notice* of such action.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage):

1. the date the *Plan* is terminated

2. the last day of the calendar month in which the covered *employee* ceases to be in one (1) of the eligible classes

   This includes termination of *active employment* of the covered *employee*, an *employee* on disability, *leave of absence*, or other *leave of absence*, unless the *Plan* specifically provides for continuation during these periods.

3. the date of the covered *employee's* death
4. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the date the *Plan* or *dependent* coverage under the *Plan* is terminated
2. the date that the *employee's* coverage under the *Plan* terminates for any reason, including death
3. the date a covered spouse loses coverage due to loss of dependency
4. the last day of the calendar month in which a person ceases to be a *dependent* as defined by the *Plan*
5. the last day of the calendar month that a *dependent* child ceases to be a *dependent* as defined by the *Plan* due to age as listed in the Eligible Classes of Dependents provisions
6. the date of the covered *dependent's* death
7. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA.**

H. Continuation During Periods of Employer-Certified Disability, Leave of Absence, or Layoff

A person may remain eligible for a limited time if active, full-time work ceases due to disability, *leave of absence,* or layoff. This continuance will end as follows:

1. for disability leave only: the date the *employer* ends the continuance
2. for *leave of absence* or layoff only: the date the *employer* ends the continuance

While continued, coverage will be that which was in force on the last day worked as an active *employee*. However, if benefits are reduced for others in the class, they will also be reduced for the continued person.

I. Continuation During Family and Medical Leave

Regardless of the established leave policies mentioned above, this *Plan* shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor.

During any leave taken under FMLA, the *employer* will maintain coverage under this *Plan* on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period.

If *Plan* coverage terminates during the *FMLA leave*, coverage will be reinstated for the *employee* and their covered *dependents* if the *employee* returns to work in accordance with the terms of the *FMLA leave*. Coverage will be reinstated only if the person(s) had coverage under this *Plan* when the *FMLA leave* started and will be reinstated to the same extent that it was in force when that coverage terminated.

J. Rehiring a Terminated Employee

If your employment ends and you are rehired by the *employer* within ninety (90) days following termination, your coverage will take effect on the rehire date.

If you were not covered under the *Plan* on the date of your termination or you are rehired by the employer more than ninety (90) days after your termination date, you will be treated as a new *employee* and will be required to satisfy the *waiting period*.

K. Open Enrollment

Every year during the annual *open enrollment period*, covered *employees* and their covered *dependents* will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every year during the annual *open enrollment period*, *employees* and their *dependents* who are *late enrollees* will be able to enroll in the *Plan*.

Benefit choices made during the *open enrollment period* will become effective January 1 and remain in effect until the next January 1 unless there is a special enrollment event or change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage *waiting periods* will be considered satisfied when changing from one benefit option under the *Plan* to another benefit option under the *Plan*.

Benefit choices for *late enrollees* made during the *open enrollment period* will become effective January 1.

A *plan participant* who fails to make an election during an active *open enrollment period* will no longer be covered under this *Plan*. A *plan participant* will automatically retain their present coverages during a passive *open enrollment period*. However, if an *employee* is enrolled in an FSA, they are required to actively elect these benefits during the *open enrollment period* each year in order to retain their present coverage. *Plan participants* will receive detailed information regarding open enrollment from their *employer*.

SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act. In addition, the Transparency in Coverage (TIC) regulations contain transparency requirements. Portions of the CAA and TIC are described briefly below. Enforcement dates, standards for implementation, coordination with other entities, legal developments, and updates offered by federal and/or state entities directly impact actions and availability of the items described. In addition, some plan types are not subject to the CAA and/or TIC, or certain provisions of either.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements. These are:

1. *emergency services* provided by *non-network* providers or facility
2. covered services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

The section below contains further information about how these *claim* categories apply to your *Plan*.

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, *emergency services* are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the *emergency services* you receive are provided by a *non-network* provider or facility, covered services will be processed at the *network* benefit level in accordance with the CAA.

Note that if you receive *emergency services* from a *non-network* provider or facility, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider or facility. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider or facility determines you are stable and the *non-network* provider satisfies all of the following requirements:

1. determines that you are able to travel to a *network* facility by non-emergency or non-medical transport to an available *network* provider or facility within a reasonable distance based on your condition
2. complies with the *notice* and consent requirement
3. determines that you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are defined as:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a *physician* or non-physician practitioner
2. items and services provided by assistant surgeons, hospitalists, and intensivists
3. diagnostic services, including radiology and laboratory services

4. items and services provided by a *non-participating provider* if there is no *participating provider* who can furnish such item or service at such facility

This *notice* and consent exception also does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your consent and offering the required notice not later than seventy-two (72) hours prior to the delivery of services
2. the *notice* is given and consent is obtained on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

To help you determine whether a provider is *non-network*, the *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network cost-sharing amount* will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-share, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your *cost sharing amounts* for emergency services or for covered services received by a *non-network* provider at a *network* facility will be calculated as defined by the CAA, such as the median plan *network* contract rate that we pay *network* providers for the geographic area where the covered service is provided if other calculation criteria does not apply. Any out-of-pocket cost you pay to a *non-network* provider for either *emergency services* or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*.

D. Appeals

If you receive *emergency services* from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description. A provider can dispute the payment they received from the *Plan* by utilizing a process set up the CAA, or if applicable, state law. The CAA process includes Open Negotiation, and if unresolved, Independent Dispute Resolution. Importantly, this process does not include the *plan participant*, and you are not required to participate. To learn more about the CAA, you can visit **https://www.cms.gov/nosurprises**.

E. Transparency Requirements

Under your *Plan*, the following are provided as required by the CAA and TIC. Depending on how the *Plan* interacts with other entities, these may be provided from the *Third Party Administrator*, the *network*, Pharmacy Benefit Manager, and/or other stakeholders (ex. Customer Care or Member Services):

1. protections with respect to *surprise billing claims* by providers
2. estimates on what *non-network* providers may charge for a particular service
3. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

When asked, a paper copy of the type of information you request from the above list can be provided.

Through the price comparison/shoppable services tool(s) associated with your *Plan* or through Member Services at the phone number on the back of your ID card, you can receive the following:

1. cost sharing information that you would be responsible for, for a service from a specific *network* provider
2. a list of all *network* providers
3. cost sharing information on a *non-network* provider's services based on the *network's* reasonable estimate based on what the *network* would pay a *non-network* provider for the service

As applicable, under machine readable requirements from the TIC, the *network*, Pharmacy Benefit Manager, *Third Party Administrator*, and/or entities associated with your *Plan* will provide access through separate publicly accessible websites that contain the following information:

1. *network* negotiated rates
2. historical *non-network* allowed amounts
3. drug pricing information

F. Continuity of Care

If a *network* provider leaves the *network* for any reason other than termination for failure to meet applicable quality standards, fraud, or otherwise defined by the CAA, you may be able to continue seeing that provider for a limited period of time and still receive *network* benefits. The CAA permits you to request and decide to continue to have benefits provided under the same terms and conditions as you would have had under the plan document had the provider not moved to *non-network* status. If authorized, continuity of care ends ninety (90) days after you are notified by the *Plan* or its delegate of the right to request continuity of care or the date you are no longer under care of the provider, whichever of these is earlier.

Continuity of care under the CAA is permitted for a *plan participant* who, with respect to a provider, qualifies based on any of the following circumstances:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility
2. is undergoing a course of institutional or inpatient care from the provider or facility
3. is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility

Under the CAA, the term 'serious and complex condition' means, with respect to a *participant*, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage, one (1) of the following:

1. in the case of an acute *illness*, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
2. in the case of a chronic *illness* or condition, a condition that satisfies both of the following criteria:
    a. is life-threatening, degenerative, potentially disabling, or congenital
    b. requires specialized medical care over a prolonged period of time

If you wish to continue seeing the same provider/facility and you believe continuity of care under the CAA applies, you or your provider/facility should contact the entity responsible for Member Services on back of your card for how to apply for continuity of care.

SECTION IV—MEDICAL NETWORK INFORMATION

A. Network and Non-Network Services

Network Provider Information

The *Plan* has entered into an agreement with a medical *network* that maintains contractual agreements with certain *hospitals*, *physicians*, and other health care providers which are called *network* providers. Because these *network* providers have agreed to charge reduced fees to persons covered under the *Plan*, the *Plan* can afford to reimburse a higher percentage of their fees.

Therefore, when a *plan participant* uses a *network* provider, that *plan participant* will receive better benefits from the *Plan* than when a *non-network* provider is used. It is the *plan participant's* choice as to which provider to use.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* or the *Plan's* medical *network* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse for the *allowable charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles*, *co-insurance*, *co-payments*, limitations, and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator* as outlined in the Quick Reference Information Chart.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

Provider Non-Discrimination

To the extent that an item or service is a *covered charge* under the *Plan*, the terms of the *Plan* shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable state law. This provision does not preclude the *Plan* from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided, and does not require the *Plan* to accept all types of providers as a *network* provider.

B. Choosing a Physician – Patient Protection Notice

The *Plan* does not require you to select a *primary care physician* (*PCP*) to coordinate your care, and you do not have to obtain a referral to see a specialist.

You do not need prior authorization from the *Plan* or *Third Party Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the *network* who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

C. Special Reimbursement Provisions

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

1. **Medical Emergency.** In a *medical emergency*, a *plan participant* should try to access a *network* provider for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network* providers will be covered until the *plan participant's* condition has stabilized to the extent that they can be safely transferred to a *network* provider's care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.
2. **No Choice of Provider.** If, while receiving treatment at a *network* facility and provider (other than from a surgeon in a non-emergency situation), a *plan participant* receives ancillary services or supplies from a *non-network* provider in a situation in which they have no control over provider selection (such as in the selection of an ambulance, emergency room *physician*, anesthesiologist, assistant surgeon, or a provider for *diagnostic services*), such *non-network* services or supplies will be covered at *network* benefit levels. Charges that meet

this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

3. **Providers Outside of Network Area.** If *non-network primary care physicians* or specialists are used because the necessary service is not in the *network* or is not reasonably accessible to the *plan participant* due to geographic constraints [over thirty (30) miles from home or work], such *non-network* care will be covered at *network* benefit levels. Charges that meet this definition will be paid based on the *maximum allowable charges*. The *plan participant* will be responsible for *notifying* the *Third Party Administrator* for a review of any *claim* that meets this definition.

Additional information about this option, as well as a list of *network* providers, will be given to *plan participants*, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* services and billing.

D. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call the *Claims Administrator* to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up-to-date health Identification Card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1-800-810-2583. Or you can call them collect at 1-804-673-1177.

If you need *inpatient hospital* care, you or someone on your behalf should contact the *Claims Administrator* for *pre-certification* as outlined in the Quick Reference Information Chart. Keep in mind, if you need emergency medical care, go to the nearest *hospital*. There is no need to call before you receive care.

Please refer to the **Health Care Management Program** *pre-certification* provisions in this booklet for further information. You can learn how to get *pre-certification* when you need to be admitted to the *hospital* for emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange *inpatient hospital* care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any *co-payment*, *co-insurance*, or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

1. doctor services
2. *inpatient hospital* care not arranged through Blue Cross Blue Shield Global Core
3. *outpatient* services

You will need to file a *claim* form for any payments made up front.

When you need Blue Cross Blue Shield Global Core *claim* forms, you can get international *claims* forms in the following ways:

1. call the Blue Cross Blue Shield Global Core Service Center at the numbers above
2. online at **www.bcbsglobalcore.com** or **MyAmeriBen.com**

You will find the address for mailing the *claim* on the form.

E. Network Information

You may obtain more information about the providers in the *network* by contacting the *network* by phone or by visiting their website.

Anthem

1-833-835-2714

www.anthem.com

All locations

SECTION V—SCHEDULE OF BENEFITS

A. Verification of Eligibility: 1-844-209-0071

Call this number to verify eligibility for *Plan* benefits **before** charges are *incurred*. Please note that oral or written communications with the *Third Party Administrator* regarding a *plan participant's* or beneficiary's eligibility or coverage under the *Plan* are not *claims* for benefits, and the information provided by the *Third Party Administrator* or other *Plan* representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

B. Schedule of Benefits

All benefits described in the **Schedule of Benefits** are subject to the exclusions and limitations described more fully herein, including, but not limited to, the *Plan Administrator's* determination that care and treatment is *medically necessary*; those charges are in accordance with the *maximum allowable charge*; and that services, supplies, and care are not *experimental/investigational*.

This document is intended to describe the benefits provided under the *Plan,* but due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all *covered charges* and/or exclusions with specificity. If you have questions about specific supplies, treatments, or procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

The *Plan Administrator* retains the right to audit *claims* to identify treatment(s) that are, or were, not *medically necessary*, *experimental*, *investigational*, or not in accordance with the *maximum allowable charges*.

Pre-Certification

The following services must be *pre-certified*, or reimbursement from the *Plan* will be reduced:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
    a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
    b. long term acute care facility (LTAC), not *custodial care*
    c. *skilled nursing facility*/rehabilitation facility
    d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

    The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.
2. *inpatient* and *outpatient surgery*, including surgical pain management injections

    Pre-certification is not required for office *surgeries,* all colonoscopies/sigmoidoscopies (screening and diagnostic), and intra-articular hyaluronic acid injections.
3. *adoptive cell therapy*
4. cardiac catheterization
5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
6. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

    This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.
7. *durable medical equipment (DME)* in excess of $500 (purchase/rental price)
8. *gene therapy*
9. genetic/genomic testing (excluding amniocentesis)
10. home health care
11. lung perfusion study

12. non-emergent air ambulance and chartered air flights
13. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)
    a. computed tomographic (CT) studies
    b. coronary CT angiography
    c. MRI/MRA
    d. nuclear cardiology
    e. nuclear medicine (including SPECT scans)
    f. PET scans
14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of ten (10) visits per *calendar year* per therapy type
15. specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    Pre-certification is not required for intra-articular hyaluronic acid injections.
16. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

Please see the Health Care Management Program section in this document for details.

C. Deductible Amount

Deductibles are dollar amounts that the *plan participant* must pay before the *Plan* pays. Before benefits can be paid in a *calendar year*, a *plan participant* must meet the *deductible* shown in the applicable Schedule of Medical Benefits.

This amount will accrue toward the 100% maximum *out-of-pocket limit*.

D. Common Accident Deductible

When two (2) or more *plan participants* who are covered under the same benefit plan are involved in an accident, only the *individual deductible* amount will be required to be met before benefits will be paid for *covered charges* that directly result from the accident when the following conditions are met:

1. at least two (2) of the *plan participants* involved in the accident receive *covered charges* directly resulting from the accident
2. the combined *allowed amount* for all *covered charges* for all *plan participants* involved in the accident is equal to or greater than the *individual deductible* amount

Claims will be credited to the *deductible* of the *employee* during the *calendar year* in which the accident occurred.

E. Benefit Payment

Each *calendar year*, benefits will be paid for the *covered charges* of a *plan participant* that are in excess of the *deductible*, any *co-payments*, and any amounts paid for the same services. Payment will be made at the rate shown under the reimbursement rate in the applicable Schedule of Medical Benefits. No benefits will be paid in excess of the *maximum benefit* amount or any listed limit of the *Plan*.

Services rendered may have professional, facility, and other components for which *physicians* and facilities may bill separately.

F. Out-of-Pocket Limit

Covered charges are payable at the percentages shown each *calendar year* until the *out-of-pocket limit* shown in the applicable Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *plan participant* will be payable at 100% (except for the charges excluded) for the remainder of the *calendar year*.

The *out-of-pocket limit* includes applicable amounts paid for *deductibles*, *co-payments*, and *co-insurance*.

G. Diagnosis Related Grouping (DRG)

Diagnosis related grouping (*DRG*) is a method for reimbursing *hospitals* for *inpatient* services. This is when a provider bills for services that go together in a group, or bundle, instead of the individual services that make up the group separately. The provider has agreed to a set *DRG* rate with the *network*. When a service is rendered, regardless of what the provider bills, the *DRG* amount has already been set for that specific group of services. A *DRG* amount can be higher or lower than the actual billed charge because it is based on an average cost for the services rendered.

In the case where the *DRG* amount on an eligible *claim* is higher than the actual billed charges, the following will determine how each party's cost sharing will be determined:

1. the *Plan* will base their portion of the charge on the *network allowed amount*
2. the *plan participant's* portion of the charge will be based on the billed charges
3. the difference in the *network allowed amount* versus the actual billed charges will be the responsibility of the *Plan*

H. Co-Insurance

For *covered charges incurred* with a *network* provider, the *Plan* pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of *covered charge*, and is specified in the applicable Schedule of Medical Benefits. You are responsible for the difference between the percentage the *Plan* pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network* provider, the *Plan* pays a specified percentage of *covered charges* at the *maximum allowable charge*. In those circumstances, you are responsible for the difference between the percentage the *Plan* pays and 100% of the billed amount, unless your *claim* is a *surprise billing claim*.

These amounts for which you are responsible are known as *co-insurance*. Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-insurance* applies towards satisfaction of the *out-of-pocket limit*.

I. Co-Payments

In certain cases, instead of paying *co-insurance*, you must pay a specific dollar amount, as specified in the applicable Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment* and is typically payable to the health care provider at the time services or supplies are rendered.

Unless otherwise stated in the applicable Schedule of Medical Benefits, *co-payments* are applied per provider per day.

Unless noted otherwise in the Special Comments column of the applicable Schedule of Medical Benefits, your *co-payments* apply toward satisfaction of the *out-of-pocket limit*.

J. Balance Bill

The *balance bill* refers to the amount you may be charged for the difference between a *non-network* provider's billed charges and the *allowable charge*.

Network providers will accept the *allowable charge* for *covered charges*. They will not charge you for the difference between their billed charges and the *allowable charge*.

Non-network providers have no obligation to accept the *allowable charge*. You are responsible to pay a *non-network* provider's billed charges, even though reimbursement is based on the *allowable charge*. Depending on what billing arrangements you make with a *non-network* provider, the provider may charge you for full billed charges at the time of service or seek to *balance bill* you for the difference between billed charges and the amount that is reimbursed on a *claim*.

Any amounts paid for *balance bills* do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *balance billing/surprise billing*.

Refer to the **Prescription Drug Benefits** section of this plan document for additional information on *prescription drug* coverage.

K. High Deductible Health Plan (HDHP)

A qualified *high deductible health plan* (*HDHP*) with a *health savings account* (*HSA*) provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The *Plan* gives you greater control over how health care benefits are used. An *HDHP* satisfies certain statutory requirements with respect to minimum *deductibles* and *out-of-pocket limits* for both individual and family coverage. These minimum *deductibles* and maximum *out-of-pocket limits* are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

How This Plan Works

This *Plan* features higher annual *deductibles* and *out-of-pocket limits* than other traditional health plans. With the exception *of preventive care*, you must meet the annual *deductible* before the *Plan* pays benefits. It is called a *high deductible health plan* or *HDHP*.

It is paired with a *health savings account* (*HSA*). You may elect to make pre-tax contributions from your paycheck to your *HSA* each pay period. The *HDHP* provides medical and *prescription drug* coverage, and the *HSA* provides a tax-free way to help you save for health expenses in retirement. The *HDHP* gives you flexibility and discretion to determine how to use your health care benefits.

You can pay your *deductible* with funds from your *HSA*, or you can choose to pay your *deductible* out-of-pocket, allowing your *health savings account* to grow. Preventive care services are not subject to the *deductible*. These benefits are paid at 100%.

Applying Expenses to the Deductible

If you have not met your *deductible*, you will be responsible for 100% of the *allowed amount* for your health care expenses. If you use a *network* provider, the provider will submit the *claim* to the *Third Party Administrator* on your behalf. If you use a *non-network* provider, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Third Party Administrator* to ensure your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Third Party Administrator* stating how much the negotiated payment amount is and the amount for which you are responsible.

L. Requirements for a Health Savings Account (HSA)

To be eligible for enrollment in a *health saving account*, you must:

1. be enrolled in a qualified *HDHP*
2. in general, not have any other non-*HDHP* medical coverage including coverage under a health flexible spending account or health reimbursement account

   You are allowed to have auto, dental, vision, disability, and long-term care insurance at the same time as an *HDHP*.
3. not be enrolled in a general purpose health care flexible spending account (and your spouse may not be enrolled in a general purpose flexible spending account)
4. not be enrolled in *Medicare*
5. not be claimed as a *dependent* on someone else's tax return

Qualified Medical Expenses

A partial list is provided in IRS Publication 502, available at **www.irs.gov**.

M. Schedule of Medical Benefits – HDHP Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *deductible* includes *prescription drugs*. The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-insurance* does not apply to the *deductible*. When applicable, *claims* for a common accident will be credited to the covered *employee* and their *deductible*.		
Individual Plan	$1,500	$3,000
Per *family unit*	$3,000	$6,000
Family Unit – Non-Embedded Deductible If you are enrolled in the family option on the *high deductible health plan*, there is not an individual *deductible* embedded in the *family unit deductible*. Before your *Plan* helps you pay for any of your medical bills, the entire amount of the *family unit deductible* must be met first. It can be met by one (1) family member or a combination of family members; however, there are no benefits (except for *preventive care*) until expenses equaling the *family unit deductible* amount have been *incurred*. **For example,** if you, your spouse, and child are on a family plan with a $3,000 *family unit* non-embedded *deductible* and the individual *deductible* is $1,500, and your child *incurs* $1,500 in medical bills, your *Plan* will NOT help pay subsequent medical bills until the *family unit deductible* of $3,000 has been met yet.		
Co-Insurance Out-of-Pocket Limit, per Calendar Year This *out-of-pocket limit* includes *co-insurance*.		
Per *plan participant*	$2,000	$4,000
Per *family unit*	$4,000	$8,000
Overall Maximum Out-of-Pocket Limit, per Calendar Year The overall *out-of-pocket limit* includes *co-payments*, *co-insurance*, *deductibles*, and covered *prescription drug* charges. The *network* and *non-network out-of-pocket limits* do not accumulate towards each other.		
Per *plan participant*	$3,500	$7,000
Per *family unit*	$7,000	$14,000
Family Unit – Embedded Out-of-Pocket Limit If you are enrolled in the *family unit* option, your *Plan* contains two (2) components: an individual *out-of-pocket limit* and a *family unit out-of-pocket limit*. Having two (2) components to the *out-of-pocket limit* allows each member of your *family unit* the opportunity to have their *covered charges* be payable at 100% (except for the charges excluded) prior to the entire dollar amount of the *family unit out-of-pocket limit* being met. The individual *out-of-pocket limit* is embedded in the *family unit out-of-pocket limit*.		
The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise. **NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:** 1. cost containment penalties 2. amounts over *maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges		

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
General Percentage Payment Rule	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Generally, most *covered charges* are subject to the benefit payment percentage contained in this row, unless otherwise noted. This Special Comments column provides additional information and limitations about the applicable *covered charges*, including the expenses that must be *pre-certified* and those expenses to which the *out-of-pocket limit* does not apply.
Accidental Injury	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Advanced Imaging	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Includes Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans, excluding services rendered in an emergency room setting. ***Pre-certification* is required.**
Allergy Testing, Injection, and Serum	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Ambulance Service	90% *co-insurance* after *network deductible*		***Pre-certification* is required** for non-emergent air ambulance and chartered flights. Please refer to the **Medical Benefits** section, Covered Medical Charges, Ambulance, for a further description and limitations of this benefit.
Anesthesia	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Attention Deficit Disorders and Attention Deficit Hyperactivity Disorders (ADD/ADHD)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Chemotherapy Drugs/Infusions and Radiation Treatments	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required.**
Chiropractic Treatment	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	*Spinal manipulations* and all other services, including physical therapy, apply to the rendering provider's benefit level. **Manipulations Calendar Year Maximum:** $1,000 per *plan participant*. X-rays are not included in this maximum.
Dental Injury	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Diabetic Education	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Diabetic Supplies	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Diabetic supplies are covered under both the medical and pharmacy benefits of this *Plan*.

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Diagnostic Testing	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Dialysis, Outpatient	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Durable Medical Equipment (DME)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required** for *DME* in excess of $500 purchase/rental price.
Emergency Room	90% *co-insurance* after *network deductible*		
Foot Care (Routine)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	If billed with an office visit, the office visit *co-payment* still applies. For treatment of metabolic or peripheral-vascular disease only.
Genetic/Genomic Testing	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required.**
Hearing Services			
Hearing Aids	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	**Benefit Maximum:** $5,000 every five (5) years per *plan participant*.
Hearing Exams (Diagnostic)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Implantable Hearing Devices	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Home Health Care	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required.**
Hospice Care			
Hospice Care	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Bereavement Counseling	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Infertility Testing	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Injections and Infusion Therapy	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Benefits are available for injections and infusion therapies received in an office setting other covered facility.
Inpatient Hospital			
Physician Visits	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Room and Board	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Limited to the semi-private room rate when such semi-private room rate is available, unless necessary due to a sickness or *injury* or in the case that the *hospital* has private or single-bed rooms only. ***Pre-certification* is required.**

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Lab and X-Ray	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Lenses Following Eye Surgery/Eye Injury	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	**Benefit Maximum per Surgery/Eye Injury:** $50 for eyeglasses, including frames; $75 for one (1) contact lens; $150 for two (2) contact lenses. Replacements are not covered.
Maternity			
Maternity Services	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	*Dependent* child *pregnancy* is not covered.
Birthing Center	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Mental Disorders & Substance Use Disorder			
Outpatient	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Includes intensive psychiatric day treatment and partial hospitalization.
Inpatient	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required.**
Nutritional Therapy/ Counseling	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Office Visit	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Oral Surgery	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required** for *inpatient* and *outpatient* surgical procedures**.**
Orthotic Appliances/ Prosthetics	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Outpatient Observation Stays	90% *co-insurance* after *network deductible*		After twenty-three (23) observation hours, a confinement will be considered at this benefit level. Prior to twenty-three (23) observation hours, benefits will pay at the applicable benefit level.
Outpatient Surgery	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required** for *outpatient surgical procedures* (other than office surgeries, colonoscopies, sigmoidoscopies, and intra-articular hyaluronic acid injections).
Pervasive Development Disorders (Autism)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Private Duty Nursing	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Private duty nursing while in a hospital or other qualified treatment facility if not covered.
Routine Newborn Care	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Routine newborn care is subject to the newborn's *deductible* and *out-of-pocket limit*. However, in circumstances limited by the *network*, the routine newborn charges will go towards the plan of the covered mother.

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Skilled Nursing Facility/ Extended Care	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	**Benefit Maximum:** Sixty (60) days per *plan participant* per *sickness* or *injury*. Long term acute care and *rehabilitation hospital* services apply toward this maximum. ***Pre-certification* is required.**
Sleep Disorders/Sleep Studies	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Telehealth Services			
LiveHealth Online	90% *co-insurance* after *deductible*	Not covered	Telemedicine benefit provided through Anthem at **www.livehealthonline.com** or call 1-855-603-7985. Anthem BCBS members will be charged $59 which will be applied to their *deductible* and *out-of-pocket limit*. Once the *deductible* is met, the appropriate *co-insurance* will apply.
Other Telehealth Providers	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Temporomandibular Joint Syndrome (TMJ)/Occlusion Treatment Services	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Therapy Services - Rehabilitation/Habilitation			
Physical Therapy Occupational Therapy Speech Therapy	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	***Pre-certification* is required** for physical therapy, occupational therapy, and speech therapy in excess of ten (10) visits per *calendar year* per therapy type.
Applied Behavioral Analysis (ABA) Therapy	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Cardiac Rehabilitation	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Transplants	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Refer to the **Medical Benefits** section for a further description and limitations of this benefit and any associated covered travel expenses. All other related services will pay under the applicable benefit level. **Travel Expenses Limitation:** $10,000 per transplant per *plan participant*. ***Pre-certification* is required.**

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Urgent Care	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	Includes retail/walk-in clinics.
Vision Exam (Medical)	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Wigs	90% *co-insurance* after *network deductible*		**Limited to hair loss related to chemotherapy, radiation therapy, burns, or alopecia.** **Calendar Year Maximum:** Limited to one (1) wig up to a maximum of $300 per *plan participant*.

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE If the service is listed as A or B rated on the U.S. Preventive Service Task Force list, Health Resources and Services Administration (HRSA), the IRS Safe Harbor preventive services list, or *preventive care* for children under Bright Future guidelines, then the service is covered at 100% when performed by a *network* provider at a Routine Wellness Care visit. For more information about preventive services please refer to the following websites: **https://www.healthcare.gov/coverage/preventive-care-benefits/** **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** **www.hrsa.gov** **Safe Harbor Services:** **https://www.irs.gov/pub/irs-drop/n-04-23.pdf** **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** The *Plan* does not limit all federally mandated *preventive care* services to age/frequency/gender guidelines as outlined by the USPSTF.			
Routine Wellness Care	No charge	**Up to $500 per year:** 100%, *deductible* waived **Charges in excess of $500:** 70%, *deductible* waived	Services include routine physical exam, screening and wellness labs and x-rays, immunizations, gynecological exam, pap smear, PSA test, 2D and 3D mammogram, colorectal cancer screening, blood work, bone density testing, and shingles vaccine. Please refer to the **Medical Benefits** section, Covered Medical Charges, Preventive Care, for a further description and limitations of this benefit.
Breastfeeding Pump and Supplies	No charge		Breastfeeding support, supplies, and counseling, including breast pumps purchased over-the-counter. **Benefit Maximum:** one (1) pump per pregnancy.
Contraceptive Services	No charge	**Up to $500 per year:** 100%, *deductible* waived **Charges in excess of $500:** 70%, *deductible* waived	Services include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion. **Benefit Limitations:** Services are available to all female *plan participants*.
Hearing Exam (Routine)	No charge	**Up to $500 per year:** 100%, *deductible* waived **Charges in excess of $500:** 70%, *deductible* waived	
School and Sports Physical	No charge	**Up to $500 per year:** 100%, *deductible* waived **Charges in excess of $500:** 70%, *deductible* waived	**Calendar Year Maximum:** One (1) visit per *plan participant*.

Refer to the Medical Benefits section, Medical Plan Exclusions subsection for additional information relating to excluded services.

N. Schedule of Prescription Drug Benefits – HDHP Option

The *prescription drug* benefits are separate from the medical benefits and are administered by Navitus and Pillar Rx. Refer to the **Prescription Drug Benefits** section of this plan document for additional information on *prescription drug* coverage.

Prescription drug charges do apply to the medical *deductible*.

Prescription drug charges do apply to the medical out-of-pocket maximum.

Benefits shown as *co-insurance* are listed for the percentage the *Plan* will pay.

Network Retail Pharmacy Option (34 to 90-day supply)	**Network Mail Order Pharmacy Option** (90-day supply)
Preventive Rx No charge **Generic Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Formulary Brand Name Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Non-Formulary Brand Name Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Specialty Drugs** 90% *co-insurance* after Medical *Plan deductible* is met	**Preventive Rx** No charge **Generic Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Formulary Brand Name Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Non-Formulary Brand Name Drugs** 90% *co-insurance* after Medical *Plan deductible* is met **Specialty Drugs** Limited to a thirty-four (34) day supply
Over-the-Counter Non-Sedating Anti-Histamines 90% *co-insurance* after medical *Plan deductible* **Over-the-Counter Proton Pump Inhibitors** 90% *co-insurance* after medical *Plan deductible*	
Certain *preventive care prescription drugs* [including generic contraceptives (and brand contraceptives when a generic equivalent is not available)] received by a *network pharmacy* are covered at 100% and the *deductible*/*co-payment*/*co-insurance* (if applicable) is waived. Please refer to the following website for information on the types of payable *preventive care prescription drugs*: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.** The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the Navitus and PillarRx list at **www.navitus.com.**	

Claims for reimbursement of *prescription drugs* are to be submitted to Navitus and Pillar Rx at:

Navitus Health Solutions, LLC
Attn: Claims
PO Box 999
Appleton, WI 54912

NOTE: For a complete list of covered drugs and supplies, and applicable limitations and exclusions, please refer to the Navitus and Pillar Rx Drug Coverage List, which is incorporated by reference and is available from Navitus and Pillar Rx at 1-866-378-4755 or **www.navitus.com**.

SECTION VI—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are *incurred* for care of an *injury* or *illness* while a *plan participant* is covered for these benefits under the *Plan*.

A. Covered Medical Charges

Covered charges are the *maximum allowable charges* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions, and other provisions of this *Plan*. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **3D Mammogram.**
2. **Accidental Injuries.** Services and supplies to treat *accidental injuries*.
3. **Adoptive Cell Therapy/Gene Therapy.** For FDA approved adoptive cell therapy along with associated services and supplies. ***Pre-certification* is required**. Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.
4. **Advanced Imaging.** Charges for advanced imaging, including Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine (including SPECT scans), and PET scans. Charges include the readings of these medical tests/scans. ***Pre-certification* is required.** *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
5. **Allergy Services.** Charges for allergy testing and the cost of the resultant serum preparation (antigen) and its administration, when rendered by a *physician* or in the *physician's* office.
6. **Ambulance.** Benefits will be provided for licensed ground and air ambulance services used to transport you from the place where you are *injured* or stricken by *illness*, or for inter-facility transport, as deemed *medically necessary,* to the nearest accredited general *hospital* with adequate facilities for treatment. Charges for services requested for a licensed ground or air ambulance service, when the patient is not transported, will not be covered by the *Plan*. Services for chartered flights will be covered by the *Plan*. ***Pre-certification* is required** for chartered air flights and non-emergent air ambulance.
7. **Anesthetics.** Includes anesthetic, oxygen, intravenous injections/solutions, and the administration of these items.
8. **Attention Deficit Disorders and Attention Deficit Hyperactivity Disorders (ADD/ADHD).**
9. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
10. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed *medically necessary,* provided services are rendered in a *medical care facility* as defined by this *Plan*.
11. **Chemotherapy/Radiation.** Radiation or chemotherapy and treatment with radioactive substances, including materials and services of technicians for applicable diagnoses. ***Pre-certification* is required.**
12. **Chiropractic.** Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
13. **Circumcision.** Circumcision for newborns from birth to six (6) months. After six (6) months, only *medically necessary* circumcisions will be covered.
14. **Clinical Trials.** This *Plan* will cover routine patient costs for a *qualified individual* participating in an *approved clinical trial* that is conducted in connection with the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an *investigational* new drug application reviewed by the Food and Drug Administration, or is exempt from *investigational* new drug application requirements. Refer to the Medical Plan Exclusions subsection for a further description and limitations of this benefit. ***Pre-certification* is required.**
15. **Convalescent Nursing Home Benefit.** Charges for room and board and nursing care are payable as shown in the applicable Schedule of Medical Benefits. Benefits for a private or single room are limited to the charge for a semi-private room in the facility. *Custodial care* is not a covered expense.

    Benefits are only payable for a confinement that:

    a. begins within fifteen (15) days of discharge from a *hospital* or prior convalescent nursing home confinement of at least three (3) consecutive days

b. is necessary for care of the same *injury* or *sickness* which caused the prior confinement

c. occurs while the *plan participant* is under the care of a qualified *physician* who ordered the confinement

16. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this *Plan* only if that care is completed within twelve (12) months following the injury and is for the following oral *surgical procedures*:

    a. *emergency* repair due to *injury*

    b. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor, and roof of the mouth

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.

17. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this *Plan* when they are provided by a *physician*. This is different from nutritional counseling/nutritional therapy.

18. **Diabetic.** Insulin, lancets, calibration liquid, insulin needles, and other diabetic supplies when prescribed by a *physician*. Diabetic supplies are covered under both the medical and pharmacy benefits of this *Plan*.

    Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.

19. **Diagnostic Testing.**

20. **Dialysis.** If you are diagnosed with a condition requiring dialysis, you may be able to enroll in *Medicare*. Upon beginning dialysis treatments, *Medicare*, if applicable, will coordinate benefits with the *Plan* as the secondary payer for months four (4) through thirty-three (33) of the coordination period while you are receiving dialysis treatments. The *Plan* will not enroll you in *Medicare*; it is your decision and your responsibility to enroll in *Medicare*, if applicable.

21. **Durable Medical Equipment (DME).** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Repair of *DME* is not covered. Delivery, set-up, and education charges pertaining to *DME* are covered.

    ***Pre-certification* is required when the purchase and/or rental price is expected to exceed $500.**

    Replacement of purchased equipment if either:

    a. the replacement is needed because of a change in your physical condition

    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    The following items will be considered under the DME benefit:

    a. **Diabetic Equipment.** Includes insulin pumps and related supplies, continuous blood glucose monitors and related supplies, and glucometers. For additional diabetic supplies, refer to the applicable Schedule of Medical Benefits or refer to the **Prescription Drug Benefits** section of this *Plan*.

       Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic equipment and supplies related *preventive care* benefits.

    b. **Oxygen.** Oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

22. **Family History.** Charges related to services provided with a diagnosis of family history, including as covered under applicable federal law.

23. **Foot Care.** Treatment for metabolic or peripheral-vascular *disease*, plantar fasciitis, neuromas, nail bed removal, or cutting/surgical procedures when *medically necessary* and not otherwise excluded.

24. **Genetic/Genomic Testing and Counseling.** Genetic and genomic testing to identify the potential for, or existence of, a medical condition and/or to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. ***Pre-certification* is required.**

    Refer to the **Federal Notices** section for the statement of rights under the Genetic Information Nondiscrimination Act of 2008 (GINA).

25. **Hearing Aids and Implantable Hearing Devices.** Charges for services, supplies, and hearing exams in connection with hearing aids and implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Batteries for related hearing devices are excluded. Benefits include aural therapy in connection with covered implantable hearing devices and apply to the Speech Therapy benefit level. See the Speech Therapy benefit in the applicable Schedule of Medical Benefits subsection for any applicable benefit maximum.
26. **Hearing Exams.** Charges for routine and diagnostic hearing exams.
27. **Home Health Care.** Charges for *home health care services and supplies* are covered only for care and treatment of an *illness* or *injury* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care plan*. A home health care visit will be considered a periodic visit by a *physician* acting within the scope of their license and/or as defined under *home health care services*.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required.**
28. **Home Infusion Therapy.**
29. **Home Visits.** When a provider visits the home for covered services, commonly known as a 'house call.' This is separate from home health care and therapy done in the home.
30. **Hospice Care.** *Hospice care services and supplies* for *plan participants*. Services must be rendered by a state-licensed *hospice care agency* and included in a written *hospice care plan* established and periodically reviewed by the attending *physician*. The *physician* must certify the *plan participant* is terminally *ill* and that *hospital* confinement would be required in the absence of the hospice care. The *hospice care plan* shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *plan participant* by the *hospice care agency*. Benefits are provided for:
    a. medical supplies
    b. visits by a *physician*
    c. bereavement counseling services for the hospice patient's immediate family (covered spouse and/or other covered *dependents*)

        A licensed pastoral counselor will be considered a covered provider for purposes of bereavement counseling, subject to all other *Plan* provisions.

    Covered charges will be payable as shown in the applicable Schedule of Medical Benefits.
31. **Hospital Care.** The medical services and supplies furnished by a *hospital*, *ambulatory surgical facility*, or a *birthing center*. *Covered charges* for *room and board* will be payable as shown in the applicable Schedule of Medical Benefits. ***Pre-certification* is required for inpatient admissions.**
    a. *Room and board* charges made by a *hospital* having only private rooms will be paid at the semi-private room rate when such semi-private room rate is available, unless necessary due to a sickness or *injury* or in the case that the *hospital* has private or single-bed rooms only.
    b. Charges for an *intensive care unit* stay do not apply to the semi-private room rate.
    c. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services are covered for dental procedures if *medically necessary* and if any of the following conditions apply:
        i. They are a *plan participant*
        ii. The *plan participant* is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office.
        iii. The *plan participant* has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*.

    This benefit does not cover the *dentist's* services.
32. **Infertility.** Services include office visits and initial *diagnostic testing*.
33. **Laboratory Studies.** *Covered charges* for diagnostic lab testing and services.
34. **Lenses.** The initial purchase of eyeglasses, contact lenses, or intraocular lenses for the following conditions:

a. following cataract surgery
b. damaged lens due to eye trauma
c. congenital cataract
d. congenital aphakia
e. lens subluxation/displacement
f. anisometropia of two (2) diopters or greater, and uncorrectable vision with the use of glasses or contacts
g. replacement of a previously implanted, *medically necessary* intraocular lens due to anatomical change, inflammatory response, or mechanical failure

A clear lens extraction intraocular lens implant for the correction of refractive error is not considered *medically necessary*. Intraocular lenses used to correct presbyopia and astigmatism are not considered *medically necessary*.

Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

35. **Mastectomy Bras and Camisoles.** Mastectomy bra and camisole purchases will be limited to two (2) total items per *plan participant* per *calendar year*.

36. **Maternity.** *Pregnancy* and complications of *pregnancy* shall be covered as any other *illness* for the *employee* or spouse. Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the *pregnancy*. Charges for a planned home birth will be considered a covered benefit.

NOTE: Breastfeeding support, counseling, maintenance, breast milk storage supplies, pump parts, and other supplies are also available without cost sharing when services are received from a *network* or *non-network* provider.

The care and treatment of *pregnancy* for a *dependent* child is limited to certain *preventive care* services. *Pregnancy* tests are not considered *preventive care* even when performed in conjunction with covered birth control services. Visit **https://www.healthcare.gov/coverage /preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations** for a current listing of required *pregnancy* related *preventive care* benefits.

Delivery and hospitalization stay may be subject to *pre-certification* if over the standards set forth in the Newborns' and Mothers' Health Protection Act. Refer to the **Federal Notices** section for the statement of rights under the Newborns' and Mothers' Health Protection Act for certain protections mothers and newborns have regarding *hospital* stays.

37. **Medical Foods.** Medical foods are considered a *covered charge* if intravenous therapy (IV) or tube feedings are *medically necessary*. Medical foods taken orally are not covered under the *Plan*, except for PKU formula when *medically necessary*.

38. **Medical Supplies.** Charges for surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Also included are supplies and dressings when *medically necessary* for surgical wounds, cancer, burns, diabetic ulcers, colostomy bags and catheters, ostomy supplies, and surgical and orthopedic braces, unless covered under the **Prescription Drug Benefits** section. Jobst/compression stockings are limited to two (2) pair or four (4) units.

39. **Mental Disorders and Substance Use Disorder.** Coverage for mental health treatments are considered the same as benefits provided for other medical conditions. *Inpatient* and *outpatient* treatment for *mental disorders*, including counseling done in a group setting and family counseling when billed with a covered diagnosis, will be eligible when rendered by a licensed psychiatrist or licensed psychologist or when rendered by a *physician* as defined. Includes *applied behavioral analysis* (*ABA*) therapy, psychiatric day treatment, residential treatment, partial hospitalization, and intensive *outpatient* programs. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

***Pre-certification* is required for inpatient admissions.**

Refer to the **Federal Notices** section for the statement of rights under the *Mental Health Parity and Addiction Equity Act of 2008*.

40. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of their license. This *Plan* will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

41. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health emergency, as required by federal regulation. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.
42. **Neuropsychological Testing.** Tests used to evaluate patients who have experienced a traumatic brain injury, brain damage, or organic neurological problems (e.g., dementia). May also be used to evaluate the progress of a patient who has undergone treatment or rehabilitation for a neurological *injury* or *illness*.
43. **Nutritional Counseling/Nutritional Therapy.**
44. **Obesity/Morbid Obesity.** Charges for the care and treatment of *morbid obesity*. Includes charges for bariatric *surgery*, such as gastric bypass, stapling and intestinal bypass, and lap band *surgery*. Reversals of obesity surgical services are covered.
45. **Oral Surgery.** Care of the mouth, teeth, gums, and alveolar processes will be a *covered charge* under this *Plan* only if that care is for the following oral *surgical procedures*:
    a. excision of unerupted, impacted teeth
    b. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth when pathological examination is required
    c. incision and drainage of an abscess or cyst
    d. charges for hospital confinement or treatment in a free-standing surgical center for dental treatment, which must be documented by a letter of necessity from the attending qualified practitioner or dentist for the *claim* to be considered
    e. charges for the extraction of seven (7) or more teeth at the same time
    f. repair of or initial replacement of natural teeth damaged due to injury

       To be a covered expense under the *Plan*, the replacement expense must be incurred within one (1) year of the injury. Damage resulting from biting or chewing will not be considered an *injury*.
    g. removal of impacted teeth

    NOTE: No charge will be covered under this *Plan* for dental and oral *surgical procedures* involving orthodontic care of teeth, periodontal *disease*, and preparing the mouth for fitting of or continued use of dentures.
46. **Orthognathic Surgery/LeFort Procedures.** *Surgery* to correct malposition in the bones of the jaw.
47. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, cranial helmets, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*. Benefits for repair or replacement of an orthotic appliance due to normal use, adolescent growth, or pathological changes will be provided.
48. **Physician Care.** The professional services of a *physician* for medical services. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the surgeon's *maximum allowable charge*.

    Charges for **multiple *surgical procedures*** will be a *covered charge* subject to the following provisions:
    a. If bilateral or multiple *surgical procedures* are performed by one (1) surgeon, benefits will be determined based on the *maximum allowable charge* that is allowed for the primary procedures; the *maximum allowable charge* will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures.
    b. If multiple unrelated *surgical procedures* are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the *maximum allowable charge* for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the *maximum allowable charge* allowed for that procedure.
    c. If a co-surgeon is required, meaning skills of both surgeons are necessary to perform distinct parts of a specific operative procedure, payment is based for each physician on dividing the payment equally between the two (2) surgeons. *Surgeries* performed by co-surgeons that have the same specialty are not covered under the *Plan*, unless *medically necessary*.

49. **Pre-Admission Testing.** Includes diagnostic labs, x-rays, and EKGs that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. You should make sure your *hospital* will accept the results of these tests.
50. **Preventive Care.** Benefits will be provided for *preventive care*, including, but not limited to:
    a. **Adult Physical Examination, Well-Baby, and Well-Child Examinations.**
    b. **Colorectal Cancer Screening.**
    c. **Contraceptives.** Injections, implants, devices, and associated *physician* charges are covered under the medical benefits of this *Plan*. Self-administered contraceptives are covered under the Prescription Drug Benefits.
    d. **Gynecological Exam.**
    e. **Mammogram.**
    f. **Pap Smear.**
    g. **Prostate Specific Antigen Test.**
    h. **Immunizations.** Pediatric and adult preventive vaccinations, inoculations, and immunizations, as recommended by the Centers for Disease Control and Prevention (CDC), including, but not limited to:
        i. **HPV Vaccine.**
        ii. **Influenza Vaccine.**
        iii. **Shingles Vaccine.**

        The *Plan* contributes to at least one (1) state-funded vaccination program, which covers the provider's costs associated with immunization serum for eligible, minor children up to the age of nineteen (19). Should a provider bill a vaccine charge for a child who is covered by that state's immunization program, regardless of their eligibility under the *Plan*, the *Plan* will consider its financial obligation of that *claim* satisfied through its contribution to the state funded immunization program and will not remit payment for that *claim*, except as may be required by applicable federal law. The administration of immunizations is covered.
    i. **Preventive Lab and X-Ray.** Screening and wellness laboratory and x-ray services related to routine examinations.
    j. **Sterilization.** Services for tubal ligation or other voluntary sterilization procedures for female *plan participants*.
    k. **Tobacco Cessation.** Education, counseling, and behavioral intervention services provided by a *physician* for smoking/vaping cessation up to two (2) attempts per *calendar year*, consisting of four (4) visits lasting ten (10) minutes each.

    NOTE: Additional *preventive care* shall be covered as required by applicable law if provided by a *network* provider. A current listing of required *preventive care* can be accessed at the following websites:
    a. https://www.healthcare.gov/coverage/preventive-care-benefits/
    b. **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**
    c. **https://www.irs.gov/pub/irs-drop/n-04-23.pdf**
    d. **https://www.irs.gov/pub/irs-drop/n-19-45.pdf**
51. **Private Duty Nursing.** Charges in connection with care, treatment, and services of a private duty nurse. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.
52. **Prosthetic Devices.** The initial purchase of artificial limbs, eyes, and breast prostheses, including service and repair of an artificial limb, eye, or breast prosthesis, and replacement when the attending *physician* indicates *medical necessity* due to a change in the body condition, and the artificial limb or eye cannot be repaired or made serviceable.

    The following devices will be considered under the prosthetic benefit:
    a. **Sleep Apnea Oral Devices.**
    b. **TMJ Oral Devices.**

53. **Reconstructive Surgery.** Reconstructive *surgery* expenses are covered in the following circumstances:
    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part
    b. to correct damage caused by an *accidental injury*
    c. for breast reconstruction following a total or partial *mastectomy*, as follows:
        i. reconstruction of the breast on which the *mastectomy* has been performed
        ii. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
        iii. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

    All other reconstructive *surgeries* will be covered under the *Plan* when *medically necessary*, except as otherwise excluded herein.

    Refer to the **Federal Notices** section for the statement of rights to *surgery* and prostheses following a covered *mastectomy* under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

54. **Routine Newborn Care.** Routine well-baby care is care while the newborn is *hospital*-confined after birth and includes *room and board* and other normal care for which a *hospital* makes a charge.

    This coverage is only provided if the newborn child is an eligible *dependent* and a parent either:
    a. is a *plan participant* who was covered under the *Plan* at the time of the birth
    b. enrolls (as well as the newborn child if required) in accordance with the Special Enrollment Periods provisions with coverage effective as of the date of birth

    The benefit is limited to *allowable charges* for well-baby care after birth while the newborn child is *hospital* confined as a result of the child's birth.

55. **School and Sports Physicals.** A health examination required for school admissions, including sports physicals. Refer to the applicable Schedule of Medical Benefits for any limitations that may apply.

56. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases an alternative method of treatment is available that would save yourself the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.

57. **Skilled Nursing Facility.** The *room and board* and nursing care furnished by a *skilled nursing facility* will be payable if and when:
    a. The patient is confined as a bed patient in the facility.
    b. The attending *physician* certifies that the confinement is needed for further care of the condition that caused the *hospital* confinement.
    c. The attending *physician* completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the *skilled nursing facility*.

    ***Pre-certification* is required** for inpatient admissions. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.

58. **Sleep Disorders/Sleep Studies.** Care and treatment for sleep disorders, including sleep studies performed in the home.

59. **Sterilization.** Services for vasectomy or other voluntary sterilization procedures for male *plan participants*. Female sterilization and family planning counseling is covered under the Preventive Care provision of this *Plan*. The *Plan* does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

60. **Surgery.** Benefits for the treatment of *illnesses* and *injuries,* including fractures and dislocations, are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies. ***Pre-certification* is required** for outpatient surgical procedures (other than office surgeries, colonoscopies, sigmoidoscopies, and intra-articular hyaluronic acid injections).

61. **Temporomandibular Joint Syndrome (TMJ).** Benefits for medical or dental services for treatment of *temporomandibular joint* disorders.

62. **Therapy Services.** Services include the following therapy types rendered on an *inpatient* or *outpatient* basis:

a. **Physical Therapy.** Benefits include aquatic therapy.

b. **Occupational Therapy.**

c. **Speech Therapy.** Benefits include aural therapy following a covered implantable hearing device.

Therapy in the home applies to the *outpatient* Therapy Services maximum unless rendered as part of a *home health care plan*. ***Pre-certification* is required** for *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of ten (10) visits per *calendar year* per therapy type.

Rehabilitation Services. The *Plan* covers rehabilitation services to help a *plan participant* achieve a previous level of function, independence, and quality of life. Maintenance therapy is not covered for habilitative/rehabilitative services.

Habilitation Services. The *Plan* covers *habilitation services* that help a *plan participant* learn to improve skills and functions for daily living that they may not be developing as expected for their age range.

63. **Transplants.** Under the Transplant benefit, the *Plan* reimburses you for covered services and supplies that are limited to the following criteria:

    a. *pre-certification* must be obtained

    b. the recipient is a *participant* under the *Plan*

       Whether the donor of an organ or tissue is, or is not, a *plan participant*, the donor's *hospital*, surgical, and medical expenses will be eligible on the basis of a *claim* made by the *plan participant*.

    c. the transplant procedure is not *experimental/investigational* in nature

    d. medical and surgical treatment or devices must be approved by the U.S. Food and Drug Administration (FDA)

    e. donated human organs or tissue

    f. *medically necessary* human organ and tissue transplants

The *Plan* reserves the right to make final judgment regarding coverage of *experimental*, *investigational*, and unproven procedures and treatments. *Medically necessary* means those transplant-related services which are determined by the *Plan* to be medically appropriate for the diagnosis and clinical status of the *plan participants* and their *dependents*, rendered in an appropriate setting, and of demonstrated medical value. The fact that a *physician* has performed or prescribed a transplant-related service, or the fact that it may be the only treatment for a *disease*, does not mean that is *medically necessary*.

Benefits include organ acquisition charges and tissue typing donor search charges.

Benefits are available for donors, limited to organ procurement surgery and post-transplant follow-up care.

Transplant-related services and supplies are covered up to one (1) year following the transplant when they are related to transplantation, recommended by a *physician*, provided at or arranged by a transplant *hospital*, and determined to be *medically necessary*. Such services and supplies include but are not limited to *hospital* charges, *physician* charges, and ancillary services.

Refer to the Travel Expenses provision in the Covered Medical Charges for applicable travel benefits.

64. **Travel Expenses.** Covered travel and lodging expenses are only covered for services related to transplants and *adoptive cell therapy*.

Eligible expenses for travel, lodging, and meals up to a combined maximum of $10,000 for the *plan participant* (while not a *hospital inpatient*) and companion(s) who are traveling on the same day(s) to and/or from the site of treatment for the purposes of an evaluation, the procedure, and/or necessary post-discharge follow-up. Benefits are paid at a per diem (per day) rate of up to $50 per day for the *plan participant* or up to $100 per day for the *plan participant* plus companion(s). If the *plan participant* is an enrolled *dependent* and minor child, the transportation expenses of companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the *plan participant* and/or the donor lives more than fifty (50) miles from the designated *network* facility. These benefits will be reimbursed upon the submission to the *Plan* of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service provider. Refer to the **Claims and Appeals** section for instructions on how to submit a *claim* for reimbursement. The listed expenses must be *incurred* within five (5) days prior to the procedure and one hundred twenty (120) days after the procedure. Applicable travel expenses will also be covered during the

transplant evaluation period. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision. Examples of eligible travel expenses may include airfare (at coach rate), taxi or ground transportation, or mileage reimbursement at the IRS rate for the most direct route between the *plan participant's* home and the designated *network* facility. Refer to the Medical Plan Exclusions subsection for a further description and limitations of eligible travel expenses for reimbursement.

65. **Virtual Visits.** Services rendered telephonically or electronically, performed by providers other than the *Plan's* telemedicine vendor, when performed for otherwise covered services.
66. **Vision Services.** Benefits are available for vision examinations, including refraction and contact lens fitting, when performed in conjunction with a medical diagnosis.
67. **Wigs**. *Covered charges* will be payable as shown in the applicable Schedule of Medical Benefits.
68. **X-Rays.** Diagnostic x-rays.

B. Medical Plan Exclusions

The following list is intended to give you a general description of expenses for services and supplies that are not covered by the *Plan*. Items that are not listed as excluded may be considered based on *medical necessity*, standard of care, and medical appropriateness. This list is not exhaustive.

NOTE: All exclusions related to prescription drugs are shown in the Prescription Drug Benefits section.

1. **Abortion.** Services, supplies, care, treatment, or drugs in connection with an abortion unless the life of the mother is endangered by the continued *pregnancy*. Complications from a non-covered abortion are covered. The abortion pill is covered.
2. **Alternative Medicine.** Charges for the following, including related drugs, are excluded under this *Plan*: holistic or homeopathic treatment, naturopathic services, thermography, acupuncture, acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), art therapy, music therapy, dance therapy, horseback therapy, mechanotherapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
3. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any *plan participant* in the armed forces of a government.
4. **Athletic Training.**
5. **Biofeedback.**
6. **Chelation Therapy.** Except for lead poisoning.
7. **Clinical Trials.** The following items are excluded from *approved clinical trial* coverage under this *Plan*:
    a. the *investigational* item, device, or service, itself
    b. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
    c. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

    If one (1) or more *participating providers* do participate in the *approved clinical trial*, the qualified *plan participant* must participate in the *approved clinical trial* through a *participating network* provider, if the provider will accept the *plan participant* into the trial.

    The *Plan* does not cover routine patient care services that are provided outside of this *Plan's* health care provider *network* unless *non-network* benefits are otherwise provided under this *Plan*.
8. **Complications from a Non-Covered Service.** Care, services, or treatment required as a result of complications from a treatment not covered under the *Plan*. Complications from a non-covered abortion and *dependent daughter* pregnancy/births are covered.
9. **Cord Blood.** Harvesting and storage of umbilical cord blood.
10. **Cosmetic.** Cosmetic or reconstructive procedures and attendant hospitalization, except for newborn children or due to trauma or *disease*, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Complications or subsequent *surgery* related in any way to any previous cosmetic procedure shall not be covered, regardless of *medical necessity*.
11. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling; education, social, behavioral, or recreational therapy; sex or interpersonal relationship counseling; or counseling provided by *plan participant's* friends, *employer*, school counselor, or schoolteacher.
12. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order or commitment.
13. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, or *custodial care*.
14. **Dental Care.** Normal dental care benefits, including any dental, gum treatments, or oral *surgery* except as otherwise specifically provided herein.
15. **Diabetic Shoes.**
16. **Educational or Vocational Testing.** Services for educational or vocational testing or training. Educational services such as asthma self-management education and Lamaze, except as listed herein.

17. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat *injuries* that are sustained, or an *illness* that is contracted, including infections and complications, while the *plan participant* was under, and due to, the care of a provider wherein such *illness*, *injury*, infection, or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator*, in its sole discretion, unreasonably gave rise to the expense.
18. **Examinations.** Any health examination required by any law of a government to secure insurance or professional or other licenses, except as required under applicable federal law.
19. **Excess Charges.** Any charge for care, supplies, treatment, and/or services that are not payable under the *Plan* due to application of any *Plan* maximum or limit, charges which are in excess of the *maximum allowable charge*, or services not deemed to be *reasonable* or *medically necessary*, based upon the *Plan Administrator's* determination as set forth by and within the terms of this document.
20. **Exercise Programs.** Exercise programs for treatment of any condition, except for *physician* supervised cardiac rehabilitation, occupational, or physical therapy, if covered by this *Plan*.
21. **Experimental/Investigational.** Care and treatment that is *experimental/investigational*. This exclusion shall not apply if the charge is for routine patient care for costs *incurred* by a *qualified individual* who is a *participant* in an *approved clinical trial*. Charges will be covered only to the extent specifically set forth in this plan document.
22. **Foot Care.** Services for routine, palliative, or cosmetic foot care including flat foot conditions, supportive devices for the foot (orthotics), treatment of subluxation of the foot, care of corns, bunions (except capsular or bone *surgery*), callouses, toenails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet.
23. **Foot Orthotics.** Custom molded or non-custom molded orthotics are not covered under the *Plan*.
24. **Foreign Travel.** Expenses for planned and/or routine services received or supplies purchased outside the United States, including those rendered on a cruise ship, are excluded under this *Plan*. Services in the case of a *medical emergency* or provided through the Global Core Program are a *covered charge*.
25. **Gender.**
26. **Government Coverage.** Care, treatment, or supplies furnished by a program or agency funded by any government, except as stated herein. This exclusion does not apply to Medicaid, a Veteran's Administration facility, or when otherwise prohibited by applicable law. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.
27. **Growth Hormones.** Growth hormones are covered through the Prescription Drug Benefits program. Please refer to the section entitled **Prescription Drug Benefits**.
28. **Gynecomastia.** Any treatment of enlargement of the breast tissue in males.
29. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for wigs as shown in the applicable Schedule of Medical Benefits.
30. **Hospice Care.** Services for spiritual counseling; services performed by a family member or volunteer workers, homemaker, or housekeeping services; food services (such as Meals on Wheels); legal and financial counseling services; respite care; and services or supplies not included in the *hospice care plan* or not specifically set forth as a hospice benefit.
31. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an *employee* of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
32. **Hospital Services.** *Hospital* services when hospitalization is primarily for *diagnostic testing*/studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
33. **Hyperhidrosis.** Any treatment of excessive sweating.
34. **Immediate Family Member.** Any charge for care, supplies, treatment, and/or services that are rendered by a provider who is related to the *plan participant* by blood or marriage or who ordinarily dwells in the *plan participant's* household.

35. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
36. **Impotence.** Care, treatment, services, supplies, or medication in connection with treatment for impotence, unless considered organic in nature.
37. **Infertility.** Care, supplies, services, and treatment for *infertility*, including, but not limited to, artificial insemination, in vitro fertilization, or any assisted reproductive technology (ART) procedure, except for *diagnostic services* rendered for *infertility* evaluation.
38. **Long Term Care.**
39. **Maternity.** Care and treatment of *pregnancy* for a *dependent* daughter only (please refer to Covered Medical Charges, Maternity, for further information). Charges for services related to surrogate *pregnancy*.
40. **Medicare.** Any charge for benefits that are provided, or which would have been provided had the *plan participant* enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (*Medicare*), including any amendments thereto, or under any federal law or regulation, except as provided in the sections entitled **Coordination of Benefits** and **Medicare**.
41. **Milieu Therapy.** A treatment program based on manipulation of the *plan participant's* environment for their benefit.
42. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of their peers to have been negligent in their actions, as negligence is defined by the jurisdiction where the activity occurred.
43. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
44. **No Legal Obligation.** Any charge for care, supplies, treatment, and/or services that are provided to a *plan participant* for which the provider of a service customarily makes no direct charge, for which the *plan participant* is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including, but not limited to, fees, care, supplies, or services for which a person, company, or any other entity except the *plan participant* or this benefit *Plan*, may be liable for necessitating the fees, care, supplies, or services.
45. **No Physician Recommendation.** Care, treatment, services, or supplies not recommended and approved by a *physician*. Treatment, services, or supplies when the *plan participant* is not under the regular care of a *physician*. Regular care means ongoing medical supervision or treatment which is appropriate care for the *injury* or *illness*.
46. **Non-Emergency Hospital Admissions.** Care and treatment billed by a *hospital* for *medical non-emergency care* admissions on a Friday or a Saturday. This does not apply if *surgery* is performed within twenty-four (24) hours of admission.
47. **Non-Medical Expenses.** Expenses including, but not limited to, those for preparing medical reports or itemized bills, completion of claim forms or medical records unless otherwise required by law, calling a patient to provide their test results, sales tax, shipping and handling, expenses for failure to keep a scheduled visit or appointment, *physician* or *hospital* stand-by services, holiday or overtime rates, membership or access fees, educational brochures, or reports prepared in connection with litigation.
48. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order (unless required under applicable federal law), including, but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, syringes, bandages, Methadone, or Rogaine hair preparations, special foods or diets, vitamins, minerals, dietary and nutritional supplements, *experimental* drugs, including those labeled "Caution: Federal law prohibits dispensing without prescription," and prescription medications related to health care services which are not covered under this *Plan*.
49. **Not Actually Rendered.** Any charge for care, supplies, treatment, and/or services that are not actually rendered.
50. **Not Medically Necessary.** Any charge for care, supplies, treatment, and/or services that are not *medically necessary*, unless specifically stated as covered herein.
51. **Occupational or Workers' Compensation.** Charges for care, supplies, treatment, and/or services for any condition, *illness*, *injury*, or complication thereof arising out of or in the course of employment (including self-employment), or an activity for wage or profit. If you are covered as a *dependent* under this *Plan* and you are self-employed or employed by an *employer* that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases

workers' compensation insurance will cover your costs, but if you do not have such coverage, fail to file, or receive a denial for failure to file timely, you may end up with no coverage at all.

52. **Orthopedic Shoes.**
53. **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services by a *provider* who did not render an actual service to the *participant*. *Covered charges* are limited to those certified by a *physician* who is attending the *plan participant* as required for the treatment of *injury* or *disease* and performed by an appropriate provider. This exclusion does not apply to interdisciplinary team conferences to coordinate patient care.
54. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-medical grade stockings, ear plugs, non-*prescription drugs* and medicines, first-aid supplies, seat risers, and non-hospital adjustable beds.
55. **Personal Injury Insurance.** Expenses in connection with an automobile *accident* for which benefits payable hereunder are, or would be otherwise covered by, mandatory *no-fault automobile insurance* or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family-owned vehicle or a pedestrian.
56. **Prescription Drugs.** Prescription drugs charges covered under the Prescription Drug Benefits, other than those covered in a *physician's* office or *inpatient* admission.
57. **Prior to Effective Date or After Termination Date.** Services, supplies, or accommodations provided prior to the *plan participant's* effective date or after the termination of coverage. In the event coverage is terminated during a *hospital* admission, the *Plan* will only consider *covered charges* as those *incurred* before coverage was terminated, unless extension of benefits applies.
58. **Prohibited by Law.** Any charge for care, supplies, treatment, and/or services to the extent that payment under this *Plan* is prohibited by law.
59. **Repair of Purchased Equipment.** Maintenance and repairs needed due to misuse or abuse are not covered.
60. **School**. Services performed in a school setting. This exclusion also applies to services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school.
61. **Self-Inflicted.** Any loss due to an intentionally self-inflicted *injury*. This exclusion does not apply in either of the following circumstances:
    a. to an *injury* resulting from being the victim of an act of domestic violence
    b. to an *injury* resulting from a medical (including both physical and *mental health*) condition
62. **Smoking/Vaping Cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under applicable federal law. Tobacco cessation care and treatment is otherwise excluded under the medical benefits
63. **Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
64. **Subrogation, Reimbursement, and/or Third-Party Responsibility.** Any charges for care, supplies, treatment, and/or services of an *injury* or *illness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third-party responsibility provisions. Refer to the **Reimbursement and Recovery Provisions** section.
65. **Transplants.** The following transplant and/or *adoptive cell therapy*-related expenses are not covered by the *Plan*:
    a. when the recipient is not an eligible *plan participant*
    b. charges for any artificial or mechanical organ

       This exclusion does not apply to cardiac assist devices such as LVADs.
    c. services for a condition that is not directly related, or a direct result, of the transplant or *adoptive cell therapy*
    d. any of the following or similar items associated with travel:

a. entertainment items such as alcohol, cigarettes, toys, books, movies, theater tickets, theme park tickets, flowers, greeting cards, stationary, stamps, postage, gifts, internet service, tips, coupons, vouchers, or travel tickets, frequent flyer miles

b. convenience items such as toiletries, paper products, maid service, laundry/dry cleaning, kennel fees, babysitter/childcare, valet parking, faxing, cell phones, phone calls, newspapers

c. mortgage, rent, security deposit, furniture, utility bills, appliances, utensils, vacation/apartment rentals

d. vehicle maintenance, automobile mileage, taxi fares, parking, moving trucks/vehicles, mileage within the medical transplant facility city

e. cash advances/lost wages

f. rental cars, buses, taxis, or shuttle service, except as specifically approved by the *Claims Administrator*

g. prepayments or deposits

h. taxes

66. **Vertebral Axial Decompression (Vax-D).**

67. **Vision Care Exclusions.** Expenses for the following:

a. surgical correction of refractive errors and refractive keratoplasty procedures, including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK)

b. routine eye examinations, purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses is payable as following ocular *surgery* when the lens of the eye has been removed such as with a cataract extraction

c. orthoptics (eye muscle exercises), orthoptic therapy, vision training, or subnormal vision aids

d. orthokeratology lenses for reshaping the cornea of the eye to improve vision

68. **War.** Any loss that is due to a declared or undeclared act of war.

69. **Weight Loss.** Weight loss or dietary control programs.

SECTION VIII—HEALTH CARE MANAGEMENT PROGRAM

A. Introduction

The health care management program consists of several components to assist *plan participants* in staying well: providing optimal management of chronic conditions, provisions of support, and service coordination during times of acute or new onset of a medical condition.

The scope of the health care management program consists of the following components (each of which will be further discussed in this section):

1. utilization review
2. concurrent review and discharge planning
3. case management

B. Utilization Review

The utilization review program is designed to help ensure all *plan participants* receive *medically necessary* and appropriate health care while avoiding unnecessary expenses.

The purpose of the program is to determine what services are *medically necessary* and eligible for payment by the *Plan*. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not *pre-certified*, it means that either the *Plan* will not pay for the charges, or the *Plan* will not consider that course of treatment as *medically necessary* and appropriate for the maximum reimbursement under the *Plan*. The patient is urged to review why there is a discrepancy between what was requested and what was certified before *incurring* charges.

Your *employer* has contracted with the *Medical Management Administrator* in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the *Plan*. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

Elements of the Utilization Review Program

The program consists of:

1. **Pre-Certification.** Review of the *medical necessity* for non-emergency services before medical and/or surgical services are provided.
2. **Retrospective Review.** Review of the *medical necessity* of the health care services provided on an *emergency* basis, after they have been provided.
3. **Concurrent Review.** Ongoing assessment of the health care as it is being provided, especially, but not limited to, *inpatient* confinement in a *hospital* or covered *medical care facility* (based on the admitting diagnosis and the listed services requested by the attending *physician*).
4. **Discharge Planning.** Certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment.

What Services Must Be Pre-Certified (Approved Before they are Provided)

The provider, patient, or family member must call the *Medical Management Administrator* to receive certification of certain health care management services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an *emergency*.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the out-of-pocket limit.

The following services must be *pre-certified* before the services are provided:

1. *inpatient* pre-admission certification and continued stay reviews (all ages, all diagnoses)
   a. surgical and non-surgical (excluding routine vaginal or cesarean deliveries)
   b. long term acute care facility (LTAC), not *custodial care*
   c. *skilled nursing facility*/ rehabilitation facility

d. *inpatient mental health/substance use disorder* treatment (includes *residential treatment facility* services)

The attending *physician* does not have to obtain *pre-certification* from the *Plan* for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

2. *Inpatient* and *outpatient surgery*, including surgical pain management injections

   Pre-certification is not required for office *surgeries*, all colonoscopies/sigmoidoscopies (screening and diagnostic), and intra-articular hyaluronic acid injections.

3. *adoptive cell therapy*
4. cardiac catheterization
5. chemotherapy drugs/infusions and radiation treatments for oncology diagnoses
6. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening *disease* or condition

   This *Plan* does not cover clinical trials related to other *diseases* or conditions. Refer to the **Medical Benefits** section of this document for a further description and limitations of this benefit.

7. *durable medical equipment (DME)* in excess of $500 (purchase/rental price)
8. *gene therapy*
9. genetic/genomic testing (excluding amniocentesis)
10. home health care
11. lung perfusion study
12. non-emergent air ambulance and chartered air flights
13. *outpatient* advanced imaging (excluding services rendered in an emergency room setting)
    a. computed tomographic (CT) studies
    b. coronary CT angiography
    c. MRI/MRA
    d. nuclear cardiology
    e. nuclear medicine (including SPECT scans)
    f. PET scans
14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of ten (10) visits per *calendar year* per therapy type
15. specialty infusion/injectable medications over $3,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

    Pre-certification is not required for intra-articular hyaluronic acid injections.

16. transplant (other than cornea), including, but not limited to, kidney, liver, heart, lung, pancreas, and bone marrow replacement to stem cell transfer after high-dose chemotherapy

Services rendered in an emergency room or urgent care setting do not require *pre-certification*.

In order to maximize Plan reimbursements, please read the following provisions carefully.

How to Request Pre-Certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the *Medical Management Administrator* will, in conjunction with the attending *physician*, certify the care as *medically necessary* for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the *Medical Management Administrator* **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the *plan participant* and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*
6. the proposed medical services
7. the proposed date(s) of services
8. the proposed length of stay

If there is an *emergency* admission to the *medical care facility*, the patient, patient's family member, *medical care facility*, or attending *physician* must contact the *Medical Management Administrator* within **forty-eight (48) hours** of the first business day after the admission. Refer to the Quick Reference Information Chart for contact information.

The *Medical Management Administrator* will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure will reduce reimbursement received from the *Plan*.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits are determined by the *Plan* at the time a formal *claim* for benefits is submitted according to the procedures outlined within the **Claims and Appeals** section of this plan document.

NOTE: If your admission or service is determined to **not** be *medically necessary*, you may pursue an *appeal* by following the provisions described in the **Claims and Appeals** section (First Level Appeal of a Pre-Service Claim subsection) of this document. The *plan participant* and provider will be informed of any denial or non-certification in writing.

Appeals of a Denial of Pre-Certification from the Medical Management Administrator

Pre-certification decisions are considered *claims* decisions that are subject to *appeal*. Refer to the **Claims and Appeals** section (Other Pre-Service Claims subsection) for details on how to *appeal* and the timeframes for appealing a *pre-service claim* decision.

C. Concurrent Review and Discharge Planning

How Concurrent Review Works

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the medical management program. The *Medical Management Administrator* will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician*, *medical care facilities*, and *plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

How to File a Concurrent Claim for Benefits under this Plan

Refer to the **Claims and Appeals** section (Concurrent Care Claims subsection) for details on how to *appeal* a denial of a concurrent review. No benefits will be paid for any charges related to days of confinement to a *hospital* or other *health care facility* that have not been determined to be *medically necessary* by the *Medical Management Administrator*.

D. Case Management

Case management is designed to help manage the care of patients who have special or extended care *illnesses* or *injuries*. Case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of case management is to identify and coordinate cost-effective medical care, which meets accepted standards of medical practice. Case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients, and others.

Cases are identified for possible case management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

The *Plan* may elect, at its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the *Plan*. The alternative benefits shall be determined on a case-by-case basis, and the *Plan's* determination to provide the benefits in one (1) instance shall not obligate the *Plan* to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the *Plan* to strictly enforce the provisions of the *Plan*.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the *Plan*. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connection with the treatment plan shall be subject to all *Plan* limits and cost sharing provisions.

Benefits under case management may be provided if the *Medical Management Administrator* determines that the services are *medically necessary*, appropriate, cost-effective, and feasible. All decisions made by case management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

All case management is a voluntary service. There are no reductions of benefits or penalties assessed if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

E. **Courtesy Reviews**

The *Medical Management Administrator* may perform *courtesy reviews*. *Courtesy reviews* are a pre-service assessment of *medical necessity* only and are not a guarantee of benefits. *Courtesy reviews* will be made as soon as possible after the request has been submitted, but no later than thirty (30) days. Completion of a *courtesy review* is not a requirement of the *Plan* and should not be a cause for delay in treatment of *medically necessary* care. Contact the *Medical Management Administrator* for any questions by phone at 1-800-786-7930 or by fax at 1-208-955-1541. Refer to the **Claims and Appeals** section for timeframes and other information regarding filing *claims*.

SECTION IX—PRESCRIPTION DRUG BENEFITS

A. About Your Prescription Benefits

The prescription drug benefits are separate from the medical benefits and are administered by Navitus and Pillar Rx (PBM Vendor). This program allows you to use your ID card at a nationwide *network* of participating *pharmacies* to purchase your prescriptions. When purchasing *prescription drugs* at retail *pharmacies* or through mail order, using your ID card at participating *pharmacies* provides you with the best economic benefit.

Claims for reimbursement of *prescription drugs* are to be submitted to Navitus and Pillar Rx at:

Navitus Health Solutions, LLC
PO Box 999
Attn: Claims
Appleton, WI 54912

B. Co-Payments

The *co-payment* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits. The *co-payment* amount is not a *covered charge* under the Medical Plan.

C. Co-Insurance

Once you have met the Medical Plan's *calendar year deductible*, your *co-insurance* is applied to each covered *pharmacy* drug or mail order drug charge and is shown in the applicable Schedule of Prescription Drug Benefits.

D. Manufacturer Coupons

Any amounts in the form of manufacturer coupons or drug savings discount cards used for brand name drugs when there is a generic equivalent available, unless the brand name is *medically necessary*, do not apply to the *deductible* or *out-of-pocket limit*.

E. Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart *disease*, high blood pressure, asthma, etc.). Because of volume buying, , the mail order *pharmacy*, may be able to offer *plan participants* significant savings on their prescriptions.

F. Tablet Splitting

The tablet splitting program, which is optional for *plan participants*, has identified medications which are taken once daily. The price for a low or high dose tablet is on average the same. Because of this flat pricing of dosage strengths, splitting a tablet of a higher strength to get the desired dose lowers the cost of the medication by up to 50%. Tablet splitting is only available for certain medications under RxCents through Navitus. For more information visit www.navitus.com.

G. Specialty Pharmacy Program

Lumicera is a specialty pharmacy program offered through a partnership with a specialty *pharmacy* experience in handling specialty drugs. The specialty pharmacy program covers some limited drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. Lumicera also provides personalized support, education, a proactive refill process, and free delivery, as well as information about health care needs related to the chronic *disease*.

To start using Lumicera, call toll free at 1-855-847-3553.

H. Prior Authorization

Prescriptions for specialty drug medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions.

The authorization process may be initiated by the *plan participant*, the local *pharmacy*, or the *physician* by calling Navitus and Pillar Rx at 1-866-378-4755.

I. Step Therapy Program

Step therapy is a program where you first try a proven, cost-effective medication (called a 'prerequisite drug' in this document) before moving to a more costly drug treatment option. With this program, trying one (1) or more prerequisite drugs is required before a certain prescription medication will be covered under your *pharmacy* benefits plan. Prerequisite drugs are FDA-approved and treat the same condition as the corresponding step therapy drugs. Step therapy promotes the appropriate use of equally effective but lower-cost drugs first. You, your *physician*, or the person you appoint to manage your care can ask for an exception if it is *medically necessary* for you to use a more expensive drug on the step therapy list. If the request is approved, Navitus and Pillar Rx will *notify* you or your *physician*. The medication will then be covered at the applicable *co-insurance/co-payment* under your *Plan*. You will also be *notified* of approvals where states require it. If the request is denied, Navitus and Pillar Rx will *notify* you and your *physician*. For information on which drugs are part of the step therapy program under your *Plan* call the Navitus and Pillar Rx customer service number on your ID card.

J. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Plan participants enrolled in either Part A or Part B of *Medicare* are also eligible for *Medicare* Part D Prescription Drug benefits. It has been determined that the *prescription drug* coverage provided in this *Plan* is generally better than the standard *Medicare* Part D *prescription drug* benefits. Because this *Plan's prescription drug* coverage is considered creditable coverage, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this *Plan*, payment under this *Plan* may coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the *Plan* for information on how this *Plan* will coordinate benefit payment.

K. Covered Prescription Drug Charges

1. **Abortion.** Drugs that induce abortion such as Mifepristone (RU-486).
2. **Compounded Prescription Drugs.** All compounded *prescription drugs* containing at least one (1) prescription ingredient in a therapeutic quantity.
3. **Diabetic.** Insulin, lancets, calibration liquid, insulin needles, continuous blood glucose monitor, glucometer, and other diabetic supplies when prescribed by a *physician.* Diabetic supplies are covered under both the medical and pharmacy benefits of this *Plan*.

   Visit **https://www.irs.gov/pub/irs-drop/n-19-45.pdf** for a current listing of diabetic supplies related *preventive care* benefits.
4. **Growth Hormones.** Covered only as *medically necessary*. ***Pre-certification* is required.**
5. **Injectable Drugs.** Injectable drugs or any prescription directing administration by injection.
6. **Over-the-Counter Drugs.** OTC items specifically stated as covered in this *Plan* will be covered. When OTC items are provided as a necessary part of a covered expense incurred in a qualified *physician's* office, *hospital*, or other facility, it will be covered. Otherwise, drugs, food, or nutritional supplements that are available without a written prescription of a qualified *physician* are not covered.
7. **Prescribed by Physician.** All drugs prescribed by a *physician* that require a prescription either by federal or state law.

   This excludes any drugs stated as not covered under this *Plan*.
8. **Prescription Drugs mandated under PPACA.** Certain preventive medications (including contraceptives) received by a *network pharmacy* are covered and subject to the following limitations:
   a. generic preventive *prescription drugs* are covered at 100%, and the *deductible/co-payment* (if applicable) is waived
   b. if no *generic drug* is available, then the *formulary brand* will be covered at 100%, and the *deductible/co-payment/co-insurance* (if applicable) is waived

   This provision includes, but is not limited to, the following categories of drugs (In order for these medications to be covered at 100%, a prescription is required from your *physician*, including over-the-counter drugs.):

a. **Breast Cancer Risk-Reducing Medications.** Medications such as tamoxifen or raloxifene for women who are at increased risk for breast cancer and at low risk for adverse medication effects.

b. **Contraceptives**. Women's contraceptives including, but not limited to, oral contraceptives, transdermal contraceptives (i.e., Ortho-Evra), vaginal rings (i.e., Nuvaring), implantable contraceptive devices, injectable contraceptives, and *emergency* contraception.

c. **Immunizations.** Certain vaccinations are available without cost sharing including vaccines for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papillomavirus), pertussis, varicella, and meningitis.

d. **Tobacco/Vaping Cessation Products**. Such as nicotine gum, smoking deterrent patches, or generic tobacco cessation medications. These drugs are payable without cost sharing up to two (2), twelve (12)-week course of treatment per *calendar year*, which applies to all products. Thereafter, tobacco cessation products are not covered under the *Plan*.

e. **Preparation 'Prep' Products for a Colon Cancer Screening Test.** The *Plan* covers the over-the-counter or prescription strength products prescribed as preparation for a payable preventive colon cancer screening test, such as a colonoscopy.

Please refer to the following website for information on the types of payable preventive medications: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.

L. Limits to This Benefit

This benefit applies only when a *plan participant incurs* a covered *prescription drug* charge. The covered drug charge for any one (1) prescription will be limited to:

1. refills only up to the number of times specified by a *physician*
2. refills up to one (1) year from the date of order by a *physician*
3. a ninety (90) day supply for retail and mail-order prescriptions

M. Prescription Drug Plan Exclusions

This benefit will not cover a charge for any of the following:

1. **Administration.** Any charge for the administration of a covered *prescription drug*.
2. **Appetite Suppressants/Dietary Supplements.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
3. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
4. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
5. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.
6. **Experimental/Investigational.** *Experimental/investigational* drugs and medicines, even though a charge is made to the *plan participant*. A drug or medicine labeled: "Caution: Federal law prohibits dispensing without prescription."
7. **FDA.** Any drug not approved by the Food and Drug Administration.
8. **Immunization.** Immunization agents or biological sera.
9. **Impotence.** A charge for impotence medication.
10. **Infertility.** A charge for *infertility* medication.
11. **Inpatient Medication.** A drug or medicine that is to be taken by the *plan participant*, in whole or in part, while *hospital* confined. This includes being confined in any *institution* that has a facility for the dispensing of drugs and medicines on its premises.

12. **Medical Exclusions.** A charge excluded under the Medical Plan Exclusions subsection, unless specifically covered in this **Prescription Drug Benefits** section.
13. **No Charge.** A charge for *prescription drugs* which may be properly received without charge under local, state, or federal programs.
14. **Non-Network.** *Prescription drugs* received outside of a *network* location will not be covered.
15. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
16. **Refills.** Any refill that is requested more than one (1) year after the prescription was written or any refill that is more than the number of refills ordered by the *physician.*
17. **Tobacco/Smoking Cessation.** A charge for *prescription drugs*, such as nicotine gum or smoking deterrent patches, for smoking cessation, except as required by law.

SECTION XI—CLAIMS AND APPEALS

A. Introduction

This section contains the *claims* and *appeals* procedures and requirements for the Kentucky Rural Electric Cooperative Employers Benefit Plan.

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within fifteen (15) months from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

The following types of *claims* are covered by the procedures in this section:

1. **Pre-Service Claim.** Some *Plan* benefits are payable without a financial penalty only if the *Plan* approves services **before** services are rendered. These benefits are referred to as *pre-service claims* (also known as *pre-certification* or prior authorization). The services that require *pre-certification* are listed in the **Health Care Management Program** section of this document.
2. **Urgent Care Claim.** An *urgent care claim* is a *claim* (request) for medical care or treatment in which:
    a. applying the time periods for *pre-certification* could seriously jeopardize the life or health of the individual or the ability of the individual to regain maximum function
    b. in the opinion of a *physician* with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*
    c. the *claim* involves urgent care
3. **Concurrent Care Claim.** A *concurrent care claim* refers to a *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A *concurrent care claim* also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.
4. **Post-Service Claim.** *Post-service claims* are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

Following is a description of how the *Plan* processes *claims* for benefits and reviews the *appeal* of any *claim* that is denied.

If a *claim* is denied, in whole or in part, or if *Plan* coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an *adverse benefit determination*.

A *claimant* has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described later in this section, the *Plan's* final decision is known as a *final internal adverse benefit determination*. If the *claimant* receives *notice* of a *final internal adverse benefit determination*, or if the *Plan* does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent *external review*. The *external review* procedures are also described later in this section.

Both the *claims* and the *appeal* procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all *claims* and *appeals* procedures, both internal and external, before they can file a lawsuit. However, this rule may not apply if the *Plan Administrator* has not complied with the procedures described in this section. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeals* procedures or the *external review* process, including the discretionary authority to interpret the terms of the *Plan*, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator* as outlined in the Quick Reference Information Chart.

B. Timeframes for Claim and Appeal Processes

	Post-Service Claims	Pre-Service Claim Types		
		Urgent Care Claim	Concurrent Care Claim	Other Pre-Service Claim
Claimant must submit *claim* for benefit determination within:	twelve (12) months	twenty-four (24) hours		
Plan must make initial *benefit determination* as soon as possible but no later than:	thirty (30) days	seventy-two (72) hours	before the benefit is reduced or treatment terminated	fifteen (15) days
Extension permitted during initial *benefit determination*:	fifteen (15) days	no	no	fifteen (15) days
First-level *appeal* review must be submitted to the *Plan* within:	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days	one hundred eighty (180) days
Plan must make first *appeal benefit determination* as soon as possible but no later than:	thirty (30) days per benefit *appeal*	thirty-six (36) hours	before the benefit is reduced or treatment terminated	fifteen (15) days for each level of *appeal*
Extension permitted during *appeal* review:	no	no	no	no
Second-level appeal must be submitted in writing within:	sixty (60) days	sixty (60) days	sixty (60) days	sixty (60) days
Plan must make second *appeal benefit determination* as soon as possible but no later than:	thirty (30) days	thirty-six (36) hours	thirty (30) days	thirty (30) days
Appeal for external review must be submitted after a final adverse benefit determination within:	four (4) months	four (4) months	four (4) months	four (4) months
Plan will complete preliminary review of *IRO* request within:	five (5) business days	five (5) business days	five (5) business days	five (5) business days

C. Types of Claims Managed by the Medical Management Administrator

The following types of *claims* are managed by the *Medical Management Administrator*:

1. *urgent care claims*
2. *concurrent care claims*
3. other *pre-service claims*

The process and procedures for each *pre-service claim* type are listed below.

D. Urgent Care Claims

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an *urgent care claim* will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician*, with knowledge of the *claimant's* medical condition, determines is an *urgent care claim* (as described herein) shall be treated as an *urgent care claim* under the *Plan*. *Urgent care claims* are a subset of *pre-service claims*.

How to File Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the *Medical Management Administrator* and provide the following:

1. information sufficient to determine whether, or to what extent, benefits are covered under the *Plan*
2. a description of the medical circumstances that give rise to the need for expedited review

If you or your *authorized representative* fail to provide the *Plan* with the above information, the *Plan* will provide *notice* as soon as reasonably possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of your *claim*. You will be afforded a reasonable amount of time under the circumstance, but

no less than the timeframe shown in the Timeframes for Claim and Appeal Processes, to provide the specified information.

Notification of Benefit Determination of Urgent Care Claims

Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than the deadline shown in the Timeframes for Claim and Appeal Processes subsection. However, if the *Plan* gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The *Plan* will then provide you with the *notice* of *benefit determination* within forty-eight (48) hours after the earlier of:

1. receipt of the specified information
2. the end of the period of time given you to provide the information

If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a concurrent care decision, a *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of your *claim* for extension of treatment or care, as long as the *claim* is made within the timeframe shown in the Timeframes for Claim and Appeal Processes before the prescribed period of time expires or the prescribed number of treatments ends.

Notification of Adverse Benefit Determination of Urgent Care Claims

If an *urgent care claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator's notification* of an *adverse benefit determination* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the expedited review process applicable to the *claim*
8. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
9. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of an Urgent Care Claim

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes for when a claimant may file a written request for an *appeal* of the decision upon *notification* of an *adverse benefit determination.* However, for *concurrent care*

claims, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Urgent Care Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

You may *appeal* an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Medical Management Administrator*. All necessary information, including the *Medical Management Administrator's benefit determination* on review, will be transmitted between the *Medical Management Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

Time Period for Deciding Appeals of Urgent Care Claims

Appeals of *urgent care claims* will be decided by the *Plan Administrator* or its designee as soon as possible, taking into account the *medical emergencies*, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. A decision communicated orally will be followed-up in writing.

Notification of Appeal Denials of Urgent Care Claims

The *Plan Administrator* or its designee shall provide *notification* of the decision on an *urgent care claim* orally, but a follow-up written *notification* will be provided no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the oral *notice*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request
7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

E. Concurrent Care Claims

Your *claim* for medical care or treatment is a *concurrent care claim* if your *claim* has been approved to provide an ongoing course of treatment over a period of time, which either involves a reduction or termination by the *Plan* of such course of treatment (other than by *Plan* amendment or termination), or a request by you or on your behalf to extend or expand your treatment.

If your request involves concurrent care (the continuation/reduction of an ongoing course of treatment), you may file the *claim* by writing (orally for an expedited review) to the *Medical Management Administrator*.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided *notification* of the termination or reduction sufficiently in advance of the reduction or termination to allow you to *appeal* and obtain a determination of that *adverse benefit determination* before the benefit is reduced or terminated.
2. The *Plan* will provide you free of charge with any new or additional evidence considered, relied upon, or generated by the *Plan* (or at the direction of the *Plan*) in connection with the denied *claim*. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the *Plan* issues an *adverse benefit determination* or review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the *notice* of *adverse benefit determination* on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

3. A *concurrent care claim* that involves urgent care will be processed according to the initial review and *appeals* procedures and timeframes noted under the Urgent Care Claims subsection (above).
4. If a *concurrent care claim* does not involve urgent care, the request may be treated as a new benefit *claim* and decided within the timeframe appropriate to the type of *claim* (i.e., as a *pre-service claim* or a *post-service claim*). Such *claims* will be processed according to the initial review and *appeals* procedures and timeframes applicable to the claim-type, as noted under the Other Pre-Service Claims subsection (below) or the Post-Service Claims subsection listed later in this section.
5. If the *concurrent care claim* is approved, you will be *notified* orally followed by written (or electronic, as applicable) *notice* provided after the oral *notice* no later than the timeframe shown in the Timeframes for Claim and Appeal Processes

F. Other Pre-Service Claims

Claims that require *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* are considered *other pre-service claims* (e.g. a request for *pre-certification* under the health care management program). Refer to the **Heath Care Management Program** section to review the list of services that require *pre-certification*.

How to File Other Pre-Service Claims

Typically, other *pre-service claims* are made on a *claimant's* behalf by the treating *physician*. However, it is the *claimant's* responsibility to ensure that the other *pre-service claim* has been filed. The *claimant* can accomplish this by having their health care provider contact the *Medical Management Administrator* to file the *other pre-service claim* on behalf of the *claimant*.

Other *pre-service claims* must include the following information:

1. the name of this *Plan*
2. the identity of the *claimant* (name, address, and date of birth)
3. the proposed date(s) of service
4. the name and credentials of the health care *provider*
5. an order or request from the health care provider for the requested service
6. the proposed place of service
7. a specific diagnosis
8. a specific proposed service code for which approval or payment is requested [current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format]
9. clinical information for this *Plan* to make a *medical necessity* determination

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the *Plan's* procedures for filing other *pre-service claims*, the *Plan* will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the *notice* to follow the proper procedures.

Notification of Benefit Determination of Other Pre-Service Claims

Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. Refer to the Incomplete Claims subsection if such an extension is necessary due to your failure to submit the information necessary to decide the *claim*.

Notification of Adverse Benefit Determination of Other Pre-Service Claims

If the other *pre-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Other Pre-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s), and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*

4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Other-Pre-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *Medical Management Administrator* to review in conjunction with your *appeal*. Send all information to the *Medical Management Administrator* as listed in the Quick Reference Information Chart.

Time Period for Deciding Appeals of Other Pre-Service Claims

Appeals of other *pre-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time appropriate to the medical circumstances, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing.

Notification of Appeal Denials of Other Pre-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan*

to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

G. Second Level Appeals Process for Urgent Care, Concurrent Care, and Other Pre-Service Claims

If your *appeal* of a *claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator*. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes from the date you are *notified* of the original *appeal* decision. For *claims*, this second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

H. External Review of Pre-Service Claims

Refer to the External Review of Claims section for the full description of the *external review* process under the *Plan*.

I. Incomplete Claims

Incomplete *pre-service claims* and/or *post-service claims* can be addressed through the extension of time described herein. (Refer to *Clean Claim* in the **Defined Terms** section.) If the reason for the extension is the failure to provide necessary information and the *claimant* is appropriately *notified*, this *Plan's* period of time to make a decision is suspended from the date upon which *notification* of the missing necessary information is sent until the date upon which the *claimant* responds or should have responded.

The *notification* will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this *Plan* will decide the *claim* within the extension described herein.

However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of:

1. the date on which you respond to the request for additional information

2. the date established by the *Plan* for the furnishing of the requested information (shown in the Timeframes for Claim and Appeal Processes)

If the requested information is not provided within the time specified, the *claim* may be denied. If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the *Plan* may, in its sole discretion, renew its consideration of the denied *claim* if the *Plan* receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the *Plan's* reconsideration and subsequent *benefit determination*.

J. Post-Service Claims

The *Claims Administrator* manages the *claims* and first-level *appeal* process of *post-service claims*. The *Plan Administrator* manages the second-level appeal process of *post-service claims*.

Post-service claims are *claims* that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard *claim* and an electronic bill, submitted for payment after services have been provided, are examples of *post-service claims*. A *claim* regarding rescission of coverage will be treated as *post-service claim*.

How to File Post-Service Claims

In order to file a *post-service claim*, you or your *authorized representative* must submit the *claim* in writing on a form pre-approved by the *Plan*. Pre-approved *claim* forms are available from your *employer*.

All *claims* must be received by the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes from the date of the expense and must include the following information:

1. the *plan participant's* name, Social Security Number, and address
2. the covered *employee's* name, Social Security Number, and address if different from the *plan participant's*
3. the provider's name, tax identification number, address, degree, and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed (if payment is to be made to the provider)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the *Plan*

Send complete information to your local Blue Cross/Blue Shield office.

Notification of Benefit Determination of Post-Service Claims

The *Plan* will *notify* you or your *authorized representative* of its *benefit determination* (whether adverse or not) no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after receipt of the *claim*. However, this period may be extended one (1) time by the *Plan* for up to the timeframe shown in the Timeframes for Claim and Appeal Processes if the *Plan* both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original time period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the *Plan*, even if you haven't submitted all the information necessary to make a *benefit determination*. Refer to the Incomplete Claims subsection for information regarding incomplete *claims*.

Notification of Adverse Benefit Determination of Post-Service Claims

If a *post-service claim* is denied in whole or in part, the denial is considered to be an *adverse benefit determination*. The *Plan Administrator* or its designee shall provide written or electronic *notification* of the *adverse benefit determination*. This *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the determination was based
4. a description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you, upon request
6. if the *adverse benefit determination* is based on the *medical necessity* or *experimental* or *investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such an explanation will be provided free of charge, upon request
7. a description of the *Plan's* review or *appeal* procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any *claim* denied after an *appeal*
8. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

How to File an Appeal of Post-Service Claims

You may *appeal* any *adverse benefit determination* to the *Plan Administrator*. The *Plan Administrator* is the sole *fiduciary* of the *Plan* and exercises all discretionary authority and control over the administration of the *Plan* and has sole discretionary authority to determine eligibility for *Plan* benefits and to construe the terms of the *Plan*. Refer to the timeframe shown in the Timeframes for Claim and Appeal Processes in which a *claimant* may file a written request for an *appeal* of the decision after receiving *notification* of an *adverse benefit determination*. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within the timeframe shown in the Timeframes for Claim and Appeal Processes. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The *Plan Administrator* or its designee will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Plan Administrator* or its designee written comments, documents, records, and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so; however, a formal hearing may not be allowed. The *Plan Administrator* or its designee will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if it:

1. was relied upon in making the *benefit determination*
2. was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that *benefit determinations* are made in accordance with plan documents and *Plan* provisions have been applied consistently with respect to all *claimants*
4. constituted a statement of policy or guidance with respect to the *Plan* concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time of receipt of a written *appeal* in accordance with the procedures of the *Plan*. This timing is without regard to whether all the necessary information accompanies the filing.

Before the *Plan Administrator* or its designee issues its *final internal adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the *adverse benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the *Plan* in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing of Appeals of Denied Post-Service Claims

You or your *authorized representative* must file an *appeal* of an *adverse benefit determination* within the timeframe shown in the Timeframes for Claim and Appeal Processes after receiving *notification* of the *adverse benefit determination*.

Requests for *appeal* which do not comply with the above requirement will not be considered.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the *Third Party Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707

Time Period for Deciding Appeals of Post-Service Claims

Appeals of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing.

Notification of Appeal Denials of Post-Service Claims

If your *appeal* is denied, in whole or in part, the *Plan Administrator* or its designee will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. identification of the *claim*, including date of service, name of provider, *claim* amount (if applicable), and a statement that the diagnosis code(s) and treatment code(s) and their corresponding meaning(s) will be provided to the *claimant* as soon as feasible upon request
2. the specific reason(s) for the *adverse benefit determination*, including the denial code(s) and corresponding meaning(s), and the *Plan's* standard, if any, used in denying the *claim*
3. reference to the specific *Plan* provisions on which the *adverse benefit determination* was based
4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records, and other information that are relevant to the *claim*

   You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One (1) way to find out what may be available is to contact your local U.S. Department of Labor Office.
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. if the denied *appeal* was based on a *medical necessity*, *experimental/investigational*, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the *Plan* to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request

7. a description of any additional material or information necessary for the *claimant* to perfect the *claim* and an explanation of why such material or information is necessary
8. a description of the *Plan's* internal and *external review* procedures and the time limits applicable to such procedures
9. a statement describing any additional *appeal* procedures offered by the *Plan* and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a)
10. information about the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process

K. Second-Level Appeal Process of Post-Service Claims

The *Plan Administrator* or its designee manages the second-level *appeal* process for *post-service claim* decisions.

The *Plan Administrator* or its designee will be identified in the *notification* of denial of your first-level *appeal* and will not be the individual who made the original decision regarding the denial of your first-level *appeal* or a subordinate of such individual.

If your *appeal* of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *Plan Administrator* or its designee. This request for a second-level *appeal* must be made in writing within the timeframe shown in the Timeframes for Claim and Appeal Processes. For *claims*, this second-level review is mandatory; i.e., you are required to undertake this second-level *appeal* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan Administrator* or its designee will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first-level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled Post-Service Claims above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Plan Administrator* or its designee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the *adverse benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *post-service claims* will be decided by the *Plan Administrator* or its designee within a reasonable period of time, but no later than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *Plan Administrator* or its designee receives the *appeal*. The *Plan Administrator* or its designee's decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the provision entitled Notification of Appeal Denials of Post-Service Claims above.

L. External Review Rights

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review*, and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeals* procedures before you can request a voluntary *external review*.

If you decide to seek *external review*, an *independent review organization (IRO)* will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier *claims* and *appeals* decisions, but it must observe the written terms of the plan document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, the *Third Party Administrator*, and the *Plan*.

M. External Review of Claims

The *external review* process is available only where the *final internal adverse benefit determination* is denied on the basis of any of the following:

1. a medical judgment (which includes but is not limited to *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit)

2. a determination that a treatment is *experimental* or *investigational*
3. a rescission of coverage

If your *appeal* is denied, you or your *authorized representative* may request further review by an *independent review organization (IRO)*. This request for *external review* must be made, in writing, within the timeframe shown in the Timeframes for Claim and Appeal Processes beginning the date you are *notified* of an *adverse benefit determination* or *final internal adverse benefit determination*. This *external review* is mandatory; i.e., you are required to undertake this *external review* before you may pursue civil action under Section 502(a) of ERISA.

The *Plan* will complete a preliminary review of the request within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of receipt of the *external review* request to determine whether:

1. the *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided
2. the *adverse benefit determination* or the *final internal adverse benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination)
3. the *claimant* has exhausted the *Plan's* internal *appeal* process
4. the *claimant* has provided all the information and forms required to process an *external review*

The *Plan* will *notify* the *claimant* within the timeframe shown in the Timeframes for Claim and Appeal Processes following completion of its preliminary review if either:

1. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1-866-444-EBSA (3272)]
2. the request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the timeframe shown in the Timeframes for Claim and Appeal Processes or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later

NOTE: If the *adverse benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review* process, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* or its designee will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

1. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
2. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for *external review*. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO*, within the timeframe shown in the Timeframes for Claim and Appeal Processes following the date of receipt of the *notice*, additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
3. Within the timeframe shown in the Timeframes for Claim and Appeal Processes after the date of assignment of the *IRO*, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the *adverse benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not delay the conduct of the *external review*. If the *Plan* fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the *adverse benefit determination* or *final internal adverse benefit determination*. The *IRO* must *notify* the *claimant* and the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes after making the decision.
4. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must forward the information to the *Plan* within the timeframe shown in the Timeframes for Claim and Appeal Processes. Upon receipt of any such information, the *Plan* may reconsider its *adverse benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the *Plan* must not delay the *external review*. The *external review* may be terminated as a result of the reconsideration only if the *Plan* decides, upon completion of its reconsideration, to reverse its *adverse benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. The *Plan* must provide written *notice* of its

decision to the *claimant* and the assigned *IRO* within the timeframe shown in the Timeframes for Claim and Appeal Processes. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the *Plan*.

5. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the *Plan's* internal *claims* and *appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider the following in reaching a decision:
    a. the *claimant's* medical records
    b. the attending health care professional's recommendation
    c. reports from appropriate health care professionals and other documents submitted by the *Plan*, *claimant*, or the *claimant's* treating provider
    d. the terms of the *claimant's Plan* to ensure that the *IRO's* decision is not contrary to the terms of the *Plan*, unless the terms are inconsistent with applicable law
    e. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
    f. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the *Plan* or with applicable law
    g. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this *notice* to the extent the information or documents are available
6. The assigned *IRO* must provide written *notice* of the final *external review* decision within the timeframe shown in the Timeframes for Claim and Appeal Processes after the *IRO* receives the request for the *external review*. The *IRO* must deliver the *notice* of *final external review decision* to the *claimant* and the *Plan*.
7. The assigned *IRO's* decision *notice* will contain:
    a. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* [including the date or dates of service, the health care provider, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial]
    b. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision
    c. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
    d. a discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision
    e. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health *Plan* or to the *claimant*
    f. a statement that judicial review may be available to the *claimant*
    g. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

If you remain dissatisfied with the outcome of the *external review*, you may pursue civil action under Section 502(a) of ERISA.

Generally, a *claimant* must exhaust the *Plan's claims* and *appeals* procedures in order to be eligible for the *external review* process. However, in some cases the *Plan* provides for an expedited *external review* if either:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeals* procedures would seriously jeopardize the *claimant's* life, health, or ability to regain maximum function, and the *claimant* has filed a request for an expedited internal review.
2. The *claimant* receives a *final internal adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final internal adverse benefit*

determination concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received *emergency services*, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the *Plan* must determine and *notify* the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a *notice* of the decision as expeditiously as the *claimant's* medical condition or circumstances require, but in no event more than the timeframe shown in the Timeframes for Claim and Appeal Processes after the *IRO* receives the request for an expedited *external review*. If the original *notice* of its decision is not in writing, the *IRO* must provide written confirmation of the decision within the timeframe shown in the Timeframes for Claim and Appeal Processes to both the *claimant* and the *Plan*.

N. Designation of Authorized Representative

A *plan participant* is permitted to appoint an *authorized representative* to act on behalf of the *plan participant* with respect to a benefit *claim* or *appeal* of a denial. In connection with a *claim* involving urgent care, the *Plan* will permit a health care professional with knowledge of the *plan participant's* medical condition to act as the *plan participant's authorized representative*. In the event a *plan participant* designates an *authorized representative*, all future communications from the *Plan* will be with the representative, rather than the *plan participant*, unless the *plan participant* directs the *Plan Administrator*, in writing, to the contrary. If you wish to change/alter your authorized representative, or the time frame, you will need to submit these changes in writing.

O. Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a *claim*. The *plan participant* must comply with this requirement as a necessary condition to coverage.

P. Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *plan participant* whose condition, *illness*, or *injury* is the basis of a *claim*. This right may be exercised only where not prohibited by law.

Q. Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the *plan participant* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a *claim*. In the event of the death or incapacity of a *plan participant*, and in the absence of written evidence to this *Plan* of the qualification of a guardian for their estate, this *Plan* may, in its sole discretion, make any and all such payments to the individual or *institution* which, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

R. Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *plan participant* to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the *plan participant* and the assignee, has been received before the proof of loss is submitted.

No *plan participant* shall at any time, either during the time in which they are a *plan participant* in the *Plan*, or following their termination as a *plan participant*, in any manner, have any right to assign their right to sue to recover benefits under the *Plan*, to enforce rights due under the *Plan*, or to any other causes of action which they may have against the *Plan* or its fiduciaries.

A provider which accepts an *assignment of benefits*, in accordance with this *Plan* as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

S. Recovery of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such, this *Plan* may pay benefits that are later found to be greater than the *maximum allowable charge*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant* or *dependent* on whose behalf such payment was made.

A *plan participant*, *dependent*, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or to whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand or *incur* prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then that *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. in error
2. pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. pursuant to a misstatement made to obtain coverage under this *Plan* within two (2) years after the date such coverage commences
4. with respect to an ineligible person
5. in anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement And Recovery Provisions**
6. pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

   This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of their covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent* of the *plan participant*.

If the *Plan* seeks to recoup funds from a provider due to a *claim* being made in error, a *claim* being fraudulent on the part of the provider, and/or a *claim* that is the result of the provider's misstatement, said provider shall, as part of its *assignment of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount.

SECTION XII—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered charges* when two (2) or more plans, including *Medicare*, are paying. When a *plan participant* is covered by this *Plan* and another plan, or the *plan participant's* spouse is covered by this *Plan* and by another plan, or the couple's covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Standard Coordination of Benefits (COB)

The plan that pays first according to the rules will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to 100% of the total *allowable charges*.

Example: Assume all *deductibles* are met, billed services are considered *covered charges* under both plans, the primary plan pays 80% of the *allowable amount*, and the secondary plan pays 90% of the *allowable amount*. A *plan participant* incurs a *claim* with a *network* provider in which the *allowable amount* is $1,000.

Primary Plan	$800
Secondary Plan	$200
Patient Responsibility	$0
Total Amount Paid	$1,000

PPO Plan Option: When this Plan is secondary to other insurance, the resulting *claims* will have the *deducible* waived for all covered services. Once a coordination of benefits form is received by the *Claims Administrator*, the *plan participant* will receive a $600 credit.

B. Excess Insurance

If at the time of *injury*, *illness*, *disease*, or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of coverage.

The *Plan's* benefits will be excess to, whenever possible:

1. any primary payer besides the *Plan*
2. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured or underinsured motorist coverage
3. any policy of insurance from any insurance company or guarantor of a third party
4. workers' compensation or other liability insurance company
5. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

C. Allowable Charge

For a charge to be allowable it must be within the *Plan's maximum amount* and at least part of it must be covered under this *Plan*.

In the case of HMO (health maintenance organization) or other *network* only plans, this *Plan* will not consider any charges in excess of what an HMO or *network* provider has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *plan participant* does not use an HMO or *network* provider, this *Plan* will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *plan participant* used the services of an HMO or *network* provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the *allowable charge*.

D. General Limitations

When medical payments are available under any other insurance source, the *Plan* shall always be considered the secondary carrier.

E. Application to Benefit Determinations

The *Plan* shall be secondary in coverage to any medical payments provision, *no-fault automobile insurance* policy, or personal *injury* protection policy regardless of any election made by anyone to the contrary. The *Plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will adhere to these rules in the following order:

1. Plans that do not have a coordination provision, or one like this, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the *allowable charge*:
    a. The benefits of the plan which covers the person directly (that is, as an *employee*, member, or subscriber) are determined before those of the plan which covers the person as a *dependent*.
    b. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a *dependent* of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a *dependent* of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
        ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
    e. When a *child's* parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the *child* as a *dependent* will be considered next. The benefit plan of the parent without custody will be considered last.
        iii. This rule will be in place of items (i.) and (ii.) immediately above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before *other plans* that cover the child as a *dependent*.
        iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one (1) of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of *benefit determination* rules

outlined above when a child is covered as a *dependent* and the parents are not separated or divorced.

v. For parents who were never married to each other, the rules apply as set out above, as long as paternity has been established.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the *Plan* will never pay more than 50% of *allowable charges* when paying secondary.

g. When a married *dependent* child is covered as a *dependent* on both a spouse's plan and a parent's plan, and the policies are both effective on the same day, the benefits of the policy holder whose birthday falls earlier in a year are determined before those of the policy holder whose birthday falls later in that year.

3. *Medicare* will pay primary, secondary, or last to the extent stated in federal law. Refer to the *Medicare* publication Your Guide to Who Pays First at **https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first**. When *Medicare* would be the primary payer if the person had enrolled in *Medicare*, this *Plan* will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The *Plan* reserves the right to coordinate benefits with respect to *Medicare* Part D. The *Plan Administrator* will make this determination based on the information available through Centers for Medicare & Medicaid Services (CMS). If CMS does not provide sufficient information to determine the amount *Medicare* would pay, the *Plan Administrator* will make *reasonable* assumptions based on published *Medicare* fee schedules.

4. If a *plan participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first, and this *Plan* will pay second.

5. When an adult *dependent* is covered by their spouse's plan and is also covered by a parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the *other plan*.

6. When an adult *dependent* is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.

7. The *Plan* will pay primary to Tricare and a state *Children's Health Insurance Plan* to the extent required by federal law.

G. Coordination with Government Programs

1. **Medicaid/IHS.** If a *plan participant* is covered by both this *Plan* and Medicaid or Indian Health Services (IHS), this *Plan* pays first and Medicaid or IHS pays second.

2. **Veterans Affairs or Military Medical Facility Services.** If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of a military-service-related *illness* or *injury*, benefits are not covered by this *Plan*. If a *plan participant* receives services in a U.S. Department of Veterans Affairs Hospital or Military Medical Facility on account of any other condition that is not a military-service-related *illness* or *injury*, benefits are covered by the *Plan* to the extent those services are *medically necessary* and the charges are within this *Plan's maximum allowable charge*.

3. **Other Coverage Provided by State or Federal Law.** If you are covered by both this *Plan* and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this *Plan* pays second, unless applicable law dictates otherwise.

H. Claims Determination Period

Benefits will be coordinated on a *calendar year* basis. This is called the claims determination period.

I. Right to Receive or Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or *notice* to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* shall furnish to the *Plan* such information as may be necessary to implement this provision.

J. Facility of Payment

Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability. This *Plan* may repay *other plans* for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this *Plan*.

K. Right of Recovery

In accordance with the **Claims and Appeals** section, Recovery of Payments subsection, whenever payments have been made by this *Plan* with respect to *allowable charges* in a total amount, at any time, in excess of the *maximum amount* of payment necessary at that time to satisfy the intent of this article, the *Plan* shall have the right to recover such payments, to the extent of such excess, from any one (1) or more of the following as this *Plan* shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the *Plan* determines are responsible for payment of such *allowable charges*, and any future benefits payable to the *plan participant* or their *dependents*. Please see the Recovery of Payments subsection for more details.

L. Exception to Medicaid

In accordance with ERISA, the *Plan* shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the *Plan* or making a determination about the payments for benefits received by a *plan participant* under the *Plan*.

SECTION XIII—MEDICARE

A. Application to Active Employees and Their Spouses

An active *employee* and their spouse (when eligible for *Medicare*) may, at the option of such *employee*, elect or reject coverage under this *Plan*. If such *employee* elects coverage under this *Plan*, the benefits of this *Plan* shall be determined before any benefits provided by *Medicare*. If coverage under this *Plan* is rejected by such *employee*, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

B. Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by federal regulations, this *Plan* will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this *Plan* would be calculated as the secondary payer (as described under the section entitled **Coordination of Benefits**). The *plan participant* will be assumed to have full *Medicare* coverage (that is, both Parts A & B) whether or not the *plan participant* has enrolled for the full coverage. If the provider accepts assignment with *Medicare*, *covered charges* will not exceed the *Medicare* approved expenses.

SECTION XIV—SUBROGATION AND REIMBURSEMENT PROVISIONS

These **Subrogation and Reimbursement Provisions** apply when the *Plan* pays benefits as a result of *injuries* or *illnesses* the *plan participant* sustained, and the *plan participant* has a right to a recovery or have received a recovery from any source.

A. **Definitions**

As used in these **Subrogation and Reimbursement Provisions**, '*plan participant'* includes anyone on whose behalf the *Plan* pays benefits. These **Subrogation and Reimbursement Provisions** apply to all current or former *plan participants* and *Plan* beneficiaries. The provisions also apply to the parents, guardian, or other representative of a *dependent* child who incurs *claims* and is or has been covered by the *Plan*. The *Plan's* rights under these provisions shall also apply to the personal representative or administrator of the *plan participant's* estate, the *plan participant's* heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative shall be subject to these **Subrogation and Reimbursement Provisions**. Likewise, if the covered person's relatives, heirs, and/or assignees make any recovery because of *injuries* sustained by the covered person, or because of the death of the covered person, that recovery shall be subject to this provision, regardless of how any recovery is allocated or characterized.

As used in these **Subrogation and Reimbursement Provisions**, 'recovery' includes, but is not limited to, monies received from any person or party; any person's or party's liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers' compensation insurance or fund, premises medical payments coverage, restitution, or "no-fault" or personal *injury* protection insurance and/or automobile medical payments coverage; or any other first- or third-party insurance coverage, whether by lawsuit, settlement, or otherwise. Regardless of how the *plan participant* or the *plan participant's* representative or any agreements allocate or characterize the money the *plan participant* receives as a recovery, it shall be subject to these provisions.

B. **Subrogation**

Immediately upon paying or providing any benefit under the *Plan*, the *Plan* shall be subrogated to, or stand in the place of, all of the *plan participant's* rights of recovery with respect to any *claim* or potential *claim* against any party, due to an *injury*, *illness*, or condition to the full extent of benefits provided or to be provided by the *Plan*. The *Plan* has the right to recover payments it makes on the *plan participant's* behalf from any party or insurer responsible for compensating the *plan participant* for the *plan participant's illnesses* or *injuries*. The *Plan* has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the *Plan*. The *Plan* may assert a *claim* or file suit in the *plan participant's* name and take appropriate action to assert its subrogation *claim*, with or without the *plan participant's* consent. The *Plan* is not required to pay the *plan participant* part of any recovery it may obtain, even if it files suit in the *plan participant's* name.

C. **Reimbursement**

If the *plan participant* receives any payment as a result of an *injury*, *illness*, or condition, the *plan participant* agrees to reimburse the *Plan* first from such payment for all amounts the *Plan* has paid and will pay as a result of that *injury*, *illness*, or condition, up to and including the full amount of the *plan participant's* recovery. If the *plan participant* obtains a recovery and the *Plan* has not been repaid for the benefits the *Plan* paid on the *plan participant's* behalf, the *Plan* shall have a right to be repaid from the recovery in the amount of the benefits paid on the *plan participant's* behalf. The *plan participant* must promptly reimburse the *Plan* from any recovery to the extent of benefits the *Plan* paid on the *plan participant's* behalf regardless of whether the payments the *plan participant* receives makes the *plan participant* whole for the *plan participant's* losses, *illnesses*, and/or injuries.

D. **Secondary to Other Coverage**

The *Plan* shall be secondary in coverage to any medical payments provision, *no-fault automobile insurance* policy, or personal *injury* protection policy regardless of any election made by the *plan participant* to the contrary. The *Plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

E. **Assignment**

In order to secure the *Plan's* rights under these **Subrogation and Reimbursement Provisions**, The *plan participant* agrees to assign to the *Plan* any benefits or *claims* or rights of recovery the *plan participant* has under any automobile policy or other coverage, to the full extent of the *Plan's* subrogation and reimbursement *claims*. This assignment allows the *Plan* to pursue any *claim* the *plan participant* may have regardless of whether the *plan participant* chooses to pursue the *claim*.

F. **Applicability to All Settlements and Judgments**

Notwithstanding any allocation or designation of the *plan participant's* recovery made in any settlement agreement, judgment, verdict, release, or court order, the *Plan* shall have a right of full recovery, in first priority, against any recovery the *plan participant* makes. Furthermore, the *Plan's* rights under these **Subrogation and Reimbursement Provisions** will not be reduced due to the *plan participant's* own negligence. The terms of these **Subrogation and Reimbursement Provisions** shall apply and the *Plan* is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to the *plan participant's* recovery identify the medical benefits the *Plan* provided or purport to allocate any portion of such recovery to payment of expenses other than medical expenses. The *Plan* is entitled to recover from any recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

G. **Constructive Trust**

By accepting benefits from the *Plan*, the *plan participant* agrees that if the *plan participant* receives any payment as a result of an *injury*, *illness,* or condition, the *plan participant* will serve as a constructive trustee over those funds. The *plan participant* and the *plan participant's* legal representative must hold in trust for the *Plan* the full amount of the recovery to be paid to the *Plan* immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of the *plan participant's fiduciary* duty to the *Plan*. Any recovery the *plan participant* obtains must not be dissipated or disbursed until such time as the *Plan* has been repaid in accordance with these **Subrogation and Reimbursement Provisions**.

H. **Lien Rights**

The *Plan* will automatically have a lien to the extent of benefits paid by the *Plan* for the treatment of the *plan participant's illness*, *injury,* or condition upon any recovery related to treatment for any *illness*, *injury,* or condition for which the *Plan* paid benefits. The lien may be enforced against any party who possesses funds or proceeds from the *plan participant's* recovery including, but not limited to, the *plan participant*, the *plan participant's* representative or agent, and/or any other source possessing funds from the *plan participant's* recovery. The *plan participant* and the *plan participant's* legal representative acknowledge that the portion of the recovery to which the *Plan's* equitable lien applies is a *Plan* asset. The *Plan* shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the *Plan's* lien and/or to obtain (or preclude the transfer, dissipation, or disbursement of) such portion of any recovery in which the *Plan* may have a right or interest.

I. **First-Priority Claim**

By accepting benefits from the *Plan*, the *plan participant* acknowledges the *Plan's* rights under these **Subrogation and Reimbursement Provisions** are a first-priority *claim* and are to be repaid to the *Plan* before the *plan participant* receives any recovery for the *plan participant's* damages. The *Plan* shall be entitled to full reimbursement on a first-dollar basis from any recovery, even if such payment to the *Plan* will result in a recovery which is insufficient to make the *plan participant* whole or to compensate the *plan participant* in part or in whole for the losses, injuries, or *illnesses* the *plan participant* sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a recovery is available are insufficient to satisfy in full the *Plan's* subrogation *claim* and any *claim* held by the *plan participant*, the *Plan's* subrogation *claim* shall be first satisfied before any part of a recovery is applied to the *plan participant's claim*, the *plan participant's* attorney fees, other expenses or costs. The *Plan* is not responsible for any attorney fees, attorney liens, other expenses, or costs the *plan participant incurs*. The common fund doctrine does not apply to any funds recovered by any attorney the *plan participant* hires regardless of whether funds recovered are used to repay benefits paid by the *Plan*.

J. **Cooperation**

The *plan participant* agrees to cooperate fully with the *Plan's* efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

1. The *plan participant* must promptly *notify* the *Plan* of how, when, and where an *accident* or incident resulting in personal *injury* or *illness* to the *plan participant* occurred, all information regarding the parties involved, and any other information requested by the *Plan*.
2. The *plan participant* must *notify* the *Plan* within thirty (30) days of the date when any *notice* is given to any party, including an insurance company or attorney, of the *plan participant's* intention to pursue or investigate a *claim* to recover damages or obtain compensation due to the *plan participant's injury*, *illness*, or condition.
3. The *plan participant* must cooperate with the *Plan* in the investigation, settlement, and protection of the *Plan's* rights. In the event that the *plan participant* or the *plan participant's* legal representative fails to do whatever is necessary to enable the *Plan* to exercise its subrogation or reimbursement rights, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.
4. The *plan participant* and the *plan participant's* agents shall provide all information requested by the *Plan*, the *Claims Administrator*, or its representative, including, but not limited to, completing and submitting any applications or other forms or statements as the *Plan* may reasonably request and all documents related to or filed in personal *injury* litigation.
5. The *plan participant* recognizes that to the extent that the *Plan* paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the *reasonable* value of those payments or the actual paid amount, whichever is higher.
6. The *plan participant* must not do anything to prejudice the *Plan's* rights under these **Subrogation and Reimbursement Provisions**. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the *Plan*.
7. The *plan participant* must send the *Plan* copies of all police reports, *notices*, or other papers received in connection with the *accident* or incident resulting in personal *injury* or *illness* to the *plan participant*.
8. The *plan participant* must promptly *notify* the *Plan* if the *plan participant* retains an attorney or if a lawsuit is filed on the *plan participant's* behalf.
9. The *plan participant* must immediately *notify* the *Plan* if a trial is commenced, if a settlement occurs, or if potentially dispositive motions are filed in a case.

In the event that the *plan participant* or the *plan participant's* legal representative fails to do whatever is necessary to enable the *Plan* to exercise its rights under these **Subrogation and Reimbursement Provisions**, the *Plan* shall be entitled to deduct the amount the *Plan* paid from any future benefits under the *Plan*.

If the *plan participant* fails to repay the *Plan*, the *Plan* shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the *Plan* has paid or the amount of the *plan participant's* recovery, whichever is less, from any future benefit under the *Plan* if either of the following apply:

1. The amount the *Plan* paid on the *plan participant's* behalf is not repaid or otherwise recovered by the *Plan*.
2. The *plan participant* fails to cooperate.

In the event the *plan participant* fails to disclose the amount of the *plan participant's* settlement to the *Plan*, the *Plan* shall be entitled to deduct the amount of the *Plan's* lien from any future benefit under the *Plan*.

The *Plan* shall also be entitled to recover any of the unsatisfied portion of the amount the *Plan* has paid or the amount of the *plan participant's* recovery, whichever is less, directly from the providers to whom the *Plan* has made payments on the *plan participant's* behalf. In such a circumstance, it may then be the *plan participant's* obligation to pay the provider the full billed amount, and the *Plan* will not have any obligation to pay the provider or reimburse the *plan participant*.

The *plan participant* acknowledges the *Plan* has the right to conduct an investigation regarding the *injury*, *illness*, or condition to identify potential sources of recovery. The *Plan* reserves the right to *notify* all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The *plan participant* acknowledges the *Plan* has notified the *plan participant* that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share the *plan participant's* personal health information in exercising these **Subrogation and Reimbursement Provisions**.

The *Plan* is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these **Subrogation and Reimbursement Provisions**.

K. **Discretion**

The *Plan* Administrator has sole discretion to interpret the terms of the **Subrogation and Reimbursement Provisions** of this *Plan* in its entirety and reserves the right to make changes as it deems necessary.

SECTION XV—CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as Amended, certain *employees* and their families covered under the Kentucky Rural Electric Cooperative Employers Benefit Plan (*Plan*) will be entitled to the opportunity to elect a temporary extension of health coverage (called COBRA continuation coverage) where coverage under the *Plan* would otherwise end. This *notice* is intended to inform *plan participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This *notice* is intended to reflect the law and does not grant or take away any rights under the law.

Refer to the Quick Reference Information Chart for the COBRA Administrator's contact information. Complete instructions on COBRA, as well as election forms and other information, will be provided by the *Plan Administrator* or its designee to *plan participants* who become qualified beneficiaries under COBRA.

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

A. COBRA Continuation Coverage

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *plan participants* and their eligible family members (called qualified beneficiaries) at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the *Plan* (the qualifying event). The coverage must be identical to the *Plan* coverage that the qualified beneficiary had immediately before the qualifying event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active *employees* who have not experienced a qualifying event (in other words, similarly situated non-COBRA beneficiaries).

COBRA continuation coverage does not run concurrent with the coverage under the terms of the *Plan*.

B. Qualified Beneficiary

In general, a qualified beneficiary can be:

1. Any individual who, on the day before a qualifying event, is covered under a *Plan* by virtue of being on that day either a covered *employee*, the spouse of a covered *employee*, or a *dependent* child of a covered *employee*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
2. Any child who is born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, and any individual who is covered by the *Plan* as an *alternate recipient* under a *Qualified Medical Child Support Order*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the *Plan* under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the *Plan* coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
3. A covered *employee* who retired on or before the date of substantial elimination of *Plan* coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse, or *dependent* child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or *dependent* child was a beneficiary under the *Plan*.

The term 'covered *employee*' includes any individual who is provided coverage under the *Plan* due to their performance of services for the *employer* sponsoring the *Plan*, self-employed individuals, independent contractor, or corporate director. However, this provision does not establish eligibility of these individuals. Eligibility for *Plan* coverage shall be determined in accordance with *Plan's* **Eligibility, Effective Date, and Termination Provisions** section.

An individual is not a qualified beneficiary if the individual's status as a covered *employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a

qualified beneficiary, then a spouse or *dependent* child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

C. Qualifying Event

The following are considered to be qualifying events if they would cause the *plan participant* to lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage:

1. the death of a covered *employee*
2. the termination (other than by reason of the *employee's* gross misconduct), or reduction of hours, of a covered *employee's* employment
3. the divorce or legal separation of a covered *employee* from the *employee's* spouse

   If the *employee* reduces or eliminates the *employee's* spouse's *Plan* coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. a covered *employee's* enrollment in any part of the *Medicare* program
5. a *dependent* child's ceasing to satisfy the *Plan's* requirements for a *dependent* child (for example, attainment of the maximum age for dependency under the *Plan*)
6. a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an *employer* from whose employment a covered *employee* retired at any time.

If the qualifying event causes the covered *employee*, or the covered spouse or a *dependent* child of the covered *employee*, to cease to be covered under the *Plan* under the same terms and conditions as in effect immediately before the qualifying event [or in the case of the bankruptcy of the *employer*, any substantial elimination of coverage under the *Plan* occurring within twelve (12) months before or after the date the bankruptcy proceeding commences], the persons losing such coverage become qualified beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered *employee*, the spouse, or a *dependent* child of the covered *employee*, for coverage under the *Plan* that results from the occurrence of one (1) of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) does not constitute a qualifying event. A qualifying event will occur, however, if an *employee* does not return to employment at the end of the *FMLA leave* and all other COBRA continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of *FMLA leave*, and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the *Plan* provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to COBRA continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the *Plan* during the *FMLA leave*.

D. Notice of Unavailability of Continuation Coverage

The *Plan* may sometimes deny a request for COBRA coverage, including an extension of coverage, when the *Plan Administrator* determines the *plan participant* is not entitled to receive it.

When a *Plan Administrator* makes the decision to deny a request for COBRA coverage from a *plan participant*, the *Plan* must give the *plan participant* a *notice* of unavailability of COBRA coverage. The *notice* must be provided within fourteen (14) days after the request is received relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration, and the *notice* must explain the reason for denying the request.

E. Factors to Consider in Electing COBRA Continuation Coverage

When considering options for health coverage, qualified beneficiaries should consider:

1. **Premiums.** This *Plan* can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the marketplace, may be less expensive. Qualified beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's *employer*) within thirty (30) days after *Plan* coverage ends due to one (1) of the qualifying events listed above.
2. **Provider Networks.** If a qualified beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a *network* in considering options for health coverage.
3. **Drug Formularies.** For qualified beneficiaries taking medication, a change in health coverage may affect costs for medication—and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
4. **Severance Payments.** If COBRA rights arise because the *employee* has lost their job and there is a severance package available from the *employer*, the former *employer* may have offered to pay some or all of the *employee's* COBRA payments for a period of time. This can affect the timing of coverage available in the marketplace. In this scenario, the *employee* may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
5. **Service Areas.** If benefits under the *Plan* are limited to specific service or coverage areas, benefits may not be available to a qualified beneficiary who moves out of the area.
6. **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the *Plan* requires *participants* to pay *co-payments*, *deductibles*, *co-insurance*, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher *deductible* and higher *co-payments*.

Other Coverage Options

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

F. Procedure for Obtaining COBRA Continuation Coverage

The *Plan* has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

G. The Election Period

The election period is the timeframe within which the qualified beneficiary must elect COBRA continuation coverage under the *Plan*. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and ends sixty (60) days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date *notice* is provided to the qualified beneficiary of their right to elect COBRA continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect COBRA continuation coverage are forfeited.

NOTE: If a covered *employee* who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the *employee* and their covered *dependents* have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended. Any person who qualifies or thinks that they and/or their family members may qualify for assistance under this special provision should contact the *Plan Administrator* for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period. Refer to the Quick Reference Information Chart for the *Plan Administrator's* contact information.

H. Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event

The *Plan* will offer COBRA continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely *notified* that a *qualifying event* has occurred. The *employer* (if the *employer* is not the *Plan Administrator*) will *notify* the *Plan Administrator* of the *qualifying event* within thirty (30) days following the date coverage ends when the qualifying event is any of the following:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to the *employer*
4. enrollment of the *employee* in any part of *Medicare*

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

Notice Procedures

Any *notice* that you provide must be in writing. Oral *notice*, including *notice* by telephone, is not acceptable. You must mail, fax, or hand-deliver your *notice* to the person, department, or firm listed below, at the following address:

Kentucky Rural Electric Cooperative
4775 Lexington Road
Winchester, KY 40391
1-859-745-9672

If mailed, your *notice* must be postmarked no later than the last day of the required *notice* period. Any *notice* you provide must state all of the following:

1. the name of the plan or plans under which you lost or are losing coverage
2. the name and address of the *employee* covered under the *Plan*
3. the name(s) and address(es) of the qualified beneficiary(ies)
4. the qualifying event and the date it happened

If the qualifying event is a **divorce or legal separation**, your *notice* must include a **copy of the divorce decree or the legal separation agreement.**

Be aware that there are other *notice* requirements in other contexts, for example, in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives timely *notice* that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered *employees* may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that *Plan* coverage would otherwise have been lost. If you or your spouse or *dependent* children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

I. Waiver Before the End of the Election Period

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

J. If a Qualified Beneficiary Has Other Group Health Plan Coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to *Medicare* or become covered under other group health plan coverage.

K. When a Qualified Beneficiary's COBRA Continuation Coverage Can be Terminated

During the election period, a qualified beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which *timely payment* is not made to the *Plan* with respect to the qualified beneficiary
3. the date upon which the *employer* ceases to provide any group health plan (including a successor plan) to any *employee*
4. the date, after the date of the election, that the qualified beneficiary first becomes covered under any *other plan*
5. the date, after the date of the election, that the qualified beneficiary first enrolls in the *Medicare* program (either Part A or Part B, whichever occurs earlier)
6. in the case of a qualified beneficiary entitled to a disability extension, the later of:
    a. twenty-nine (29) months after the date of the qualifying event
    b. the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier
    c. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension

The *Plan* can terminate for cause the coverage of a qualified beneficiary on the same basis that the *Plan* terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent *claim*.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the *Plan* solely because of the individual's relationship to a qualified beneficiary, if the *Plan's* obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, the *Plan* is not obligated to make coverage available to the individual who is not a qualified beneficiary.

When the *Plan* terminates COBRA coverage early for any of the reasons listed above, the *Plan Administrator* must give the qualified beneficiary a *notice* of early termination. The *notice* must be given as soon as practicable after the decision is made, and it must describe all of the following:

1. the date of termination of COBRA coverage
2. the reason for termination
3. any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy

L. Maximum Coverage Periods for COBRA Continuation Coverage

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends either:
    a. eighteen (18) months after the qualifying event if there is not a disability extension

b. twenty-nine (29) months after the qualifying event if there is a disability extension

2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered *employee* ends on the later of:
   a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
   b. eighteen (18) months [or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment
3. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered *employee* during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
4. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event.

M. Circumstances in Which the Maximum Coverage Period Can Be Expanded

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second qualifying event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are qualified beneficiaries at the time of and with respect to both qualifying events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be *notified* of the second qualifying event within sixty (60) days of the second qualifying event. This *notice* must be sent to the *Plan Sponsor* in accordance with the procedures above.

N. How a Qualified Beneficiary Becomes Entitled to a Disability Extension

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a qualified beneficiary in connection with the *qualifying event* that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the *Plan Administrator* with *notice* of the disability determination on a date that is both within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month maximum coverage. Said *notice* shall be provided to the *Plan Administrator*, in writing, and should be sent to the *Plan Sponsor* in accordance with the procedures above.

O. Payment for COBRA Continuation Coverage

For any period of COBRA continuation coverage under the *Plan*, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled qualified beneficiary due to a disability extension. The *Plan* will terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which *timely payment* is not made.

The *Plan* must allow payment for COBRA continuation coverage to be made in monthly installments. The *Plan* is also permitted to allow for payment at other intervals.

P. Timely Payment for COBRA Continuation Coverage

Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the *Plan* by a later date is also considered *timely payment* if either under the terms of the *Plan*, covered *employees* or qualified beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the *Plan* does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than forty-five (45) days after the date on which the election of COBRA

continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to the *Plan*.

If *timely payment* is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan's* requirement for the amount to be paid, unless the *Plan notifies* the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the *notice* is provided. A shortfall in a *timely payment* is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Q. Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage

If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the *Plan* will, during the one hundred eighty (180) day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the *Plan*.

R. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the *Plan Sponsor*. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

S. Keep Your Plan Administrator Informed of Address Changes

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

T. If You Wish to Appeal

In general, COBRA-related *claims* are not governed by ERISA and the related federal regulations. In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA related *claims*, all determinations regarding COBRA eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing plan document. Accordingly, if a qualified beneficiary wishes to *appeal* a COBRA eligibility or coverage determination made by the *Plan*, such *claims* must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The *Plan* will respond to all complete *appeals* in accordance with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. A qualified beneficiary who files an *appeal* with the *Plan* must exhaust the administrative remedies afforded by the *Plan* prior to pursuing civil action in federal court under COBRA.

SECTION XVI—FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the *Plan* is funded as follows:

A. For Employee and Dependent Coverage

Funding is derived from the funds of the *employer* and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the *Plan* as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the *Plan* through the *Third Party Administrator*.

Payment for Coverage

The specific amount you must pay for coverage is announced each *calendar year*. You pay your contributions for medical coverage on a **before-tax** basis. This means that your payments for these coverages come from your pay before federal, and in most cases, state taxes are withheld. That way, you should pay less in taxes.

The amount and frequency of that contribution is determined by Kentucky Rural Electric Cooperative (within permissible government guidelines) and announced on an annual basis.

B. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records, or a delay in making any changes, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a *Plan* reimbursement amount, the *Plan* retains a contractual right to the overpayment. The person or *institution* receiving the overpayment will be required to return the amount paid in error. In the case of a *plan participant*, the amount of overpayment may be deducted from future benefits payable.

SECTION XVII—CERTAIN PLAN PARTICIPANTS' RIGHTS UNDER ERISA

A. Introduction

Plan participants in this *Plan* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all *plan participants* shall be entitled to:

1. examine, without charge, at the *Plan Administrator's* office, all plan documents and copies of all documents governing the *Plan*, including a copy of the latest annual report (form 5500 series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
2. obtain copies of all plan documents and other *Plan* information upon written request to the *Plan Administrator*

   The *Plan Administrator* may make a *reasonable* charge for the copies.
3. continue health care coverage for a *plan participant*, spouse, or other *dependents* if there is a loss of coverage under the *Plan* as a result of a qualifying event

   Employees or *dependents* may have to pay for such coverage.
4. review this summary plan description and the documents governing the *Plan* or the rules governing COBRA continuation coverage rights

B. Enforce Your Rights

If a *plan participant's claim* for a benefit is denied or ignored, in whole or in part, the *plan participant* has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to *appeal* any denial, all within certain time schedules.

Under ERISA, there are steps a *plan participant* can take to enforce the above rights. For instance, if a *plan participant* requests a copy of plan documents or the latest annual report from the *Plan* and does not receive them within thirty (30) days, the *plan participant* may file suit in a federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and to pay the *plan participant* up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If the *plan participant* has a *claim* for benefits which is denied or ignored, in whole or in part, the *plan participant* may file suit in state or federal court.

In addition, if a *plan participant* disagrees with the *Plan's* decision or lack thereof concerning the qualified status of a *medical child support order*, the *plan participant* may file suit in federal court.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for *plan participants*, ERISA imposes obligations upon the individuals who are responsible for the operation of the *Plan*. The individuals who operate the *Plan*, called fiduciaries of the *Plan*, have a duty to do so prudently and in the interest of the *plan participants* and their beneficiaries. No one, including the *employer* or any other person, may fire a *plan participant* or otherwise discriminate against a *plan participant* in any way to prevent the *plan participant* from obtaining benefits under the *Plan* or from exercising their rights under ERISA.

If it should happen that the *Plan* fiduciaries misuse the *Plan's* money, or if a *plan participant* is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the *plan participant* is successful, the court may order the person sued to pay these costs and fees. If the *plan participant* loses, the court may order the *plan participant* to pay these costs and fees (for example, if it finds the *claim* or suit to be frivolous).

D. Assistance with Your Questions

If the *plan participant* has any questions about the *Plan*, they should contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. If the *plan participant* has any questions about this statement or their rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, that *plan participant* should contact either 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**. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

SECTION XVIII—FEDERAL NOTICES

A. Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

An *employee* or *dependent* who is eligible, but not enrolled in this *Plan*, may enroll if:

1. The *employee* or *dependent* is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of such Act, and coverage of the *employee* or *dependent* is terminated due to loss of eligibility for such coverage, and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after such Medicaid or CHIP coverage is terminated.
2. The *employee* or *dependent* becomes eligible for assistance with payment of *employee* contributions to this *Plan* through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or *dependent* requests enrollment in this *Plan* within sixty (60) days after the date the *employee* or *dependent* is determined to be eligible for such assistance.

If a *dependent* becomes eligible to enroll under this provision and the *employee* is not then enrolled, the *employee* must enroll in order for the *dependent* to enroll.

B. Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA generally prohibits discrimination in group premiums based on *genetic information* and the use of *genetic information* as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of *genetic information* in group health plan coverage. GINA provides clarification with respect to the treatment of *genetic information* under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Mental Health Parity and Addiction Equity Act of 2008

Regardless of any limitations on benefits for *mental disorders/substance use disorder* treatment otherwise specified in the *Plan*, any aggregate lifetime limit, annual limit, financial requirement, *non-network* exclusion, or treatment limitation on *mental disorders/substance use disorder* benefits imposed by the *Plan* shall comply with federal parity requirements, if applicable.

D. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not do any of the following:

1. restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section
2. set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) or ninety-six (96) hours, as applicable, stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay
3. require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours, as applicable

However, the plan or issuer may pay for a shorter stay than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a delivery by cesarean section if the attending provider (e.g., your *physician*, nurse midwife, or *physician* assistant), discharges the mother or newborn after consultation with the mother.

E. Non-Discrimination Policy

This *Plan* will not discriminate against any *plan participant* based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This *Plan* will not establish rules for eligibility based on health status, medical condition, *claims* experience, receipt of health care, medical history, evidence of insurability, *genetic information*, or disability.

This *Plan* intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986. If the *Plan Administrator* determines before or during any *plan year* that this *Plan* may fail to

satisfy any non-discrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated individuals, the *Plan Administrator* shall take such action as the *Plan Administrator* deems appropriate, under rules uniformly applicable to similarly situated covered *employees*, to assure compliance with such requirements or limitation.

F. Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

Employees going into or returning from military service may elect to continue *Plan* coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) under the following circumstances. These rights apply only to *employees* and their *dependents* covered under the *Plan* immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's *dependents* under such an election shall be the lesser of:
    a. the twenty-four (24) month period beginning on the date on which the person's absence begins
    b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the *Plan*, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or *waiting period* may not be imposed in connection with the reinstatement of coverage upon re-employment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or *waiting period* may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been *incurred* in, or aggravated during, the performance of *uniformed service*.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator* as outlined in the Quick Reference Information Chart. The *employee* may also have continuation rights under *USERRA*. In general, the *employee* must meet the same requirements for electing *USERRA* coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The *employee* may elect *USERRA* continuation coverage for the *employee* and their *dependents*. Only the *employee* has election rights. *Dependents* do not have any independent right to elect *USERRA* health plan continuation.

G. Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered *mastectomy*.

The *Plan* will pay charges *incurred* for a *plan participant* who is receiving benefits in connection with a *mastectomy* and then elects breast reconstruction in connection with the *mastectomy*. Coverage will include:

1. reconstruction of the breast on which the *mastectomy* has been performed
2. *surgery* and reconstruction of the other breast to produce a symmetrical appearance
3. prosthesis and treatment of physical complications of all stages of *mastectomy*, including lymphedemas

SECTION XIX—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the *employer's* workforce perform services in connection with administration of the *Plan*. In order to perform these services, it is necessary for these *employees* from time to time to have access to Protected Health Information (PHI) (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the *Privacy Standards*), these *employees* are permitted to have such access subject to the following:

1. **General.** The *Plan* shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this **Compliance with HIPAA Privacy Standards** section is met. 'Protected Health Information' shall have the same definition as set out in the *Privacy Standards* but generally shall mean individually identifiable health information about the past, present, or future physical or *mental health* condition of an individual, including information about treatment or payment for treatment.
2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to business associates and members of the *employer's* workforce shall be used or disclosed by them only for purposes of *Plan* administrative functions. The *Plan's* administrative functions shall include all *Plan* payment and health care operations. The terms 'payment' and 'health care operations' shall have the same definitions as set out in the *Privacy Standards*, but the term 'payment' generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill *Plan* responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. 'Health care operations' generally shall mean activities on behalf of the *Plan* that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating, and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. *Genetic information* will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The *Plan* shall disclose Protected Health Information only to members of the *employer's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the *Plan*. For purposes of this **Compliance with HIPAA Privacy Standards** section, members of the *employer's* workforce shall refer to all *employees* and other persons under the control of the *employer*.
    a. **Updates Required.** The *employer* shall amend the *Plan* promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the *Plan*.
    c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the *Privacy Standards*, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised
        ii. applying appropriate sanctions against the person(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment
        iii. mitigating any harm caused by the breach, to the extent practicable
        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages
        v. providing *notification* in accordance with HIPAA requirements
4. **Certification of Employer.** The *employer* must provide certification to the *Plan* that it agrees to all of the following:

a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law

b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the *Plan* agrees to the same restrictions and conditions that apply to the *employer* with respect to such information

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *employer*

d. report to the *Plan* any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law

e. make available Protected Health Information to individual *Plan* members in accordance with Section 164.524 of the *Privacy Standards*

f. make available Protected Health Information for amendment by individual *Plan* members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the *Privacy Standards*

g. make available the Protected Health Information required to provide any accounting of disclosures to individual *Plan* members in accordance with Section 164.528 of the *Privacy Standards*

h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the *Plan* available to the Department of Health and Human Services for purposes of determining compliance by the *Plan* with the *Privacy Standards*

i. if feasible, return or destroy all Protected Health Information received from the *Plan* that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible

j. ensure the adequate separation between the *Plan* and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the *Privacy Standards*

5. The following members of Kentucky Rural Electric Cooperative's workforce are designated as authorized to receive Protected Health Information from Kentucky Rural Electric Cooperative Employers Benefit Plan (*Plan*) in order to perform their duties with respect to the *Plan*:

   a. Chief Executive Office

   b. Bookkeeper

B. Compliance with HIPAA Electronic Security Standards

Under the *Security Standards* for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the *Security Standards*), the *employer* agrees to the following:

1. The *employer* agrees to implement *reasonable* and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the *employer* creates, maintains, or transmits on behalf of the *Plan*. Electronic Protected Health Information shall have the same definition as set out in the *Security Standards*, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement *reasonable* and appropriate security measures to protect the Electronic Protected Health Information.

3. The *employer* shall ensure that *reasonable* and appropriate security measures are implemented to comply with the conditions and requirements set forth in **Compliance with HIPAA Privacy Standards**, provisions Authorized Employees and Certification of Employers described above.

SECTION XX—DEFINED TERMS

The following terms have special meanings and will be italicized when used in this *Plan*. The failure of a term to appear in italics does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Active Employment

Performance by the *employee* of all the regular duties of their occupation at an established business location of the participating *employer*, or at another location to which they may be required to travel to perform the duties of their employment. An *employee* shall be deemed actively at work if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered actively at work if they have effectively terminated employment.

Adoptive Cell Therapy

A type of immunotherapy in which T cells (a type of immune cell) are given to a patient to help the body fight diseases, such as cancer. In cancer therapy, T cells are usually taken from the patient's own blood or tumor tissue, grown in large numbers in the laboratory, and then given back to the patient to help the immune system fight the cancer. Sometimes, the T cells are changed in the laboratory to make them better able to target the patient's cancer cells and kill them. Types of adoptive cell therapy include, but not limited to, chimeric antigen receptor T-cell (CAR T-cell) therapy and tumor-infiltrating lymphocyte (TIL) therapy. Also called adoptive cell transfer, *cellular adoptive immunotherapy*, and T-cell transfer therapy.

Adverse Benefit Determination

Any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Charges

The *maximum amount/maximum allowable charge* for any *medically necessary*, eligible item of expense, at least a portion of which is covered under a plan. When some *other plan* pays first in accordance with the Application to Benefit Determinations subsection in the **Coordination of Benefits** section herein, this *Plan's* allowable charges shall in no event exceed the *other plan's* allowable charges. When some *other plan* provides benefits in the form of services rather than cash payments, the *reasonable* cash value of each service rendered, in the amount that would be payable in accordance with the terms of the *Plan*, shall be deemed to be the benefit. Benefits payable under any *other plan* include the benefits that would have been payable had *claim* been duly made therefore.

Alternate Recipient

Any child of a *plan participant* who is recognized under a *medical child support order* as having a right to enrollment under this *Plan* as the *plan participant's* eligible *dependent*. For purposes of the benefits provided under this *Plan*, an alternate recipient shall be treated as an eligible *dependent*, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a *plan participant*.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Applied Behavioral Analysis (ABA) Therapy

Applied Behavioral Analysis (ABA) Therapy is an umbrella term describing principles and techniques used in the assessment, treatment, and prevention of challenging behaviors and the promotion of new desired behaviors.

The goal of ABA Therapy is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. ABA Therapy is a combination of services for adaptive behavior treatment, which applies the principles of how people learn and motivations to change behavior. ABA Therapy is designed to address multiple areas of behavior and function such as to increase language and communication, enhance attention and focus, and help with social skills and memory. It generally includes psychosocial interventions, should address factors that may exacerbate behavioral challenges, and is most effective when initiated as soon as feasible after diagnosis is made.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other *life-threatening disease or condition* and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one (1) or more of the following:
    a. The National Institutes of Health
    b. The Centers for Disease Control and Prevention
    c. The Agency for Health Care Research and Quality
    d. The Centers for Medicare and Medicaid Services
    e. a cooperative group or center of any of the entities described in sub-clauses a. through d. above, the Department of Defense, or the Department of Veterans Affairs
    f. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
    g. any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by *qualified individuals* who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs
        ii. The Department of Defense
        iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Assignment of Benefits

An arrangement by which a patient may request that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the *plan participant* authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility.

Authorized Representative

An authorized representative is a person or organization a *plan participant* has designated to act on their behalf to submit or *appeal* a *claim*. By authorizing a person or organization to act on your behalf, you are giving them permission to see your Protected Health Information (PHI) and act on all matters related to your *claim* and/or *appeal*. If you choose to authorize a person to act on your behalf, all future communications shall be with the designee. Where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Balance Bill/Surprise Bill

Balance bill refers to the difference between a *non-network provider's* total billed charges and the *allowable charges* off of which the *Plan* will base its reimbursement.

Non-network providers have no obligation to accept the *allowable charge* as payment in full. You are responsible to pay a *non-network provider's* billed charges, even though the *Plan's* reimbursement is based on the *allowable charge*. Any amounts paid for balance bills do not count toward the *deductible*, *co-insurance*, or *out-of-pocket limit*.

Refer to the **Consolidated Appropriations Act of 2021 and Transparency in Coverage Regulations** section for additional provisions pertaining to *non-network* surprise billing *claims*.

Benefit Determination

The *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Birthing Center

Any freestanding health facility, place, professional office, or *institution* which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide the following:

1. facilities for obstetrical delivery and short-term recovery after delivery
2. care under the full-time supervision of a *physician* and either a registered nurse (R.N.) or a licensed nurse-midwife
3. have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement

Blue Distinction Center

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

See also *Center of Excellence*.

Brand Name

A trade name medication.

Calendar Year/Benefit Year

January 1st through December 31st of the same year. All *deductibles* and benefit maximums accumulate during the calendar year.

Cellular Immunotherapy

A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases. Some types of immunotherapy only target certain cells of the immune system. Others affect the immune system in a general way. Types of immunotherapy include cytokines, vaccines, bacillus Calmette-Guerin (BCG), and some monoclonal antibodies.

Center of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The *Plan Administrator* shall determine what *network* Centers of Excellence are to be used.

Any *plan participant* in need of an organ transplant may contact the *Third Party Administrator* as outlined in the Quick Reference Information Chart to initiate the *pre-certification* process resulting in a referral to a Center of Excellence. The *Third Party Administrator* acts as the primary liaison with the Center of Excellence, patient, and attending *physician* for all transplant admissions taking place at a Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to *plan participant(s)* and updated as requested.

Claim

Any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, in accordance with a *Plan's* reasonable procedure for filing benefit claims.

Some requests made to the *Plan* are specifically not claims for benefits; for example:

1. an inquiry as to eligibility which does not request benefits
2. a request for prior approval where prior approval is not required by the *Plan*
3. casual inquiries about benefits such as verification of whether a service/item is a covered benefit or the estimated cost for a service

Claimant

Any *plan participant* or beneficiary making a *claim* for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words 'you' and 'your' are used interchangeably with 'claimant.'

Claims Administrator

See *Third Party Administrator*.

Clean Claim

A *claim* that can be processed in accordance with the terms of this plan document without obtaining additional information from the service provider or a third party. It is a *claim* which has no defect, impropriety, or special circumstance that delays *timely payment*. A clean *claim* does not include:

1. *claims* under investigation for fraud and abuse
2. *claims* under review for *medical necessity*
3. fees under review for *usual and customariness* and *reasonableness*
4. any other matter that may prevent the expense(s) from being considered a *covered charge*

The claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A *claim* will not be considered to be a clean claim if the *participant* has failed to submit required forms or additional information to the *Plan* as well.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Care Claim

A *Plan* decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Co-Payment

A specific dollar amount a *plan participant* is required to pay and is typically payable to the health care provider at the time services or supplies are rendered.

Cost Sharing Amounts

The dollar amount a *plan participant* is responsible for paying when covered services are received from a provider. Cost sharing amounts include *co-insurance*, *co-payments*, *deductible* amounts, and *out-of-pocket limits*. Providers may bill you directly or request payment of *co-insurance* and/or *co-payments* at the time services are provided. Refer to the applicable Schedules of Benefits for the specific cost sharing amounts that apply to this *Plan*.

Courtesy Review

A pre-service review of requested services for benefits which are neither on the pre-certification list nor an exclusion of the *Plan*.

Covered Charges

The *maximum allowable charge* for a *medically necessary* service, treatment, or supply, meant to improve a condition or *plan participant's* health, which is eligible for coverage in this *Plan*. Covered charges will be determined based upon all other *Plan* provisions. When more than one (1) treatment option is available, and

one (1) option is no more effective than another, the covered charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the applicable Schedule of Medical Benefits section and as determined elsewhere in this document.

Custodial Care

Care (including *room and board* needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. The following are examples of custodial care:

1. help in walking and getting out of bed
2. assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered

Deductible

A specified portion of the *covered charges* that must be *incurred* by a *plan participant* before the *Plan* has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent

For information regarding eligibility for dependents, refer to the section entitled **Eligibility, Effective Date, and Termination Provisions**.

Developmental Delay

A delay in the appearance of normal developmental milestones achieved during infancy and early childhood, caused by organic, psychological, or environmental factors. Conditions are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.

Diagnosis Related Grouping (DRG)

A method for reimbursing *hospitals* for *inpatient* services. A DRG amount can be higher or lower than the actual billed charge because it is based on an average for that grouping of diagnoses and procedures.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a *disease* or condition. It must be ordered by a *physician* or other professional provider.

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the *Plan* is furnished showing that the individual concerned is covered as an *employee* under any workers' compensation law, occupational disease law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one (1) not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the *Plan*, be regarded as a *sickness*, *illness*, or disease.

Durable Medical Equipment (DME)

Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an *illness* or *injury*, and is appropriate for use in the home.

Emergency

A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, and hemorrhage. Other emergencies and acute conditions

may be considered on receipt of proof, satisfactory to the *Plan*, that an emergency did exist. The *Plan* may, at its own discretion, request satisfactory proof that an emergency or acute condition did exist.

Emergency Medical Condition

A medical condition of recent onset and severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.

Emergency Services

A medical screening examination [as required under Section 1867 of the Social Security Act (EMTALA)] within the capability of the *hospital* emergency department, including routine ancillary services, to evaluate a *medical emergency* and such further medical examination and treatment as are within the capabilities of the staff and facilities of the *hospital* and required under EMTALA to stabilize the patient.

Employee

A person who is active on the regular payroll of the *employer*, has begun to perform the duties of their job with the *employer*, and is regularly scheduled to work for the *employer* on a full basis in an employee/*employer* relationship.

Employer

Kentucky Rural Electric Cooperative

Enrollment Date

The first day of coverage, or if there is a *waiting period*, the first day of the *waiting period*.

Essential Health Benefits

Benefits set forth under the *Patient Protection and Affordable Care Act of 2010* (*PPACA*), including the categories listed in the state of Kentucky benchmark plan.

Experimental/Investigational

Services, supplies, care, and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The *Plan Administrator* must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The *Plan Administrator* shall be guided by a reasonable interpretation of *Plan* provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the *claim* and the proposed treatment. The decision of the *Plan Administrator* will be final and binding on the *Plan.* The *Plan Administrator* will be guided by the following principles, any of which comprise a definition of experimental/investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished
2. if the drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval
3. if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis
4. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its

maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis

'Reliable evidence' shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility, or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Benefits covered under the Clinical Trials provision are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care, and/or treatments are considered experimental, investigative, or unproven.

Explanation of Benefits (EOB)

A document sent to the *plan participant* by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination*, under applicable state or federal external review procedures.

Family Unit

The covered *employee* and the family members who are covered as *dependents* under the *Plan*.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the *Plan* or the disposition of its assets, renders investment advice to the *Plan*, or has discretionary authority or responsibility in the administration of the *Plan*.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two (2) levels of *appeals*, the second-level *appeal* results in a final internal *adverse benefit determination* that triggers the right to *external review*.

FMLA Leave

A *leave of absence* which the *employer* is required to extend to an *employee* under the provisions of the FMLA.

Formulary

A list of prescription medications compiled by the third-party payer of safe and effective therapeutic drugs specifically covered by this *Plan*.

Gene Therapy

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. It is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

1. replacing a disease-causing gene with a healthy copy of the gene
2. inactivating a disease-causing gene that is not functioning properly
3. introducing a new or modified gene into the body to help treat a disease

Generic Drug

A *prescription drug* which has the equivalency of the *brand name* drug with the same use and metabolic disintegration. This *Plan* will consider as a generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information

Information about the genetic tests of an individual or their family members and information about the manifestations of *disease* or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested *disease*, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

The *Plan* complies with Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) as it applies to group health plans.

Habilitative Services/Habilitation Services

Treatment and services that help a *plan participant* keep, learn, or improve skills and functions for daily living that they may not be developing as expected for their age range. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Health Savings Account (HSA)

A tax-exempt or custodial account that you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you *incur*. You must be eligible to qualify for an HSA (refer to the **Schedule of Benefits** section of this document). Both *employer* and *employee* may contribute to an *HSA* in the same year. Annual contribution limits are subject to IRS guidelines. Participation in a qualified *high deductible health plan* is required for participation in an *HSA* program.

High Deductible Health Plan (HDHP)

A medical plan with lower premiums and a minimum *deductible* amount, set forth by federal law, which is higher than a traditional health plan *deductible*.

Home Health Care Agency

An organization that meets all of these tests: its main function is to provide *home health care services and supplies*; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan

Must meet these tests: it must be a formal written plan made by the patient's attending *physician* which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the home health care is in place of *hospital* confinement; and it must specify the type and extent of *home health care services and supplies* required for the treatment of the patient.

Home Health Care Services and Supplies

Include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a *home health care agency* (this does not include general housekeeping services); physical, occupational, and speech therapy; medical supplies; and laboratory services by or on behalf of the *hospital*.

Hospice Care Agency

An organization whose main function is to provide *hospice care services and supplies* and is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan

A plan of terminal patient care that is established and conducted by a *hospice care agency* and supervised by a *physician*.

Hospice Care Services and Supplies

Provided through a *hospice care agency* and under a *hospice care plan* and includes *inpatient* care in a *hospice unit* or other licensed facility, and home health care, and family counseling during the bereavement period.

Hospice Unit

A facility or separate *hospital* unit that provides treatment under a *hospice care plan* and admits at least two (2) unrelated persons who are expected to die within six (6) months.

Hospital (Acute or Long-Term Acute Care Facility)

A provider licensed and operated as required by law, which provides all of the following and is fully accredited by The Joint Commission:

1. room, board, and nursing care
2. a staff with one (1) or more doctors on hand at all times
3. twenty-four (24) hour nursing service
4. all the facilities on site are needed to diagnose, care, and treat an *illness* or *injury*

The term hospital does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care
7. subacute care

Refer to the defined terms for *Residential Treatment Facility* and *Substance Use Disorder/Mental Health Treatment Center* for the specific requirements applicable to those facility types.

Illness

For a covered *employee* and covered spouse: a bodily disorder, *disease*, physical illness, or *mental disorder*. Illness includes *pregnancy*, childbirth, miscarriage, or complications of *pregnancy*.

For a covered dependent other than spouse: a bodily disorder, *disease*, physical illness, or *mental disorder*, not including *pregnancy* or its complications.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Review Organization (IRO)

An entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

Infertility

Incapable of producing offspring.

Injury

An *accidental bodily injury*, which does not arise out of, which is not caused or contributed by, and which is not a consequence of, any employment or occupation for compensation or profit.

In-Network

See *Network*.

Inpatient

Treatment in an approved facility during the period when charges are made for *room and board*.

Institution

A facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community *mental health* center, *residential treatment facility*, psychiatric treatment facility, *substance use disorder treatment center*, alternative *birthing center*, home health care center, or any other such facility that the *Plan* approves.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a *hospital* solely for the care and treatment of patients who are critically *ill*. This also includes what is referred to as a coronary care unit or an acute care unit. It has facilities for special nursing care not available in regular rooms and wards of the *hospital*; special lifesaving equipment which is immediately available at all times; at least two (2) beds for the accommodation of the critically *ill*; and at least one (1) registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Late Enrollee

A *plan participant* who enrolls under the *Plan* other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the *Plan* or during a special enrollment period.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted livings.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem.

This includes services performed solely to preserve the present level of function or prevent regression for an *Illness*, *injury*, or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. the negotiated rate established in a contractual arrangement with a provider
4. the *usual and customary* and/or *reasonable* amount
5. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of forty (40) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of forty (40) (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty-five (35) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)

4. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of thirty-five (35) (or 120% of the 95th percentile in an age and sex matched growth chart) or greater and a clinically serious condition related to obesity [e.g. type 2 diabetes, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, Blount disease (tibia vara), slipped capital femoral epiphysis]
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a *non-participating provider* within the designated *network* area.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Plan

Kentucky Rural Electric Cooperative Employers Benefit Plan, which is a benefits plan for certain *employees* of Kentucky Rural Electric Cooperative and is described in this document. Kentucky Rural Electric Cooperative Employers Benefit Plan is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Kentucky Rural Electric Cooperative, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Kentucky Rural Electric Cooperative

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.
3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the **Health Care Management Program**).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**. For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, pediatricians, internists, OBGYNs, gynecologists, certified nurse midwife, chiropractor, nurse practitioner, physician assistant, and clinical/multi-specialty group.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.

5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. *room*, *board*, and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, *long-term acute care facility*, or any other similar nomenclature.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

    This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.
7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.

SECTION XXI—PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Kentucky Rural Electric Cooperative, hereby adopts the provisions of this Kentucky Rural Electric Cooperative Employers Benefit Plan, and its duly authorized officer has executed this summary plan description effective the first day of January 2023.

Commented [ALW3]: Signature lines will be added upon approval of this document

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-844-209-0071.

P.O. Box 7186
Boise ID 83707

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coverage Period: 01/01/2023 – 12/31/2023
Taylor County RECC: HDHP Plan Option
Coverage for: Individual and Family | **Plan Type:** HDHP

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 1-844-209-0071. 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.MyAmeriBen.com or call 1-844-209-0071 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	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.
	Per participant:	$1,500	$3,000	
	Per family:	$3,000	$6,000	
Are there services covered before you meet your deductible?	Yes, for preventive care services when performed in network.			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?	**Co-Insurance Out-of-Pocket Maximum**			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.
		Network	**Non-Network**	
	Per participant:	$2,000	$4,000	
	Per family:	$4,000	$8,000	
	Overall Out-of-Pocket Maximum			
		Network	**Non-Network**	
	Per participant:	$3,500	Unlimited	
	Per family:	$7,000	Unlimited	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	non-medically necessary services.	
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-833-835-2714for a list of network providers. **Yes, for prescription drugs:** Navitus and Pillar Rx. For a list of retail and mail pharmacies, log on to www.navitus.com or call 1-866-378-4755.	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
		Network Provider (You will pay the least)	Non-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% co-insurance after deductible	30% co-insurance after deductible	——————————none——————————
	Specialist visit	10% co-insurance after deductible	30% co-insurance after deductible	——————————none——————————
	Preventive care/screening/ immunization	No Charge	30% co-insurance, deductible waived	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	30% co-insurance after deductible	——————————none——————————
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	30% co-insurance after deductible	Includes computed tomographic (CT) studies, coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans (excluding services rendered in an emergency room setting). **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $100 per occurrence.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Generic drugs	**Retail (34-Day Supply):** 10% co-insurance after deductible **Retail/Mail Order (90-Day Supply):** 10% co-insurance after deductible **OTC Proton Pump Inhibitors and Non-Sedating Anti-Histamines:** 10% co-insurance after deductible **Preventive Rx:** No charge	Not covered	**Retail/Mail Order Prescriptions:** Up to ninety (90) day supply. **Specialty Prescriptions:** Up to thirty (30) day supply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.navitus.com.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	**Retail (30-Day Supply):** 10% co-insurance after deductible **Retail/Mail Order (90-Day Supply):** Not Covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $100 per occurrence.
	Physician/surgeon fees	10% co-insurance after deductible	30% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	**True Medical Emergency:** 10% after network deductible **Non-Emergency Care:** 10% co-insurance after deductible		——————————none——————————
	Emergency medical transportation	10% co-insurance after network deductible		**Pre-certification is required** for non-emergent air ambulance and chartered flights. Failure to obtain pre-certification may reduce

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				benefits by $100 per occurrence.
	Urgent care	10% co-insurance after deductible	30% co-insurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $100 per occurrence.
	Physician/surgeon fees	10% co-insurance after deductible	30% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance after deductible	30% co-insurance after deductible	Intensive psychiatric day treatment and partial hospitalization are included in this benefit.
	Inpatient services	10% co-insurance after deductible	30% co-insurance after deductible	Residential treatment facility services are included in this benefit. **Pre-certification is required** for inpatient stays**.** Failure to obtain pre-certification may reduce benefits by $100 per occurrence.
If you are pregnant	Office visits	10% co-insurance after deductible	30% co-insurance after deductible	Dependent daughter pregnancy is not covered. Cost-sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% co-insurance after deductible	30% co-insurance after deductible	
	Childbirth/delivery facility services	10% co-insurance after deductible	30% co-insurance after deductible	
If you need help recovering or have other special needs	Home health care	10% co-insurance after deductible	30% co-insurance after deductible	——————none——————
	Rehabilitation services	10% co-insurance after deductible	30% co-insurance after deductible	**ABA Therapy Monthly Maximum:** $500 per plan participant. **Pre-certification is required** for physical therapy and occupational therapy in excess of ten (10) visits per calendar year per therapy type**.** Failure to obtain pre-certification may reduce benefits by $100 per occurrence.
	Habilitation services	10% co-insurance after deductible	30% co-insurance after deductible	
	Skilled nursing care	10% co-insurance after deductible	30% co-insurance after deductible	**Benefit Maximum:** Sixty (60) days per sickness or injury per plan participant, combined with rehabilitation facilities. **Pre-certification is required.** Failure to obtain

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				pre-certification may reduce benefits by $100 per occurrence.
	Durable medical equipment	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required** for DME purchases and rentals in excess of $500. Failure to obtain pre-certification may reduce benefits by $100 per occurrence.
	Hospice services	10% co-insurance after deductible	30% co-insurance after deductible	——————none——————
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
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Routine Eye Care (Adult)
- 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 – limited to $1,000 per calendar year
- Hearing Aids – limited to $5,000 every five (5) years
- Private Duty Nursing – not covered when plan participant is in a hospital or other qualified treatment facility
- Routine Foot Care – for treatment of metabolic or peripheral-vascular disease

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact Isolved at 1-800-594-6957. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
You may also contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

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

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-844-209-0071

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 1-844-209-0071.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-209-0071.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-209-0071.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-209-0071.

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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 cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	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	$500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,000**

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 cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	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	$70
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,570**

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

The plan's overall deductible	$1,500
Specialist cost sharing	10%
Hospital (facility) cost sharing	10%
Other cost sharing	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.

Humana
Group Medicare
Advantage

Humana Medicare Employer Plan – Rating Assumptions and Stipulations

TAYLOR COUNTY RECC

Proposal Terms

The benefits presented on the previous page are a high-level summary. Please consult the Plan Design Exhibit for a more detailed outline of the benefits proposed. Final benefits may differ due to annual changes in CMS benefit requirements.

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana will hold the proposed rate(s) unless there are material changes to existing or implementation of new federal regulations or requirements, and/or any unforeseen/unusual circumstances (i.e. pandemic) that would impact Group Medicare.

Humana will hold the proposed rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

All members are retired and enrolled in Medicare Part A and/or Part B.

A minimum average employer contribution level of 76% of the proposed premium for the plan.

A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.

Enrolled membership should not change from current, or differ from the information provided, by more than 10% per year. This proposal assumes 34 currently enrolled members.

Humana's Medicare Advantage plan is the only plan offered and there is no additional secondary plan wrapping around or offered in conjunction with this plan for all current and future Medicare eligible retirees.

Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.

Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy TrOOP accumulators will be reset on January 1 each year.

We are pleased to present this Humana Group Medicare Advantage proposal to you and assume all information provided is accurate with the understanding if there is a material change from the current offering environment, Humana has the right to revise or rescind the quote.

Humana Group Medicare Advantage

HUMANA MEDICARE EMPLOYER Rx PLAN

2023 Rx for Standard Plan Rx 127
Group Plus Formulary - PDG 2

30 day Supplies

Plan/ Option	30 day Standard Retail from $0 to Catastrophic (1)				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$20	$40	$80	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($80 maximum out-of-pocket per prescription)	$7,400

Plan/ Option	30 day Standard Mail Order from $0 to Catastrophic (1)				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$20	$40	$80	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($80 maximum out-of-pocket per prescription)	$7,400

*Tier 1: Generic or Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

Humana Group Medicare Advantage

90 day Supplies

Plan/ Option	90 day Standard Retail (2) from $0 to Catastrophic (1)				90 day Standard Retail (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$30	$60	$120	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($120 maximum out-of-pocket per prescription)	$7,400

Plan/ Option	90 day Standard Mail Order (2) from $0 to Catastrophic (1)				90 day Standard Mail Order (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$0	$40	$80	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($80 maximum out-of-pocket per prescription)	$7,400

Footnotes
1 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,400.
2 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations
When a member purchases a drug at an out-of-network pharmacy in an emergency situation:
a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,
b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price, not to include maximums.

Humana
Group Medicare
Advantage

Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

Humana Group Medicare Advantage

HUMANA MEDICARE EMPLOYER LPPO PLAN

2023 LPPO for Standard Plan 079 Option 064 - Passive

		2022		2023	
Annual Maximum Out-of-Pocket		• In-Network: $1,000 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Extra Services and the Plan Premium). • Combined In and Out-of-Network: $1,000 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Extra Services, Worldwide Coverage and the Plan Premium).		• In-Network: $0 per individual per plan year (excludes Part D Pharmacy, Extra Services and the Plan Premium). • Combined In and Out-of-Network: $0 per individual per plan year (excludes Part D Pharmacy, Extra Services, Worldwide Coverage and the Plan Premium).	
Annual Deductible		• Combined In and Out-of-Network: NONE • Combined In-Network Exclusions: N/A • Combined Out-of-Network Exclusions: N/A		• Combined In and Out-of-Network: NONE • Combined In-Network Exclusions: N/A • Combined Out-of-Network Exclusions: N/A	
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Non-Network Coverage Plan Pays (1):	Network Coverage Plan Pays (1):	Non-Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Surgical Procedures	100%	100%	100%	100%
	• Allergy Shots and Injections	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%	100%	100%
Specialist	• Office Visit	100%	100%	100%	100%
	• Advanced Imaging Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Surgical Procedures	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
	• Podiatry Services (Medicare-covered)	100%	100%	100%	100%
	• Chiropractic Services (Medicare-covered)	100%	100%	100%	100%
	• Cardiac Therapy	100%	100%	100%	100%
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%	100%	100%
	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
	• Allergy Shots and Injections	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%	100%	100%
	• Chemotherapy Drugs	100%	100%	100%	100%
	• Dental Services (Medicare-covered)	100%	100%	100%	100%
	• Hearing Services (Medicare-covered)	100%	100%	100%	100%
	• Vision Services (Medicare-covered)	100%	100%	100%	100%
	• Eyewear for Post-Cataract Surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%	100%	100%
	• Acupuncture (Medicare-covered) • Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. • Limited to 20 combined visit(s) per year	100%	100%	100%	100%

Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening • Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit	100%	100%	100%	100%
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% per admission	100% per admission	100% per admission	100% per admission
	• Inpatient Physician Services	100%	100%	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission	100% per admission	100% per admission	100% per admission
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
Outpatient Hospital	• Surgical Services	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
	• Advanced Imaging Services	100%	100%	100%	100%
	• Nuclear Medicine Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
	• Cardiac Therapy	100%	100%	100%	100%
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%	100%	100%
	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
	• Chemotherapy Drugs	100%	100%	100%	100%
	• Renal Dialysis Services	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
	• Outpatient Physician Services	100%	100%	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%	100%	100%
Urgent Care Center	• Urgently Needed Care	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
Emergency Room	• Emergency Services (2)	100%	100%	100%	100%
	• Emergency Room Physician Services	100%	100%	100%	100%
Ambulance	• Ambulance Services	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation
Travel Benefit	• US Travel Benefit	Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	N/A	Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	N/A

Humana Group Medicare Advantage

Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	N/A	80% coinsurance limited to emergency Medicare-covered services. $100 deductible per year, $25,000 Maximum Benefit per year or 60 consecutive days, whichever is reached first.	N/A	80% coinsurance limited to emergency Medicare-covered services. $100 deductible per year, $25,000 Maximum Benefit per year or 60 consecutive days, whichever is reached first.
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
Freestanding Radiological Facility	• Advanced Imaging Services	100%	100%	100%	100%
	• Nuclear Medicine Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
Ambulatory Surgical Center	• Surgical Procedures	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
Freestanding Laboratory	• Lab Services	100%	100%	100%	100%
Dialysis Center	• Renal Dialysis Services	100%	100%	100%	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	100%	100%	100%	100%
	• Diabetic Monitoring Supplies	100%	100%	100%	100%
Medical Supply Provider	• Medical Supplies	100%	100%	100%	100%
Prosthetics Provider	• Prosthetics	100%	100%	100%	100%
Pharmacy (Part B Only)	• Durable Medical Equipment	100%	100%	100%	100%
	• Medical Supplies	100%	100%	100%	100%
	• Diabetic Monitoring Supplies	100%	100%	100%	100%
	• Medicare-covered Part B Drugs	100%	100%	100%	100%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	N/A	100%	N/A
	• Specialist - Virtual Visit	100%	N/A	100%	N/A
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	N/A	100%	N/A
	• Urgently Needed Care - Virtual Visit	100%	N/A	100%	N/A
Other Benefits	• COVID-19 Testing and Treatment - Based on Place of Treatment (POT)	•100%	•100%	•Available	•Available

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.			
Extra Benefits (MSB)	• SilverSneakers®	Available	Available
	• Personal Health Coaching	Available	Available
	• Smoking Cessation (Additional)	Available	Available
	• Meal Program	Available	Available
	• Post-Discharge Transportation Services	Available	Available
	• Post-Discharge Personal Home Care	Available	Available
Care Management	• **Clinical Programs/Disease Management (3)** *- Case Management* *- Humana at Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Available	Available

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.
2023 COVID-19 Testing and Treatment Update: Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.

Humana

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card. CMS does not permit discussing the below services with potential enrollees prior to enrollment.			
Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Available	Available
	• Dental Discount (Florida GoldPlus) - Available in Florida only	Available	Available
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Available	Available
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Available	Available
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Available	Available
	• Lifeline® Medical Alert Systems	Available	Available
	• Meal Delivery Discount (Freshly) - Not available in Alaska, Hawaii or Puerto Rico	Available	Available
	• Meal Delivery Discount (Mom's Meals)	Available	Available
	• Bill Management Service (Silver Bills)	Not Available	Available
	• Vision Discount (EyeMed)	Available	Available

Go365® by Humana is included in this plan:
Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Certain services under the plan require authorization by network providers. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

Humana.

Taylor County RECC
Mr. Jeff Williams

Humana Group Medicare Advantage Plan Renewal

In signing this document, you are accepting the renewal, effective January 1, 2023, of the Group Medicare plan(s) submitted by your Humana Account Executive and described in the enclosed renewal package. **The new rate is effective January 1, 2023. It is important that we receive acceptance of your renewal no later than October 1, 2022. This will ensure we meet CMS requirements and provide on-time delivery of member materials.**

2023 Plan/Option: LPPO 064 W/RX # 127 2023 Rate: $362.12

You, the Plan Sponsor, understand, acknowledge, and agree that:

- You have carefully reviewed the enclosed renewal package.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase premium, or terminate an individual's coverage or the plan coverage.
- The Plan Sponsor can subsidize different premium amounts for different classes of enrollees in a plan provided: 1) such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly), 2) the premium cannot vary for individuals within a given class of enrollees, and 3) the Plan Sponsor must pass through any direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or in those instances where the subscriber to or participant in the plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays). With regard to the Part D premium, different classes of enrollees cannot be based on eligibility for the Part D Low-Income Subsidy (LIS).
- If plan enrollees are entitled to a reduction of their premium as Part D LIS enrollees and Humana receives a Low-Income Premium Subsidy for such enrollees, Humana will pass the Low-Income Premium Subsidy amount through to the LIS enrollees to reduce their premiums.
- With regard to the Part D premium, the Plan Sponsor cannot charge an enrollee for prescription drug coverage provided under the PDP/MAPD plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any).

Organization: TAYLOR COUNTY RECC

Signature: [signature]

Title: CEO

Date: 9-23-22

Important reminder: Please sign and return the enclosed "Humana Group Medicare Advantage Plan Renewal" form no later than **October 1, 2022** to accept the plan's benefits and rates and continue the plan in the coming year.

Y0040_GHHKSAMEN_042022_C

DELTA DENTAL®

Delta Dental PPO Plus Premier

Our national Preferred Provider Program

Welcome!

Your dental program is administered by Delta Dental of Kentucky, Inc., a Kentucky not-for-profit dental service corporation. Delta Dental of Kentucky is the Commonwealth's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at (800) 955-2030 or access our website at www.deltadentalky.com.

You can easily verify your own benefits, claims and eligibility information online 24 hours a day, seven days a week by visiting www.deltadentalky.com and selecting the Consumer Toolkit. The Consumer Toolkit will also allow you to print claim forms, ID cards, explanation of benefits (EOBs), review your claims status, choose to receive paperless EOBs, search our Dentist directories, read oral health tips and more.

We look forward to serving you!

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Note: Please read this Certificate with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental Plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to this Plan and you should ignore the conflicting statement in this Certificate.

1. Delta Dental PPO Plus Premier Certificate

Delta Dental of Kentucky, Inc., issues this Certificate to you, the Subscriber. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and your employer or organization.

The Benefits provided under This Plan are subject to change as required by any state or federal law.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

2. Definitions

This section defines terms having special meanings in the Certificate and Summary of Dental Plan Benefits. A word or phrase starting with a capital letter has a special meaning. It is defined either in this Definitions section or in the text itself.

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a claim; or any failure to make payment (in whole or in part) for the benefits you sought, including any determination based on eligibility.

Alternate Benefit

A Benefit provided in cases where alternative methods of treatment exist for the same Dental Service. In this case, Benefits are provided for the least costly, professionally acceptable treatment. This is a determination of Benefits under this Plan. It is not a recommendation of which service should be provided. The Dentist and patient should decide the course of treatment. If the dental procedure used is different from the procedure covered under this Certificate, the Dentist may bill the patient for the difference between the Maximum Approved Fee for the service provided and the amount paid by Delta Dental for the claim.

Benefit Year

The annual period of your coverage as shown in the Summary of Dental Plan Benefits. Your Benefit Year ends at the same time your coverage ends.

Benefits

Payment for the Covered Services under This Plan.

Certificate

This document is your Certificate of Coverage. Delta Dental will provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits. Any changes in this Certificate will be based on changes to the contract between Delta Dental and your Group. The Certificate may also be referred to as This Plan.

Children or Child

Your natural children; stepchildren; adopted children; children by virtue of legal guardianship; or children who reside with you during the waiting period for adoption or legal guardianship.

Completion Dates

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.
- For appliances, on the date the appliance is placed.
- For implants, on the date the implant is placed.

Copayment

The percentage of the bill that you are responsible for after you have met your Deductible, if any. Please refer

to The Summary of Dental Benefits for percentages and Deductibles.

Cosmetic Dentistry

Any procedure that is for general appearance and is not caused by disease, prevention, diagnosis, injury, decay, fracture or orthodontic correction.

Covered Services

The Dental Services shown in your Summary of Dental Plan Benefits are the Covered Services that will be paid under This Plan. The Covered Services must be provided by or under the direction of a Dentist. Covered Services includes services that are not reimbursed because of a Deductible, Copayment, waiting period, Maximum Payment, frequency, or other limit.

Deductible

The amounts a person or a family as a whole must pay toward Covered Services before Delta Dental begins paying for those services. The Summary of Dental Plan Benefits lists the Deductibles, if any, that apply to you and your family. The individual Deductibles apply toward the family Deductible. No Eligible Person pays more than the individual Deductible for that person while the total of Deductibles for all Eligible Persons in the family cannot exceed the family Deductible.

Delta Dental

Delta Dental of Kentucky, Inc., a Kentucky not-for-profit dental service corporation that provides dental benefits to its Subscribers.

Delta Dental Plan

A Delta Dental company that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental PPO

Delta Dental's national preferred provider organization program that can reduce your out-of-pocket expenses if you receive care from a Delta Dental PPO Dentist.

Delta Dental PPO Plus Premier

This program offers the Delta Dental PPO plan and also has back-up coverage through Delta Dental Premier that will pay at the Premier Dentist Schedule.

Delta Dental Premier

Delta Dental's national managed fee-for-service dental benefits program.

Dental Services

Any service, treatment or care you receive from a dental professional. Any dental procedure or materials related to the procedure. A Dental Service may or may not be a Covered Service.

Dentist

A person licensed to practice dentistry in the state in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** is a Dentist who has signed an agreement in his or her state to participate in Delta Dental PPO. PPO Dentists agree to accept Delta Dental's payment, your Copayment and Deductible, if any, as payment in full for Covered Services.
- **Delta Dental Premier Dentist ("Premier Dentist")** is a Dentist who has signed an agreement in his or her state to participate in Delta Dental Premier. Premier Dentists agree to accept the Maximum Approved Fee as payment in full for Covered Services.
- **Non-participating Dentist** is a Dentist who has not signed an agreement with any Delta Dental Plan to participate in Delta Dental PPO or Delta Dental Premier.
- **Out-of-Country Dentist** is a Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Premier Dentists are sometimes collectively referred to as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Non-participating Dentists, and Out-of-Country Dentists are sometimes collectively referred to as **"Non-participating Dentists."** Non-participating Dentists may bill you for the difference between the amount charged and the Maximum Approved Fee in addition to Deductibles, Copayments and charges for Non-Covered Services.

Eligible Dependent(s)

The Summary of Dental Plan Benefits has specific information about This Plan's rules for dependent eligibility, but generally, your Eligible Dependents are:

- Your legal spouse or domestic partner. Please check the Summary of Dental Plan Benefits for coverage;
- Your unmarried Children living with you. Please refer to your Summary of Dental Plan Benefits for specific age limits of This Plan;
- Any unmarried Children for whom you or your legal spouse are financially responsible for their medical or dental care under the terms of a court decree or who have been named as alternate recipients under a Qualified Medical Child Support Order (QMCSO);
- Your Children who have reached the age specified in your Summary of Dental Plan Benefits, but who are totally and permanently disabled by a physical and/or mental condition. You must submit medical reports confirming the Child's initial or continuing total disability;
- Your child, a post-secondary, full-time student who has taken a medically necessary leave of absence from the school due to a serious illness or injury. Coverage is extended up to one year during such leave of absence;

These definitions and age limits of Eligible Dependents may be superseded by any applicable state and/or federal laws.

Effective Date

The date on which your coverage under your Group contract begins.

Eligible Person

Any Subscriber or Eligible Dependent with coverage under This Plan.

Group

The employer, trust or other plan sponsor that has entered into a contract with Delta Dental.

Investigational

A device, treatment, procedure or service that is being studied to determine if it should be used for patient care. We reserve the sole right to determine what is Investigational. Approval by the Food and Drug Administration (FDA) does not mean that we approve the service. Devices and any services involved in clinical trials are Investigational.

Maximum Approved Fee

The maximum amount a Participating Dentist can charge the patient and Delta Dental combined for a Covered Service. The Maximum Approved Fee requirements are the lowest of:

- The Submitted Amount;
- The lowest fee regularly charged, offered or received by an individual Dentist for a dental service, regardless of the Dentist's contract with another dental benefits organization;
- The maximum fee that the local Delta Dental Plan approves for a given procedure in a given region or specialty, under normal circumstances, based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists are not allowed to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. Maximum Payment amounts are described in the Summary of Dental Plan Benefits.

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist.

Non-Covered Service

A Non-Covered Service is any Dental Service that is not a Covered Service.

Open Enrollment Period

The period of time, as determined by your employer or organization, during which an eligible person may enroll or be enrolled for Benefits. Open Enrollment is held once in a 12-month period.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Plan.

Pre-Treatment Estimate

A process where Delta Dental issues a written estimate of dental benefits, which may be available under your coverage for proposed dental treatment. Your Dentist may submit a request for a Pre-Treatment Estimate in advance of providing the treatment.

A Pre-Treatment Estimate can be provided at your or your Dentist's request and is provided for informational purposes only. It is not required before you receive any dental care or for approval of future dental benefits payment. You will receive the same benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefit provided on a Pre-Treatment Estimate notice is based on your coverage on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

A Pre-Treatment Estimate is not a claim for Benefits, pre-authorization, pre-certification, or reservation of future Benefits.

Premier Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Plan.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimates and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount

The amount a Dentist bills for a specific treatment or service. A Participating Dentist cannot charge you or your Eligible Dependents for the difference between this amount and the Maximum Approved Fee for Covered Services.

Subscriber

You, when your employer or organization notifies Delta Dental that you are eligible to receive dental benefits under This Plan.

Summary of Dental Plan Benefits

A description of the specific provisions of your Group dental coverage. The Summary of Dental Plan Benefits is, and should be read as, a part of this Certificate, and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Eligible Persons pursuant to this Certificate including the Summary of Dental Plan Benefits.

3. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental PPO Dentist.

- Delta Dental PPO Dentists agree to accept payment according to the PPO Dentist Schedule and, in most cases, this will result in a reduction of their fees. You are responsible for any Copayment and Deductible plus any balance not reimbursed under This Plan up to the PPO Dentist Schedule fee.

- Delta Dental Premier Dentists agree to accept payment according to the Premier Dentist Schedule. You are responsible for any Deductible and Copayment plus any balance not reimbursed under This Plan up to the PPO Dentist Schedule fee. Please check the Summary of Dental Plan Benefits as the Copayment and Deductible may be higher.

- If you choose a Dentist who does not participate in either program, you will be responsible for any difference between the Maximum Approved Fee and the Dentist's Submitted Fee, in addition to any Copayment or Deductible.

To verify that a Dentist is a Participating Dentist in This Plan, you can use Delta Dental's online Dentist Directory at www.deltadentalky.com or call (800) 955-2030.

4. Accessing Your Benefits

To utilize your coverage, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with the Benefits, how claim payments are made and provisions of This Plan.

2. Make an appointment with your Dentist. Tell your Dentist that you have dental benefits coverage with Delta Dental of Kentucky PPO Plan. Your Dentist should call Delta Dental at (800) 955-2030 or go to www.deltadentalky.com with any questions about This Plan

3. After you receive your dental treatment, you or the dental office staff will file a claim form with:

   - The Subscriber's full name and address;
   - The Subscriber's Delta Dental ID number;
   - The name and date of birth of the person receiving dental care.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our Customer Service at 1-800-955-2030.

Questions and Assistance

Questions about your coverage should go to your Human Resources department or to our Customer Service department by US mail, phone, or e-mail:

Delta Dental Customer Service
P.O Box 242810
Louisville, KY 40224-2810
(800) 955-2030
customerservice@deltadentalky.com.

Always include your name, your Group's name and number, the Subscriber's Delta Dental ID number and your daytime telephone number with any correspondence.

If you (a) need the assistance of the state agency that regulates insurance or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone, or e-mail.

Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517
Frankfort, Kentucky 40602
800-595-6053
http://insurance.ky.gov/

Claim Forms

Most Dentists will submit your dental claims for you. A Non-participating Dentist may require you to submit the claim yourself. You can access a claim form on our website at www.deltadentalky.com or by calling Customer Service at 1-800-955-2030. Mail the completed claim forms to:

Delta Dental
P.O. Box 242810
Louisville, KY 40224-2810.

All claims must be filed with Delta Dental within the 12 months following the date of service.

5. How Claim Payment is Made

If your Dentist is a Participating Dentist, Delta Dental will base payment on the lesser of the Submitted Amount or the Maximum Approved Fee for a Covered Service.

Delta Dental will send payment directly to a Participating Dentist and you will be responsible for any applicable Copayments or Deductibles and any amounts that exceed Maximum Payment amounts under your coverage. You will be responsible for the Dentist's Submitted Amount for any Non-Covered Service.

For Covered Services rendered by a Non-participating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you, and you will be responsible for making full payment to the Dentist including any difference between Delta Dental's payment and the Dentist's Submitted Amount.

To be eligible for coverage under This Plan, a Dental service must be:

1. A Covered Service.
2. Performed by a Dentist or, as applicable, a registered dental hygienist or other dental professional as permitted by state law.
3. Consistent with the symptoms, diagnosis or treatment of the condition, disease or injury.
4. Payable under the Processing Policies of Delta Dental.
5. Not solely for the convenience of you or your Dentist.
6. The most appropriate level of service that can safely be provided to you.
7. Received after your Effective Date and completed before your coverage ends.

We will pay the claim within (30) days from the date we receive a properly completed claim form, as prescribed by applicable law, including all required information, to determine the amount payable under This Plan. You agree that any person or entity having medical information relating to the dental benefits claimed, may give us that information. We may provide such information to other persons in accordance with our published Notice of Privacy Practices under HIPAA.

After we process the claim, you and/or your Dentist will receive an Explanation of Benefits (EOB), unless you have no financial responsibility. The EOB is not a bill, but a statement to help you understand the coverage you are receiving. The EOB shows:

- Total amount charged by the Dentist for services received (Submitted Amount).
- The maximum amount that your Dentist will receive (Maximum Approved Fee).
- The amount for which you are responsible (patient payment).

Delta Dental will process and pay all submitted claims in accordance with this Certificate and applicable law. We cannot deny a claim or withhold payment upon your request.

In the event of death, any Benefits payable to a Covered Person will be paid to that person's estate.

If Delta Dental pays a claim in error we may recover the overage from you or, if applicable, the Dentist. As an alternative, Delta Dental reserves the right to deduct from any pending or future claim any amounts you or the Dentist may owe us. Payment of any claim in error does not mean that similar claims will be paid in the future.

6. Benefit Categories

This Plan covers only Covered Services listed in the Summary of Dental Plan Benefits. If there is any conflict between the Certificate and the Summary of Dental Plan Benefits, the Summary of Dental Plan Benefits will control. The following is a description of various Dental Services that can be selected for a dental program. Please review the Exclusions and Limitations section regarding the information listed below. **Your Benefits at the time of your treatment depend on several factors. These include your continued eligibility for benefits; your available annual or lifetime Maximum Payment; any coordination of benefits; the status of your coverage; your Dentist, This Plan's limitations, and any other provisions**.

Diagnostic and Preventive Services

Diagnostic and Preventive Services

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, evaluations, prophylaxes (routine cleanings), space maintainers, and topical fluoride treatments.

Brush Biopsy

Oral brush biopsy procedure and laboratory analysis used to detect oral cancer. Using this diagnostic procedure, Dentists can identify and treat abnormal cells that could become cancerous, or they can detect the disease in its earliest and most treatable stage.

Radiographs

X-rays as required for routine care or as needed to diagnose the condition of your teeth.

Emergency Palliative Treatments

Emergency treatment to temporarily relieve pain.

Basic Services

Oral Surgery Services

Extractions and dental surgery, including pre-operative and post-operative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance following periodontal therapy (periodontal cleanings).

Relines and Repairs

Relines and repairs to partial dentures and complete dentures, and repairs to bridges.

Restorative Services

Services to rebuild and repair natural tooth structure damaged by disease, decay, fracture, or injury. Restorative services include:

- Minor restorative services, such as amalgam (silver) fillings and composite resin (white) fillings on anterior teeth.
- Major restorative services, such as crowns, when teeth cannot be restored with another filling material.

Major Services

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, partial dentures, and complete dentures).

Orthodontic Services

Services, treatment and procedures to correct malposed teeth (such as braces).

Other Benefits

Any additional Benefits specified in The Summary of Dental Plan Benefits.

7. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for the same will be your responsibility.

1. General anesthesia as relating to Periodontic, Prosthetic, Restorative, Endodontic or Orthodontic services or for the sole purpose of patient management.
2. Services for injuries or conditions payable under Workers' Compensation or employer's liability laws. Services that are received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX of the Social Security Act (Medicaid).
3. [Dental Services received from a dental or medical department maintained by or on behalf of the Group, a mutual benefit association, labor union, trustee, or similar person or group.]
4. Cosmetic surgery, bleaching or dentistry for aesthetic reasons, as determined by Delta Dental.
5. A complete occlusal adjustment.
6. Services rendered before the Effective Date or after the termination date of This Plan.
7. Charges for hospitalization, laboratory tests, and histopathological examinations.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services as determined by Delta Dental, for which no valid dental need can be demonstrated or which are specialized techniques.
10. Services as determined by Delta Dental that are Investigational in nature, including services or supplies required to treat complications from Investigational procedures.
11. Services, as determined by Delta Dental, which are not rendered in accordance with generally accepted standards of dental practice.
12. Treatment by anyone other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional as determined by Delta Dental under the scope of the professional's license as permitted by applicable state law.
13. Services for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Replacement, repair or adjustments to space maintainers.
15. Services received as a result of dental disease, defect, or injury for any military-connected disability or condition or due to an act of war, declared or undeclared.
16. Services required while incarcerated in a penal institution or while in custody of law enforcement authorities, including work release programs.

17. Services for injuries sustained from participating in a civil disturbance or while committing an assault or felony.
18. Services that are covered under another group medical or dental plan. We will coordinate coverage where permissible under applicable laws.
19. Services that are not within the categories of Benefits that have been selected by your employer or organization and that are not covered under the terms of this Certificate.
20. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
21. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medications, etc.).
22. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
23. Temporary root canal fillings on permanent teeth.
24. Chemical curettage.
25. Personalization/characterization of any service or appliance.
26. Separate claims for tooth preparation, temporary services, bases, impressions, local anesthesia or other services that are components of a complete procedure will be subject to the Maximum Approved Fee.
27. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
28. Mounted case analyses.
29. Consultations.
30. Subperiosteal implants and bone grafts.
31. Laser Assisted New Attachment Procedure, also known as LANAP, Wavelength-optimized Periodontal Therapy, Deep Pocket Therapy with New Attachment and similar laser periodontal treatment procedures are considered to be Investigational procedures and are not covered under the terms of this Certificate.

Delta Dental will make no payment for the following services. Participating Dentists <u>may not</u> charge you or your Eligible Dependents for these services. All charges from Non-participating Dentists for the following will be your responsibility:

1. The completion of forms or submission of claims.
2. Consultations, when performed in conjunction with examinations/evaluations.
3. Local anesthesia.
4. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
5. Infection control.
6. Temporary crowns.
7. Gingivectomy as an aid to the placement of a restoration.
8. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
9. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
10. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
11. Post-operative X-rays, when done following any completed service or procedure.
12. Periodontal charting.
13. Pins and/or preformed posts, when done with core buildups for crowns, onlays, or inlays.
14. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
15. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

16. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
17. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
18. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
19. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
20. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
21. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The following benefits are limited as described in your Summary of Dental Plan Benefits:

- Oral examinations/evaluations.
- Routine teeth cleaning (prophylaxis).
- Bitewing X-rays.
- Full mouth or panographic X-rays (which include bitewing X-rays),
- Preventive fluoride treatments are payable once per Benefit Year to the age specified in your Summary of Dental Plan Benefits.

The benefits for the following services are limited as follows, unless otherwise specified in your Summary of Dental Plan Benefits. All charges for services that exceed these limitations will be your responsibility.

1. A separate benefit is not provided for **periapical or bitewing x-rays** when performed on the same date as a complete series or a panorex.
2. Benefits for a **problem-focused examination** are limited to two in a Benefit Year.
3. When the total amount charged for **individual periapical x-rays** equals or exceeds the Maximum Approved Fee for a complete series, Benefits are limited to the Maximum Approved Fee for a complete series. Benefits will also be subject to the limitations for a complete series.
4. **Space maintainers** are payable up to the age of 14 and are limited to one placement per location.
5. **Topical fluoride applications** are provided only for Eligible Persons up to the age of 19 and are limited to one application per Benefit Year.
6. **Sealants** are limited to topically applied acrylic plastic or composite material exclusively for the purpose of preventing tooth decay and are payable for people up to the age of 16. They must be placed on the occlusal surface of permanent molars that are free of decay and Benefits are limited to one application per tooth in a two-year period.
7. **Sealants repair or replacement** is covered only when performed after two years of the original placement or replacement. If performed within the two-year time limit, it will be considered part of a completed procedure and not a separate Benefit.
8. **Amalgam and resin restorations** are allowed once per tooth surface in a two-year period. **Composite resin or acrylic restorations** in posterior teeth are paid as an Alternate Benefit at amalgam Approved Fee unless specified otherwise in your Summary of Dental Plan Benefits.
9. Services are provided for one **restoration** in each tooth surface in an episode of treatment.
10. **Root canal treatment** includes periapical x-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, and routine postoperative procedures. No separate charges will be paid for these procedures. Retreatment is payable after two years.
11. **Payments for pulpotomies are** limited to primary (baby) teeth.
12. **Stainless steel crowns** are limited to once per tooth in a two-year period on primary teeth only.
13. **Pulp capping** is a Covered Service for exposure of the pulp only and if performed on the same day as the final restoration is limited to the Maximum Approved Fee for the complete procedure.
14. **Remineralization** includes temporary restoration. Permanent restorations are not

payable within two months following the temporary placement.

15. **Payment for periodontal maintenance** is limited as listed in your Summary of Dental Plan Benefits provided the patient has completed active periodontal therapy.

16. **Periodontal scaling and root planing** is limited to once in a Benefit Year unless otherwise specified in your Summary of Dental Plan Benefits.

17. **Occlusal guards** are limited to one in a five-year period on permanent teeth. Occlusal guards for Children with primary or mixed primary and permanent teeth are not covered.

18. **Bone replacement grafts** are payable only when performed around natural teeth. (They are not covered in conjunction with implants, extractions for ridge augmentation or to replace bone lost in the area of an abscess).

19. **Osseous surgery** or osseous grafts are payable once per area within a three-year period.

20. Payment for **crowns, inlays, and onlays** is limited to one per tooth in a five-year period.

21. Services for any **optional gold restoration,** crown or jacket, are limited to the Maximum Approved Fee for an amalgam, synthetic or plastic restoration.

22. **Porcelain veneer** or cast crowns are payable when an Eligible Dependent is 12 years of age or over. For Eligible Dependents under the age of 12, an acrylic crown or preformed crown may be payable with approval.

23. **Denture reline or rebases** is payable once in a three-year period and at least six months after initial placement.

24. Benefits for **repair of a full or partial denture** are limited to 50% of the Maximum Approved Fee for a replacement denture.

25. **Oral Surgery** procedure includes routine postoperative procedures, dry socket treatments and sutures. These services are not payable as a separate benefit.

26. **General anesthesia** is limited to the following procedures when administered by a Dentist licensed to administer general anesthesia;

    a. Removal of impacted tooth – partially bony

    b. Removal of impacted tooth – completely bony

    c. Removal of impacted tooth – completely bony, with unusual surgical complications

    d. Surgical removal of residual root

    e. Oroantral fistula closure

    f. Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)

    g. Five or more extractions performed on the same date of service.

    h. General anesthesia is not payable for the sole purpose of patient management.

27. **Tissue conditioning** is limited to three times in an episode of treatment.

28. **Denture or bridge replacement** is payable five years after the initial placement, however no replacement is payable for lost or stolen dentures or bridges.

29. **Fixed bridges** or removable cast partials are only payable for Eligible Dependents after the age of 16.

30. Benefits for **special techniques** or personalized restorations with a bridge or denture are limited to the Maximum Approved Fee for a standard procedure.

31. Benefits for an **overdenture**, including necessary crowns and root canal treatment, are limited to the Maximum Approved Fee for a full denture.

32. **Interim dentures** (stayplates) are payable only for Children under age 17 to replace extracted anterior permanent teeth during the healing period.

33. Payment for **implants** is limited to one implant per tooth in a five-year period.

34. When **implants** are not a Covered Service under this plan, Alternate Benefits may be payable for missing tooth replacement or partial denture payment.

35. In the event you **transfer from one Dentist** to another during your course of treatment, or more than one Dentist performs services for one procedure, Benefits are limited to the Maximum Approved Fee for the services of one Dentist.

Orthodontic Services

1. The diagnosis for Orthodontic Services must show that the handicapping malocclusion is abnormal and can be corrected. It is recommended that your Dentist submit a treatment plan to us to determine the Benefits available. One diagnosis and treatment plan is payable in a five-year period.

   We may review your dental records to determine if Benefits will be provided for the requested services.

2. All Orthodontic Services are considered to have been rendered on the date performed.
3. Orthodontic Services are subject to the total Maximum Payment per Eligible Person. Please refer to the Summary of Dental Benefits for your Maximum Payment.
4. Payment for orthodontic treatment, including appliances, will not exceed three years.
5. If the orthodontic treatment plan is terminated before completion of the case for any reason, Delta Dental's obligation for payment ends on the last day in which the patient was treated.
6. Replacement and/or repair of any appliance furnished under the orthodontic treatment plan are not covered.

Orthodontic Processing Policies

1. Benefits are paid as the services are rendered; therefore, lump sum payments cannot be made if full payment was made in advance.
2. Payments will be made for the following treatment;

   - Orthodontic records (if charged separately)
   - Down payment or initial fee (placement of appliances)
   - Monthly adjustments (paid each month as services are rendered.)
   - Retainers are paid as a one-time fee and monthly adjustments are included in this fee.

8. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when an Eligible Person has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan's Benefits are determined before or after another plan's benefits.

You must submit all your claims to each plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your claim or does not pay the full claim, the secondary plan will then calculate any additional payment under these rules.

Which Plan is Primary?

This Plan is a Secondary Plan unless:

- the other plan has rules coordinating its benefits with those of This Plan; and,
- both those rules and This Plan's rules make This Plan the Primary Plan.

The primary plan is determined by the first of the following rules that applies:

1. **Dependent or Non-dependent.**

The plan that covers the Eligible Person as other than a Dependent is always primary.

2. **Children (parents who are not divorced or separated) and the Birthday Rule.**

   The Plan of the parent with the first birthday in a calendar year is always primary for Children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that covers the Children for the longer period will be primary.

3. **Children (Parents Divorced or Separated)**.

   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If a court decree states that the parents will share custody without stating that one of the parents is responsible for the Child's health care expenses, Delta Dental follows the birthday rule (see #2 above).

   If neither of these rules applies, the order will be determined as follows:

   - First, the plan of the parent with custody of the Child.
   - Then, the plan of the spouse of the parent with custody of the Child.
   - Next, the plan of the parent without custody of the Child; and,
   - Last, the plan of the spouse of the parent without custody of the Child.

   <u>If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.</u>

4. **Active or Inactive Employee.**

   The plan of the employee who is not laid off nor retired is Primary.

5. **COBRA Continuation of Coverage.**

   The plan of the Eligible Person that is not provided under a right of continuation pursuant to federal law (that is COBRA) or a similar state law is primary.

6. **Length of Coverage.**

   The plan that has covered the Eligible Person for the longer time is primary.

7. **None of the Above Applies.**

   If none of the rules above determines the order of Benefits, the allowable expense will be shared equally between plans.

How Delta Dental Pays as Primary Plan

When This Plan is Primary, it will pay Benefits under This Plan as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When This Plan is secondary, any difference between the amount we pay on a claim and the amount we would have paid if we had been Primary will be added to a Benefit Reserve under Kentucky law. At the end of a benefit year, we will reimburse the Covered Person for any non-reimbursed allowable expenses incurred during the previous year up to the total amount of your Benefit Reserve. At that time, your Benefit Reserve will be returned to zero and will start over for the next year. Examples of non-reimbursed expenses may include deductibles and copayments.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. We may get needed facts from, or give them to, any other organization or person. Delta Dental need not tell, or get the consent of, any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the claim.

Payment Made By Other Plans

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of

services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If Delta Dental pays more than it should have paid under this COB provision, it may recover the excess from one or more of the following:

- The people it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

Payment includes the reasonable cash value of any Benefits provided in the form of services.

9. Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination that you think is incorrect, you or your Dentist should contact us at (800)955-2030 or customerservice@deltadentalky.com. Ask them to check the claim to make sure it was processed correctly. We provide this opportunity for you to describe the problem and why you think your claim was improperly denied. We will correct any errors quickly and without delay. This inquiry is not required and is not a formal appeal for review of your claim.

Whether or not you ask us informally to recheck the claim, you can submit your claim to a formal claims appeal procedure described below.

If you decide to appeal, you should seek a review as soon as possible. However, you must file an appeal within 180 days of the date you received your notice of an Adverse Benefit Determination. To appeal your claim, send your request by email to:

customerservice@deltadentalky.com

or in writing to:

Customer Service
Delta Dental of Kentucky
P O Box 242810
Louisville, Kentucky 40224

Your appeal should include your name, address, the Subscriber's Delta Dental ID and all information related to your appeal. This includes comments, documents, or records submitted by your Dentist and any other comments or information you wish to provide in support of your appeal. You are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, or records and other information we have that are relevant to your appeal. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it via certified mail, return receipt requested.

We will conduct your appeal by making a fresh determination of your claim based on a review of the information available. We will not defer to our original decision. The individuals who conduct the appeal will not be the persons who made the initial decision or those persons' subordinates. If your claim was denied for missing information, you or your Dentist may resubmit the claim with complete information. If the decision is based, in whole or in part, on a dental judgment (including determinations with respect to whether a particular treatment, or service is Investigational or not appropriate under your Certificate), the reviewer(s) will, as necessary, consult a dental health care professional with appropriate training and experience. The dental health care professional will not be the same individual, or that person's subordinate, consulted during the initial determination.

The reviewer(s) will make a determination within 30 days of receipt of your appeal. Delta Dental will send a written decision to you, your representative, and if applicable, your Dentist.

If we uphold any part or all of the initial Adverse Benefit Determination, you or your Dentist may contact the Department of Insurance, PO Box 517, Frankfort, Kentucky 40602, or online at http://insurance.ky.gov and request a review of our decision.

Notice. Your initial notice of an Adverse Benefit Determination will inform you of the following:

- specific reason(s) for the denial.
- the Plan provision(s) on which the denial is based.
- the review procedures for dental claims, including applicable time limits.
- that upon request, you are entitled to access, free of charge, all documents, records and other information relevant to your claim.

The notice will also contain or reference:

- a description of any additional materials necessary to complete your claim.

- an explanation of why such materials are necessary.
- a statement that you have the right to bring a civil action in court if you receive an Adverse Benefit Determination after your claim has been completely reviewed according to this claims appeal procedure.
- any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination.
- a statement that a copy of such rule, guideline or protocol may be obtained upon request, at no charge.

If the Adverse Benefit Determination is based on a matter of dental judgment or appropriateness under your coverage, the notice will also contain:

- an explanation of the scientific or clinical judgment on which the determination was based; or,
- a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

10. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When your employer or organization advises Delta Dental to terminate your coverage.
- If we receive your premium more than 30 days late (or as specified in your Group contract). If so, the termination will occur on the date through which premiums are paid.
- For fraud or material misrepresentation in the submission of any claim or eligibility information.
- For any other reason stated in the Contract between Delta Dental and your Group.

Delta Dental will not continue eligibility for any Eligible Person under This Plan beyond the termination date given by your employer or organization. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or comparable, applicable state law.

11. Continuation of Coverage

Your Group may be required to comply with provisions under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or the Uniformed Services Employment and Reemployment Rights Act of 1984 ("USERRA"). If your coverage would otherwise end, you and/or your Eligible Dependents may have the right, under certain circumstances, to continue coverage, at your expense, beyond the time coverage would normally end. You should check with your Group's benefit administrator to determine your eligibility for coverage continuation.

When is Plan Continuation Coverage Available?

Continuation coverage may be available if your coverage or a covered Dependent's coverage would otherwise end because of any of these reasons:

1. Your employment ends for any reason other than your gross misconduct.
2. Your hours of work are reduced so that you are no longer a full-time employee.
3. You are divorced or legally separated.
4. You die.
5. Your Child is no longer eligible to be a covered Dependent.
6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact your Group's Benefit administrator to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 (ERISA).

12. General Provisions

Family and Medical Leave Act of 1993 (FMLA)

Your Group determines whether or not you are eligible for FMLA. If you take FMLA leave, you will retain eligibility for coverage during this period. You and your Eligible Dependents will be considered eligible even if you are not actively working. If the Subscriber does not retain coverage during the leave period, any Eligible Person who was covered immediately prior to the leave may be reinstated upon return to work. In that event, there will be no new waiting period for pre-existing conditions.

Privacy of Your Health Information

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental is committed to protecting your health information. You may obtain a copy of our HIPAA Notice of Privacy Practices by contacting us at customerservice@deltadentalky.com.

Children's Health Insurance Program (CHIP)

You may have special enrollment rights under CHIP. You should ask your Group's benefit administrator if you are eligible. Under the law, you and your Eligible Dependents not enrolled in the plan have the right to request enrollment . This must be done within 60 days of when you or your Eligible Dependents are terminated from Medicaid or state CHIP coverage as a result of loss of eligibility or if you or your Eligible Dependents become eligible for a premium assistance subsidy under Medicaid or state CHIP. You should notify your Group's benefit administrator if you are eligible for this special enrollment.

Assignment

Services and payments to Eligible Persons are for the personal benefit of those persons. You cannot transfer or assign payments other than to allow us to make direct payments to Participating Dentists.

Subrogation and Right of Reimbursement

Subrogation happens when you or your Eligible Dependents are involved in an automobile accident or require Covered Services that may entitle you to recover damages from a third party.

Delta Dental may have the right to be paid any amount you recover up to the amount we paid under This Plan.

You agree that Delta Dental has first priority in any payment an Eligible Person receives from someone else or that person's insurance company. We may exercise our right to direct recovery against the Eligible Person. You or your legal representative must do whatever is necessary to enable us to exercise our rights. You also agree to do nothing that could harm our right to recover.

Obligation to Assist in Delta Dental's Reimbursement Activities

You and your Eligible Dependents are required to provide Delta Dental with:

- any information concerning other insurance coverage that may be available. (This includes automobile, home, and other liability insurance coverage, and coverage under another group health plan; and,
- the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits for the same Covered Services for which Delta Dental made payments.

You and your Eligible Dependents are required to:

- cooperate fully with us to exercise our right to subrogation and reimbursement.
- refrain from doing anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount).
- sign any document deemed by Delta Dental to be relevant in protecting our subrogation and reimbursement rights.
- provide relevant information when requested.

The term "information" includes any documents, insurance policies, police or other investigative

reports, and any other facts that we may reasonably request. Failure by an Eligible Person to cooperate with Delta Dental in the exercise of these rights may result in a reduction of future benefit payments available to you under This Plan in an amount up to the total amount paid by us, but for which we were not reimbursed.

Dentist-Patient Relationship

You are free to choose any Dentist. However, you should keep in mind the differences in payment levels between Participating and Non-participating Providers. We do not recommend or warrant any Dentist and a Dentist may decline to provide care to you for any lawful reason. Each Dentist maintains the dentist-patient relationship with the patient and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Delta Dental contracts with Participating Dentists in order to reduce dental care costs. We are not responsible or liable for the furnishing of Covered Services, but merely for the payment of them under the terms of This Plan. You will have no claim against us for acts or omissions of any Dentist from whom you receive services. We have no responsibility for any act or omission of any Dentist or the failure or refusal of any Dentist to provide services to you. This Plan does not give anyone any claim, right or cause of action based on what any Dentist or other dental professional does or does not do.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, Delta Dental will only pay for Covered Services received while that person was covered under This Plan.

Certain services begun before the loss of eligibility may be covered if they are completed within a 60-day period from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Governing Law

This Certificate will be governed by and interpreted under the laws of the Commonwealth of Kentucky.

Actions

No action on a legal claim arising out of or related to This Plan can be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived that person's right to bring suit on such legal claim. This provision does not preclude you from seeking a decision from a jury trial once all administrative appeals have been exhausted.

Change of Certificate or Contract

Delta Dental may amend your Certificate or Summary of Dental Plan Benefits or adjust the premiums from time to time. We will inform the Group in writing at least 30 days before any amendment goes into effect. No agent or other person has the authority to change any provisions in this Certificate, Summary of Dental Plan Benefits or the provisions of the contract on which it is based. No change in this Certificate or Summary of Dental Plan Benefits will be effective until approved, in writing, by an officer of Delta Dental.

Change of Status

You must notify Delta Dental, through your Group, of any event that changes the status of an Eligible Person. These events include, marriage, birth, death, divorce, and entrance into military service.

Right of Recovery Due to Fraud

We have the right to recover from any eligible Person any payment that we make because of fraud or

material misrepresentation. This includes any payment for:

- services that were sought or received under fraudulent, false, or misleading circumstances.
- a claim that contains false or misrepresented information.
- a claim that is determined to be fraudulent due to the acts of any Eligible Person.

We may recover any payments made to any Eligible Person that were based on false, fraudulent, misleading, or misrepresented information. We may deduct that amount from any payments properly due to an Eligible Person. We will provide an explanation of any payment being recovered at the time we make the deduction.

Legally Mandated Benefits

Any law that requires broader coverage or more favorable treatment for Eligible Persons than is provided by This Plan controls over This Plan.

Claims, Pre-Treatment Estimate, Inquiries or Review

P.O. Box 242810
Louisville, Kentucky 40224-2810

An Equal Opportunity Employer

DELTA DENTAL®

https://www.DeltaDentalKY.com

April 3, 2023

Bookkeeping Department
TAYLOR COUNTY RECC
PO Box 100
Campbellsville, KY 42719-0100

Re: Dental Plan Rate Review, Group #688960-4001

Dear Bookkeeping Department,

Enclosed are the rates and renewal documents related to your contract renewal.

If you have any questions or need additional information, please feel free to contact me at (502) 736-4685 or jessica.willis@deltadentalky.com.

Sincerely,

Jessica Willis
Account Manager

cc: Mr. Robert Caulk

DELTA DENTAL®

Delta Dental of Kentucky
Delta Dental PPO plus Premier™
Summary of Dental Plan Benefits

Group Name: TAYLOR COUNTY RECC

Group Number: 688960-4001

Benefit Year: January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Non-participating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Denture Repair – repairs to complete or partial dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Fixed Prosthodontic Repair – to bridges	50%	50%	50%
Implant Repair – implant maintenance, repair, and removal	50%	50%	50%
Relines and Rebase – to dentures	50%	50%	50%
Adjustments to Dentures – adjustments to complete or partial dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 13 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.

- Sealants are payable once per tooth per two-year period for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Payment for crowns, inlays, and onlays are payable once per tooth in any five-year period. Stainless steel crowns are payable once per tooth in any two-year period on primary teeth only.
- Composite resin (white) restorations are payable on posterior teeth.
- Root canal treatment is inclusive of periapical X-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, and routine post-operative procedures. Separate charges are not Covered Services for these procedures. Retreatment is payable two years after the initial treatment.
- Denture and/or bridge replacement is payable five-years post initial place. Replacement is not a Covered Service for lost or stolen dentures and/or bridges. Interim dentures are payable only for people under age 17 to replace extracted anterior permanent teeth.
- The initial installation of any prosthodontic service to replace missing teeth or teeth that were lost before coverage began, including congenitally missing teeth is not payable. Replacements of existing appliances can be considered.
- Fixed bridges or removable cast partials are payable only for Eligible Dependents over age 16. Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, implant crowns, partial dentures, and complete dentures) may be subject to an Alternate Benefit.
- Porcelain and resin facings on bridges are payable on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, and sealants.

Maximum Payment – $1,000 per person total per Benefit Year on all services.

Dependent Age Limit – Dependents are covered up to age 26.

Waiting Period – There is a 12-month waiting period for certain services. Major Restorative Services, Relines and Adjustments, Fixed Prosthodontic Repair, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.

Eligible People – The subscriber (you) is eligible for dental benefits when your employer or organization notifies Delta Dental.

Also eligible at your option are your legal spouse and your children who meet the age requirements noted above. Enrollees and dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which your employment is terminated.

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflict with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages above are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

DELTA DENTAL®

Delta Dental of Kentucky

Renewal Rates for TAYLOR COUNTY RECC #688960

Effective June 1, 2023

Rates

Rates per subscriber per month	Current Rate(s) June 1, 2022 through May 31, 2023	Renewal Rate(s) June 1, 2023 through May 31, 2024
Subscriber only	$28.84	$28.84
Subscriber and spouse	$58.82	$58.82
Subscriber and child(ren)	$55.39	$55.39
Subscriber, spouse and child(ren)	$91.71	$91.71
Overall Percent Change	0.00%	

Rating Requirements

Tied to medical: No

Covered Persons choosing this dental plan are required to remain enrolled for a period of 12 months. Should a Covered Person choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Rating Assumptions

Rates do not include any applicable claims taxes. The rates are valid only for the effective date noted above and are guaranteed for a one year contract.

Self-billing is not allowed and you agree to pay as invoiced each month.

Subscriber materials which are produced by Delta Dental will be updated and provided when plan changes apply and are always available to view or print at https://www.DeltaDentalKY.com.

Printed dentist directories are not included. You can find participating dentists on our website at https://www.DeltaDentalKY.com.

The plan specifications are subject to Delta Dental's standard exclusions and limitations, including:

- Oral exams (including evaluations by a specialist) are payable twice per calendar year. Limited oral evaluations for a specific problem or complaint are also payable twice in the same calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in a lifetime.
- Fluoride treatments are payable once per calendar year for people age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 13 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Payment for crowns, inlays, and onlays are payable once per tooth in any five-year period. Stainless steel crowns are payable once per tooth in any two-year period on primary teeth only.
- Composite resin (white) restorations are payable on posterior teeth.
- Root canal treatment is inclusive of periapical X-rays, cultures, follow-up care, treatments, pulpotomy or pulpectomy, and routine post-operative procedures. Separate charges are not Covered Services for these procedures. Retreatment is payable two years after the initial treatment.
- Denture and/or bridge replacement is payable five-years post initial place. Replacement is not a Covered Service for lost or stolen dentures and/or bridges. Interim dentures are payable only for people under age 17 to replace extracted anterior permanent teeth.
- The initial installation of any prosthodontic service to replace missing teeth or teeth that were lost before coverage began, including congenitally missing teeth is not payable. Replacements of existing appliances can be considered.
- Fixed bridges or removable cast partials are payable only for Eligible Dependents over age 16. Services and appliances that replace missing natural teeth (such as bridges, endosteal implants, implant crowns, partial dentures, and complete dentures) may be subject to an Alternate Benefit.
- Porcelain and resin facings on bridges are payable on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 26
RESPONSIBLE PARTY: Patsy Walters

Request 26. Provide detailed descriptions of all early retirement plans or other staff reduction programs Taylor RECC has offered or intends to offer its employees during the test year. Include all cost-benefit analyses associated with these programs.

Response 26. Taylor County does not offer, nor does it intend to offer, an early retirement plan or staff reduction plan in the test period or going forward.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 27
RESPONSIBLE PARTY: Patsy Walters

Request 27. Provide a complete description of Taylor RECC's other post-employment benefit package(s) provided to its employees.

Response 27. For all current retirees and employees who were hired on or before November 30, 2005 who hereafter retire, in order for such insurance to be made available, a retiree or an eligible employee who retirees from employment at the Cooperative in the future must have attained at least age sixty (60) and have at least thirty (30) years of service with the Cooperative.

For all eligible employees described in above paragraph, the Cooperative will provide Humana Medicare Employer designed Passive and Passive Waiver LPPO 079064 with RX 127.

Please see the Humana Policy listed in the response to Request 25.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 28
RESPONSIBLE PARTY: Patsy Walters

Request 28. Provide a complete description of the financial reporting and ratemaking treatment of Taylor RECC's pension costs.

Response 28. Utility Pension costs that are incurred are spread to the general ledger accounts that are charged with labor. These expense accounts would directly impact the ratemaking revenue requirement.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 29
RESPONSIBLE PARTY: Jeff Williams

Request 29. Regarding Taylor RECC's employee compensation policy:

a. Provide Taylor RECC'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 Taylor RECC'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 Taylor RECC's compensation policy was last reviewed by a consultant, provide any study or report provided by the consultant

Response 29a. While there is not currently a written policy or procedure for Taylor County, compensation is managed by the CEO and by his use of an outside consultant and NRECA salary study data.

Response 29b. Please see the response to part (a) above. Taylor County is committed to maintaining a competitive compensation program. Taylor County's objectives include:

- Attracting and retaining quality personnel
- Ensuring pay administration is fair and equitable for all employees
- Determining pay increases and promotions on the basis of demonstrated individual performance
- Ensuring opportunities for employees reflect changes in competitive compensation trends and economic conditions
- Ensuring administration of this program complies with all relevant regulations and laws

Response 29c. Once the policy or procedure is written, our counsel, board and the CEO will craft the policy with the help of other relevant policies and our salary study consultant.

Response 29d. Not applicable. Taylor County is in the process of policy and procedure review/rewrite.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 30
RESPONSIBLE PARTY: Jeff Williams

Request 30. State whether Taylor RECC's expenses for wages, salaries, benefits, and other compensation included in the test year, and any adjustments to the test year, are compliant with the board of director's compensation polity.

Response 30 The utility's expenses for wage, salaries, benefits and other compensation are compliant with the policies and procedures of Taylor County and its board of directors. The board delegates authority to the CEO to make hiring and salary decisions while following the guidelines for wage and salaries.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 31
RESPONSIBLE PARTY: Patsy Walters

Request 31. Provide, in the format provided in Schedule I, the following information for Taylor RECC;s compensation and benefits for the test year and the three most recent calendar years preceding the test year. Provide information individually for each corporate officer and by category for Directors, Managers, Supervisors, Exempt, Non-Exempt, Union and Non-Union hourly employees. 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 or deferred compensation.
g. Other amounts paid and reported on the employees' W-2 (specify).
h. Healthcare benefit cost.
    (1) Amount paid by Taylor RECC
    (2) Amount paid by employee
i. Dental benefits cost.
    (1) Amount paid by Taylor RECC
    (2) Amount paid by employee.

j. Vision benefit cost.

(1) Amount paid by Taylor RECC.

(2) Amount paid by employee.

k. Life insurance cost.

(1) Amount paid by Taylor RECC

(2) Amount paid by employee.

l. Accidental death and disability benefits.

(1) Amount paid by Taylor RECC.

(2) Amount paid by employee.

m. Defined Benefit Retirement.

(1) Amount paid by Taylor RECC.

(2) Amount paid by employee.

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

o. Cost of any other benefit available to an employee (specify).

Response 31a. through 31o. Please see attached. The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 32
RESPONSIBLE PARTY: Patsy Walters

Request 32. For each item of benefits listed in Item 31 above for which an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate waws determined.

Response 32.

Healthcare Benefits:

For 2018 through 2022 the coop paid the full premium cost for single and family policies on HDHP.

Beginning in 2023 the coop paid 95% of the premium for single, employee/spouse, employee/children and family, the employee was responsible for the remaining 5% of the premium.

For 2024 the coop will pay 90% of the premium for single, employee/spouse, employee/children and family, the employee was responsible for the remaining 10% of the premium.

For 2025 the coop will pay 88% of the premium for single, employee/spouse, employee/children and family, the employee was responsible for the remaining 12% of the premium.

Dental Benefits:

For 2018 through September 2022 the employee was responsible for all of the premium.

Beginning in October 2022 the coop paid 80% while the employee is responsible for the remaining 20%.

Defined Contribution (401K):

For 2018 through 2022 the coop contributed 10% of the participants gross wages provided the employee's elective contribution is equal to 3% or more of his or her gross wages.

Beginning in 2023 the coop will contribute 16% of the participants base salary provided the employee's elective contribution is equal to 3% or more of his or her base salary.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 33
RESPONSIBLE PARTY: Patsy Walters

Request 33. Provide a listing of all healthcare plan categories, dental plan categories, and vison plan categories available to corporate officers individually and to groups defined as Corporate Officers, 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 33. Please refer to Taylor County's responses to Request Nos. 23 and 32 above.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 34
RESPONSIBLE PARTY: Patsy Walters

Request 34. Provide a listing of all life insurance plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union and Non-Union Hourly employees. Include the associated employee contribution rates and employer contribution rates of the total premium cost for each plan category.

Response 34. Basic life insurance of two-times salary is provided by Taylor County for every employee, which Taylor County pays 100% of the premiums. An employee, at their own expense, can choose to purchase up to five-times their salary in supplemental life insurance. Additional AD&D insurance, spouse and child life insurance can be purchased by the employee at their expense as well. These options apply to every employee.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 35
RESPONSIBLE PARTY: Patsy Walters

Request 35. Provide a listing of all retirement plans available to corporate officers individually, and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union and Non-Union Hourly employees. Include the associated employee contribution rates, if any, and employer contribution rates of the total premium cost for each plan category.

Response 35.

	401(k)	
	EMPLOYEE CONTRIBUTION RATE	EMPLOYER CONTRIBUTION RATE
CEO	100%	16% AFTER EMPLOYEE 3%
DIRECTORS	NOT OFFERED	
MANAGERS	100%	16% AFTER EMPLOYEE 3%
SUPERVISORS	100%	16% AFTER EMPLOYEE 3%
EXEMPT	100%	16% AFTER EMPLOYEE 3%
NON-EXEMPT	100%	16% AFTER EMPLOYEE 3%
UNION	100%	16% AFTER EMPLOYEE 3%
NON-UNION HOURLY	100%	16% AFTER EMPLOYEE 3%

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 36
RESPONSIBLE PARTY: Patsy Walters

Request 36. Provide an analysis of Taylor RECC's expenses for research and development activities for the test year and the three preceding calendar years. For the test year, include the following:

a. The basis of fees paid to research organizations and Taylor RECC's portion of the total revenue of each organization, including where the contribution is monthly and 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 Taylor RECC by each organization during the test year and the preceding calendar year;

d. Total expenditures of each organization including the basic nature of costs incurred by the organization; and

e. Details of the expected benefits to Taylor RECC.

Response 36a. through 36e. This request is not applicable to Taylor County. Taylor County did not have any research or development activities in the test year or the three preceding calendar years.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 37
RESPONSIBLE PARTY:

Request 37. Provide a running total for the following information concerning the cost of preparing the case:

a. A detailed schedule of expenses incurred to date for the following categories: For each category, 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 any invoices, contracts, or other documentation that support charges incurred in the preparation of this rate case. Indicate any costs incurred for this case that occurred during the test year.

(1) Accounting;
(2) Engineering;
(3) Legal;
(4) Consultants; and
(5) Other Expenses (Identify separately).

b. 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 37 a. above, 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 work papers and calculations.

c. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in 37.a. above. Updates will be due when

Taylor RECC files its monthly financial statements with the Commission, through the month of the public hearing.

Response 37a. and 37.b Please see attached. Some of the attachments are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

Response 37c. Taylor County will provide the requested monthly updates of the actual costs incurred in conjunction with the rate case.

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: March 1, 2022	**Invoice #:** 220206
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in February 2022

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Review financial data. Prepare draft unadjusted revenue requirement. Emails and calls with staff on same.	2.0 hours	$225.00	$ 450.00
				TOTAL	**$ 450.00**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
923.00
OTSD 05
SERVICES PROVIDED IN FEB 2022

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/639

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 101749

Vendor	Check Nbr	Check Date	Check Amount
3129	101749	03/10/22	$450.00

Pay FOUR HUNDRED FIFTY DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

⑈101749⑈ [redacted]

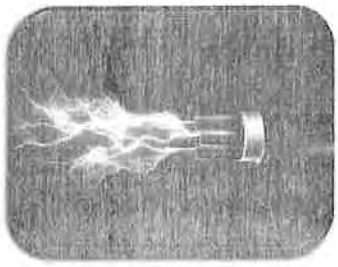
3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 101749
Check Date: 03/10/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
220206	SERVICES PROVIDED IN FEB 2022	03/01/22	~~923.00~~ 183.00	450.00



CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: April 1, 2022	**Invoice #:** 220305
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in March 2022

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Review initial data request responses. Review depreciation study draft. Emails and calls with staff on same.	6.5 hours	$225.00	$ 1,462.50
				TOTAL	**$ 1,462.50**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

#3129
07SD05
923.D
Services Provided in Mar 2022

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 101894

Vendor	Check Nbr	Check Date	Check Amount
3129	101894	04/07/22	$1,462.50

Pay ONE THOUSAND, FOUR HUNDRED SIXTY-TWO DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

⑈101894⑈ [redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 101894
Check Date: 04/07/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
220305	SERVICES PROVIDED IN MAR 2022	04/01/22	~~923.00~~ 183.03	1,462.50

The Prime Group

Date: April 1, 2022

Billed to: Taylor County RECC
625 West Main Street
Campbellsville, KY 42718

Contact: Patsy Walters, Accounting Supervisor

51.0 hours of consulting services for Steve Seelye @ $230.00/hour performed during March working on a Depreciation Study for Taylor County RECC.	$11,730.00
1.50 hours of consulting services for Eric Blake @ $175.00/hour performed during March assisting Seelye with a Depreciation Study for Taylor County RECC.	$ 262.50
Total Amount due for March	**$11,992.50**

Please remit payment to: **The Prime Group, LLC**
P.O. Box 837
Crestwood, KY 40014-0837

Please note that a Late Payment Charge of 3% will be applied to the net amount owed if payment is not received within 60 days of the billing date specified above.

20070
923.00
OTSD 05
DEPRECIATION STUDY

The Prime Group, LLC
P. O. Box 837 • Crestwood, KY • 40014-0837
Phone 502-409-4059 FAX 502-241-4392

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 101930

Vendor	Check Nbr	Check Date	Check Amount
20070	101930	04/07/22	$11,992.50

Pay **ELEVEN THOUSAND, NINE HUNDRED NINETY-TWO DOLLARS AND 50/100 CENTS**

GENERAL FUND

To The
Order Of THE PRIME GROUP LLC
P O BOX 837
CRESTWOOD, KY 40014-0837

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

20070 Please Detach and Retain Statement Check Nbr: 101930
THE PRIME GROUP LLC Check Date: 04/07/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
SA00000000031008	DEPRECIATION STUDY	04/01/22	~~923.00~~ 183.00	11,992.50

CATALYST
CONSULTING LLC
3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: May 1, 2022	**Invoice #:** 220404
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in April 2022

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Process information provided and begin cost of service study. Emails and calls with staff on same.	18.5 hours	$225.00	$ 4,162.50
				TOTAL	**$ 4,162.50**

PW
5/2/22

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
923.00
OTSD 05
SERVICES PROVIDED IN APR 2022

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-760/639

No. 102195

Vendor	Check Nbr	Check Date	Check Amount
3129	102195	05/05/22	$4,162.50

Pay FOUR THOUSAND, ONE HUNDRED SIXTY-TWO DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

⑈102195⑈ [redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 102195
Check Date: 05/05/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
220404	SERVICES PROVIDED IN APR 2022	05/01/22	~~923.00~~ 113.00	4,162.50

The Prime Group

Date: May 1, 2022

#20070
0750 05
2000
923.60

Billed to: Taylor County RECC
625 West Main Street
Campbellsville, KY 42718

Contact: Patsy Walters, Accounting Supervisor

Depreciation Study - Apr 2022

2.0 hours of consulting services for Steve Seelye @ $230.00/hour performed during April working on a Depreciation Study for Taylor County RECC.	$ 460.00
Total Amount due for April	**$ 460.00**

Please remit payment to: **The Prime Group, LLC**
P.O. Box 837
Crestwood, KY 40014-0837

Please note that a Late Payment Charge of 3% will be applied to the net amount owed if payment is not received within 60 days of the billing date specified above.

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42718

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY

No. 102258

Vendor	Check Nbr	Check Date	Check Amount
79070	102258	05/12/22	$460.00

Pay FOUR HUNDRED SIXTY DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of THE PRIME GROUP LLC
P O BOX 837
CRESTWOOD, KY 40014-0837

[redacted]

AM: 460.00 CK: 102258 DT: 05/26 SQ: 80102230 Paid

Journal Entry Memo

DISTRIBUTION

DATE 06/30/22

Voucher No. JE 20220626

	ACCOUNT NO.	TITLE OF ACCOUNT	DEBIT	CREDIT
OTSD 05	18300	PRELIM SURVEY & INVEST CHGS	12,452.50	
	92300	OUTSIDE SERVICES EMPLOYED		(12,452.50)
		THE PRIME GROUP LLC		
		MOVE SERVICES PROVIDED APRIL 2022		
		TO PRELIM SURVEY & INVEST CHGS GL #183.00		
		DEPRECIATION STUDY		
	PREPARED BY:	*Patsy Walters*		
	BOOKKEEPER			

Goss Samford, PLLC
Suite B-325
2365 Harrodsburg Road
Lexington, KY 40504
Telephone: 859-368-7740

May 06, 2022
Invoice No. 6269

Taylor County RECC
Mr. Barry Myers, General Manager
625 West Main Street
Campbellsville, KY 42718

Client Number: 7260 Taylor County RECC
Matter 7260 Taylor County RECC - 2022 General Rate Case
For Services Rendered Through 4/30/2022.

Fees

Date	Timekeeper	Description	Hours	Amount
4/27/2022	LAH	Exchange emails with S. Seelye re depreciation study completed.	0.10	$26.50
4/28/2022	LAH	Office conference with D. Samford re depreciation study complete.	0.10	$26.50
4/28/2022	DSS	Office conference with A. Honaker re depreication study.	0.10	$29.50
		Billable Hours / Fees:	**0.30**	**$82.50** ✓

Timekeeper Summary

Timekeeper LAH worked 0.20 hours at $265.00 per hour, totaling $53.00.

Timekeeper DSS worked 0.10 hours at $295.00 per hour, totaling $29.50.

#7071
OTSD 01
923.00
Depreication Study

Continued On Next Page

#5/20/22 mailed W-9 request with check

Client Number: 7260
Matter Number: 7260

Current Invoice Summary

Prior Balance:	$0.00
Payments Received:	$0.00
Unpaid Prior Balance:	$0.00
Current Fees:	$82.50
Advanced Costs:	$0.00
TOTAL AMOUNT DUE:	**$82.50**

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 102307

Vendor	Check Nbr	Check Date	Check Amount
7071	102307	05/19/22	$82.50

Pay EIGHTY-TWO DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of GOSS SAMFORD, PLLC
SUITE B-325
2365 HARRODSBURG RD
LEXINGTON KY 40504

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

7071 Please Detach and Retain Statement Check Nbr: 102307
GOSS SAMFORD, PLLC Check Date: 05/19/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
6269	DEPREICATION STUDY	05/06/22	~~923.00~~ 183.00	82.50

Journal Entry Memo

DISTRIBUTION

DATE 06/30/22

Voucher No. JE 202206-20

	ACCOUNT NO.	TITLE OF ACCOUNT	DEBIT	CREDIT
OTSD 01	18300	PRELIM SURVEY & INVEST CHGS	82.50	
	92300	OUTSIDE SERVICES EMPLOYED		(82.50)
		GOSS SAMFORD, PLLC		
		MOVE SERVICES PROVIDED APRIL 2022		
		TO PRELIM SURVEY & INVEST CHGS GL #183.00		
		DEPRECIATION STUDY		
	PREPARED BY:	*Patsy Walters*		
	BOOKKEEPER			

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: June 1, 2022	**Invoice #:** 220506
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in May 2022

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Process information provided included purchased power, functional assignment, and zero intercept analyses. Emails and calls with staff on same.	6.5 hours	$225.00	$ 1,462.50
				TOTAL	**$ 1,462.50**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

P O _____
Rec'd Patsy Date 06/01/2022
Price & Ext _____
Posted _____ Acct No. _____
Approved JM
Check No _____

3129
923.00
OTSO OS
SERVICES PROVIDED IN MAY 2022

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719

A Touchstone Energy® Cooperative

VOID VOID

No. 102395

Vendor	Check Nbr	Check Date	Check Amount
3129	102395	06/09/22	$1,462.50

Pay ONE THOUSAND, FOUR HUNDRED SIXTY-TWO DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129 Please Detach and Retain Statement Check Nbr: 102395
CATALYST CONSULTING LLC Check Date: 06/09/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
220506	SERVICES PROVIDED IN MAY 2022	06/01/22	~~923.00~~ 183.00	1,462.50

Journal Entry Memo

DISTRIBUTION

DATE 06/30/22

Voucher No. JE 202206-25

	ACCOUNT NO.	TITLE OF ACCOUNT	DEBIT	CREDIT
OTSD 05	18300	PRELIM SURVEY & INVEST CHGS	7,537.50	
	92300	OUTSIDE SERVICES EMPLOYED		(7,537.50)
		CATALYST CONSULTING LLC		
		MOVE SERVICES PROVIDED FROM FEB-MAY 2022		
		TO PRELIM SURVEY & INVEST CHGS GL #183.00		
		COST OF SERVICE & RATE STUDY		
	PREPARED BY:	*Patsy Walters*		
	BOOKKEEPER			

Goss Samford, PLLC
Suite B-325
2365 Harrodsburg Road
Lexington, KY 40504
Telephone: 859-368-7740

July 11, 2022

Invoice No. 6389

Taylor County RECC
Mr. Barry Myers, General Manager
625 West Main Street
Campbellsville, KY 42718

Client Number: 7260 Taylor County RECC
Matter 7260 Taylor County RECC - 2022 General Rate Case
For Services Rendered Through 6/30/2022.

Fees

Date	Timekeeper	Description	Hours	Amount
6/10/2022	LAH	Office conference with D. Samford re entry of appearance for environmental surcharge review case; review email and attachments from P. Walters; draft Entry of Appearance and Statement Regarding Electronic Procedures; draft cover letter; prepare both documents for filing; email documents to P. Walters for review and approval; electronically file same.	0.70	$185.50
6/10/2022	DSS	Office conference with A. Honaker re case status.	0.10	$29.50
		Billable Hours / Fees:	**0.80**	**$215.00** ✓

Timekeeper Summary

Timekeeper LAH worked 0.70 hours at $265.00 per hour, totaling $185.50.

Timekeeper DSS worked 0.10 hours at $295.00 per hour, totaling $29.50.

Payment Detail

Date	Description	Amount
5/27/2022	Check Number 102307 against Inv# 6269	($82.50)
	Total Payments Received:	**($82.50)**

Continued On Next Page

Client Number: 7260
Matter Number: 7260

Current Invoice Summary

Prior Balance:	$82.50
Payments Received:	($82.50)
Unpaid Prior Balance:	$0.00
Current Fees:	$215.00
Advanced Costs:	$0.00
TOTAL AMOUNT DUE:	**$215.00**

Last Payment: 5/27/2022

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-768/839

No. 102806

Vendor	Check Nbr	Check Date	Check Amount
7071	102806	07/21/22	$215.00

Pay TWO HUNDRED FIFTEEN DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of GOSS SAMFORD, PLLC
SUITE B-325
2365 HARRODSBURG RD
LEXINGTON KY 40504

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

7071
GOSS SAMFORD, PLLC

Please Detach and Retain Statement

Check Nbr: 102806
Check Date: 07/21/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
6389	2022 GENERAL RATE CASE	07/11/22	183.00	215.00

Goss Samford, PLLC
Suite B-325
2365 Harrodsburg Road
Lexington, KY 40504
Telephone: 859-368-7740

August 09, 2022
Invoice No. 6434

Taylor County RECC
Mr. Barry Myers, General Manager
625 West Main Street
Campbellsville, KY 42718

Client Number: 7260 Taylor County RECC
Matter 7260 Taylor County RECC - 2022 General Rate Case
For Services Rendered Through 7/31/2022.

Fees

Date	Timekeeper	Description	Hours	Amount
7/29/2022	LAH	Telephone conference with J. Williams re updates and board meeting documents.	0.50	$132.50
		Billable Hours / Fees:	**0.50**	**$132.50** ✓

Timekeeper Summary

Timekeeper LAH worked 0.50 hours at $265.00 per hour, totaling $132.50.

Payment Detail

Date	Description	Amount
7/27/2022	Check Number 102806 against Inv# 6389	($215.00)
	Total Payments Received:	**($215.00)**

Continued On Next Page

Client Number: 7260
Matter Number: 7260

Current Invoice Summary

Prior Balance:	$215.00
Payments Received:	($215.00)
Unpaid Prior Balance:	$0.00
Current Fees:	$132.50
Advanced Costs:	$0.00
TOTAL AMOUNT DUE:	**$132.50**

Last Payment: 7/27/2022

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719

A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 103153

Vendor	Check Nbr	Check Date	Check Amount
7071	103153	09/01/22	$132.50

Pay ONE HUNDRED THIRTY-TWO DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of GOSS SAMFORD, PLLC
SUITE B-325
2365 HARRODSBURG RD
LEXINGTON KY 40504

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

7071 Please Detach and Retain Statement Check Nbr: 103153
GOSS SAMFORD, PLLC Check Date: 09/01/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
6434	2022 GENERAL RATE CASE	08/09/22	183.00	132.50

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: November 1, 2022	**Invoice #:** 221005
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in October 2022

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Continue COS modeling. Emails and calls with staff on same.	9.5 hours	$225.00	$ 2,137.50
				TOTAL	**$ 2,137.50**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

Recd _____ Date _____
Price & Ext _____
Posted _____ Acct No. ___
Approved _____
Check No _____

3129
[redacted] 183.00
OTSD 05
Services provided in Oct 2022

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719

A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

VOID

No. 103594

Vendor	Check Nbr	Check Date	Check Amount
3129	103594	11/10/22	$2,137.50

Pay TWO THOUSAND, ONE HUNDRED THIRTY-SEVEN DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 103594
Check Date: 11/10/22

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
221005	SERVICES PROVIDED IN OCT 2022	11/01/22	183.00	2,137.50

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: February 1, 2023	**Invoice #:** 230105
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in January 2023

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Complete unadjusted COS. Emails and calls with staff on same.	9.0 hours	$225.00	$ 2,025.00
				TOTAL	**$ 2,025.00**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
183.00
OTSD OS
SERVICES PROVIDED IN JAN 2023

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 104250

Vendor	Check Nbr	Check Date	Check Amount
3129	104250	02/09/23	$2,025.00

Pay TWO THOUSAND, TWENTY-FIVE DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 104250
Check Date: 02/09/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
230105	SERVICES PROVIDED IN JAN 2023	02/01/23	183.00	2,025.00

HONAKER LAW OFFICE

L. Allyson Honaker
allyson@hloky.com
(859) 368-8803 (office)
(859)396-3172 (mobile)

1795 Alysheba Way, Ste 6202
Lexington, KY 40509

February 06, 2023

Invoice No. 214

Taylor County RECC
Mr. Jeff Williams
PO Box 100
Campbellsville, KY 42718

JEFF RATE CASE 183 Account

Client Number: 07340 Taylor County RECC
Matter Number: 07340-0002 Taylor County RECC- 2023 Rate
For Services Rendered Through 1/31/2023.

Fees

Date	Timekeeper	Description	Hours	Amount
1/22/2023	LAH	Exchange emails with B. Koenig re drafting list of exhibits needed for full rate case.	0.10	$26.50
1/23/2023	BHK	Compiled draft list of exhibits for client to begin compiling information for the rate case. Sent to A. Honaker for review.	0.70	$175.00
1/23/2023	LAH	Review email and draft exhibit list from B. Koenig re rate case filing; email B. Koenig re same.	0.20	$53.00
1/24/2023	BHK	Revise list of exhibits re: witness coverage from John Wolfram.	0.40	$100.00
1/24/2023	LAH	Exchange emails with B. Koenig re exhibit list.	0.10	$26.50
1/25/2023	BHK	Revise list of exhibits and sent to Patsy Walters and team to begin preparation for rate case.	0.40	$100.00
1/25/2023	LAH	Review email from B. Koenig to P. Walters re exhibit list.	0.10	$26.50
1/26/2023	LAH	Exchange texts with J. Wolfram re timing of filing rate case; update B. Koenig on status.	0.20	$53.00

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

1/27/2023	LAH	Exchange emails with B. Koenig re drafting outlines for Application and Testimony; telephone conference with J. Wolfram re status.	0.30	$79.50
1/31/2023	BHK	Review of last rate case 2012-00023, review of witnesses needed and notes, and preparation for new rate case.	1.60	$400.00
		Billable Hours / Fees:	**4.10**	**$1,040.00**

Timekeeper Summary

Timekeeper LAH worked 1.00 hours at $265.00 per hour, totaling $265.00.

Timekeeper BHK worked 3.10 hours at $250.00 per hour, totaling $775.00.

Current Invoice Summary

Prior Balance:	$0.00
Payments Received:	$0.00
Unpaid Prior Balance:	$0.00
Current Fees:	$1,040.00
Advanced Costs:	$0.00
TOTAL AMOUNT DUE:	**$1,040.00**

Thank You for Letting Us Serve You.
Payment Due Upon Receipt.

P O _____
Recd _____ Date _____
Price & Ext 805.00
Posted _____ Acct No. 183.00
Approved _____ UTSO 01
Check No _____ 2023 GENERAL RATE CASE

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 104356

Vendor	Check Nbr	Check Date	Check Amount
8056	104356	02/16/23	$5,415.00

Pay FIVE THOUSAND, FOUR HUNDRED FIFTEEN DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of HONAKER LAW OFFICE PLLC
1795 ALYSHEBA WAY, STE 6202
LEXINGTON KY 40509

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

8056
HONAKER LAW OFFICE PLLC

Please Detach and Retain Statement

Check Nbr: 104356
Check Date: 02/16/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
213	JAN 2023 BILLING	02/06/23	923.00	4,375.00
214	2023 GENERAL RATE CASE	02/06/23	183.00	1,040.00

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: March 1, 2023	**Invoice #:** 230207
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in February 2023

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Present unadjusted results to BOD. Emails and calls with staff on same.	7.0 hours	$225.00	$ 1,575.00
2	Mileage	2/20 Travel to Campbellsville	182.0 miles	$0.655	$119.21
				TOTAL	**$ 1,694.21**

PW

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
183.00
OTSD 05
Services Provided in FEB 2023

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719

A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 104442

Vendor	Check Nbr	Check Date	Check Amount
3129	104442	03/09/23	$1,694.21

Pay ONE THOUSAND, SIX HUNDRED NINETY-FOUR DOLLARS AND 21/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 104442
Check Date: 03/09/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
230207	SERVICES PROVIDED IN FEB 2023	03/01/23	183.00	1,694.21

HONAKER
LAW
OFFICE

L. Allyson Honaker
allyson@hloky.com
(859) 368-8803 (office)
(859)396-3172 (mobile)

#8054
193.00
OTSO 01
2023 General Rate Case

1795 Alysheba Way, Ste 6202
Lexington, KY 40509

March 06, 2023
Invoice No. 236

Taylor County RECC
Mr. Jeff Williams
PO Box 100
Campbellsville, KY 42718

Client Number: 07340 Taylor County RECC
Matter 07340-0002 Taylor County RECC - 2023 Rate
For Services Rendered Through 2/28/2023.

Fees

Date	Timekeeper	Description	Hours	Amount
2/17/2023	LAH	Exchange multiple emails with J. Wolfram re upcoming board meeting.	0.20	$53.00
2/17/2023	LAH	Begin review of information to draft pleadings for rate case filing; review statutes and regulations re same.	1.00	$265.00
2/19/2023	LAH	Review slide deck presentaton for board meeting prepared by J. Wolfram.	0.50	$132.50
2/20/2023	BHK	Attend meeting to discuss the rate case and unadjusted cost of service study prepared by J. Wolfram. Discussion regarding procedure and comparing customer charge of Kentucky's co-ops and policies of the PSC of gradualism, non-recurring charge policy, case precedent regarding changes to charges for certain classes of customers. Discussion regarding talking-points for customer service and board members to explain that Taylor Co RECC has avoided a rate increase for longer than most and now it is reasonable and appropriate to seek a rate case to insure that the utility is able to maintain safe reliable service to its members.	1.50	$375.00

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

2/20/2023	BHK	Discussion with A. Honaker and review of rate materials required, as well as draft proposal of cost of service study power point in preparation for the board meeting regarding the rate case.	0.50	$125.00
2/20/2023	LAH	Review statutes and regulations to prepare for board meeting to discuss unadjusted COSS with J. Wolfram; attend board meeting and participate in discussion on unadjusted COSS; edit Resolution and forward same to L. Marcum for signatures; separate conferences with B. Koenig re meeting and next steps.	2.00	$530.00
2/20/2023	LAH	Exchange emails with J. Williams re B. Koenig attending board meeting; exchange emails with B. Koenig re same; forward slide presentation to B. Koenig to prepare for meeting.	0.30	$79.50
2/24/2023	LAH	Review prior rate case filings and make notes for items to include in Taylor County's rate proceeding.	2.00	$530.00
		Billable Hours / Fees:	**8.00**	**$2,090.00**

Timekeeper Summary

Timekeeper LAH worked 6.00 hours at $265.00 per hour, totaling $1,590.00.

Timekeeper BHK worked 2.00 hours at $250.00 per hour, totaling $500.00.

Payment Detail

Date	Description	Amount
2/21/2023	Check Number 104356 against Inv# 214	($1,040.00)
	Total Payments Received:	**($1,040.00)**

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

3/6/2023
Page: 3

Current Invoice Summary

Prior Balance:	$1,040.00	
Payments Received:	($1,040.00)	**Last Payment: 2/21/2023**
Unpaid Prior Balance:	$0.00	
Current Fees:	$2,090.00	
Advanced Costs:	$0.00	
TOTAL AMOUNT DUE:	**$2,090.00**	

Thank You for Letting Us Serve You.
Payment Due Upon Receipt.

P O _____
Recd _____ Date _____
Price & Ext _____
Posted _____ Acct No. _____
Approved _____
Check No _____

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 104554

Vendor	Check Nbr	Check Date	Check Amount
8056	104554	03/16/23	$3,365.00

Pay THREE THOUSAND, THREE HUNDRED SIXTY-FIVE DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of HONAKER LAW OFFICE PLLC
1795 ALYSHEBA WAY, STE 6202
LEXINGTON KY 40509

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

8056 Please Detach and Retain Statement Check Nbr: 104554
HONAKER LAW OFFICE PLLC Check Date: 03/16/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
235	FEB 2023 BILLING	03/06/23	923.00	1,275.00
236	2023 GENERAL RATE CASE	03/06/23	183.00	2,090.00

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: April 1, 2023	**Invoice #:** 230304
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. _____ For Services Provided in March 2023

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Update pro forma adjustments, COS and rate design. Emails and calls with staff on same.	6.0 hours	$225.00	$ 1,350.00
				TOTAL	**$ 1,350.00**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
183.00
OTSD 05
Services Provided in MAR 2023

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/639

No. 104647

Vendor	Check Nbr	Check Date	Check Amount
3129	104647	04/06/23	$1,350.00

Pay ONE THOUSAND, THREE HUNDRED FIFTY DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 104647
Check Date: 04/06/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
230304	SERVICES PROVIDED IN MAR 2023	04/01/23	183.00	1,350.00

HONAKER
LAW
OFFICE

L. Allyson Honaker
allyson@hloky.com
(859) 368-8803 (office)
(859)396-3172 (mobile)

1795 Alysheba Way, Ste 6202
Lexington, KY 40509

April 05, 2023

Invoice No. 285

Taylor County RECC
Mr. Jeff Williams
PO Box 100
Campbellsville, KY 42718

Client Number: 07340 Taylor County RECC
Matter Number: 07340-0002 Taylor County RECC- 2023 Rate
For Services Rendered Through 3/31/2023.

Fees

Date	Timekeeper	Description	Hours	Amount
3/13/2023	LAH	Telephone conference with B. Koenig re starting drafts for Application, etc.	0.20	$53.00
3/13/2023	LAH	Telephone conference with A. Honaker re drafts of Application and Testimony status.	0.20	$53.00
3/21/2023	BHK	Discussion regarding preparation of testimony and application exhibits, timing of filing and work plan to complete materials for client timeline with A. Honaker coordinating with J. Wolfram and client.	0.30	$75.00
3/21/2023	LAH	Conference with B. Koenig re timeline for filing application and progress of same.	0.30	$79.50
3/26/2023	LAH	Draft portions of Application and Testimony for rate filing.	1.80	$477.00
3/27/2023	LAH	Complete draft of Application and Testimony of J. Williams; begin preparing cover sheets for exhibits from table of contents.	2.80	$742.00
3/27/2023	LAH	Exchange texts and emails with J. Williams re depreciation study and meeting to discuss rate case.	0.10	$26.50

Continued On Next Page

3/28/2023	LAH	Exchange texts and emails with J. Wolfram re rate case.	0.10	$26.50
3/30/2023	LAH	Review draft Application and edit same; complete drafts of cover sheets for exhibits; review table of contents and make edits to same.	1.20	$318.00
3/30/2023	BHK	Discussion with A. Honaker regarding work in progress on application and kick-off meeting set for 3-31.	0.20	$50.00
3/30/2023	LAH	Review texts and email re meeting scheduled for rate case; email same to B. Koenig; telephone conference with B. Koenig re same.	0.20	$53.00
3/31/2023	LAH	Participate in video conference with J. Williams, et. al. re status of rate proceeding; telephone conference with B. Koenig re same and estimated dates for filing; review J. Williams draft testimony and edit same from meeting; begin draft of P. Walters' testimony.	1.70	$450.50
3/31/2023	BHK	Discussion regarding meeting to start rate case and set timing for notice and filing. Notes for materials still in progress and reports needed to file.	0.30	$75.00
		Billable Hours / Fees:	**9.40**	**$2,479.00**

Timekeeper Summary

Timekeeper LAH worked 8.60 hours at $265.00 per hour, totaling $2,279.00.

Timekeeper BHK worked 0.80 hours at $250.00 per hour, totaling $200.00.

Payment Detail

Date	Description	Amount
3/21/2023	Check Number 104554 against Inv# 236	($2,090.00)
	Total Payments Received:	**($2,090.00)**

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

4/5/2023
Page: 3

Current Invoice Summary

Prior Balance:	$2,090.00
Payments Received:	($2,090.00)
Unpaid Prior Balance:	$0.00
Current Fees:	$2,479.00
Advanced Costs:	$0.00
TOTAL AMOUNT DUE:	**$2,479.00**

Last Payment: 3/21/2023

Thank You for Letting Us Serve You.
Payment Due Upon Receipt.

P.O. _____
Recd _____ Date _____
Price & Ext _____
Posted _____ Acct No
Approved _____
Check No

8056
183.00
OTSO 01
2023 General Rate Case

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 104789

Vendor	Check Nbr	Check Date	Check Amount
8056	104789	04/17/23	$3,054.00

Pay THREE THOUSAND, FIFTY-FOUR DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of HONAKER LAW OFFICE PLLC
1795 ALYSHEBA WAY, STE 6202
LEXINGTON KY 40509

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

8056 Please Detach and Retain Statement Check Nbr: 104789
HONAKER LAW OFFICE PLLC Check Date: 04/17/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
284	MAR 2023 BILLING	04/05/23	923.00	575.00
285	2023 GENERAL RATE CASE	04/05/23	183.00	2,479.00

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: May 1, 2023	**Invoice #:** 230403
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Review Case No. 2023-00147 For Services Provided in April 2023

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Finalize analysis of pro forma adjustments, COS and rate design. Present to BOD. Review notices. Emails and calls with staff on same.	10.0 hours	$225.00	$ 2,250.00
				TOTAL	**$ 2,250.00**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

3129
183.00
OTSD OS
SERVICES PROVIDED IN APR 2023

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 104901

Vendor	Check Nbr	Check Date	Check Amount
3129	104901	05/04/23	$2,250.00

Pay TWO THOUSAND, TWO HUNDRED FIFTY DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129
CATALYST CONSULTING LLC

Please Detach and Retain Statement

Check Nbr: 104901
Check Date: 05/04/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
230403	SERVIES PROVIDED IN APR 2023	05/01/23	183.00	2,250.00

HONAKER LAW OFFICE

L. Allyson Honaker
allyson@hloky.com
(859) 368-8803 (office)
(859)396-3172 (mobile)

1795 Alysheba Way, Ste 6202
Lexington, KY 40509

May 07, 2023
Invoice No. 317

Taylor County RECC
Mr. Jeff Williams
PO Box 100
Campbellsville, KY 42718

Client Number: 07340 Taylor County RECC
Matter 07340-0002 Taylor County RECC- 2023 Rate
For Services Rendered Through 4/30/2023.

Fees

Date	Timekeeper	Description	Hours	Amount
4/1/2023	BHK	Review email from J. Wolfram and A. Honaker re: reports ready for review for rate case.	0.30	$75.00
4/2/2023	LAH	Review lengthy email from J. Wolfram re COSS; review near final drafts attached by J. Wolfram; continue drafting testimony of P. Walters.	1.30	$344.50
4/3/2023	LAH	Exchange emails with B. Koenig re attachments provided by J. Wolfram; forward attachments to B. Koenig; review drafts of Application, Cover Sheets and Testimony of J. Williams and edit same; complete draft Q&A for P. Walters; office conference with B. Koenig re review of same; review multiple emails from P. Walters with draft exhibits; begin reviewing exhibits.	3.00	$795.00
4/3/2023	BHK	Review excel reports from J. Wolfram for cost of service study, proposed rates and revenue requirement for rate case application.	0.50	$125.00
4/4/2023	LAH	Email to B. Koenig re drafts ready for review.	0.10	$26.50

Continued On Next Page

Client Number: 07340 5/7/2023
Matter Number: 07340-0002 Page: 2

4/4/2023	BHK	Email re: work plan and testimony, exhibits review for A. Honaker to send to client.	0.20	$50.00
4/5/2023	BHK	Review draft testimony for Patsy Walters.	0.30	$75.00
4/5/2023	BHK	Review and edit draft testimony of Jeff Williams for application.	0.50	$125.00
4/5/2023	BHK	Review of draft of application text.	0.40	$100.00
4/5/2023	LAH	Review email and edits from B. Koenig to testimony; combine all drafts into zip file and email same to J. Williams, P. Walters and J. Wolfram for review and comment.	0.40	$106.00
4/6/2023	BHK	Review of 32 exhibits-cover sheets to look for edits and to look for material still needed from client and consultant.	0.50	$125.00
4/6/2023	LAH	Review email from B. Koenig re exhibit cover sheets.	0.10	$26.50
4/11/2023	LAH	Exchange emails with J. Williams re rate case and notice.	0.10	$26.50
4/12/2023	BHK	Review emails from Williams, J. Wolfram, A. Honaker, P. Walters re: rate case preparation.	0.30	$75.00
4/12/2023	BHK	Review excel spreadsheets from J. Wolfram for rate case, COSS, and rate requirements.	0.40	$100.00
4/12/2023	LAH	Review emails and excel spreadsheets from COSS from J. Wolfram to prepare for meeting.	0.60	$159.00
4/12/2023	LAH	Review multiple emails and attachments from P. Walters re exhibits for rate case; edit and update exhibit cover sheets with information provided by P. Walters; review testimony and edit same; begin draft of customer notice; telephone conference with B. Koenig re status of drafts.	2.20	$583.00
4/13/2023	BHK	Meeting with J. Williams, P.Walters, J. Wolfram, A.Honaker re: rate case materials and presentation of rate case to board of directors.	0.50	$125.00
4/13/2023	LAH	Video conference with J. Williams, et. al. re rate case updates.	0.50	$132.50
4/13/2023	BHK	Review of materials sent by J. Wolfram re: rates, customer charge, and energy charge in preparation for meeting with board re: rate case application.	0.40	$100.00
4/19/2023	BHK	Review cost of service study revisions, power point deck and excel sheets for revenue requirement in preparation for scheduled board meeting at 1pm on 4-20-23.	0.60	$150.00
4/19/2023	BHK	Discussion with A. Honaker re: Taylor County RECC rate case, and meeting with board and revisions from J. Wolfram.	0.30	$75.00

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

4/19/2023	LAH	Telephone conference with J. Williams re board meeting; exchange texts with J. Wolfram re COSS; review emails from J. Wolfram and J. Williams re same; review COSS files provided by J. Wolfram to prepare for board meeting; review slide presentation from J. Wolfram for meeting.	0.80	$212.00
4/20/2023	LAH	Telephone conference with J. Wolfram re board meeting.	0.10	$26.50
4/20/2023	LAH	Draft Board Resolution for rate case filing.	0.40	$106.00
4/20/2023	LAH	Participate in board meeting for COSS presentation from J. Wolfram.	0.50	$132.50
4/20/2023	BHK	Meeting with J. Williams, and Taylor County RECC Board Meeting, J. Wolfram, A. Honaker, regarding the materials prepared by J. Wolfram and charges to request in rate application.	0.50	$125.00
4/20/2023	BHK	Discussion with A. Honaker re: rate case application requirements and preparation for timeline of Notice to customers and notices to file with the PSC.	0.40	$100.00
4/20/2023	LAH	Participate in virtual meeting with J. Williams, and Taylor County RECC regarding the materials prepared by J. Wolfram and charges to request in rate application.	0.50	$132.50
4/27/2023	BHK	Review of rate case information for customer notice from J. Wolfram and A. Honaker.	0.30	$75.00
4/27/2023	LAH	Exchange multiple emails with J. Williams and J. Wolfram re customer notice; review and edit draft customer notice; review information provided by J. Wolfram for rate tables for customer notice; revise and insert customer tables to notice; telephone conference with J. Wolfram re changes to COSS; review board resolution; send customer notice to J. Wolfram and B. Koenig for review; review changes to rates from J. Wolfram; prepare final version of customer notice and email same to J. Williams, et. al. for Kentucky Living.	0.90	$238.50
4/28/2023	BHK	Review of emails re: Customer Notice to Ky Living, Notice filings to PSC and revisions made by J. Wolfram regarding rates for Notice.	0.30	$75.00
4/28/2023	LAH	Draft notice to use electronic procedures and cover letter; email same to Commission for filing; email exchange with J. Williams, et. al. re filing complete; review acknowledgment letter for filing and case number assigned.	0.30	$79.50

Continued On Next Page

Client Number: 07340
Matter Number: 07340-0002

5/7/2023
Page: 4

4/28/2023	LAH	Review emails from P. Walters re questions on exhibits; review draft documents to continue preparing for rate case.	0.90	$238.50
		Billable Hours / Fees:	**19.40**	**$5,040.50**

Timekeeper Summary

Timekeeper LAH worked 12.70 hours at $265.00 per hour, totaling $3,365.50.

Timekeeper BHK worked 6.70 hours at $250.00 per hour, totaling $1,675.00.

Payment Detail

Date	Description	Amount
4/20/2023	Check Number 104789 against Inv# 285	($2,479.00)
	Total Payments Received:	**($2,479.00)**

Current Invoice Summary

Prior Balance:	$2,479.00	
Payments Received:	($2,479.00)	**Last Payment: 4/20/2023**
Unpaid Prior Balance:	$0.00	
Current Fees:	$5,040.50	
Advanced Costs:	$0.00	
TOTAL AMOUNT DUE:	**$5,040.50**	

Thank You for Letting Us Serve You.
Payment Due Upon Receipt.

P O #8056
Recd Date 07SD 01
Price & Ext 2000
Posted Acct No.
Approved 183.00
Check No
2023 General Rate Case

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-786/839

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

No. 105044

Vendor	Check Nbr	Check Date	Check Amount
8056	105044	05/18/23	$6,340.50

Pay SIX THOUSAND, THREE HUNDRED FORTY DOLLARS AND 50/100 CENTS

GENERAL FUND

To The
Order Of HONAKER LAW OFFICE PLLC
1795 ALYSHEBA WAY, STE 6202
LEXINGTON KY 40509

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

8056
HONAKER LAW OFFICE PLLC

Please Detach and Retain Statement

Check Nbr: 105044
Check Date: 05/18/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
316	2023 GENERAL RATE CASE	05/07/23	923.00	1,300.00
317	2023 GENERAL RATE CASE	05/07/23	183.00	5,040.50

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: June 1, 2023	**Invoice #:** 230506
Client: Taylor County RECC P. O. Box 100 Campbellsville, KY 42719 Attn: Patsy Walters	**Project:** 2021 Rate Filing Case No. 2023-00147 For Services Provided in May 2023

#	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support for 2021 rate review. Prepare final testimony and exhibits. Review draft filing. Emails and calls with staff on same.	15.0 hours	$225.00	$ 3,375.00
				TOTAL	**$ 3,375.00**

Please remit payment to Catalyst Consulting LLC as noted above. Thank you.

#3129
183.00
OTSD 05
SERVICES PROVIDED IN MAY 2023

TAYLOR COUNTY RECC
P.O. BOX 100
CAMPBELLSVILLE, KENTUCKY 42719
A Touchstone Energy® Cooperative

TAYLOR COUNTY BANK - CAMPBELLSVILLE, KY 73-788/839

No. 105115

Vendor	Check Nbr	Check Date	Check Amount
3129	105115	06/08/23	$3,375.00

Pay THREE THOUSAND, THREE HUNDRED SEVENTY-FIVE DOLLARS AND 00/100 CENTS

GENERAL FUND

To The
Order Of CATALYST CONSULTING LLC
3308 HADDON ROAD
LOUISVILLE KY 40241

AUTHORIZED SIGNATURE

AUTHORIZED SIGNATURE

[redacted]

3129 Please Detach and Retain Statement Check Nbr: 105115
CATALYST CONSULTING LLC Check Date: 06/08/23

We herewith hand you our check in settlement of items listed below.

Invoice Nbr	Description	Invoice Date	Exp Acct	Amount
230506	SERVICES PROVIDED IN MAY 2023	06/01/23	183.00	3,375.00

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 38
RESPONSIBLE PARTY: Patsy Walters

Request 38. Provide the following information for the most recent calendar year concerning Taylor RECC and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs charged, either directly or allocated, by the service company to Taylor RECC. Indicate Taylor RECC's accounts where these costs were 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 company to Taylor RECC. Indicate Taylor RECC's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

Response 38a. and 38b. Please refer to Taylor County's Application Exhibit 24. Taylor County had no amounts charged or allocated to it by an affiliate during the most recent calendar year.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 39
RESPONSIBLE PARTY: Patsy Walters

Request 39. Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 38:

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

b. Provide the names of affiliates to whom Taylor RECC provided some form of service and the type of service Taylor RECC 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 39a. through 39c. Please refer to Taylor County's response to Request Nos. 38a and b above.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 40
RESPONSIBLE PARTY: Patsy Walters

Request 40. Describe Taylor RECC'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 40. Taylor County has not engaged in lobbying activities.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 41
RESPONSIBLE PARTY: Patsy Walters

Request 41. Regarding demand-side management, conservation, and energy-efficiency programs, provide the following:

a. A list of all programs currently offered by Taylor RECC.

b. The total cost incurred for thee programs by Taylor RECC in each of the three most recent calendar years.

c. The total energy and demand reductions realized through these programs in each of the three most recent calendar years.

d. The total cost for these programs included in the test year and expected energy reductions to be realized from these programs.

Response 41a. **SimpleSaver-AC and Water Heater** - This program allows for the installation of utility provided switches on air conditioners and water heaters that can be managed by the utility during peak usage to reduce load.

SimpleSaver –Thermostat - This program allows for the installation of utility provided thermostats. Participation in this program can be managed by the utility during peak usage to reduce load.

Touchstone Energy Home - The program offers an incentive to encourage new homes to be built to higher standards for thermal integrity and equipment efficiency including high efficient air-to-air heat pumps or geothermal heat pumps.

Button-Up - The program offers incentives to End-Use Retail Members ("retail member") who add insulation in the attic and use weatherization techniques to reduce heat loss in the home.

Heat Pump Retrofit - The program provides an incentive to retail members to convert the home from less efficient resistive heat sources to more efficient air-to-air heat pumps, geothermal heat pumps, or mini-split heat pumps.

Energy Star Manufactured Home - The program provides an incentive to the retail member to purchase a new manufactured home constructed to ENERGY STAR® standards for manufactured homes.

Response 41b.

Costs related to demand-side management, conservation, and energy-efficiency programs.				
		2020	**2021**	**2022**
Revenues from EKPC				
	Incentive to member	17,305.00	19,230.00	13,510.00
	Lost Revenue	23,024.00	30,041.00	9,708.00
	Administrative Cost	1,800.00	2,520.00	1,040.00
		42,129.00	51,791.00	24,258.00
Expenses				
	Incentive to member	17,305.00	19,230.00	13,510.00
	Labor, Benefits, Uniforms, Transportation	37,990.88	42,483.43	44,298.71
		55,295.88	61,713.43	57,808.71
	Net Income/(Expense)	(13,166.88)	(9,922.43)	(33,550.71)

Response 41c.

January 01, 2020 to December 31, 2020

Owner-Member	Taylor County RECC	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2020			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
Residential	771	771	167	166,548	0.005	0.009
CFL	750	750	18	18,000	0.003	0.002
ENERGY STAR MANUFACTURED HOME	2	2	8	8,120	0.002	0.001
Heat Pump Retrofit (14 SEER)	12	12	90	90,396	0.000	0.004
Heat Pump Retrofit (15 SEER & up / Geo)	7	7	50	50,032	0.000	0.003
Total	771	771	167	166,548	0.005	0.009
MWh	167					
Winter MW	0.005					
Summer MW	0.009					

January 01, 2022 to December 31, 2022

Owner-Member	Taylor County RECC	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2022			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
Residential	4,012	4,012	184	183,847	0.022	0.016
Button Up - Level I	1	1	8	7,649	0.006	0.002
Heat Pump Retrofit (14 SEER)	2	2	15	15,066	0.000	0.001
Heat Pump Retrofit (15 SEER & up / Geo)	9	9	65	65,132	0.000	0.004
LED	4,000	4,000	96	96,000	0.016	0.010
Total	4,012	4,012	184	183,847	0.022	0.016
MWh	184					
Winter MW	0.022					
Summer MW	0.016					

January 01, 2021 to December 31, 2021

Owner-Member	Taylor County RECC	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2021			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
Residential	127	127	186	185,930	0.000	0.009
CFL	100	100	2	2,400	0.000	0.000
Heat Pump Retrofit (14 SEER)	16	16	105	105,462	0.000	0.004
Heat Pump Retrofit (15 SEER & up / Geo)	11	11	78	78,068	0.000	0.004
LED	0	0	0	0	0.000	0.000
Total	127	127	186	185,930	0.000	0.009
MWh	186					
Winter MW	0.000					
Summer MW	0.009					

Response 41d.

Costs related to demand-side management, conservation, and energy-efficiency programs.		
		Test Year - 2021
Revenues from EKPC		
	Incentive to member	19,230.00
	Lost Revenue	30,041.00
	Administrative Cost	2,520.00
		51,791.00
Expenses		
	Incentive to member	19,230.00
	Labor, Benefits, Uniforms, Transportation	42,483.43
		61,713.43
	Net Income/(Expense)	(9,922.43)

January 01, 2021 to December 31, 2021

Owner-Member	Taylor County RECC	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2021			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
Residential	127	127	186	185,930	0.000	0.009
CFL	100	100	2	2,400	0.000	0.000
Heat Pump Retrofit (14 SEER)	16	16	105	105,462	0.000	0.004
Heat Pump Retrofit (15 SEER & up / Geo)	11	11	78	78,068	0.000	0.004
LED	0	0	0	0	0.000	0.000
Total	127	127	186	185,930	0.000	0.009
MWh	186					
Winter MW	0.000					
Summer MW	0.009					

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 42
RESPONSIBLE PARTY: Patsy Walters

Request 42. Provide the following information with regard to uncollectible accounts for the test year and three preceding calendar years (taxable year acceptable):

a. Reserve account balance at the beginning of the year;
b. Charges to 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 42.a. through 42.f. - Please see attached. The attachments are Excel spreadsheets that are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 43
RESPONSIBLE PARTY: Patsy Walters

Request 43. Provide an analysis of Other Operating Taxes as shown in Schedule J for the most recent calendar year.

Response 43. Please see attached. The attachments are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 44
RESPONSIBLE PARTY: Patsy Walters

Request 44. Provide a detailed analysis of expenses incurred during the test year for professional services, as shown in Schedule K, 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 Taylor RECC according to each invoice, and a description of the services performed.

Response 44.

Schedule K

Taylor County Rural Electric Cooperative Corporation Case #2023-00147

Analysis of Professional Services Expenses For The Test Year

line No.	Item (a)	Rate Case (b)	Annual Audit (c)	other (d)	total (e)
1	Legal			$ 64,203.15	$ 64,203.15
2	Engineering			$ 44,994.46	$ 44,994.46
3	Accounting		$ 13,750.00	$ 800.00	$ 14,550.00
4	Other				$ -
5	Total		$ 13,750.00	$ 109,997.61	$ 123,747.61

Please see the attached work papers. The work papers are Excel spreadsheets which are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 45
RESPONSIBLE PARTY: Patsy Walters

Request 45. Provide the following information for Taylor RECC. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

a. A detailed analysis of all charges booked during the text year for advertising expenditures. Include a complete breakdown of Account No. 913 – Advertising Expenses, and any other advertising expenditures included in any other expense accounts, as shown in Schedule L1. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.

b. An analysis of Account No. 930 – Miscellaneous General expenses for the test year. Include a complete breakdown of this account as shown in Schedule L2 and provide detailed workpapers supporting this analysis. At a minimum, the workpapers 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 L2.

c. An analysis of Account No. 426 – Other Income Deductions for the test year. Include a complete breakdown of this account as shown in Schedule L3 and provide detailed workpapers supporting this analysis. At a minimum, the workpapers 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 L3.

Response 45.a. Taylor County did not have Advertising Expenses for the test year.

Response 45.b. Please see attached. The attachment is an Excel spreadsheet that is being uploaded into the Commission's electronic filing system separately.

Response 45.c. Taylor County does not have Other Income Deductions for the test year.

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE
DATE RANGE FROM 01/01/21 TO 12/31/21

RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	16	2000		2023	01/14/21	VN 27018	.00	.00	14.04-	PAYROLL TAX-TAYLOR CO
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27018	.00	.00	300.00-	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27018	.00	.00	26.88-	DIRECTOR MILEAGE
AP	1	232.10	BDEX	16	2000		2023	01/14/21	VN 27018	.00	14.04	.00	PAYROLL TAX-TAYLOR CO
AP	1	232.10	BDEX	01	2000		2023	01/14/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	01/14/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
JE	49	0.00	EMBF	05	2000		2023	01/15/21	V 20210105	.00	304.08	.00	TO RECORD HEALTH SAV 12/01-15/20
JE	49	0.00	EMBF	05	2000		2023	01/15/21	V 20210140	.00	459.37	.00	REC HEALTH SAV REIMB 12/16-31/20
AP	1	232.10	BDEX	05	2000		2023	01/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF	06	2000		2023	01/28/21	V 20210109	.00	119.37	.00	REC HEALTH SAV REIMB 1/01-15/21
JE	40	165.20	BDEX	20	2000		2023	01/31/21	V 20210127	.00	825.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	01/31/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27019	.00	8.96	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27011	.00	9.52	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	02/11/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	02/11/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	05	2000		2023	02/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF	05	2000		2023	02/25/21	V 20210210	.00	389.05	.00	REC HEALTH SAVINGS 1/16-31/21
JE	40	165.20	BDEX	20	2000		2023	02/28/21	V 20210214	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	02/28/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
AP	1	232.10	BDEX	06	2000		2023	03/11/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	03/11/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	03/11/21	VN 27016	.00	4.48	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING

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PRG. ACCTANAL (ANLA) — FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX	06	2000		2023	03/11/21	VN 27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	03/11/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	03/11/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
JE	49	0.00	EMBF	05	2000		2023	03/11/21	V 20210304	.00	70.02	.00	TO REC HEALTH SAVING 2/1-15/21
JE	49	0.00	EMBF	05	2000		2023	03/11/21	V 20210305	.00	799.01	.00	TO RECORD HEALTH SAV 2/16-28/21
AP	1	232.10	BDEX	05	2000		2023	03/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
AP	1	232.10	BDEX	11	2000		2023	03/18/21	VN 27011	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	03/18/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
JE	49	0.00	EMBF	05	2000		2023	03/25/21	V 20210314	.00	36.09	.00	TO REC HEALTH SAVINGS 3/1-15/21
AP	1	232.10	BDEX	11	2000		2023	03/25/21	VN 27011	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	03/25/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
JE	40	165.20	BDEX	20	2000		2023	03/31/21	V 20210325	.00	1,125.00	.00	MONTHLY ALLOC- DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	03/31/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27011	.00	23.52	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	04/01/21	VN 27019	.00	8.96	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	04/01/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	05	2000		2023	04/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF	05	2000		2023	04/22/21	V 20210409	.00	267.58	.00	TO REC HEALTH SAVINGS 3/16-31/21
JE	49	0.00	EMBF	05	2000		2023	04/26/21	V 20210410	.00	295.91	.00	TO REC HEALTH SAVINGS 4/01-15/21
AP	1	232.10	BDEX	11	2000		2023	04/30/21	VN 220031	.00	143.04	.00	OTHER DIRECTOR EXPENSE
JE	40	165.20	BDEX	20	2000		2023	04/30/21	V 20210418	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	04/30/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	49	0.00	EMBF	05	2000		2023	05/01/21	V 20210514	.00	1,066.33	.00	TO REC HEALTH SAVINGS 5/1-15/21
JE	49	0.00	EMBF	05	2000		2023	05/12/21	V 20210512	.00	165.38	.00	TO REC HEALTH SAVINGS 4/16-30/21
AP	1	232.10	BDEX	05	2000		2023	05/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
AP	1	232.10	BDEX	11	2000		2023	05/20/21	VN 27011	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	05/20/21	VN 27011	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27011	.00	23.52	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE

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PRG. ACCTANAL (ANLA) — FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX	01	2000		2023	05/20/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	05/20/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	04	2000		2023	05/27/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-SIGN CHECKS
AP	1	232.10	BDEX	06	2000		2023	05/27/21	VN 27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	09	2000		2023	05/31/21	VN 220031	.00	155.98	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX	20	2000		2023	05/31/21	V 20210518	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	05/31/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27018	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27020	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27020	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27022	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27022	.00	10.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27019	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27019	.00	28.00	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27011	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	16	2000		2023	06/10/21	VN 27011	.00	.00	31.37-	PAYROLL TAX-TAYLOR CO
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	11	2000		2023	06/10/21	VN 27016	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27011	.00	.00	300.00-	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27011	.00	.00	19.04-	DIRECTOR MILEAGE
AP	1	232.10	BDEX	16	2000		2023	06/10/21	VN 27011	.00	31.37	.00	PAYROLL TAX-TAYLOR CO
AP	1	232.10	BDEX	01	2000		2023	06/10/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	06/10/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
JE	49	0.00	EMBF	05	2000		2023	06/10/21	V 20210605	.00	395.08	.00	TO REC HEALTH SAVINGS 5/16-31/21
AP	1	232.10	BDEX	05	2000		2023	06/18/21	VN 2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF	05	2000		2023	06/25/21	V 20210606	.00	347.16	.00	TO REC HEALTH SAVINGS 6/1-15/21
AP	1	232.10	BDEX	09	2000		2023	06/30/21	VN 220031	.00	138.49	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX	20	2000		2023	06/30/21	V 20210614	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	06/30/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	40	131.13	EMBF	05	2000		2023	07/06/21	V 20210732	.00	66.72	.00	TO CORRECT JE 20210704
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN 27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING

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PRG. ACCTANAL (ANLA) — FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN	27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN	27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN	27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	07/08/21	VN	27020	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	07/08/21	VN	27020	.00	25.76	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	05	2000		2023	07/18/21	VN	2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27022	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27019	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27018	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27011	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27022	.00	29.12	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27021	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27016	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27023	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	07/22/21	VN	27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27020	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	03	2000		2023	07/22/21	VN	27023	.00	300.00	.00	DIRECTOR FEES-ANNUAL MEETING
AP	1	232.10	BDEX	09	2000		2023	07/31/21	VN	220031	.00	217.82	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX	20	2000		2023	07/31/21	V	20210726	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	07/31/21	V	FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	49	0.00	EMBF	05	2000		2023	08/03/21	V	20210801	.00	390.97	.00	TO REC HEALTH SAVINGS 7/1-15/21
JE	49	0.00	EMBF	05	2000		2031	08/09/21	V	20210819	.00	145.62	.00	TO REC HEALTH SAVINGS 7/16-31/21
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27023	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	08/12/21	VN	27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	06	2000		2023	08/12/21	VN	27023	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	05	2000		2023	08/19/21	VN	2004	.00	6,433.52	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF	05	2000		2023	08/20/21	V	20210806	.00	724.65	.00	TO REC HEALTH SAVINGS 8/1/-15/21
AP	1	232.10	BDEX	09	2000		2023	08/31/21	VN	220031	.00	143.91	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX	20	2000		2023	08/31/21	V	20210809	.00	.00	1,125.00-	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU	01	2000		10	08/31/21	V	FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	40	165.20	BDEX	20	2000		2031	08/31/21	V	20210816	.00	1,125.00	.00	REV JE 202108-09
JE	40	165.20	BDEX	20	2000		2031	08/31/21	V	20210817	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
AP	1	232.10	BDEX	01	2000		2023	09/02/21	VN	27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	09/02/21	VN	27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	06	2000		2023	09/02/21	VN	27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	01	2000		2023	09/02/21	VN	27019	.00	.00	14.29-	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX	01	2000		2023	09/02/21	VN	27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING

TAYLOR COUNTY RECC — ACCOUNT ANALYSIS — PAGE 5
PRG. ACCTANAL (ANLA) — FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27023	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27023	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27019	.00	.00	300.00-	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27019	.00	.00	7.28-	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27019	.00	14.29	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	09/02/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	09/02/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
JE	49	0.00	EMBF 05	2000		2023	09/09/21	V 20210908	.00	226.91	.00	TO REC HEALTH SAVINGS 8/16-31/21
AP	1	232.10	BDEX 05	2000		2023	09/18/21	VN 2004	.00	6,903.46	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF 05	2000		2023	09/22/21	V 20210912	.00	34.65	.00	TO REC HEALTH SAVINGS 9/1-15/21
AP	1	232.10	BDEX 09	2000		2023	09/30/21	VN 220031	.00	199.32	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX 20	2000		2023	09/30/21	V 20210920	.00	1,125.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU 01	2000		10	09/30/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	49	0.00	EMBF 05	2000		2023	10/08/21	V 20211007	.00	121.80	.00	TO REC HEALTH SAVINGS09/16-30/21
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 05	2000		2023	10/14/21	VN 27018	.00	26.88	.00	DIRECTOR INSURANCE-BLUE CROSS
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	10/14/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	10/14/21	VN 27011	.00	24.64	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27023	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	10/14/21	VN 27023	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	10/14/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	10/14/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 06	2000		2023	10/14/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
JE	49	0.00	BDEX 06	2000		2023	10/14/21	V 20211011	.00	26.88	.00	TO COR ITEM ID BDEX 05 TO BDEX06
JE	49	0.00	BDEX 05	2000		2023	10/14/21	V 20211011	.00	.00	26.88-	TO COR ITEM ID BDEX 05 TO BDEX06
AP	1	232.10	BDEX 05	2000		2023	10/18/21	VN 2004	.00	7,262.83	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF 05	2000		2023	10/25/21	V 20211017	.00	255.47	.00	TO REC HEALTH SAVING 10/01-15/21
AP	1	232.10	BDEX 09	2000		2023	10/31/21	VN 220031	.00	187.57	.00	DIRECTOR LODGING & MEALS
JE	40	165.20	BDEX 20	2000		2023	10/31/21	V 20211022	.00	2,225.00	.00	MONTHLY ALLOC- DIRECTOR HSA
JE	41	165.10	INSU 01	2000		10	10/31/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
AP	1	232.10	BDEX 04	2000		2023	11/04/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-SIGN CHECKS
AP	1	232.10	BDEX 06	2000		2023	11/04/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.10 DIRECTOR'S FEES & MILEAGE
DATE RANGE FROM 01/01/21 TO 12/31/21

RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27023	.00	22.40	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	11/11/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	11/11/21	VN 27023	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
JE	40	131.13	EMBF 05	2000		2023	11/23/21	V 20211112	.00	117.59	.00	TO REC HEALTH SAVINGS 11/1-15/21
JE	40	926.00	EMBF 05	2000		2023	11/23/21	V 20211107	.00	121.84	.00	TO REC HEALTH SAVING 10/16-31/21
AP	1	232.10	BDEX 09	2000		2023	11/30/21	VN 220031	.00	252.40	.00	DIRECTOR LODGING & MEALS
AP	1	232.10	BDEX 14	2000		2023	11/30/21	VN 220031	.00	1,238.00	.00	WINTER SCHOOL REG-CORBIN/TAYLOR
AP	1	232.10	BDEX 09	2000		2023	11/30/21	VN 220031	.00	208.84	.00	KEC ANNUAL MTG
AP	1	232.10	BDEX 09	2000		2023	11/30/21	VN 220031	.00	193.84	.00	KEC ANNUAL MTG
AP	1	232.10	BDEX 05	2000		2023	11/30/21	VN 2004	.00	7,698.61	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	40	165.20	BDEX 20	2000		2023	11/30/21	V 20211117	.00	2,225.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU 01	2000		10	11/30/21	V FJ962205	.00	875.08	.00	AMORTIZATION PREPAID INSURANCE
JE	49	0.00	EMBF 05	2000		2023	12/01/21	V 20211201	.00	79.91	.00	TO REC HEALTH SAVING 11/16-30/21
AP	1	232.10	BDEX 09	2000		2023	12/02/21	VN 19045	.00	780.39	.00	BOARD CHRISTMAS DINNER
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27018	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27018	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27022	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27022	.00	26.88	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27019	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27011	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27023	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27021	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27021	.00	19.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 01	2000		2023	12/09/21	VN 27016	.00	300.00	.00	DIRECTOR FEES-REGULAR BD MEETING
AP	1	232.10	BDEX 06	2000		2023	12/09/21	VN 27016	.00	5.60	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 05	2000		2023	12/16/21	VN 2004	.00	7,698.61	.00	DIRECTOR INSURANCE-BLUE CROSS
JE	49	0.00	EMBF 05	2000		2023	12/22/21	V 20211205	.00	127.83	.00	TO TRSF WOB W YORK TO R&W YORK
JE	49	0.00	EMBF 05	2000		2023	12/27/21	V 20211235	.00	.00	127.83-	TO TRSF WOB W YORK TO R&W YORK
JE	49	0.00	EMBF 05	2000		2023	12/27/21		.00	127.83	.00	TO REC HEALTH SAVING 12/1-15/21
JE	40	165.20	BDEX 20	2000		2023	12/31/21	V 20211207	.00	2,225.00	.00	MONTHLY ALLOC-DIRECTOR HSA
JE	41	165.10	INSU 01	2000		10	12/31/21	V FJ962205	.00	919.08	.00	AMORTIZATION PREPAID INSURANCE

NUMBER OF RECORDS FOUND - 291

TOTAL QTY .00

TOTAL DEBIT	154,267.47
TOTAL CREDIT	2,292.61-
NET BALANCE	151,974.86

TAYLOR COUNTY RECC — ACCOUNT ANALYSIS — PAGE 1
PRG. ACCTANAL (ANLA) — FOR ACCT: 930.20 DUES PAID TO ASSOC ORGANIZATION — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	DUES	01	2000		2023	01/29/21	VN 11002	.00	300.00	.00	DUES-KAEC
AP	1	232.10	DUES	01	2000		2023	02/11/21	VN 11002	.00	16,504.39	.00	DUES-KAEC
AP	1	232.10	DUES	03	2000		2023	04/22/21	VN 11016	.00	200.00	.00	DUES-MISCELLANEOUS
AP	1	232.10	DUES	01	2000		2023	05/13/21	VN 11002	.00	16,504.39	.00	DUES-KAEC
AP	1	232.10	DUES	02	2000		2031	07/31/21	VN 14002	.00	4,741.50	.00	DUES-NRECA
AP	1	232.10	DUES	01	2000		2023	08/18/21	VN 11002	.00	16,504.39	.00	DUES-KAEC
AP	1	232.10	DUES	02	2000		2031	08/31/21	VN 14002	.00	4,741.50	.00	DUES-NRECA
AP	1	232.10	DUES	02	2000		2031	09/30/21	VN 14002	.00	4,741.50	.00	DUES-NRECA
CS	80	131.11	DUES	01	2000		2023	10/18/21		.00	.00	10,015.00-	DUES REFUND 2020
AP	1	232.10	DUES	02	2000		2031	10/31/21	VN 14002	.00	4,741.50	.00	DUES-NRECA
AP	1	232.10	DUES	01	2000		2023	11/17/21	VN 11002	.00	16,504.39	.00	DUES-KAEC
AP	1	232.10	DUES	02	2000		2031	11/30/21	VN 14002	.00	4,741.50	.00	DUES-NRECA
AP	1	232.10	DUES	02	2000		2023	12/16/21	VN 14002	.00	5,726.50	.00	DUES-NRECA

NUMBER OF RECORDS FOUND - 13

TOTAL QTY .00

TOTAL DEBIT	95,951.56
TOTAL CREDIT	10,015.00-
NET BALANCE	85,936.56

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.30 FEMA ADMIN COSTS
DATE RANGE FROM 01/01/21 TO 12/31/21

PAGE 1
RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
PY	20	131.15	LARG	00	100		1251	12/22/21	P	57	68.00	1,648.07	.00	REGULAR LABOR
PY	20	131.15	LARG	00	200		1251	12/22/21	P	57	10.00	273.10	.00	REGULAR LABOR
PY	20	131.15	LARG	00	400		1251	12/22/21	P	57	10.00	259.50	.00	REGULAR LABOR
PY	20	131.15	LARG	00	2000		1251	12/22/21	P	57	8.00	207.60	.00	REGULAR LABOR
PY	20	131.15	LARG	00	200		1261	12/30/21	P	57	19.00	593.75	.00	REGULAR LABOR
PY	20	131.15	LARG	00	200		1271	12/30/21	P	57	5.00	136.55	.00	REGULAR LABOR
JE	44	165.20	EMBF	06	400		1	12/31/21	P	57	.00	21.91	.00	EMPLOYER HSA CONTRIBUTION
PY	10	242.20	ACLB	01	200		112	12/31/21	P	57	4.00	105.92	.00	ACCRUED LABOR - REGULAR
PY	10	242.20	ACLB	01	400		112	12/31/21	P	57	4.00	103.80	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	01	100		1	12/31/21	P	57	.00	47.79	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	200		1	12/31/21	P	57	.00	32.17	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	400		1	12/31/21	P	57	.00	10.54	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	2000		1	12/31/21	P	57	.00	6.02	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.20	EMBF	06	100		1	12/31/21	P	57	.00	99.39	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	200		1	12/31/21	P	57	.00	66.90	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	2000		1	12/31/21	P	57	.00	12.52	.00	EMPLOYER HSA CONTRIBUTION
JE	44	408.20	TAXP	06	2000		1	12/31/21	P	57	.00	.02	.00	TAXES - FEDERAL UNEMPLOYMENT
JE	44	408.20	TAXP	06	100		1	12/31/21	P	57	.00	.19	.00	TAXES - FEDERAL UNEMPLOYMENT
JE	44	408.20	TAXP	06	200		1	12/31/21	P	57	.00	.13	.00	TAXES - FEDERAL UNEMPLOYMENT
JE	44	408.20	TAXP	06	400		1	12/31/21	P	57	.00	.04	.00	TAXES - FEDERAL UNEMPLOYMENT
JE	44	408.30	TAXP	03	2000		1	12/31/21	P	57	.00	15.88	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	100		1	12/31/21	P	57	.00	126.09	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	200		1	12/31/21	P	57	.00	84.87	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	400		1	12/31/21	P	57	.00	27.80	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	926.00	EMBF	01	2000		1	12/31/21	P	57	.00	21.57	.00	EMPLOYER 401K CONTRIBUTION
JE	44	408.40	TAXP	07	100		1	12/31/21	P	57	.00	.38	.00	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	200		1	12/31/21	P	57	.00	.26	.00	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	400		1	12/31/21	P	57	.00	.08	.00	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	2000		1	12/31/21	P	57	.00	.05	.00	TAXES - STATE UNEMPLOYMENT
JE	44	926.00	EMBF	01	100		1	12/31/21	P	57	.00	171.27	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	200		1	12/31/21	P	57	.00	115.28	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	400		1	12/31/21	P	57	.00	37.76	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	02	2000		1	12/31/21	P	57	.00	48.59	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	100		1	12/31/21	P	57	.00	385.77	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	200		1	12/31/21	P	57	.00	259.66	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	400		1	12/31/21	P	57	.00	85.04	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	03	2000		1	12/31/21	P	57	.00	1.28	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	100		1	12/31/21	P	57	.00	10.18	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	200		1	12/31/21	P	57	.00	6.85	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	400		1	12/31/21	P	57	.00	2.24	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMEX	08	2000		1	12/31/21	P	57	.00	28.81	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	02	100		1	12/31/21	P	57	.00	3.53	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	200		1	12/31/21	P	57	.00	2.38	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	400		1	12/31/21	P	57	.00	.78	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	2000		1	12/31/21	P	57	.00	.45	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	08	100		1	12/31/21	P	57	.00	228.71	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	200		1	12/31/21	P	57	.00	153.95	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	400		1	12/31/21	P	57	.00	50.42	.00	FASB 106-EMPLOYEE
JE	44	926.00	LARG	10	2000		1	12/31/21	P	57	.00	.04	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	100		1	12/31/21	P	57	.00	.29	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	200		1	12/31/21	P	57	.00	.19	.00	TRANSP EARNINGS

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.30 FEMA ADMIN COSTS
DATE RANGE FROM 01/01/21 TO 12/31/21

PAGE 2
RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	926.00	LARG	10	400	1	12/31/21	P 57	.00	.06	.00	TRANSP EARNINGS

NUMBER OF RECORDS FOUND - 52

TOTAL QTY		128.00
TOTAL DEBIT		5,496.42
TOTAL CREDIT		.00
NET BALANCE		5,496.42

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.40 MISCELLANEOUS GENERAL EXPENSE
DATE RANGE FROM 01/01/21 TO 12/31/21

RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	MPRL 01	2000		2023	01/22/21 VN	110021	.00	9,853.81	.00	KENTUCKY LIVING MAGAZINE
CS	80	131.11	BDEX 12	2000		2023	02/01/21		.00	.00	250.00-	KAEC-C TUCKER REMI JAN 21' BD MT
AP	1	232.10	BDEX 12	2000		2023	02/11/21 VN	27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX 06	2000		2023	02/11/21 VN	27019	.00	8.96	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 14	2000		2023	02/11/21 VN	27011	.00	300.00	.00	DIRECTOR FEES-TRAINING
AP	1	232.10	BDEX 06	2000		2023	02/11/21 VN	27011	.00	9.52	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 09	2000		2023	02/11/21 VN	27011	.00	34.00	.00	DIRECTOR LODGING & MEALS
CS	80	131.11	BDEX 12	2000		2023	02/17/21		.00	.00	250.00-	REIMB FEB 2021 OUTREACH C TUCKER
AP	1	232.10	MPRL 01	2000		2023	02/17/21 VN	110021	.00	9,875.72	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	DUES 04	2000		2023	02/25/21 VN	11002	.00	341.02	.00	DUES-CHAMBER OF COMMERCE
AP	1	232.10	MISC 00	2000		2023	02/28/21 VN	13051	.00	47.70	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	EMEX 04	1000		2023	02/28/21 VN	220031	.00	18.90	.00	TRAVEL EXPENSE
AP	1	232.10	BDEX 12	2000		2023	03/01/21 VN	27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	MPRL 01	2000		2023	03/12/21 VN	110021	.00	9,904.91	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	BDEX 12	2000		2023	03/16/21 VN	27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
CS	80	131.11	BDEX 12	2000		2023	03/29/21		.00	.00	250.00-	KAEC-REMBI C TUCKER MAR21 BD MTG
AP	1	232.10	MPRL 01	2000		2023	04/08/21 VN	110021	.00	9,897.10	.00	KENTUCKY LIVING MAGAZINE
CS	80	131.11	BDEX 12	2000		2023	04/19/21		.00	.00	250.00-	KAEC REIMB CTUCKER APR 21 BD MTG
AP	1	232.10	BDEX 11	2000		2023	04/30/21 VN	8052	.00	40.91	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	ANMT 03	2000		2023	05/13/21 VN	11002	.00	92.75	.00	100- 8.5 WATT BULBS
AP	1	232.10	ELEX 00	2000		2023	05/13/21 VN	99682	.00	.00	100.00-	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/13/21 VN	99682	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	MISC 00	2000		2023	05/13/21 VN	7051	.00	50.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	MISC 00	2000		2023	05/13/21 VN	20027	.00	50.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	MISC 00	2000		2023	05/13/21 VN	1062	.00	50.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	MISC 00	2000		2023	05/13/21 VN	3049	.00	50.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	MISC 00	2000		2023	05/13/21 VN	3053	.00	50.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	70902	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	54807	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	3059	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	18025	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	69296	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	75270	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	05/20/21 VN	99682	.00	100.00	.00	ELECTION EXPENSE
AP	1	232.10	BDEX 12	2000		2023	05/20/21 VN	27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
CS	80	131.11	BDEX 12	2000		2023	06/01/21		.00	.00	250.00-	KAEC REIMB MAY21 BD MTG C TUCKER
AP	1	232.10	MPRL 01	2000		2023	06/01/21 VN	110021	.00	9,858.52	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL 01	2000		2023	06/03/21 VN	110021	.00	9,883.00	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MISC 00	2000		2023	06/11/21 VN	13051	.00	53.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	ELEX 00	2000		2023	06/22/21 VN	16072	.00	1,381.73	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	06/22/21 VN	16072	.00	2,188.15	.00	ELECTION EXPENSE
AP	1	232.10	MSML 03	2000		2023	06/24/21 VN	16007	.00	2,000.00	.00	POSTAGE ELECTION
CS	80	131.11	BDEX 12	2000		2023	06/28/21		.00	.00	250.00-	KAEC-REIMB JUN21 BD MTG C TUCKER
AP	1	232.10	EMEX 04	2000		2023	06/30/21 VN	220031	.00	39.06	.00	TRAVEL EXPENSE
AP	1	232.10	BDEX 11	2000		2023	07/08/21 VN	27019	.00	300.00	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX 06	2000		2023	07/08/21 VN	27019	.00	7.28	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX 12	2000		2023	07/08/21 VN	27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	MPRL 01	2000		2023	07/08/21 VN	110021	.00	9,897.62	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	ANMT 05	2000		2023	07/08/21 VN	20076	.00	500.00	.00	ANNUAL MTG EXPENSE - OTHER
AP	1	232.10	ELEX 00	2000		2023	07/08/21 VN	89577002	.00	200.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX 00	2000		2023	07/08/21 VN	4676001	.00	200.00	.00	ELECTION EXPENSE

TAYLOR COUNTY RECC — ACCOUNT ANALYSIS — PAGE 2
PRG. ACCTANAL (ANLA) — FOR ACCT: 930.40 MISCELLANEOUS GENERAL EXPENSE — RUN DATE 06/12/23 05:58 PM
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
AP	1	232.10	ELEX	00	2000		2023	07/08/21	VN 66280002	.00	200.00	.00	ELECTION EXPENSE
AP	1	232.10	ELEX	00	2000		2023	07/08/21	VN 11149801	.00	200.00	.00	ELECTION EXPENSE
AP	1	232.10	TAXO	06	2000		2023	07/22/21	VN 21009	.00	414.96	.00	TAXES - FED EXCISE TAX
PY	20	131.15	LARG	00	100		751	07/22/21		8.00	190.40	.00	REGULAR LABOR
PY	20	131.15	LARG	00	400		751	07/22/21		14.00	341.40	.00	REGULAR LABOR
PY	20	131.15	LAOT	01	600		751	07/22/21		3.00	121.65	.00	TIME 1/2 OVERTIME
PY	20	131.15	LARG	00	600		751	07/22/21		24.00	625.23	.00	REGULAR LABOR
CS	80	131.11	BDEX	12	2000		2023	07/26/21		.00	.00	250.00-	KAEC REIMB JUL21 BD MTG C TUCKER
PY	20	131.15	LARG	00	10		761	07/30/21		4.00	264.04	.00	REGULAR LABOR
PY	20	131.15	LARG	00	20		761	07/30/21		4.00	212.50	.00	REGULAR LABOR
PY	20	131.15	LARG	00	100		761	07/30/21		8.00	235.04	.00	REGULAR LABOR
PY	20	131.15	LARG	00	200		761	07/30/21		4.00	132.58	.00	REGULAR LABOR
PY	20	131.15	LARG	00	400		761	07/30/21		4.00	120.20	.00	REGULAR LABOR
PY	20	131.15	LARG	00	600		761	07/30/21		12.00	430.51	.00	REGULAR LABOR
PY	20	131.15	LARG	00	700		761	07/30/21		4.00	121.21	.00	REGULAR LABOR
AP	1	232.10	ANMT	01	2000		2023	07/31/21	VN 220031	.00	210.94	.00	ANNUAL MTG - PRIZES
AP	1	232.10	ANMT	05	2000		2023	07/31/21	VN 220031	.00	83.74	.00	ANNUAL MTG EXPENSE - OTHER
AP	1	232.10	ANMT	01	2000		2023	07/31/21	VN 220031	.00	867.88	.00	ANNUAL MTG - PRIZES
AP	1	232.10	ANMT	05	2000		2023	07/31/21	VN 220031	.00	103.16	.00	ANNUAL MTG EXPENSE - (SIGN)
AP	1	232.10	ANMT	05	2000		2023	07/31/21	VN 220031	.00	46.96	.00	ANNUAL MTG EXPENSE - (SIGN)
JE	44	408.40	TAXP	07	600		1	07/31/21		.00	.00	.12-	TAXES - STATE UNEMPLOYMENT
AP	1	232.10	ELEX	00	2000		2023	07/31/21	VN 13063	.00	7,618.48	.00	ELECTION EXPENSE
AP	1	232.10	ELEX	00	2000		2023	07/31/21	VN 13063	.00	2,923.59	.00	ELECTION EXPENSE
AP	1	232.10	ELEX	00	2000		2023	07/31/21	VN 13063	.00	225.00	.00	ELECTION EXPENSE
JE	44	165.10	INSU	01	10		1	07/31/21		.00	7.01	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	20		1	07/31/21		.00	5.64	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	100		1	07/31/21		.00	11.30	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	200		1	07/31/21		.00	3.52	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	400		1	07/31/21		.00	12.26	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	600		1	07/31/21		.00	31.26	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.10	INSU	01	700		1	07/31/21		.00	3.22	.00	AMORTIZATION PREPAID INSURANCE
JE	44	165.20	EMBF	06	10		1	07/31/21		.00	16.17	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	20		1	07/31/21		.00	13.02	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	100		1	07/31/21		.00	26.06	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	200		1	07/31/21		.00	8.12	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	400		1	07/31/21		.00	28.27	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	600		1	07/31/21		.00	72.11	.00	EMPLOYER HSA CONTRIBUTION
JE	44	165.20	EMBF	06	700		1	07/31/21		.00	7.42	.00	EMPLOYER HSA CONTRIBUTION
JE	44	408.20	TAXP	06	600		1	07/31/21		.00	.01	.00	TAXES - FEDERAL UNEMPLOYMENT
JE	44	408.30	TAXP	03	10		1	07/31/21		.00	20.20	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	20		1	07/31/21		.00	16.26	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	100		1	07/31/21		.00	32.55	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	200		1	07/31/21		.00	10.14	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	400		1	07/31/21		.00	35.32	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	600		1	07/31/21		.00	90.09	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.30	TAXP	03	700		1	07/31/21		.00	9.27	.00	TAXES - FICA- EMPLOYER PORTION
JE	44	408.40	TAXP	07	10		1	07/31/21		.00	.00	.03-	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	20		1	07/31/21		.00	.00	.02-	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	100		1	07/31/21		.00	.00	.04-	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	200		1	07/31/21		.00	.00	.01-	TAXES - STATE UNEMPLOYMENT
JE	44	408.40	TAXP	07	400		1	07/31/21		.00	.00	.05-	TAXES - STATE UNEMPLOYMENT

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.40 MISCELLANEOUS GENERAL EXPENSE
DATE RANGE FROM 01/01/21 TO 12/31/21

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	408.40	TAXP	07	700		1	07/31/21		.00	.00	.01-	TAXES - STATE UNEMPLOYMENT
JE	44	926.00	EMBF	01	200		1	07/31/21		.00	14.30	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	10		1	07/31/21		.00	28.48	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	20		1	07/31/21		.00	22.92	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	100		1	07/31/21		.00	45.88	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	400		1	07/31/21		.00	49.78	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	600		1	07/31/21		.00	126.98	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	01	700		1	07/31/21		.00	13.07	.00	EMPLOYER 401K CONTRIBUTION
JE	44	926.00	EMBF	02	200		1	07/31/21		.00	30.69	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	10		1	07/31/21		.00	61.12	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	20		1	07/31/21		.00	49.19	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	100		1	07/31/21		.00	98.47	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	400		1	07/31/21		.00	106.84	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	600		1	07/31/21		.00	272.52	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	02	700		1	07/31/21		.00	28.06	.00	INSURANCE-(BC/BS)
JE	44	926.00	EMBF	03	200		1	07/31/21		.00	.89	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	10		1	07/31/21		.00	1.77	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	20		1	07/31/21		.00	1.43	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	100		1	07/31/21		.00	2.86	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	400		1	07/31/21		.00	3.10	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	600		1	07/31/21		.00	7.91	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMBF	03	700		1	07/31/21		.00	.81	.00	INS-(NRECA-LONG TERM DISABILITY)
JE	44	926.00	EMEX	02	200		1	07/31/21		.00	.30	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	10		1	07/31/21		.00	.60	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	20		1	07/31/21		.00	.48	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	100		1	07/31/21		.00	.96	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	400		1	07/31/21		.00	1.04	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	600		1	07/31/21		.00	2.65	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	02	700		1	07/31/21		.00	.27	.00	TRAINING EXPENSE
JE	44	926.00	EMEX	08	200		1	07/31/21		.00	19.33	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	10		1	07/31/21		.00	38.50	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	20		1	07/31/21		.00	30.99	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	100		1	07/31/21		.00	62.04	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	400		1	07/31/21		.00	67.32	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	600		1	07/31/21		.00	171.70	.00	FASB 106-EMPLOYEE
JE	44	926.00	EMEX	08	700		1	07/31/21		.00	17.68	.00	FASB 106-EMPLOYEE
JE	44	926.00	LARG	10	200		1	07/31/21		.00	.03	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	10		1	07/31/21		.00	.06	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	20		1	07/31/21		.00	.05	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	100		1	07/31/21		.00	.10	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	400		1	07/31/21		.00	.10	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	600		1	07/31/21		.00	.26	.00	TRANSP EARNINGS
JE	44	926.00	LARG	10	700		1	07/31/21		.00	.03	.00	TRANSP EARNINGS
TR	50	184.10	TREX	00	10		1	07/31/21		4.00	57.52	.00	TRANSPORATION EXPENSE
TR	50	184.10	TREX	00	400		1	07/31/21		6.00	100.26	.00	TRANSPORATION EXPENSE
TR	50	184.10	TREX	00	500		1	07/31/21		20.00	294.52	.00	TRANSPORATION EXPENSE
TR	50	184.10	TREX	00	600		1	07/31/21		8.00	139.68	.00	TRANSPORATION EXPENSE
TR	50	184.10	TREX	00	700		1	07/31/21		4.00	41.04	.00	TRANSPORATION EXPENSE
AP	1	232.10	MPRL	01	2000		2023	08/10/21	VN 110021	.00	9,929.43	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MSGP	03	2000		2023	09/10/21	VN 8009	.00	24.04	.00	GROUNDS MAINT.
AP	1	232.10	MPRL	01	2000		2023	09/10/21	VN 110021	.00	9,928.89	.00	KENTUCKY LIVING MAGAZINE

TAYLOR COUNTY RECC
PRG. ACCTANAL (ANLA)

ACCOUNT ANALYSIS
FOR ACCT: 930.40 MISCELLANEOUS GENERAL EXPENSE
DATE RANGE FROM 01/01/21 TO 12/31/21

RUN DATE 06/12/23 05:58 PM

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
CS	80	131.11	ANMT	03	2000		2023	09/14/21		.00	.00	90.00-	EAST KY POWER- ANNU MTG-LT BULBS
AP	1	232.10	EMEX	04	900		2023	09/16/21	VN 612	.00	10.05	.00	TRAVEL EXPENSE
AP	1	232.10	MISC	00	2000		2023	09/23/21	VN 19083	.00	100.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	EMEX	04	900		2023	09/30/21	VN 220031	.00	380.70	.00	MATERIAL MGMT MTG-D WETHERFORD
AP	1	232.10	EMEX	04	900		2023	09/30/21	VN 220031	.00	30.00	.00	TRAVEL EXPENSE-PARKING FEE
CS	80	131.11	BDEX	12	2000		2023	10/04/21		.00	.00	250.00-	KAEC-MEMBER OUTREACH SEPT 2021
CS	80	131.11	BDEX	12	2000		2023	10/04/21		.00	.00	250.00-	KAEC-REIMB AUG21 BD MTG C TUCKER
AP	1	232.10	MPRL	01	2000		2023	10/06/21	VN 110021	.00	10,017.02	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	BDEX	12	2000		2023	10/14/21	VN 27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX	12	2000		2023	10/14/21	VN 27019	.00	300.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX	06	2000		2023	10/14/21	VN 27019	.00	100.80	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	10	2000		2023	10/14/21	VN 27019	.00	134.76	.00	DIRECTOR TRANSPORTATION
AP	1	232.10	BDEX	15	2000		2023	10/31/21	VN 220031	.00	1,238.00	.00	C TUCKER 2021 WINTER SCH NRECAA
AP	1	232.10	MISC	00	2000		2023	11/09/21	VN 13051	.00	53.00	.00	MISCELLANEOUS EXPENSE
AP	1	232.10	MPRL	01	2000		2023	11/10/21	VN 110021	.00	10,050.91	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	EMEX	10	2000		2023	11/18/21	VN 140023	.00	559.00	.00	RE MAG SUBSCRIPITION
AP	1	232.10	BDEX	11	2000		2023	11/22/21	VN 20012	.00	357.12	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	BDEX	11	2000		2023	11/30/21	VN 220031	.00	161.20	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	EMEX	04	2000		2023	11/30/21	VN 220031	.00	208.84	.00	TRAVEL EXPENSE
AP	1	232.10	BDEX	11	2000		2023	11/30/21	VN 220031	.00	98.58	.00	DIRECTORS CHRISTMAS GIFTS
AP	1	232.10	BDEX	09	2000		2023	11/30/21	VN 220031	.00	619.00	.00	M WOODRUM -WINTER SCHOOL
CS	80	131.11	BDEX	12	2000		2023	12/06/21		.00	.00	250.00-	KAEC REIMB DEC21 BD MTG C TUCKER
AP	1	232.10	BDEX	12	2000		2023	12/09/21	VN 27019	.00	600.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX	06	2000		2023	12/09/21	VN 27019	.00	109.20	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	09	2000		2023	12/09/21	VN 27019	.00	230.80	.00	DIRECTOR LODGING & MEALS
AP	1	232.10	BDEX	08	2000		2023	12/09/21	VN 27011	.00	619.00	.00	DIRECTOR TUITION & REGISTRATION
AP	1	232.10	BDEX	12	2000		2023	12/09/21	VN 27011	.00	600.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX	06	2000		2023	12/09/21	VN 27011	.00	19.04	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	12	2000		2023	12/09/21	VN 27016	.00	600.00	.00	DIRECTOR FEES - KAEC MEETINGS
AP	1	232.10	BDEX	06	2000		2023	12/09/21	VN 27016	.00	98.56	.00	DIRECTOR MILEAGE
AP	1	232.10	BDEX	11	2000		2023	12/09/21	VN 1100	.00	26.49	.00	OTHER DIRECTOR EXPENSE
AP	1	232.10	MPRL	01	2000		2023	12/09/21	VN 110021	.00	10,057.19	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	EMEX	04	2000		2023	12/31/21	VN 220031	.00	32.56	.00	TRAVEL EXPENSE
AP	1	232.10	EMEX	04	2000		2023	12/31/21	VN 220031	.00	32.56	.00	TRAVEL EXPENSE
AP	1	232.10	EMEX	04	2000		2023	12/31/21	VN 220031	.00	389.80	.00	TIM COFFEY TRAVEL

NUMBER OF RECORDS FOUND - 188

TOTAL QTY 131.00

TOTAL DEBIT 155,663.47
TOTAL CREDIT 2,690.28-
NET BALANCE 152,973.19

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 46
RESPONSIBLE PARTY: Patsy Walters

Request 46. Provide the name and personal mailing address of each member of Taylor RECC's board of directors. Identify the members who represent the cooperative on the board of directors of East Kentucky Power Cooperative, Inc., (EKPC). Also identify the board members who are representatives to the Kentucky Association of Electric Cooperatives or the National Rural Electric Cooperative Association. If any changes occur in board membership during the course of this proceeding, update the response to this request.

Response 46.

Chad Taylor, President - 1053 T P Cundiff Road, Columbia, KY 42728
Chris Tucker, Vice President & **KEC Representative** - 3445 Elkhorn Road, Campbellsville, Ky 42718
Bradley Irvin, Treasurer - 4766 Liberty Road, Columbia KY 42728
Greg Corbin, Director & **EKPC Representative** - 2859 Coburg Road, Greensburg KY 42743
Donald Dean Shuffett, Director – 495 Pikeview Road, Greensburg, Ky 42743
Raymond Rucker, Director - 80 Robin Road, Campbellsville, Ky 42718
Mark Woodrum, Secretary - 1054 Murphy Wolford Road, Liberty KY 42539

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 47
RESPONSIBLE PARTY: Patsy Walters

Request 47. Provide a detailed analysis of the total compensation paid to each member of the board of directors during the test year, including all fees, fringe benefits, and expenses, with a description of the type of meetings, seminars, etc., attended by each member. Identify any compensation paid to Taylor RECC's board members for serving on EKPC's board of directors. If any of the listed expenses in this analysis include the costs for director's spouse, list expenses for the directors' spouses separately.

Response 47. Please see the tables below.

Chad Taylor, TCRECC Director

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$4,200.00	$362.32	$0.00	$0.00	$13,301.48	$0.00
12/2021	NRECA Winter School						$619.00
Totals		$4,200.00	$362.32	$0.00	$0.00	$13,301.48	$619.00

Bryan Clements, TCRECC Director (Defeated in Election-July 2021)

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 7/16/21	TCRECC Board Meetings	$2,700.00	$200.72	$0.00	$0.00	$0.00	$0.00
Totals		$2,700.00	$202.72	$0.00	$0.00	$0.00	$0.00

Mark Woodrum, TCRECC Director

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
7/16/21 - 12/31/21	TCRECC Board Meetings	$1,800.00	$112.00	$0.00	$0.00	$5,478.32	$0.00
12/2021	NRECA Winter School						$619.00
Totals		$1,800.00	$112.00	$0.00	$0.00	$5,478.32	$619.00

Greg Corbin, TCRECC Director, EKPC Director

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$3,900.00	$117.60	$0.00	$0.00	$13,301.48	$0.00
1/1/21 - 12/31/21	EKPC Committee & Board Meetings	Paid by EKPC	Paid by EKPC	Paid by EKPC	Paid by EKPC	N/A	Paid by EKPC
12/2021	NRECA Winter School						$619.00
Totals		$3,900.00	$117.60	$0.00	$0.00	$13,301.48	$619.00

Note: Any compensation paid to, or expenses incurred by, Taylor County's board members for serving on EKPC's board of directors is paid directly by EKPC. Therefore, there are no associated compensation or expense items relating to service on EKPC's board or directors in the test year.

Donald Dean Shuffett, TCRECC Director - President

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$6,300.00	$375.76			$34,180.86	
12/2021	NRECA Winter School						$619.00
11/15-16/21	KEC Annual Meeting	$600.00	$19.04				
1/21/2021	CFC Workshop	$300.00	$9.52	$193.84	$34.00		
Totals		$7,200.00	$404.32	$193.84	$34.00	$34,180.86	$619.00

Raymond Rucker, TCRECC Director - Vice-President

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$4,200.00	$71.68			$13,301.48	
11/15-16/21	KEC Annual Meeting	$600.00	$98.56	$208.84			
Totals		$4,800.00	$170.24	$208.84	$0.00	$13,301.48	$0.00

Bradley Irvin, TCRECC Director - Treasurer

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging	Meals	Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$4,200.00	$349.44			$13,301.48	
Totals		$4,200.00	$349.44	$0.00	$0.00	$13,301.48	$0.00

Chris Tucker, TCRECC Director – Secretary, KEC Director

Board Meetings/Trainings/Seminars Attended w/ Compensation

Date	Description	Meeting Fees	Mileage	Lodging/Meals		Health Insurance	Other
1/1/21 - 12/31/21	TCRECC Board Meetings	$4,200.00	$118.72			$12,472.17	
6/8/2021	EKPC Annual Meeting	$300.00	$7.28				
11/15-16/21	KEC ANN MTG	$600.00	$109.20	$230.80			
03/16/21	KEC MTG	$300.00					
01/19/21	KEC MTG	$300.00	$8.96				
09/21/21	KEC MTG	$300.00	$100.80				
02/09/21	KEC OUTREACH COMM	$300.00					
04/09/21	KEC OUTREACH COMM	$300.00					
06/23/21	KEC OUTREACH COMM	$300.00					
09/03/21	KEC OUTREACH COMM	$300.00					
1/1/21 - 12/31/21	REIMB KEC MTG'S	-$2,500.00					
12/2021	NRECA Winter School						$1,238.00
Totals		$4,700.00	$344.96	$230.80		$12,472.17	$1,238.00

Note: For any Taylor County's board member serving on KEC's board of directors or committees, KEC reimburses a portion of meeting fees directly to the cooperative.

Taylor County RECC pays the medical insurance premiums for the following retired directors who qualify:

William Harris	$3,732.00
William Janes (& spouse)	$7,464.00
Bobby Rucker (& spouse)	$7,304.00
Rollin Minor (& spouse)	$7,464.00

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 48
RESPONSIBLE PARTY: Patsy Walters

Request 48. Provide Taylor RECC's written policies on the compensation of its attorneys, auditors, and all other professional service providers. Include a schedule of fees, per diems, and other compensation in effect during the test year. Include all agreements, contracts, memoranda of understanding, and any other documentation that explains the nature and type of reimbursement paid for professional services. If any changes occurred during the test year, indicate the effective date of these changes and the reason for these changes.

Response 48. Taylor County RECC does not have a written policy on the compensation of its attorneys, auditors, and all other professional service providers. Legal representation, auditing, and all other professional service providers are approved by the Board.

Taylor County and its outside legal counsel, Mr. Rob Spragens, Jr., began a professional relationship approximately 50 years ago. During the 2021 test year, Mr. Spragens' retainer fee was $50.00 per month with a per hour charge of $170.00. Mr. Spragens announced his retirement effective July 15, 2022. L. Allyson Honaker, with Honaker Law Office PLLC became outside legal counsel on August 1, 2022.

Please see attached for the legal counsel and annual audit engagement letters.

HONAKER
LAW
OFFICE

L. Allyson Honaker
allyson@hloky.com
(859)396-3172

July 20, 2022

VIA EMAIL

Mr. Jeff Williams
President & CEO
Taylor County Rural Electric Cooperative Corporation
P.O. Box 100
625 West Main St.
Campbellsville, KY 42718

Re: Engagement of Honaker Law Office, PLLC

Dear Mr. Williams:

I am pleased that you have asked Honaker Law Office, PLLC (the "Firm") to serve as your counsel. This letter will confirm my discussion with you regarding your engagement of the Firm and will describe the basis upon which the Firm will provide legal services to you. The engagement will be effective August 1, 2022. Accordingly, I submit for your approval the following provisions governing this engagement. If you are in agreement, please sign the enclosed copy of this letter in the space provided below. If you have any questions about these provisions, do not hesitate to call. Again, I am pleased to have the opportunity to serve you.

Client; Scope of Representation. The Firm's client in this matter will be Taylor County Rural Electric Cooperative Corporation (the "Client"). The Firm will be engaged to advise the Client in connection with matters arising before the Kentucky Public Service Commission (including a 2022 rate case), other general business matters and perform the general counsel duties for the Board of Directors. You may limit or expand the scope of the Firm's representation from time to time, provided that any substantial expansion must be agreed to by me. While I would be interested in assisting you in other matters, unless I am specifically engaged for some other future matter this will confirm that the Firm's representation of you is limited to the foregoing matters and will end when they are concluded.

Fees. The Firm's fees are based primarily upon the time we expend on the engagement, including travel time which is charged at regular hourly rates. These hourly rates are normally $265 for L. Allyson Honaker. However, L. Allyson Honaker has agreed to charge an hourly rate of $250 until the rates for the 2022 rate increase are placed into effect. Immediately upon the new rates are established by the Kentucky Public Commission, L. Allyson Honaker's hourly rate will

increase to the normal cooperative rate of $265 per hour. Our hourly rates are reviewed periodically and may be increased from time to time.

Potential Conflicts. As we have discussed, you are aware that the Firm represents many other companies and individuals. This can create situations where work for one client on a matter might preclude us from assisting other clients on unrelated matters. It is possible that during the time that we are representing the Client, some of our present or future clients will have disputes or transactions with the Client. In order to avoid the potential for this kind of restriction on our practice, the Client agrees that we may continue to represent or may undertake in the future to represent existing or new clients in any matter that is not substantially related to matters in which we have represented the Client, even if the interests of such clients in those other matters are directly adverse to yours. We do not intend, however, for you to waive your right to have the Firm maintain confidences or secrets that you transmit to the Firm, and we agree not to disclose them to any third party without your consent. We would, of course, take appropriate steps to insure that such information is kept confidential by us. As you are aware, the Firm also represents the Client's wholesale provider, East Kentucky Power Cooperative, Inc. ("EKPC"). In the event of a potential conflict in the representation of the Client and EKPC, the Firm will notify both the Client and EKPC of the potential conflict. No confidential information obtained from the representation of either the Client or EKPC will be divulged to the other. If it is determined that an actual conflict exists between the Client and EKPC, Client acknowledges and consents to the Firm's continued representation of EKPC.

ABA Statement of Policy. We wish to inform the Client, and the Client acknowledges, that it is the Firm's policy to comply strictly with the terms of the ABA Statement of Policy Regarding Lawyers' Responses to Auditors' Requests for Information (December 1975) in any response that the Client requests we make to the Client's auditors regarding "loss contingencies" affecting the Client.

Electronic Data Communication and Storage. In the interest of facilitating our services, we may communicate with you or others by email, facsimile transmission, send data over the Internet, store electronic data via computer software applications hosted remotely on the Internet, or allow access to data through third-party vendors' secured portals or clouds. Electronic data that is confidential to your case may be transmitted or stored using these methods. In using these data communication and storage methods, the Firm makes reasonable efforts to keep such communications and data access secure in accordance with our obligations under applicable laws and professional standards. You recognize and accept that we have no control over the unauthorized interception or breach of any communications or data once it has been sent or has been subject to unauthorized access, notwithstanding all reasonable security measures employed by us or our third-party vendors. You consent to the Firm's use of these electronic devices and applications and submission of confidential client information to third-party service providers during this engagement.

Expenses. Expenses we incur on the engagement are charged to the Client's account. Expenses include such items as court costs, charges for computerized research services and hard

copy document reproductions, long distance telephone, travel expenses, messenger service charges, overnight mail or delivery charges, extraordinary administrative support, filing fees, fees of court reporters and charges for depositions, fees for expert witnesses and other expenses we incur on your behalf. Our charges for these services reflect our actual out-of-pocket costs based on usage, and in some areas may also include our related administrative expenses.

Monthly Statements. Unless a different billing period is agreed upon with the Client, the Firm will render monthly statements indicating the current status of the account as to both fees and expenses. The statements shall be payable upon receipt. If statements are not paid in full within 30 days, we reserve the right to add a late charge of 1% per month of the amount due. If it becomes necessary for the Firm to file suit or to engage a collection agency for the collection of fees or expenses, the Client shall pay all related costs and expenses, including reasonable attorneys' fees.

Litigation Matters. If this engagement involves litigation, the Client may be required to pay the opposing party's trial costs. Such costs include filing fees, witness fees, and fees for depositions and documents used at trial. We will not settle litigated matters without the Client's express consent. We require the Client's active participation in all phases of the case.

Insurance coverage. Unless we have been explicitly retained to address insurance coverage issues (as documented in this engagement letter), we have no responsibility or obligation to: (a) identify any potentially applicable insurance coverage; (b) provide notice to any carrier; or (c) advise the Client on issues relating to insurance coverage at any point during our representation.

No Guarantee of Success It is expressly acknowledged by you that the Firm has not made any warranties or representations to you, nor have we given you any assurances as to the favorable or successful resolution of your claim or defense of the action referred to above; nor as to the favorable outcome of any legal action that may be filed; nor as to the nature or amount of any awards or distributions of property, attorney fees, costs, or any other aspects of this matter. All of the Firm's expressions relative to your case are limited only to estimates based upon our experience and judgment and are only our opinion. Such expressions should not be considered as representations, promises, or guarantees of results, which might be obtainable, either by way of a negotiated settlement or in a contested trial.

Termination. The Client has the right to terminate our representation at any time by notifying us of your intention to do so in writing. We will have the same right, subject to an obligation to give the Client reasonable notice to arrange alternative representation. In the event either party should elect to terminate our relationship, our fees and expenses incurred up to that point still will be due to us. Upon payment to us of any balance due for fees and expenses, we will return to the Client, or to whomever the Client directs, any property or papers of the Client in our possession.

Withdrawal. Under the rules of professional conduct by which we are governed, we may withdraw from our representation of the Client in the event of, for example: nonpayment of our fees and expenses; misrepresentation or failure to disclose material facts concerning the

engagement; action taken by the Client contrary to our advice; and in situations involving a conflict of interest with another client. If such a situation occurs, which we do not expect, we will promptly give the Client written notice of our intention to withdraw.

Post-Engagement Services. The Client is engaging the Firm to provide legal services in connection with a specific matter. After completion of that matter, changes may occur in the applicable laws or regulations that could have an impact on the Client's future rights and liabilities. Unless the Client engages us after completion of the matter to provide additional advice on issues arising from the matter, the Firm has no continuing obligation to advise the Client with respect to future legal developments.

Retention and Disposition of Documents. At the Client's request, its documents and property will be returned to the Client upon conclusion of our representation in the matter described above, although the Firm reserves the right to retain copies of any such documents as it deems appropriate. Our own files pertaining to the matter will be retained by the Firm for a period of five (5) years after we close our file. These Firm files include, for example, Firm administrative records, time and expense reports, personnel and staffing materials, and credit and accounting records. At the expiration of the five-year period, we will destroy these files unless you notify us in writing that you wish to take possession of them. We reserve the right to charge administrative fees and costs associated with researching, retrieving, copying and delivering such files.

Parent/Subsidiary/Affiliate Relationships. The Client may be a subsidiary of a parent organization or may itself have subsidiary or affiliated organizations. The Client agrees that the Firm's representation of the Client in this matter does not give rise to an attorney-client relationship between the Firm and any parent, subsidiary or affiliate of the Client (any of them being referred to as "Affiliate"). The Firm, during the course of its representation of the Client, will not be given any confidential information regarding any of the Client's Affiliates. Accordingly, representation of the Client in this matter will not give rise to any conflict of interest in the event other clients of the Firm are adverse to any of the Client's Affiliates.

Consultation with Counsel. From time to time, issues arise that raise questions as to our duties under the professional conduct rules that apply to lawyers. These might include conflict of interest issues, and could even include issues raised because of a dispute between us and a client over the handling of a matter. We believe that it is in our clients' interest, as well as the Firm's interest, that in the event that issues arise during a representation about our duties and obligations as lawyers, we receive expert analysis of our obligations. Accordingly, as part of our agreement concerning our representation, the Client agrees that if we determine in our own discretion during the course of the representation that it is either necessary or appropriate to consult with counsel, we have the Client's consent to do so and that our representation of the Client shall not, thereby, waive any attorney-client privilege that the Firm may have to protect the confidentiality of our communications with counsel.

Authorization. By the Client's agreement to these terms of our representation, the Client authorizes us to take any and all action we deem advisable on the Client's behalf on this matter.

We will, whenever possible, discuss with the Client in advance any significant actions we intend to take.

We appreciate the opportunity to represent you. If these terms of our engagement are acceptable to you, please return a signed copy of this letter to me in the enclosed envelope.

We look forward very much to working with you on this matter.

Sincerely,

L. Allyson Honaker
HONAKER LAW OFFICE, PLLC

The foregoing is understood and accepted:

Taylor County Rural Electric Cooperative Corporation

By: _____
Jeff Williams, President & CEO

JNM

Jones, Nale & Mattingly PLC

June 15, 2021

Barry L. Myers, General Manager
Taylor County Rural Electric Cooperative Corporation
625 West Main Street
Campbellsville, Kentucky 42718

Dear Mr. Myers:

We are pleased to confirm our understanding of the services we are to provide for Taylor County Rural Electric Cooperative Corporation (the Cooperative) for the year ended May 31, 2021.

We will audit the financial statements of the Cooperative, which comprise the balance sheet as of May 31, 2021, and the related statements of income and comprehensive income, changes in members' equities, and cash flows for the year then ended, and the related notes to the financial statements.

The auditor's report, report on compliance and internal control over financial reporting and management letter are being issued in order to enable the Cooperative to comply with the provisions of RUS's security instruments.

Audit Objective

The objective of our audit is the expression of an opinion about whether your financial statements are fairly presented in all material respects, in accordance with U. S. generally accepted accounting principles. Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America and the standards for financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, and the reporting requirement of RUS set forth in CFR Chapter XVII, Part 1773- RUS Policy on Audits of Electric Borrowers, and will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. We will issue a written report upon completion of our audit of the Cooperative's financial statements. Our report will be addressed to The Board of Directors of the Cooperative. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion or add an emphasis-of-matter or other-matter paragraph. If our opinion on the financial statements is other than unmodified, we will discuss the reasons with management in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or issue reports, or we may withdraw from this engagement.

We will also provide a report (which does not include an opinion) on internal control related to the financial statements and compliance with the provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a material effect on the financial statements as required by *Government Auditing Standards*. The report on internal control and on compliance and other matters will

include a paragraph that states that (1) the purpose of the report is solely to describe the scope of testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control on compliance and (2) the report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. The paragraph will also state that the report is not suitable for any other purpose. If during our audit we become aware that the Cooperative is subject to an audit requirement that is not encompassed in the terms of this engagement, we will communicate to management and those charged with governance that an audit in accordance with generally accepted auditing standards established by the Auditing Standards Board (United States) and the standards for financial audits contained in *Government Auditing Standards* may not satisfy the relevant legal, regulatory, or contractual requirements.

Audit Procedures – General

An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements; therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the financial statements are free of material misstatement, whether from (1) errors, (2) fraudulent financial reporting, (3) misappropriation of assets, or (4) violations of law or governmental regulations that are attributable to the Cooperative or to acts by management or employees acting on behalf of the Cooperative. Because the determination of abuse is subjective, *Government Auditing Standards* do not expect auditors to provide reasonable assurance of detecting abuse.

Because of the inherent limitations of an audit, combined with the inherent limitations of internal control, and because we will not perform a detailed examination of all transactions, there is a risk that material misstatements may exist and not be detected by us, even though the audit is properly planned and performed in accordance with U.S. generally accepted auditing standards and *Government Auditing Standards*. In addition, an audit is not designed to detect immaterial misstatements or violations of laws or governmental regulations that do not have a direct and material effect on the financial statements. However, we will inform the appropriate level of management of any material errors, fraudulent financial reporting, or misappropriation of assets that come to our attention. We will also inform the appropriate level of management of any violations of laws or governmental regulations that come to our attention, unless clearly inconsequential, and of any material abuse that comes to our attention. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any later periods for which we are not engaged as auditors. We will disclose any fraud or illegal acts that come to our attention in accordance with 7 CFR Chapter XVII, Parts 1773.9 and l 773.20(b).

Our procedures will include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of receivables and certain assets and liabilities by correspondence with selected individuals, funding sources, creditors, and financial institutions. We will also request written representations from the Cooperative's attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from you about your responsibilities for the financial statements; compliance with laws, regulations, contracts, and grant agreements and other responsibilities required by generally accepted auditing standards.

Audit Procedures - Internal Control

Our audit will include obtaining an understanding of the entity and its environment, including internal control, sufficient to assess the risks of material misstatement of the financial statements and to design the nature, timing, and extent of further audit procedures. Tests of controls may be performed to test the effectiveness of certain controls that we consider relevant to preventing and detecting errors and fraud that are material to the financial statements and to preventing and detecting misstatements resulting from illegal acts and other noncompliance matters that have a direct and material effect on the financial statements. Our tests, if performed, will be less in scope than would be necessary to render an opinion on internal control and, accordingly, no opinion will be expressed in our report on internal control issued pursuant to *Government Auditing Standards*.

An audit is not designed to provide assurance on internal control or to identify significant deficiencies or material weakness. However, during the audit, we will communicate to management and those charged with governance internal control related matters that are required to be communicated under AICPA professional standards and *Government Auditing Standards*.

Audit Procedures - Compliance

As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we will perform tests of the Cooperative's compliance with the provisions of applicable laws, regulations, contracts, agreements, and grants. However, the objective of our audit will not be to provide an opinion on overall compliance and we will not express such an opinion in our report on compliance issued pursuant to *Government Auditing Standards*.

Other Services

We will prepare the Cooperative's federal and property tax returns for the year ended December 31, 2020 based on information provided by you. We will also assist in preparing the financial statements and related notes of the Cooperative in conformity with U.S. generally accepted accounting principles based on information provided by you. These nonaudit services do not constitute an audit under *Government Auditing Standards* and such services will not be conducted in accordance with *Government Auditing Standards*.

We will perform the services in accordance with applicable professional standards, including the Statements on Standards for Tax Services issued by the American Institute of Certified Public Accountants. The other services are limited to the financial statement and tax services previously defined. We, in our sole professional judgment, reserve the right to refuse to perform any procedure or take any action that could be construed as assuming management responsibilities. We will advise management with regard to tax positions taken in the preparation of the tax return, but management must make all decisions with regard to those matters.

Management Responsibilities

In order to comply with the provisions of the RUS security instruments, management is responsible for obtaining an audit in accordance with 7 CFR Chapter XVII, P1773. Management is responsible for (1) establishing and maintain effective internal controls, including monitoring ongoing activities and for helping to ensure that appropriate goals and objectives are met; (2) following laws and regulations and (3) ensuring that management is reliable and financial information is reliable and properly reported. Management is also responsible for implementing systems designed to achieve compliance with applicable laws, regulations, contracts, and grant agreements. Management is also responsible

for the selection and application of accounting principles for the preparation and fair presentation of the financial statements and all accompanying information in conformity with U.S. generally accepted accounting principles and for compliance with applicable laws and regulations and the provisions of contracts and grant agreements.

Management is also responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. You are also responsible for providing us with (1) access to all information of which you are aware that is relevant to the preparation and fair presentation of the financial statements, (2) additional information that we may request for the purpose of the audit, and (3) unrestricted access to persons within the Cooperative from whom we determine it necessary to obtain audit evidence.

Your responsibilities include adjusting the financial statements to correct material misstatements and for confirming to us in the representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

You are responsible for the designing and implementation of programs and controls to prevent and detect fraud, and for informing us about all known or suspected fraud affecting the Cooperative involving (1) management, (2) employees who have significant roles in internal control, and (3) others where the fraud could have a material effect on the financial statements. Your responsibilities include informing us of your knowledge of any allegations of fraud or suspected fraud affecting the Cooperative received in communications from employees, former employees, grantors, regulators, or others. In addition, you are responsible for identifying and ensuring that the Cooperative complies with applicable laws, regulations, contracts, agreements, and grants and for taking timely appropriate steps to remedy fraud, noncompliance with provisions of laws, regulations, and contracts or grant agreements, or abuse that we report.

Management is responsible for establishing and maintaining a process for tracking the status of audit findings and recommendations. Management is also responsible for identifying and providing report copies of previous financial audits, attestation engagements, performance audits, or other studies related to the objectives discussed in the Audit Objectives section of this letter. This responsibility includes relating to us corrective actions taken to address significant findings and recommendations resulting from those audits, attestation engagements, performance audits, or other engagements or studies. The Cooperative is also responsible for providing management's views on our current findings, conclusions, and recommendations, as well as your planned corrective actions for the report, and for the timing and format for providing that information.

You agree to assume all management responsibilities relating to the tax services, financial statements, related notes, and any other nonaudit services we provide. You will be required to acknowledge in the management representation letter the tax services provided and our assistance with the preparation of the financial statements and related notes and that you have evaluated the adequacy of our services and have reviewed and approved the results of the services, the financial statements, and related notes prior to their issuance and have accepted responsibility for them. Further, you agree to assume all management responsibilities for the tax services, financial statement preparation services, and any other nonattest services we provide: you agree to oversee the nonaudit services

by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; evaluate the adequacy and results of the services and accept responsibility for them. You are responsible for the preparation of the supplementary information in conformity with U.S. generally accepted accounting principles. You agree to include our report on the supplementary information in any document that contains, and indicates that we have reported on, the supplementary information. You also agree to include the audited financial statements with any presentation of the supplementary information that includes our report thereon.

Engagement Administration, Fees, and Other

We may from time to time, and depending on the circumstances, use third-party service providers in serving your account. We may share confidential information about you with these service providers but remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your personal information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information and we will take reasonable precautions to determine that they have appropriate procedures in place to prevent the unauthorized release of your confidential information to others. In the event that we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider. Furthermore, we will remain responsible for the work provided by any such third-party service providers.

We understand that your employees will prepare all cash, accounts receivable, and other confirmations we request and will locate any documents selected by us for testing.

We will provide copies of our reports to the Cooperative; however, management is responsible for distribution of the reports and the financial statements. Unless restricted by law or regulation, or containing privileged and confidential information, copies of our reports are to be made available for public inspection.

The audit documentation for this engagement is the property of Jones, Nale & Mattingly PLC and constitutes confidential information. However, subject to applicable laws or regulations, audit documentation and appropriate individuals will be made available upon request and in a timely manner to the RUS or its designee, a federal agency providing direct or indirect funding, or the U.S. Government Accountability Office for purposes of a quality review of the audit, to resolve audit findings, or to carry out oversight responsibilities. We will notify you of any such request. If requested, access to such audit documentation will be provided under the supervision of Jones, Nale & Mattingly PLC personnel. Furthermore, upon request, we may provide copies of selected audit documentation to the aforementioned parties. These parties may intend, or decide, to distribute the copies or information contained therein to others, including other governmental agencies.

At the conclusion of our audit, we will submit our audit report, report on compliance and internal control over financial reporting and management letter in accordance with RUS Part 1773. We will issue a separate letter detailing any material weaknesses which we observe in your system of internal accounting control, along with recommendations for strengthening internal accounting controls and improving operating procedures if significant deficiencies are noted in these areas. We will document our audit work performed in accordance with Generally Accepted *Government Auditing Standards*

(GAGAS), the professional standards of the AICPA and the requirements of RUS Part 1773. We will make all audit-related documents available to the RUS.

We are independent with respect to the Cooperative as defined and interpreted by the Professional Ethics Division of the AICPA and *Government Auditing Standards*. We are a member in good standing of the AICPA Peer Review Program as required by RUS.

The audit documentation for this engagement will be retained for a minimum of five years after the report release date or for any additional period requested by the RUS. If we are aware that a federal awarding agency or auditee is contesting an audit finding, we will contact the party contesting the audit finding for guidance prior to destroying the audit documentation.

Joe Legel and Alan Zumstein are the engagement partners and responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

Fees for the audit services will be $13,750.

The fee estimate is based on anticipated cooperation from your personnel and the assumption that unexpected circumstances will not be encountered during the audit. If significant additional time is necessary, we will discuss it with you and arrive at a new fee estimate before we incur the additional costs. Our invoices for these fees will be rendered each month as work progresses and are payable on presentation.

You have requested that we provide you with a copy of our most recent external peer review report and any subsequent reports received during the contract period. Accordingly, our 2020 peer review report accompanies this letter.

We appreciate the opportunity to be of service to the Cooperative and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you agree with the terms of our engagement as described in this letter, please sign the enclosed copy and return it to us.

Sincerely,

JONES, NALE & MATTINGLY PLC

Joseph M. Legel, CPA
Partner

Accepted:

By: _____

Date: 6/24/21

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 49
RESPONSIBLE PARTY: Patsy Walters

Request 49. Provide Taylor RECC's policies, specifying the compensation of directors and a schedule of standard directors' fees, per diems, and other compensation in effect during the test year. If changes occurred during the test year, indicated the effective date and the reason for the changes.

Response 49. Please see attached.

#403

Wrd:director fee reimbursement 1-04-01

10/29/00

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
GUIDELINES FOR DIRECTOR FEES AND EXPENSES
JANUARY 4, 2001

Director fees are currently $300.00 per meeting.

Directors are reimbursed mileage for the personal use of vehicles for attending meetings and conferences on Cooperative business. The mileage rate for reimbursement is the current rate allowed by the Internal Revenue service.

1. Directors are paid the current fee for attending each of the twelve (12) regular board meetings.

2. The Cooperative will provide Group Medical Coverage for Directors under the Group coverage provided employees of the Cooperative. This coverage is subject to the same terms and conditions as that provided to employees. This coverage is optional and individual Directors may elect not to receive the coverage. If a Director elects not to receive this benefit no additional replacement benefit is provided. This benefit is considered taxable income to directors under IRS regulations.

3. Directors are paid the current fee and mileage for attending the annual meeting.

4. A Director may receive the current fee if he is absent from a regular board meeting or annual meeting. A Director may only be paid the fee for absence twice in a calendar year.

5. Special meetings of the Board. Directors are paid the current fee and mileage for attending special meetings of the Board.

6. Committee's of the Board of Directors. Directors are paid the current fee and expenses for attending committee meetings IE. Voucher Committee.

7. National, State, and other meetings, conferences and seminars. Directors shall receive the current board fee for each day they are attending meetings on Cooperative business, the fee being payable for days the meeting is in session only. For meetings attended out of the state of Kentucky the fee shall be paid to include one day travel time. These fees are to be paid for a maximum of two meetings per calendar year. For meetings attended over the maximum of two, the Director shall receive a maximum of two days fees and no travel time. A Director may waive the maximum payment for attending a meeting in order to receive the maximum for a meeting attended later in the year.

8. Signing checks. At times during the year when the Manager or Office Manager are not available to sign Cooperative checks it is necessary for the President or Treasurer to sign checks. The President or Treasurer may receive the current director fee and mileage for signing checks.

9. Meetings with Manager. If it is necessary for the President of the Board to meet with the Manager on Agenda items for a Board meeting the President may receive the current fee and mileage reimbursement.

10. Other director fee payments. If a Director feels he is due a current fee for conducting cooperative business not covered in Items 1 through 9 then this fee will be presented to the full board at the next regular board meeting for approval.

11. Expenses. Directors shall be reimbursed actual expenses for attendance at meetings, conference and seminars on Cooperative business. Directors may receive reimbursement for spouse expense of room and meals while attending meeting, conferences and seminars. Air travel is reimbursed for Directors only.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE
POLICY MANUAL

DEFERRED COMPENSATION FOR DIRECTORS

I. OBJECTIVE

To provide deferred compensation for directors in order to enable the Cooperative to secure and retain the best people available for the on-going success and growth of Taylor County Rural Electric Cooperative ("Cooperative").

II. POLICY

A. Members of the Board of Directors of the Cooperative ("Directors") who retire from the Board on or after April 1, 2000, and who have completed at least 12 years of service as a Director, will paid, in a lump sum in cash, an amount equal to the Director's years of service on the Board times three times the current or the then existing Board fee (whichever is higher) for attendance at a meeting, subject to the additional terms of this policy. For example, if a retiring Director has 20 years of service on the Board and the current fee for attendance at Board meetings is $200, the Director will receive a cash payment equal to 20 x 3 x $200, or $12,000.

B. Benefits under A. above will be paid within 90 days of the Director's retirement from the Board to the Director, or if the Director is deceased at the time payment is to be made, to the Director's estate.

C. For the purposes of A above, retirement means the cessation of active service as a member of the Board of Directors for any reason, provided that retirement shall not include (i) a Director's resignation following inappropriate actions of the Director that harm the interests of the Cooperative including but not limited to disparaging its reputation or seriously embarrassing the Cooperative, or (ii) removal of the Director for cause.

D. This policy may be amended or terminated by the Cooperative at any time in its sole and absolute discretion by action of the Cooperative's Board, provided that no amendment or termination will apply to Directors serving on the Board on the date the amendment or termination is adopted or to retired Directors who have earned a benefit and not yet received payment hereunder.

E. No Director may assign or alienate the benefits owed him hereunder in any way and any attempted assignment, alienation or pledge shall be null and void. The Cooperative's obligations to Directors hereunder shall be merely an unsecured promise to pay benefits out of its general assets. This policy provides benefits to

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE
POLICY MANUAL

Directors with respect to their service as independent contractors and is not governed by ERISA.

III. RESPONSIBILITY

This policy shall be administered and interpreted by the Assistant Manager with review by the General Manager and Board of Directors.

Date Policy Adopted by Board: 4/6/2000

President

HZ6.B1012
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4/1/2014 10:11 AM

I. Amendment: Amended to exclude New Directors elected after August 4, 2005.

APPROVED BY BOARD OF DIRECTORS August 4 2005

Board Policy Amended March 2, 2023:
Board voted to discontinue Severance/Deferred Compensation Package.
Years of service are to be paid thru 12/31/2022 to close the issue on Severance/Deferred Compenation Package.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE
POLICY MANUAL

HEALTH BENEFITS FOR RETIRED DIRECTORS

I. OBJECTIVE

To provide health benefits for retiring directors in order to enable the Cooperative to secure and retain the best people available for the on-going success and growth of Taylor County Rural Electric Cooperative ("Cooperative").

II. POLICY

A. Members of the Board of Directors of the Cooperative ("Directors") who retire from the Board on or after April 1, 2000, and who have completed at least 12 years of service, will be eligible for continuation of family health coverage under the group health coverage provided by the Cooperative ("Group Health Benefits") at the same cost as charged to retired employees of the Cooperative for such coverage, subject to the additional terms of this policy.

B. Group Health Benefits provided under A. above will cease upon the earliest of the following: (i) the date the Director becomes eligible for Medicare benefits (provided that if a Medicare supplement policy is made available by the Cooperative to employees, such policy shall be made available to Directors on the same basis), (ii) the date the Director becomes eligible for fully subsidized group health benefits under an employer's plan, (iii) the date the Director dies or (iv) the date the Cooperative ceases to provide Group Health Benefits to any Director or employee of the Cooperative.

C. The Cooperative may, at any time and in its complete discretion, substitute a monthly cash payment for the Group Health Benefits that would otherwise be provided to Directors under A. above. Such cash payment shall be equal to the cost at the time the payment is made of Group Health Benefits provided to Cooperative employees, less the premium that the Director would be required to pay under A. above for the coverage. The Cooperative may elect to substitute the cash payment in the event the insurance carrier declines to cover Directors, in the event the Cooperative adopts a self-insured health plan, or for any other reason or for no reason.

D. For the purposes of A. above, retirement means the cessation of active service as a member of the Board of Directors for any reason, provided that retirement shall not include (i) a Director's resignation following inappropriate actions of the Director that harm the interests of the Cooperative including but not limited to disparaging its reputation or seriously embarrassing the Cooperative, or (ii) removal of the Director for cause.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE
POLICY MANUAL

E. This policy may be amended or terminated by the Cooperative at any time in its sole and absolute discretion by action of the Cooperative's Board, provided that no amendment or termination will apply to Directors serving on the Board on the date the amendment or termination is adopted or to retired Directors who are then entitled to benefits under this policy.

III. RESPONSIBILITY

This policy shall be administered and interpreted by the Assistant Manager with review by the General Manager and Board of Directors.

Date Policy Adopted by Board: 4/6/2000

President

HZ6.B1012
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9/14/2005 1:23 PM

I. Amendment: Directors elected to the BOARD After August 4, 2005 will be eligible for Single Coverage Health Insurance only.
Health Insurance Coverage terminated upon leaving the Board of Directors.

APPROVED BY THE BOARD of DIRECTORS August 4, 2005

#403

Wrd:director fee reimbursement 1-04-01

10/29/20

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
GUIDELINES FOR DIRECTOR FEES AND EXPENSES
JANUARY 4, 2001

Director fees are currently ~~$300.00~~ per meeting. $325.00

Directors are reimbursed mileage for the personal use of vehicles for attending meetings and conferences on Cooperative business. The mileage rate for reimbursement is the current rate allowed by the Internal Revenue service.

1. Directors are paid the current fee for attending each of the twelve (12) regular board meetings.

2. ~~The Cooperative will provide Group Medical Coverage for Directors under the Group coverage provided employees of the Cooperative. This coverage is subject to the same terms and conditions as that provided to employees. This coverage is optional and individual Directors may elect not to receive the coverage. If a Director elects not to receive this benefit no additional replacement benefit is provided. This benefit is considered taxable income to directors under IRS regulations.~~

3. Directors are paid the current fee and mileage for attending the annual meeting.

4. A Director may receive the current fee if he is absent from a regular board meeting or annual meeting. A Director may only be paid the fee for absence twice in a calendar year.

5. Special meetings of the Board. Directors are paid the current fee and mileage for attending special meetings of the Board.

6. Committee's of the Board of Directors. Directors are paid the current fee and expenses for attending committee meetings IE. Voucher Committee.

7. National, State, and other meetings, conferences and seminars. Directors shall receive the current board fee for each day they are attending meetings on Cooperative business, the fee being payable for days the meeting is in session only. For meetings attended out of the state of Kentucky the fee shall be paid to include one day travel time. These fees are to be paid for a maximum of two meetings per calendar year. For meetings attended over the maximum of two, the Director shall receive a maximum of two days fees and no travel time. A Director may waive the maximum payment for attending a meeting in order to receive the maximum for a meeting attended later in the year.

8. Signing checks. At times during the year when the Manager or Office Manager are not available to sign Cooperative checks it is necessary for the President or Treasurer to sign checks. The President or Treasurer may receive the current director fee and mileage for signing checks.

9. Meetings with Manager. If it is necessary for the President of the Board to meet with the Manager on Agenda items for a Board meeting the President may receive the current fee and mileage reimbursement.

10. Other director fee payments. If a Director feels he is due a current fee for conducting cooperative business not covered in Items 1 through 9 then this fee will be presented to the full board at the next regular board meeting for approval.

11. Expenses. Directors shall be reimbursed actual expenses for attendance at meetings, conference and seminars on Cooperative business. Directors may receive reimbursement for spouse expense of room and meals while attending meeting, conferences and seminars. Air travel is reimbursed for Directors only.

New Line Item - 12. Directors will be paid a monthly retainer fee of $1,000.00

Board Policy Amended November 8, 2022.
Effective January 1, 2023

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 50
RESPONSIBLE PARTY: Patsy Walters

Request 50. Provide the date, time, and a general description of the activities at the most recent annual members' meeting. Indicate the number of new board members elected. For the most recent meeting and the five previous annual members' meetings, provide the number of members in attendance, the number of members voting for new board members, and the total cost of the meeting.

Response 50.

2022 The Drive Thru Annual Meeting was held on July 15, 2022, at the Taylor County High School campus with 390 registering members. Registration was between 8:30 a.m. and 11 p.m. EDT; prizes were awarded after the drive thru. There was no annual meeting. The Total cost was $7,502.29.

There was no official election since Green County and Adair County were uncontested. Greg Corbin, Green County, and Chad Taylor, Adair County, retained their seats. Total cost $1,031.20.

The director election was held by mail-in ballots for Casey County from June 22, 2021, through July 6, 2021. Casey County saw the election of a new director, Mark Woodrum, who defeated incumbent Bryan Clements. A total of 1,861 were counted. Total cost $15,836.95.

2020 Annual Meeting canceled due to COVID.

There was no official election since Adair County and Taylor County were uncontested. Bradley Irvin, Adair County, and Chris Tucker, Taylor County, retained their seats. Total cost $700.00.

2019 The Annual Meeting was held on July 12, 2019, at the Taylor County RECC Headquarters with 332 registering members. Registration and musical entertainment began at 8:30 a.m. EDT; business meeting began at 10 a.m.; prizes were awarded after meeting was adjourned. Total cost $10,455.61.

There was no official election since Green County and Taylor County were uncontested. Donald Dean Shuffett, Green County, and Raymond Rucker, Taylor County, retained their seats. Total cost $1,327.72.

2018 – The Annual Meeting was held on July 13, 2018, at the Taylor County RECC Headquarters with 352 registering members. Registration and musical entertainment began at 8:30 a.m. EDT; business meeting began at 10 a.m.; prizes were awarded after meeting was adjourned. Total cost $9,470.23.

There was no official election since Green County and Adair County were uncontested. Greg Corbin, Green County, and Chad Taylor, Adair County, retained their seats. Total cost $1,063.46.

2017 – The Annual Meeting was held on July 14, 2017, at the Taylor County RECC Headquarters with 338 registering members. Registration and musical entertainment began at 8:30 a.m. EDT; business meeting began at 10 a.m.; prizes were awarded after meeting was adjourned. Total cost $8,048.05.

There was no official election since Casey County was uncontested. Bryan Clements, Casey County, retained his seat. Total cost $1,002.10.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 51
RESPONSIBLE PARTY: Patsy Walters

Request 51. Provide any information, when known, that would have a material effect on net operating income, rate base, or cost of capital that have incurred after the test year but were not incorporated in the filed testimony and exhibits.

Response 51. Taylor County knows of no material item that has occurred after the test year but will inform the Commission if and when any material item is identified.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 52
RESPONSIBLE PARTY: Patsy Walters

Request 52. For the test year and the five preceding calendar years, provide a schedule detailing all nonrecurring charges by customer class which includes:

a. Type of charge;
b. Amount billed;
c. Amount recovered;
d. Number of times the charge was assessed; and
e. Support for the nonrecurring charge.

Response 52. Please see attached. The attachments are Excel spreadsheets and are being uploaded into the Commission's electronic filing system separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 53
RESPONSIBLE PARTY: John Wolfram

Request 53. 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 Taylor RECC's rate application in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 53. The three Excel spreadsheet files responsive to this request were uploaded to the Commission website on June 6, 2023, concurrent with the filing of the Application in this docket.

TAYLOR COUNTY RURAL ELECTRIC COOPERATIVE CORPORATION
PSC CASE NO. 2023-00147
RESPONSE TO REQUEST FOR INFORMATION

PSC'S REQUEST FOR INFORMATION DATED 5/11/23
REQUEST 54
RESPONSIBLE PARTY: Patsy Walters

Request 54. To the extent not already provided, provide all workpapers, calculations, and assumptions Taylor RECC used to develop its test year financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 54. Please see attached.

TAYLOR COUNTY RECC — FINANCIAL AND STATISTICAL REPORT — PAGE 1 **Witness: Patsy Walters**
PRG. OPERBSHT (OBSA) — FROM 01/21 THRU 12/21 — RUN DATE 05/26/23 07:14 AM

PART A. STATEMENT OF OPERATIONS

LINE NO		YEAR TO DATE LAST YEAR A	YEAR TO DATE THIS YEAR B	YEAR TO DATE BUDGET C	THIS MONTH D	% FROM BUDGET	% CHANGE FROM LAST YEAR
1.0	OPERATING REVENUE & PATRONAGE CAPITAL....	43,720,677.56	49,335,742.41	47,062,291.00	4,447,355.33	4.8	12.8
2.0	POWER PRODUCTION EXPENSE.....	.00	.00	.00	.00	.0	.0
3.0	COST OF PURCHASED POWER.....	33,254,997.00-	38,800,021.00-	35,604,114.00-	4,250,531.00-	9.0	16.7
4.0	TRANSMISSION EXPENSE.....	.00	.00	.00	.00	.0	.0
5.0	REGIONAL MARKET OPERATIONS EXPENSE.....	.00	.00	.00	.00	.0	.0
6.0	DISTRIBUTION EXPENSE-OPERATION.....	1,921,673.51-	2,266,759.68-	2,233,149.00-	232,532.68-	1.5	18.0
7.0	DISTRIBUTION EXPENSE-MAINTENANCE.....	1,972,675.12-	2,646,181.00-	2,197,106.00-	193,829.47-	20.4	34.1
8.0	CONSUMER ACCOUNTS EXPENSE.....	1,153,140.49-	1,288,345.11-	1,333,969.00-	96,159.68-	3.4-	11.7
9.0	CUSTOMER SERVICE & INFORMATIONAL EXPENSE.	96,854.19-	139,609.52-	153,738.00-	12,057.58-	9.2-	44.1
10.0	SALES EXPENSE.....	.00	.00	.00	.00	.0	.0
11.0	ADMINISTRATIVE & GENERAL EXPENSE.....	1,415,183.32-	1,683,907.26-	1,804,409.00-	130,440.32-	6.7-	19.0
12.0	TOTAL OPERATIONS & MAINTENANCE EXPENSE...	39,814,523.63-	46,824,823.57-	43,326,485.00-	4,915,550.73-	8.1	17.6
13.0	DEPRECIATION & AMORTIZATION EXPENSE.....	3,102,798.71-	3,259,870.44-	3,218,700.00-	277,316.06-	1.3	5.1
14.0	TAX EXPENSE - PROPERTY & GROSS RECEIPTS..	.00	.00	.00	.00	.0	.0
15.0	TAX EXPENSE - OTHER.....	55,561.87-	47,600.84-	64,800.00-	5,887.50-	26.5-	14.3-
16.0	INTEREST ON LONG TERM DEBT.....	730,070.69-	642,669.77-	960,000.00-	50,047.71-	33.1-	12.0-
17.0	INTEREST CHARGED TO CONSTRUCTION - CREDIT	.00	.00	.00	.00	.0	.0
18.0	INTEREST EXPENSE - OTHER.....	45,497.57-	27,056.93-	48,000.00-	3,307.85-	43.6-	40.5-
19.0	OTHER DEDUCTIONS.....	.00	.00	.00	.00	.0	.0
20.0	TOTAL COST OF ELECTRIC SERVICE.....	43,748,452.47-	50,802,021.55-	47,617,985.00-	5,252,109.85-	6.7	16.1
21.0	PATRONAGE CAPITAL & OPERATING MARGINS....	27,774.91-	1,466,279.14-	555,694.00-	804,754.52-	163.9	5179.1
22.0	NON OPERATING MARGINS - INTEREST.....	89,998.14	31,810.97	.00	667.90	100.0	64.7-
23.0	ALLOW. FOR FUNDS USED DURING CONSTRUCTION	.00	.00	.00	.00	.0	.0
24.0	INCOME (LOSS) FROM EQUITY INVESTMENTS....	.00	.00	.00	.00	.0	.0
25.0	NON OPERATING MARGINS - OTHER.....	35,044.54-	842,192.73	.00	4,311.30-	100.0	2503.2-
26.0	GENERATION & TRANSMISSION CAPITAL CREDITS	1,197,349.50	462,219.04	.00	462,219.04	100.0	61.4-
27.0	OTHER CAPITAL CREDITS & PATRONAGE DIVID..	107,033.70	131,606.02	.00	.00	100.0	23.0
28.0	EXTRAORDINARY ITEMS.....	.00	.00	.00	.00	.0	.0
29.0	PATRONAGE CAPITAL OR MARGINS.....	1,331,561.89	1,549.62	555,694.00-	346,178.88-	100.3-	99.9-

RATIOS

TIER	2.824	1.002	.421	5.917-
MARGINS TO REVENUE	.030	.000	.012	.078
POWER COST TO REVENUE	.761	.786	.757	.956
INTEREST EXPENSE TO REVENUE	.017	.013	.020	.011

CURRENT ASSETS : CURRENT LIABILITIES	1.3217
MARGINS & EQUITIES AS % OF ASSETS	.6501
LONG TERM DEBT AS % OF PLANT	.2451
GENERAL FUNDS TO TOTAL PLANT	3.6375
QUICK ASSET RATIO	1.0999

PART C. BALANCE SHEET

LINE NO	ASSETS AND OTHER DEBITS			LINE NO	LIABILITIES AND OTHER CREDITS		
1.0	TOTAL UTILITY PLANT IN SERVICE	102,490,432.15		30.0	MEMBERSHIPS	.00	
2.0	CONSTRUCTION WORK IN PROGRESS	348,360.18		31.0	PATRONAGE CAPITAL	62,915,311.83-	
3.0	TOTAL UTILITY PLANT	102,838,792.33		32.0	OPERATING MARGINS - PRIOR YEAR	.00	
4.0	ACCUM PROV FOR DEP & AMORT	38,947,245.16-		33.0	OPERATING MARGINS-CURRENT YEAR	1,549.62-	
5.0	NET UTILITY PLANT		63,891,547.17	34.0	NON-OPERATING MARGINS	5,448,582.89-	
				35.0	OTHER MARGINS & EQUITIES	1,778,797.97	
6.0	NON-UTILITY PROPERTY (NET)	.00		36.0	TOTAL MARGINS & EQUITIES		66,586,646.37-
7.0	INVEST IN SUBSIDIARY COMPANIES	.00					
8.0	INV IN ASSOC ORG - PAT CAPITAL	31,732,249.79		37.0	LONG TERM DEBT - RUS (NET)	4,205,665.86-	
9.0	INV IN ASSOC ORG OTHR GEN FND	226,794.23			(PAYMENTS-UNAPPLIED	.00)	
10.0	INV IN ASSOC ORG - NON GEN FND	1,172,494.02		38.0	LNG-TERM DEBT-FFB-RUS GUAR	19,304,048.31-	
11.0	INV IN ECON DEVEL PROJECTS	.00		39.0	LONG-TERM DEBT OTHER-RUS GUAR	6,200,000.00	
12.0	OTHER INVESTMENTS	7,400.00		40.0	LONG TERM DEBT - OTHER (NET)	8,267,996.93-	
13.0	SPECIAL FUNDS	.00		41.0	LNG-TERM DEBT-RUS-ECON DEV NET	.00	
14.0	TOT OTHER PROP & INVESTMENTS		33,138,938.04	42.0	PAYMENTS - UNAPPLIED	372,445.77	
				43.0	TOTAL LONG TERM DEBT		25,205,265.33-
15.0	CASH - GENERAL FUNDS	1,588,492.76					
16.0	CASH - CONSTRUCTION FUND TRUST	.00		44.0	OBLIGATION UNDER CAPITAL LEASE	434,888.46-	
17.0	SPECIAL DEPOSITS	.00		45.0	ACCUM OPERATING PROVISIONS	5,625,762.63-	
18.0	TEMPORARY INVESTMENTS	1,918,072.30		46.0	TOTAL OTHER NONCURR LIABILITY		6,060,651.09-
19.0	NOTES RECEIVABLE (NET)	.00					
20.0	ACCTS RECV - SALES ENERGY(NET)	599,088.83		47.0	NOTES PAYABLE	1,400,000.00-	
21.0	ACCTS RECV - OTHER (NET)	124,754.68		48.0	ACCOUNTS PAYABLE	549,153.00-	
22.0	RENEWABLE ENERGY CREDITS	.00		49.0	CONSUMER DEPOSITS	1,911,908.32-	
23.0	MATERIAL & SUPPLIES-ELEC & OTH	906,215.97		50.0	CURR MATURITIES LONG-TERM DEBT	.00	
24.0	PREPAYMENTS	263,281.39		51.0	CURR MATURIT LT DEBT ECON DEV	.00	
25.0	OTHER CURRENT & ACCR ASSETS	.00		52.0	CURR MATURITIES CAPITAL LEASES	.00	
26.0	TOTAL CURRENT & ACCR ASSETS		5,399,905.93	53.0	OTHER CURRENT & ACCRUED LIAB	224,448.42-	
				54.0	TOTAL CURRENT & ACCRUED LIAB		4,085,509.74-
27.0	REGULATORY ASSETS		.00				
28.0	OTHER DEFERRED DEBITS		.00	55.0	REGULATORY LIABILITIES		.00
				56.0	OTHER DEFERRED CREDITS		492,318.61-
29.0	TOTAL ASSETS & OTHER DEBITS		102,430,391.14	57.0	TOTAL LIABILITIES & OTH CREDIT		102,430,391.14-

ESTIMATED CONTRIBUTIONS IN AID OF CONSTRUCTION

58.0	BALANCE BEGINNING OF YEAR	.00
59.0	AMOUNT RECEIVED THIS YEAR (NET)	150,736.01
60.0	TOTAL CONTRIBUTIONS IN AID OF CONST	150,736.01

C E R T I F I C A T I O N

WE HEREBY CERTIFY THAT THE ENTRIES IN THIS REPORT ARE IN ACCORDANCE WITH THE ACCOUNTS AND OTHER RECORDS OF THE SYSTEM AND REFLECT THE STATUS OF THE SYSTEM TO THE BEST OF OUR KNOWLEDGE AND BELIEF.
ALL INSURANCE REQUIRED BY PART 1788 OF 7 CFR CHAPTER XVII, REA, WAS IN FORCE DURING THE REPORTING PERIOD AND RENEWALS HAVE BEEN OBTAINED FOR ALL POLICIES.

_____ _____
SIGNATURE OF OFFICE MANAGER OR ACCOUNTANT DATE

_____ _____
SIGNATURE OF MANAGER DATE