COMMONWEALTH OF KENTUCKY
BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF FLEMING-MASON ENERGY COOPERATIVE, INC. FOR A GENERAL ADJUSTMENT OF RATES	)))	Case No. 2023-00223

RESPONSES TO COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION TO FLEMING-MASON ENERGY COOPERATIVE, INC.
DATED AUGUST 15TH, 2023

This 31st day of August, 2023.

Respectfully submitted,

CAMPBELL ROGERS & STACY PLLC
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BY: _____
EARL ROGERS III
ATTORNEY FOR FLEMING-MASON ENERGY COOPERATIVE, INC.

CERTIFICATE OF SERVICE

This is to certify that the foregoing electronic filing was transmitted to the Kentucky Public Service Commission for filing on August 31st, 2023; that there are currently no parties that the Commission has excused from participation by electronic means in this proceeding; by virtue of the Commission's Order of July 22, 2021, in case number 2020-00085, no paper copies of this filing will be made.

EARL ROGERS III
ATTORNEY FOR
FLEMING-MASON ENERGY COOPERATIVE, INC.

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF	)	
FLEMING-MASON ENERGY COOPERATIVE, INC.	)	CASE NO.
FOR A GENERAL ADJUSTMENT OF RATES	)	2023-00223

VERIFICATION OF BRANDON HUNT

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FLEMING)

Brandon Hunt, President and Chief Executive Officer of Fleming-Mason Energy Cooperative, Inc., 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 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.

Brandon Hunt

The foregoing Verification was signed, acknowledged, and sworn to before me this 30th day of August 2023, by Brandon Hunt.

Jennifer L. McRoberts
Commonwealth of Kentucky
Notary Public
Commission No. KYNP61556
My Commission Expires 12/22/2026

Jennifer L. McRoberts

Commission Expiration: 12/22/26

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

THE ELECTRONIC APPLICATION OF	)	
FLEMING-MASON ENERGY COOPERATIVE, INC.	)	CASE NO.
FOR A GENERAL ADJUSTMENT OF RATES	)	2023-00223

VERIFICATION OF LAUREN C. FRITZ

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FLEMING)

Lauren C. Fritz, Chief Financial Officer of Fleming-Mason Energy Cooperative, Inc., 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 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.

Lauren C. Fritz

The foregoing Verification was signed, acknowledged, and sworn to before me this 30th day of August 2023, by Lauren C. Fritz.

Jennifer L. McRoberts
Commonwealth of Kentucky
Notary Public
Commission No. KYNP61556
My Commission Expires 12/22/2026

Jennifer L. McRoberts

Commission Expiration: 12/22/26

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF FLEMING-MASON ENERGY COOPERATIVE INC. FOR A GENERAL ADJUSTMENT OF RATES	))))	CASE NO. 2023-000223

VERIFICATION OF JOHN WOLFRAM

COMMONWEALTH OF KENTUCKY)
COUNTY OF JEFFERSON)

John Wolfram, 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 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 30 day of August 2023, by John Wolfram.

ANNE L FOYE
Notary Public - State at Large
Kentucky
My Commission Expires June 12, 2025
Notary ID KYNP29156

Commission expiration: 6-12-2025

ANNE L. FOYE NOTARY PUBLIC STATE AT LARGE KENTUCKY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 1
RESPONSIBLE PERSONS: Brandon Hunt & Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 1. Provide the following expense account data:

Request 1a. 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 Fleming-Mason Energy's annual report. Show the percentage of increase or decrease of each year over the prior year.

Response 1a. Please see attached.

Request 1b. A listing, with descriptions, of all activities, initiatives, or programs undertaken or continued by the utility since its last general rate case for the purpose of minimizing costs or improving the efficiency of its operations or maintenance activities. Include all quantifiable realized and projected savings.

Response 1b. Fleming-Mason Energy 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.

- Fleming-Mason Energy applied for the SBA/PPP loan in 2020 in the amount of $1,077,100. The loan was forgiven, enabling the cooperative to recover up to eight weeks of payroll costs, including benefits.

- Overall, Fleming-Mason Energy operates with a lean workforce for both inside and outside employees. Fleming-Mason has maintained stable employment numbers since 2008 despite member growth.

- Implemented Automated Metering Infrastructure (AMI) in 2014. This has improved efficiency within the organization and prevented workforce growth. This technology offers several intangible benefits not directly related to efficiency, but efficiency improves, nonetheless. Benefits such as outage detection, voltage monitoring, energy monitoring, and remote disconnects. Also, the enhanced ability to read meters remotely as opposed to manual contracted reading.

- Fleming-Mason Energy has remained constant with its Right of Way (ROW) program since the last rate increase to avoid large swings in ROW budgets. Careful monitoring of the program remains in place all the way up to the CEO level. Continuous improvement is still a goal and one of the reasons a subsidiary company named FM Utility Resources, LLC. (FMUR) was created. FMUR is currently a single crew that completes “cycle buster” trimming as well as capitalized work orders.

- Fleming-Mason signed an agreement with a third-party landfill generation company which produces 1.4 MW of power. The generated power purchased from the landfill provides an economic advantage over purchased power from other contracts.

- Fleming-Mason Energy benefited for several years from a large portion of financing on variable interest rates. The upward trend and high forecast of rates lead to the change from variable interest rates to fixed rates on all remaining variable interest rate loans in 2022. This change allows FME to see cost savings from interest expense as variable rates continue to trend higher.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 2
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

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.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 3
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 3. Provide the following:

Request 3a. 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.

Response 3a. Please see attached schedules showing long-term debt for the latest calendar year and for the test year.

Request 3b. An analysis of short-term debt as shown in Schedule B2 as of the end of the latest calendar year.

Response 3b. Please see attached schedules showing short-term debt for the latest calendar year and for the test year.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 4
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 4. Provide Fleming-Mason Energy'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.

Disclaimer: The contents of this guidance document does not have the force and effect of law and is not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency 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.

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

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 5
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 5. Provide the utility's long-term construction planning program.

Response 5. Please see attached.

Power System Engineering, Inc.

Full-service consultants

2019 – 2022 Construction Work Plan

Prepared for:

Fleming-Mason Energy Cooperative

Prepared by:

Power System Engineering, Inc.

February 8, 2019

2019– 2022 Construction Work Plan

for

Fleming-Mason Energy Cooperative

KENTUCKY – 052 – FLEMING
FLEMINGSBURG, KENTUCKY

Authors:

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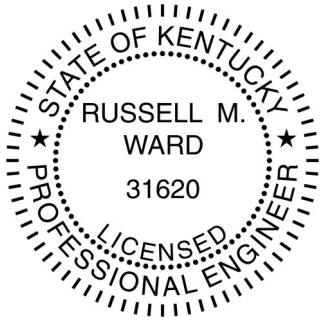
400 Bellerive #150
Nicholasville, KY 40356

www.powersystem.org

I hereby certify that this plan and report 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.

Matt Ward

Matt Ward, P.E.
Date: February 8, 2019
Reg No. 31620



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1 Executive Summary

1.1 Purpose

This report outlines a proposed distribution system construction program for Fleming-Mason Energy Cooperative (Fleming-Mason or the Cooperative) during 2019 – 2022. This report is intended to explain and justify the Cooperative's construction needs to provide adequate and reliable service to new and existing members. The report is also intended to satisfy the Rural Utilities Services (RUS) Work Plan criteria, guidelines and requirements for financing of the proposed facilities, along with, where applicable, financial support from other agencies such as the National Rural Utilities Cooperative Finance Corporation (CFC), and CoBank. The plan also provides a general engineering proposal and an estimate for distribution system capital to accommodate load growth and the replacement of aging infrastructure. A review of the Dravo Lime, Inland Paper Co Inc., Tennessee Gas Pipeline Company, LLC, and Guardian Industries Morehead Plant and the facilities feeding these consumers was not included as part of this review.

This plan was created to be consistent with the last Power Requirements Study / Load Forecast (the 2018 Load Forecast Report). The projections in the 2018 Load Forecast Report do not reflect individual substation non-coincident peak growth. The Load Forecast projects Fleming-Mason's coincident system peak growth. Therefore, this plan uses the Load Forecast projections as a guide. But final plan growth projections will reflect expected individual substation non-coincident peaks. These projections should not be less than the Load Forecast but will show additional load that must be considered in the design process.

The projects proposed in this report should be considered a general guide for system development. Since actual load growth and other factors affecting system development may vary from parameters and assumptions used in this study, periodic review and possible modification of the plans may be required through Work Plan Amendments.

1.2 Financial Results

The proposed distribution plant investment summary can be seen in Table 1-1 for system improvements, miscellaneous replacements, member service and miscellaneous distribution facilities.

Table 1-1 Summary of Plant Investments

PROJECTIONS	2019	2020	2021	2022	Work Plan Totals
New Construction (Net CIAC)					
New URD and OVHD Service - 100	$939,600	$969,400	$999,000	$1,028,600	$3,936,600
System Improvements					
New Tie Lines - 200 series	$0	$0	$0	$0	$0
Line Conversions (Site-Specific) - 300 series	$1,875,300	$1,840,700	$1,853,400	$1,560,800	$7,130,200
New Substations - 400 series	$0	$0	$0	$0	$0
Existing Substations - 500 series	$0	$0	$0	$0	$0
New Transmission - 800 series	$0	$0	$0	$0	$0
Transformers & Meters - 601	$508,200	$526,400	$542,900	$561,900	$2,139,400
Service Upgrades - 602	$94,400	$97,200	$100,150	$103,150	$394,900
Sectionalizing Equip - 603	$51,200	$52,800	$54,400	$56,000	$214,400
Regulators - 604	$81,000	$100,000	$107,000	$102,000	$390,000
Capacitors - 605	$0	$0	$0	$0	$0
Pole Replacements - 606	$639,600	$657,650	$678,000	$698,350	$2,673,600
Misc. Replacements - 607	$0	$0	$0	$0	$0
Misc. Conductor Replacements - 608 [1]	$97,000	$99,900	$102,900	$106,000	$405,800
Other					
Security Lights - 702	$255,350	$265,100	$270,500	$281,300	$1,072,250
AMI Equipment (excl meters in 601) - 705		$0	$0	$0	$0
TOTAL (NET CIAC)	$4,541,650	$4,609,150	$4,708,250	$4,498,100	$18,357,150
[1] Code 608 includes age & condition replacement projects (primarily replacing aging CWC & URD)					
		Average Per Year			$4,589,300

Table 1-2 shows the four-year construction costs by need. Approximately 17 percent of the construction costs are allocated replacement of facilities due to age/condition and normal replacement cycles, 83 percent for construction to accommodate load growth/contingency capability.

Table 1-2 Plant Investment by Project Type

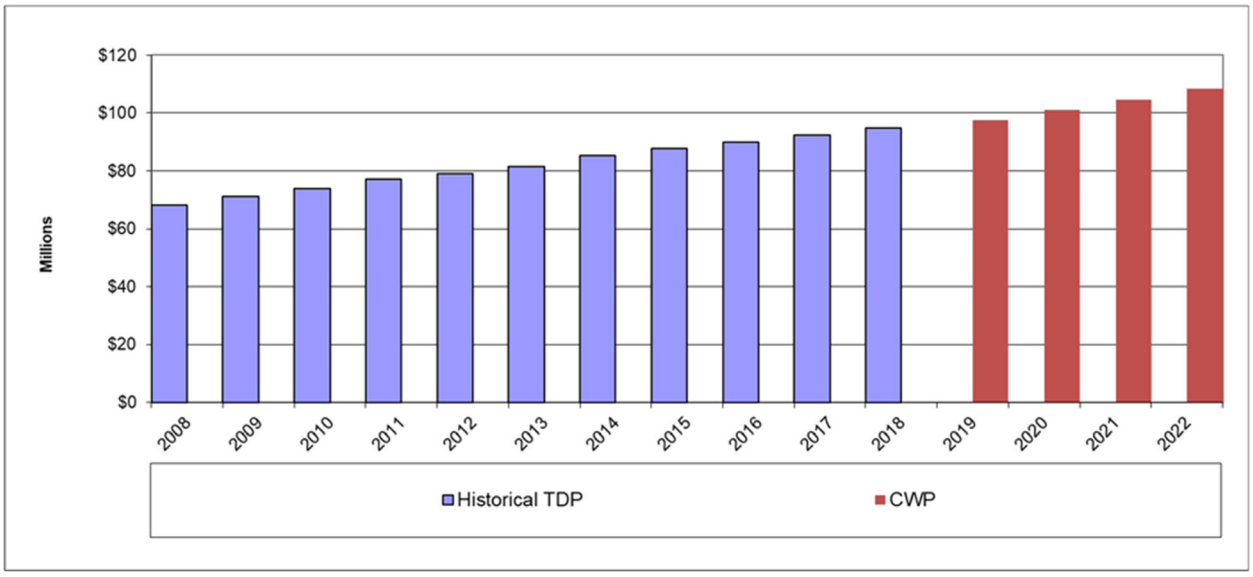
Project Type	Cost ($)	Percent
Replacement of facilities due to age/condition and normal replacement cycles	$3,079,400	17%
Construction to accommodate load growth / contingency capability	$15,277,750	83%
TOTAL	**$18,357,150**	**100%**

A comparison of the Cooperative's historical and projected annual distribution plant investment is shown in Table 1-3; Figure 1-1 shows the cumulative growth of Total Distribution Plant for the same period. The proposed distribution plant capital expenditures from 2019 – 2022 are projected to increase at an average annual rate of 4.3 percent. This rate is very close to the average rate of the past five years at 4.5 percent.

Table 1-3 Distribution Plant Additions and Retirements

	Year	TDP Beginning of Year ($)	Distribution Additions ($)	Distribution Retirements ($)	Adjustments And Transfer ($)	Additions as a Percent of TDP (%)	Average Annual Rate	Compound Growth Rate
H	2008	$68,276,435	$3,970,370	$936,242	$0	5.8%		
I	2009	$71,310,563	$3,282,913	$586,950	$0	4.6%		
S	2010	$74,006,526	$3,913,888	$713,185	$0	5.3%		
T	2011	$77,207,229	$2,797,411	$842,434	$0	3.6%		
O	2012	$79,162,206	$3,168,746	$831,583	$0	4.0%		
R	2013	$81,499,369	$4,519,232	$658,073	$0	5.5%		
I	2014	$85,360,528	$3,763,093	$1,408,125	$0	4.4%		
C	2015	$87,715,496	$3,653,129	$1,473,126	$0	4.2%		
A	2016	$89,895,499	$3,574,866	$1,147,302	$0	4.0%		
L	2017	$92,323,063	$3,580,392	$1,068,749	$0	3.9%	4.5%	3.3%
	2018	$94,834,706	$3,622,000	$967,000	$0	3.8%		
2019	2019	$97,489,706	$4,541,650	$967,000	$0	4.7%		
to	2020	$101,064,356	$4,609,150	$967,000	$0	4.6%		
2022	2021	$104,706,506	$4,708,250	$967,000	$0	4.5%		
CWP	2022	$108,447,756	$4,498,100	$967,000	$0	4.1%	4.3%	3.5%

Figure 1-1 TDP Estimates



1.3 Design Loads

The methodology for the development of the system and substation design loads is discussed in detail in Section 3. Overall, the design loads were established by considering the most current Load Forecast, historical demand data, projections from potential new consumers, and Cooperative staff perceptions. As the cooperative is an overall winter peaking system, the design load represents winter peak conditions. The Work Plan is designed to accommodate 150,200 kW of non-coincident peak demand and to serve about 25,000 consumers by the end of 2022. The design

load is defined as the sum of individual substation non-coincident peak demands, independent of the time of those individual substation peaks. Dravo Lime, Inland Paper Co Inc., Tennessee Gas Pipeline Company, LLC, and Guardian Industries Morehead Plant loads were excluded.

1.4 Recommendations

The following recommendations concern the future expansion of the Cooperative's distribution system.

1.4.1 General

1. Adopt the proposed plan as a general guide for making future system improvements.

2. Before major construction is completed, give careful consideration to the alternatives and any recommended contingency projects.

3. Periodically examine the planning criteria and system development to ensure that any dynamic conditions are recognized.

4. Periodically review the overall system regarding customer service, reliability, and changing industry requirements.

5. Schedule system improvements by developing construction work plans based on actual prevailing conditions.

6. Review the system's overcurrent protection on a regular basis so that device ratings are adequate.

1.4.2 Financial

1. Incorporate the results of this study into an updated financial forecast.

2. Perform a strategic forecast examining the long-range financial alternatives.

This report should provide a valuable guide for future system development as well as a useful tool in planning future financial requirements. Construction of facilities proposed in this study to accommodate load growth should be initiated based on load growth conditions as they actually develop. In this manner, the planning report should continue to provide overall coordination for system development, even though local changes in load growth or system conditions may require some departure from the proposed plans.

1.5 Reference Material

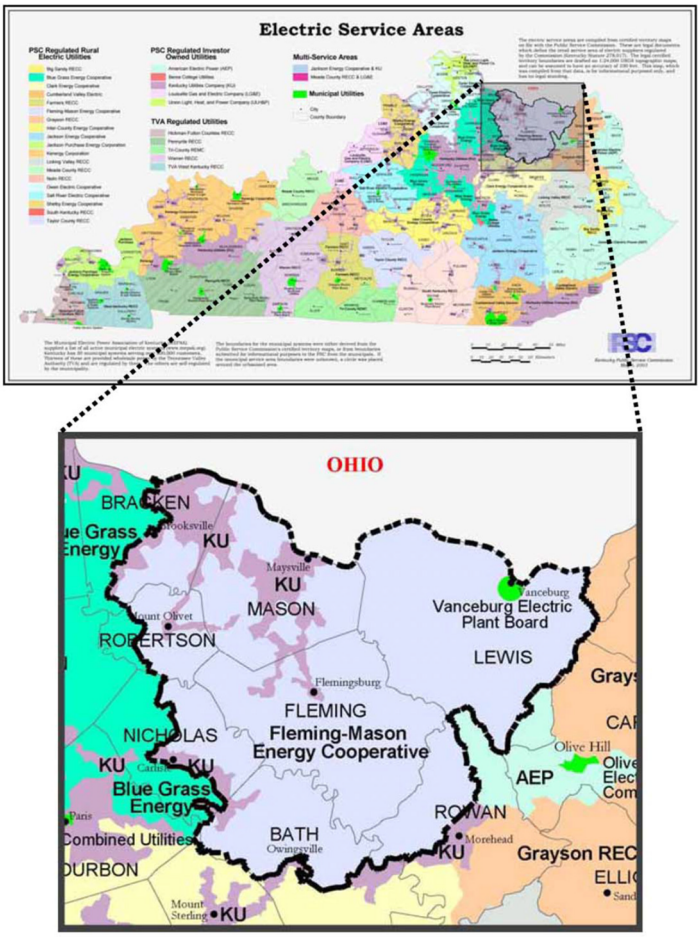
- The following reports were referenced to assist in the completion of this Work Plan.
- 2013 – 2015 Construction Work Plan prepared by Fleming-Mason Energy Cooperative dated November 2012.
- 2018 Load Forecast Report prepared by EKPC and Fleming-Mason Energy Cooperative dated June 12, 2018.

2 Existing System Review

2.1 Service Area

Fleming-Mason Energy Cooperative (Fleming-Mason or the Cooperative), KENTUCKY-052-FLEMING, owns and operates a distribution system primarily in the Kentucky counties of Bath, Bracken, Fleming, Lewis, Mason, Nicholas, Robertson, and Rowan. During 2017, the Cooperative served 24,366 customers through 3,612 miles of distribution line (according to RUS Form 7 records). Rural residential, farm and small-commercial sectors are typical of the consumers in the Cooperative's service area. The service area is defined by Kentucky statutes as shown in the Territorial Boundary Map in Figure 2-1.

Figure 2-1 Fleming-Mason Territorial Boundary Map



2.2 Power Supply

FME's power supplier is East Kentucky Power Cooperative (EKPC); an RUS financed generation and transmission cooperative. EKPC's office headquarters are in Winchester, Kentucky. As power supplier, EKPC accommodates all the generation, transmission and substation requirements of FME and other EKPC cooperatives located in the central and eastern half of Kentucky. The Cooperative takes delivery from the East Kentucky Power Cooperative (EKPC) transmission systems at 138 or 69 kV through 13 delivery points. EKPC maintains responsibility of the substation transformer, bus, and voltage regulation.

EKPC fulfills its contractual obligation to obtain adequate transmission facilities to serve each of Fleming-Mason's delivery points through the FERC-approved Open Access Transmission Tariffs of the PJM Interconnection LLC (PJM). The EKPC transmission systems is operated by PJM.

Joint planning between the Cooperative and EKPC is facilitated through long range planning meetings. Informal meetings have been held between the Cooperative and EKPC to discuss reliability and potential new cooperative delivery points.

2.3 Distribution System Performance

As of December 2017, the Cooperative's distribution system had approximately 3,439 miles of overhead conductor and 173 miles of underground cable serving 24,366 members, which corresponds to 6.7 members per mile. The entire system is operated at 7.2/12.47 kV and 14.4/24.97 kV grounded WYE. The conductor sizes vary from 8A copper to 556 ACSR.

2.3.1 Voltage and Current Levels

A review of the primary distribution system for the existing system layout for either summer or winter 2017 load levels resulted in some areas with low voltage issues being found. There are some significant deficiencies particularly for the Hilda Cranston circuit and the Murphysville Stonewall circuit under normal operation with all the facilities in service.

The Cooperative's distribution system has had and is expected to maintain a high level of power quality and service reliability. Voltage levels across the system are controlled by regulators at each delivery point and with line regulators and banks of shunt capacitors. Voltage drop levels across the entire primary distribution system are generally maintained below the RUS standard of 8 volts.

2.3.2 Losses

Estimated energy losses during the past ten years have averaged 2.7 percent and are shown in Exhibit 1. It is important to note that the distribution losses reported are artificially lowered due to the large Dravo Lime, Inland Paper Co Inc., Tennessee Gas Pipeline Company, LLC, and Guardian Industries Morehead Plant loads served by Fleming-Mason. Energy losses are estimated indirectly by subtracting the amount of energy sold from the amount of energy purchased. Some

of the year-to-year variation results from differences, which occur between the time when billing meters are read at the consumer's location and at the delivery points.

2.3.3 Power Factor

The cooperative does not presently incur power factor penalty charges but may incur power factor penalty charges in the future through the transmission portion of the wholesale power bills from EKPC. Power factor penalty charges can be assessed when a delivery point power factor falls outside the range of 90% lagging and 90% leading. It is more typical that EKPC works in coordination with FME to correct any power factor issue at the distribution level. According to recent reactive power data collected from the Fleming-Mason SCADA system, the power factor on the system is generally within reasonable tolerances.

2.3.4 Contingency Capability

Present system conditions indicate deficiencies with respect to contingency capability. Primary reasons for the lack of contingency capability on the Fleming-Mason system are insufficient conductor sizes and/or delivery point capacities. Adding additional delivery points in some areas is not economically viable at this time. Some of these items are addressed in the recommended system improvements included in this plan. The expected costs for contingency related projects were determined to be overly burdensome to incur within the timeframe of this Construction Work Plan. Resolution of all contingency deficiencies will require significant resources. The current limitation of resources will necessitate that contingency justified projects be deferred to a later plan. A contingency project list is included in this plan for reference but not slated for completion.

2.3.5 Reliability

Service reliability is quantified by SAIFI and SAIDI, which are defined in IEEE 1366-2003, Guide for Electric Power Distribution Reliability Indices. SAIFI is defined as the system average number of outages per customer. SAIDI represents the system average outage duration per customer.

Fleming-Mason maintains detailed outage records that track outages by time, duration, location and cause.

Outage records for the Cooperative are kept in accordance with RUS Bulletin 1730A-119. The average minutes per consumer for the period between January 2013 and December 2017 are shown in Table 2-1.

Table 2-1 RUS Form 7 Average Outage Min. per Consumer

Year	Power Supply	Major Event	Pre-Arranged	Other	Total
2013	25.0	71.6	8.1	81.3	186
2014	26.8	34.0	1.6	106.7	169.1
2015	25.3	238.8	2.1	123.4	389.6
2016	12.5	24.3	8.5	118.6	163.9
2017	11.3	180.0	6.4	95.6	293.3
5 yr. Avg.	20.2	109.7	5.3	105.1	240.4

The five-year average for outages in the "Other" category is well below the current RUS guideline of 200 minutes. Additional reliability goals are included in the Planning Criteria section of this report.

The line conversion and other projects recommended in this Plan, including the continued replacement of aged lines and poles throughout the long-range time frame should allow Fleming-Mason to maintain overall system reliability and reduce consumer outage times.

2.3.6 System Protection

The preparation and implementation of a system protection study is an important tool to minimize outages and outage times. System protection is reviewed any time that a major change is made to the system, such as a major line upgrade, new substation, etc.

3 Load Analysis

3.1 Purpose & Procedure

The Electric Load Forecasting process is one of the most critical steps in the planning process. This forecast not only needs to indicate non-coincident peak demand growth for each delivery point on the system but should also provide an indication of where the growth will occur. The load projections are then used in the various circuit analyses to indicate where there may be planning criteria violations, and therefore needed system improvements, which is the objective of this plan.

3.1.1 Introduction

The Cooperative uses the SEDC CIS system and WindMil voltage drop software (detailed model) to maintain a consumer loading database and model of its electrical system. Delivery point loading data is supplied through the transmission and wholesale power bills as well as the Fleming-Mason SCADA system. The 2018 Load Forecast Report was used to guide growth rates for the system. Specific growth rates for each delivery point area were developed primarily by Cooperative staff based upon historical non-coincident peak trends.

3.1.2 Purpose of Analysis

The projected loads by delivery point were allocated to the WindMil engineering model based on SEDC billing data from the summer and winter 2017 timeframes to reflect the most accurate representation of the conditions during substation non-coincident peak times. With the projected loads allocated, the existing system was analyzed to determine any immediate concerns that might need attention during the plan timeframe. The following system fundamentals were examined:

- Specific large load growth areas. Types of specific loads were determined (i.e., industrial, commercial, residential).
- Areas that are expected to maintain above-average growth.
- Operational problems due to limited feeder backfeed capability, sectionalizing concerns and aging or deteriorating facilities.
- Voltage and/or capacity concerns.
- Substation areas that presently cannot be backfed from an adjacent substation area.
- Substations' capability for sustained backup.

3.2 Historical Loads

A summary of consumer and load data for the period 2008-2017 is presented in Exhibit 1, System Load Data. During the past ten years, the number of consumers served by Fleming-Mason has varied by around 0.3 percent annually. Energy requirements during the past ten years have dropped and recovered depending largely on weather conditions from one year to the next but have not varied significantly. A breakdown of the number of consumers and energy sales for 2017 is shown below in Table 3-1.

Table 3-1 2017 Consumers and Energy Sales

Consumer Classification	Dec. 31 No. of Consumers	Percent of Total	Energy Sales (MWH)	Percent of Total
Residential	22,642	92.9%	268,823	27.5%
Seasonal	0	0.0%	0	0.0%
Irrigation	0	0.0%	0	0.0%
Commercial, 1000 kVA or less	1,714	7.0%	129,214	13.2%
Commercial, over 1000 kVA	5	0.0%	579,518	59.3%
Public Lighting	5	0.0%	92	0.0%
Public Authorities	0	0.0%	0	0.0%
Sales for Resale	0	0.0%	0	0.0%
Total	24,366	100.0%	977,647	100.0%

Total energy sales from rural residential and seasonal members account for approximately 27.5% of total sales. The small commercial consumers sized 1,000 kVA or less account for approximately 13.2% of the energy usage. The remaining sales, the majority of energy sales, are from the large commercial group, which is primarily comprised of sales to Dravo Lime, Inland Paper Co Inc., Tennessee Gas Pipeline Company, LLC, and Guardian Industries Morehead Plant.

Table 3-2 includes a list of the largest Fleming-Mason customer loads and their 2017 usage and peak load levels

Table 3-2 Large Power Consumers

Name	Substation	Circuit	Line Section or Consumer ID	2017 Annual kWh	Summer Peak		Winter Peak	
					kWh	Peak kW	kWh	Peak kW
KY STONE CO HANSON	FLEMINGSBURG	TILTON	320206014	241,600	34,400	432	8,800	14
TOLLESBORO ELEM SCHOOL	CHARTERS	TOLLESBORO	210656078	641,440	53,760	218	65,200	225
WESTERN FLEMING WTR WKS	SNOW HILL	BLUE LICKS	250552023	800,000	56,880	168	113,040	243
MAYSVILLE UTILITY COMM	MAYSVILLE	MORANSBURG	140553025	1,724,600	133,300	331	174,600	373
FLEMING CO BD OF ED	FLEMINGSBURG	TOYOSEAT	260765171	666,800	54,400	149	93,600	310
WHITE HAROLD LUMBER	HILDA	PINE HILLS	400323070	1,053,600	88,800	206	112,320	239
WHITE HAROLD MILLWORKS	HILDA	PINE HILLS	400323082	139,920	73,600	289	73,600	305
KROGER	HILDA	BLUESTONE	400332186	3,242,400	326,000	555	229,600	424
TRADEMORE SHP CTR	HILDA	BLUESTONE	400332105	290,720	23,120	99	50,640	254
GREEN TREE FOREST PROD	PLUMMERS LAN	HILLSBORO	330646066	1,325,520	98,640	598	137,160	675
GREEN TREE FOREST PROD	PLUMMERS LAN	HILLSBORO	330647038	338,560	28,800	194	29,440	204
ROWAN CO BD OF ED	HILDA	PINE HILLS	400332183	1,279,200	112,080	407	98,400	345
ROWAN CO BD OF ED	HILDA	PINE HILLS	400332235	780,200	60,000	252	74,400	280
WALLINGFORD PALLET & LUMBER	FLEMINGSBURG	UNDERBUILD	270772038	79,200	26,400	233	29,000	239
ROWAN TECHNICAL COLLEGE	HILDA	PINE HILLS	400322146	886,640	75,120	193	72,240	237
ROWAN TECHNICAL COLLEGE	SHARKEY	SHARKEY	390437049	973,760	NA	NA	141,920	254
WALMART	HILDA	BLUESTONE	400332254	4,898,400	446,400	841	378,800	662
WHITE HAROLD MILLWORKS	HILDA	PINE HILLS	400322085	1,493,600	120,000	569	140,800	683
BLUE LICKS STATE PARK	SNOW HILL	BLUELICKS	300659019	792,480	59,640	226	112,080	372
FLEMINGSBURG MATERIALS CO	FLEMINGSBURG	TILTON	320206009	137,280	34,080	341	NA	NA
LEWIS CO HIGH SCHOOL	CHARTERS	VANCEBURG	220438201	947,600	87,440	390	61,680	175
LEWIS CO JR HIGH SCHOOL	CHARTERS	VANCEBURG	220438205	524,400	48,880	235	41,360	161
LEWIS CO BD OF ED	CHARTERS	VANCEBURG	220438223	22,400	1,560	164	NA	NA
B & W PALLET	BIG WOODS	HICKORY POINTE	400322036	862,720	83,840	357	76,160	383
MITSUBISHI ELECTRIC	MAYSVILLE	INDUST PARK	190209103	4,726,000	413,200	812	377,200	678
MITSUBISHI ELECTRIC	MAYSVILLE	INDUST PARK	190209120	4,122,000	383,700	937	376,800	812
MITSUBISHI ELECTRIC	MAYSVILLE	INDUST PARK	190209119	3,322,800	294,800	640	285,600	555
MITSUBISHI ELECTRIC	MAYSVILLE	INDUST PARK	190209102	2,622,400	247,000	592	207,000	471
MITSUBISHI ELECTRIC	MAYSVILLE	INDUST PARK	190209029	1,171,200	78,400	200	112,800	205
GREEN TOKAI CO	MAYSVILLE	INDUST PARK	190209122	1,400,000	113,200	281	142,400	357
GREEN TOKAI CO	MAYSVILLE	INDUST PARK	190209101	1,908,800	164,000	353	154,000	337
GREEN TOKAI CO	MAYSVILLE	INDUST PARK	190209100	3,268,200	227,000	584	260,200	587
TOYOSEAT USA	FLEMINGSBURG	TOYOSEAT	260646021	2,361,600	251,200	620	165,200	408
TOYOSEAT USA	FLEMINGSBURG	TOYOSEAT	260646052	1,418,400	104,800	298	113,680	268
STOBER DRIVES	MAYSVILLE	INDUST PARK	190209105	1,388,160	143,840	446	94,480	298
FAMILY DOLLAR SERVICES	SHARKEY	FAMILY DOLLAR	390437020	8,294,400	794,400	1,507	655,200	1,250
VALLEY VIEW HARDWOODS INC	HILDA	BLUESTONE	400332078	1,828,800	147,200	722	180,800	812
NORTHERN CONTOURS	CHARTERS	VANCEBURG	220438233	2,166,800	176,400	683	197,800	671
LAUREL ELEMENTARY	CHARTERS	HOLLY	290544018	415,800	31,600	131	56,000	212
FEDERAL MOGUL CORP	MAYSVILLE	FEDERAL MOGUL	200102020	537,120	56,160	215	40,320	162
REEDER DAN	OAK RIDGE	MUDLICK	260207016	331,040	29,200	228	24,800	189
LOWE'S	HILDA	BLUESTONE	400332104	1,941,800	180,400	459	154,200	343
GREATER FLEMING CO REGIONAL	RECTORVILLE	OWL HOLLOW	210112005	528,600	41,000	196	67,400	243
RIVER SAND AND GRAVEL	CHARTERS	VANCEBURG	160877011	409,000	38,800	395	NA	NA
FLEMING COUNTY HOSPITAL	FLEMINGSBURG	HOSPITAL	260765223	3,592,400	374,800	684	264,000	550
MADDEN LUMBER	CHARTERS	VANCEBURG	220543002	262,320	20,040	218	21,960	231
BATH COUNTY BD OF EDUCATION	PEASTICKS	MOORES FERRY	380878061	608,640	54,400	186	36,480	151
KENTON POINTE LLC	MAYSVILLE	FEDERAL MOGUL	200102040	607,040	49,040	96	80,560	213
ROWAN COUNTY BD OF ED	HILDA	PINE HILLS	400322015	1,634,240	125,440	379	216,000	580
JW WOOD	PLUMMERS LAN	HILLSBORO	330868028	238,520	24,240	188	25,440	216
MOREHEAD WOOD PRODUCTS	HILDA	CRANSTON	340774099	2,058,000	180,000	412	176,400	426
TEXAS EASTERN GAS PIPLINE	HILLSBORO	GRANGE CITY	380217024	2,668,800	374,400	804	374,400	804
PIONEER TRACE GROUP	FLEMINGSBURG	HOSPITAL	260765030	713,280	54,640	150	105,280	280
MACA PLASTICS	MAYSVILLE	FEDERAL MOGUL	200102027	362,600	57,000	220	21,800	124
SPECIALITY PALLET	FLEMINGSBURG	UNDERBUILD	270773014	378,000	29,600	235	39,920	254

Table 3-3 is a substation summary indicating substation transformer capacity and peak demands experienced during recent summer and winter historical peak time periods.

Table 3-3 Substation Load Data

DELIVERY POINT	Transformer Base Rating (kVA)	2017 - 2018 Winter Peak Demand	2018 Summer Peak Demand
BIG WOODS	12.0	6,755	4,014
CHARTERS	11.2	14,122	9,562
FLEMINGSBURG	12.0	13,605	9,838
HILDA 2	15.0	16,376	12,110
HILLSBORO	12.0	8,502	5,130
MAYSVILLE INDUSTRIAL	12.0	7,317	7,803
MURPHYSVILLE	11.2	10,552	6,351
OAK RIDGE	11.2	7,703	4,679
PEASTICKS	11.2	11,727	6,929
PLUMMERS LANDING	11.2	8,123	4,550
RECTORVILLE	11.2	9,841	7,373
SHARKEY	12.0	12,976	7,901
SNOW HILL	11.2	7,747	4,710

3.3 Cooperative Load Forecast

The latest system load forecast for the Cooperative was completed in June 2018. The Load Forecast Report results used in this plan correspond to normal economic and weather conditions. The projections in the 2018 Load Forecast Report do not reflect individual substation non-coincident peak growth. The Load Forecast projects Fleming-Mason's coincident system peak growth. Therefore, this plan uses the Load Forecast projections as a reference guide. Final plan load growth projections reflect expected individual substation non-coincident peaks based upon historical demands. This additional load must be considered in the design process.

Using the load forecast rate as a base, trending historical substation peak demand, adding spot loads, and including the projected effect of extreme weather, resulted in an overall growth rate of 2.6%. This rate corresponds to a projected system non-coincident peak demand of 150,200 kW in 2022, excluding the Dravo Lime, Inland Paper Co Inc., Tennessee Gas Pipeline Company, LLC, and Guardian Industries Morehead Plant loads.

3.4 Design Load

The design load represents the sum of the yearly non-coincident substation peak demands, independent of month. The design loads for the individual substations are shown in Table 3-4. Additionally, ten-year load projections are shown in Exhibit 8.

3.5 Member and Load Distribution

The anticipated member and load additions developed using the previously described processes were distributed throughout the system. Historical growth patterns in particular areas, as well as input by Cooperative staff were used to locate areas of load growth. Expected spot loads are contributing to the need for improvements in certain areas. The southern and eastern areas of the system are experiencing slightly higher growth in relation to other areas of the system.

Table 3-4 Substation Design Loads

DELIVERY POINT	2017 - 2018 Winter Peak Demand	Projected Winter ACGR[1]	2018 - 2019 Projected Winter Peak	2019 - 2020 Projected Winter Peak	2020 - 2021 Projected Winter Peak	2021 - 2022 Projected Winter Peak
BIG WOODS	6,755	5.0%	7,093	7,447	7,820	8,211
CHARTERS	14,122	2.5%	14,475	14,837	15,207	15,588
FLEMINGSBURG	13,605	0.5%	13,673	13,741	13,810	13,879
HILDA 2	16,376	5.0%	17,894	18,754	19,657	20,605
HILLSBORO	8,502	1.0%	8,587	8,673	8,759	8,847
MAYSVILLE INDUSTRIAL	7,317	0.5%	7,354	7,390	7,427	7,465
MURPHYSVILLE	10,552	0.9%	10,647	10,743	10,840	10,937
OAK RIDGE	7,703	1.5%	7,819	7,936	8,055	8,176
PEASTICKS	11,727	2.1%	11,974	12,225	12,482	12,744
PLUMMERS LANDING	8,123	3.0%	8,367	8,618	8,876	9,143
RECTORVILLE	9,841	0.5%	9,890	9,940	9,989	10,039
SHARKEY	12,976	5.0%	13,625	14,806	15,522	16,273
SNOW HILL	7,747	1.8%	7,887	8,029	8,173	8,320
TOTAL SYSTEM [2]	135,347	2.6%	139,285	143,139	146,617	150,227
2018 PRS System Peak Projections [3]			**131,750**	**136,250**	**138,140**	**140,900**

DELIVERY POINT	2018 Summer Peak Demand	Projected Summer ACGR[1]	2019 Projected Summer Peak	2020 Projected Summer Peak	2021 Projected Summer Peak	2022 Projected Summer Peak
BIG WOODS	4,014	0.5%	4,034	4,054	4,074	4,095
CHARTERS	9,562	0.5%	9,609	9,657	9,706	9,754
FLEMINGSBURG	9,838	0.5%	10,830	10,880	10,929	10,979
HILDA 2	12,110	0.5%	12,871	12,932	12,993	13,054
HILLSBORO	5,130	0.5%	5,156	5,182	5,208	5,234
MAYSVILLE INDUSTRIAL	7,803	0.7%	7,858	7,913	7,968	8,024
MURPHYSVILLE	6,351	0.5%	6,383	6,415	6,447	6,479
OAK RIDGE	4,679	0.7%	4,712	4,745	4,778	4,811
PEASTICKS	6,929	0.5%	6,964	6,999	7,034	7,069
PLUMMERS LANDING	4,550	0.5%	4,573	4,596	4,619	4,642
RECTORVILLE	7,373	0.5%	7,410	7,447	7,484	7,521
SHARKEY	7,901	0.5%	7,940	8,480	8,520	8,560
SNOW HILL	4,710	0.5%	4,733	4,757	4,781	4,805
TOTAL SYSTEM [2]	90,951	0.8%	93,073	94,057	94,541	95,027
2018 PRS System Peak Projections [3]			**89,500**	**91,750**	**95,950**	**97,440**

[1] ACGR = Annual Compound Growth Rate

[2] NOTE: The "System" demand represent the greatest month's sum of each individual delivery point's NCP for the month

[3] NOTE: PRS reflects the FME system coincident peak demand growth, not the individual substation NCP

4 Planning Criteria

4.1 General

Various planning criteria have been established as a foundation for evaluating system performance. The distribution system criteria include voltage requirements, conductor thermal loading limits, substation transformer ratings, system reliability, and contingency capability.

4.2 Primary Voltage Limits

Service quality, to a large extent, is dependent upon maintaining adequate system voltage at the point where the utility is connected to the members wiring. This point is normally at the meter socket or entrance switch. In accordance with RUS Bulletin 1724D-113 and the American National Standards Institute (ANSI) Standard C84.1, the recommended maximum and minimum voltage levels are as follows in Table 4-1.

Table 4-1 Primary Voltage Ranges

Location	Maximum (V)	Minimum (V)
Substation regulated bus/feeder	126	--
Primary terminals of distribution transformer	126	118
Meter or entrance switch	126	114
Point of utilization	126	110

This study involves maintaining the required voltage on the primary line portion of the electric system. The Cooperative needs to size distribution transformers and service wire so that the combined voltage drop of the transformer and service wire does not exceed 4 volts (3.33%) at peak load. The member's electrician needs to install adequate wiring so that the voltage drop between the meter and point of utilization does not exceed 4 volts (3.33%).

The primary distribution system has been designed to limit the primary line voltage drop from the regulated substation bus to the circuit extremities to a maximum of 8 volts (6.66% on 120-volt base) at peak load. This will maintain the required 118 volts or above at the source side of the distribution transformer at the circuit's extremities while protecting members located near the substation from experiencing excessively high voltage.

Voltage drop calculations are based on unbalanced phase loading at the actual power factor for each substation. Voltage quality can be enhanced by maintaining a near unity power factor on primary feeders during peak conditions through the installation of fixed and/or switched capacitors. The effect of power factor on voltage drop is especially significant with large conductors as illustrated in Table 4-2.

Table 4-2 Effects of Power Factor on Voltage Drop

	Power Factor (%)							
	Lagging					Leading		
	85	90	95	98	100	98	95	90
Conductor	**Relative Voltage Drop (%)**							
#2 ACSR, OH	131	124	116	110	100	90	83	76
1/0 ACSR, OH	147	136	125	115	100	85	75	64
4/0 ACSR, OH	180	163	143	126	100	74	57	37
336 ACSR, OH	230	202	169	143	100	57	31	-2
556 ACSR, OH	305	260	209	167	100	33	-8[1]	-60[1]
4/0 AL, UG	145	135	124	115	100	85	76	65
500 AL, UG	163	149	134	121	100	79	67	51
750 AL, UG	167	153	136	122	100	78	64	47
Example: If a 4/0 ACSR conductor at unity power factor (100%) experiences a 4 volt drop (120 volt base), then this same conductor at 85 percent lagging power factor would experience a 7.2 volt drop (4 volts x 180% = 7.2 volts). Conversely, if this same conductor has a 95 percent leading power factor, the voltage drop would be 2.3 volts (4 volts x 57% = 2.3 volts)								
A leading power factor will result in the same amount of reactive load and losses as a lagging power factor.								
[1] A negative number indicates a voltage rise.								

4.3 Conductor Loading Limits

In general, the maximum load limit on a rural distribution circuit is usually determined on the basis of voltage considerations. In denser areas, however, thermal loading may become a limiting factor. The importance of thermal loading limits on rural systems will undoubtedly increase as the load density increases in the future. For this reason, normal and emergency thermal loading limits for various overhead and underground conductors are shown in Tables 4-4 and 4-5.

While conductor thermal limits must be recognized in the planning process, it is important to note that the thermal ratings of the substation recloser and/or sectionalizing constraints including underground cable terminations may prove more critical in site-specific situations.

Significant load currents on lines usually cause voltage drops that violate planning criteria. There may be situations when the established planning criteria are not violated for high load currents, but action should be taken anyway. Therefore, the maximum allowable load current on a single-phase line will be 50 amps. In order to provide adequate backup to all feeders and delivery point areas, the loading criteria in Table 4-3 has been established by the Cooperative.

Table 4-3 Conductor Loading Criteria

	Normal Loading	Contingency Loading
OH- 3ph Tap	70%	-
URD- 3ph Tap	70%	-
OH- 3ph Tie	50%	100%
URD- 3ph Tie	50%	100%

Table 4-4 Overhead Conductor Thermal Limits

	Winter							
	Normal De mand				Emergency Demand			
	12.5 kV		24.9 kV		12.5 kV		24.9 kV	
Conductor	Current (amps)	Power (kW)	Current (amps)	Power (kW)	Current (amps)	Power (kW)	Current (amps)	Power (kW)
#4 ACSR (#6 Cu.)	160	3,100	160	6,200	200	3,900	200	7,800
#2 ACSR (#4Cu.)	215	4,200	251	8,300	270	5,300	270	10,500
1/0 ACSR (#2 Cu.)	280	5,500	280	10,900	350	6,800	350	13,600
3/0 ACSR	375	7,300	375	14,600	475	9,300	475	18,400
4/0 ACSR	430	8,400	430	16,700	535	10,400	535	20,800
4/0 CU	599	11,600	599	23,300	680	13,200	680	26,400
336.4 MCM ACSR (250 MCM CU)	665	13,000	665	25,800	830	16,200	830	32,200
397.5 MCM ACSR	740	14,400	740	28,800	925	18,000	925	36,000
477 MCM ACSR	825	16,000	825	32,100	1,025	19,900	1,025	39,900
556 MCM ACSR	910	17,700	910	35,300	1,035	20,100	1,035	40,100
	Summer							
	Normal Demand				**Emergency Demand**			
	12.5 kV		24.9 kV		12.5 kV		24.9 kV	
Conductor	Current (amps)	Power (kW)	Current (amps)	Power (kW)	Current (amps)	Power (kW)	Current (amps)	Power (kW)
#4 ACSR (#6 Cu.)	125	2,400	125	4,900	155	3,000	155	6,000
#2 ACSR (#4Cu.)	165	3,200	165	6,400	210	4,100	210	8,200
1/0 ACSR (#2 Cu.)	215	4,200	215	8,300	270	5,300	270	10,500
3/0 ACSR	290	5,700	290	11,300	365	7,100	365	14,200
4/0 ACSR	330	6,400	330	12,800	410	8,000	410	15,900
4/0 CU	393	7,600	393	15,300	523	10,200	523	20,300
336.4 MCM ACSR (250 MCM CU)	510	9,900	510	19,800	640	12,500	640	24,800
397.5 MCM ACSR	570	11,100	570	22,200	710	13,800	710	27,600
477 MCM ACSR	630	12,200	630	24,500	790	15,400	790	30,700
556 MCM ACSR	720	14,000	720	27,900	885	17,200	885	34,300

NOTE: Assumed conditions are as follows:

1. Ambient air temperature: 40° C summer and 0° C winter
2. Wind velocity: 2 feet/second (1.36 mi./hr.)
3. Emissivity at 0.5.
4. Normal and emergency limits are based on maximum allowable conductor temperatures of 75° C and 100° C, respectively
5. Assume balanced three-phase load at 90% power factor

Table 4-5 Underground Conductor Thermal Limits

Three-Phase				
	Normal Demand		Emergency Demand	
Conductor	Current (amps)	Power @ 12.5 kV (kW)	Current (amps)	Power @ 12.5 kV (kW)
Direct Buried - 3				
#2 AL	160	3,100	190	3,700
1/0 AL	200	3,900	235	4,600
4/0 AL	300	5,800	355	6,900
350 MCM AL	380	7,400	450	8,700
500 MCM AL	450	8,700	530	10,300
750 MCM AL	535	10,400	630	12,200
1000 MCM AL	600	11,700	705	13,700
500 MCM Copper	545	10,600	640	12,400
750 MCM Cooper	625	12,200	735	14,300
1000 MCM Copper	700	13,600	825	16,000
In Single Duct - 3 Cables				
#2 AL	120	2,300	140	2,700
1/0 AL	155	3,000	185	3,600
4/0 AL	235	4,600	280	5,400
350 MCM AL	310	6,000	365	7,100
500 MCM AL	375	7,300	445	8,700
750 MCM AL	460	8,900	545	10,600
1000 MCM AL	525	10,200	620	12,100
500 MCM Copper	455	8,800	535	10,400
750 MCM Cooper	525	10,200	620	12,100
1000 MCM Copper	590	11,500	695	13,500

NOTE: Assumed conditions are as follows:

1. Assume cross-linked polyethylene (XLPE) cable with concentric neutral and jacketed
2. Ambient earth temperatures of 20°C for summer conditions
3. Thermal resistivity of earth of 90 OHM-M
4. Normal and emergency limits based on IPCEA recommended maximum conductor temperatures of 90°C and 130°C respectively.
5. Assume balanced three phase load at 90 percent power factor and 100 percent daily load factor.

4.4 Power Factor

The required capacitance will be added to the system to maintain a substation power factor between 95% lagging and 95% leading during substation non-coincident peak loads. The addition of fixed and switched capacitor banks of various sizes should be installed to maintain these levels.

4.5 Economics

4.5.1 Unit Costs

A summary of the unit construction costs and other economic parameters used in this report is presented in Exhibit 3 and are used in comparing alternatives. The unit construction costs are intended to represent installed cost and include an estimate of engineering, legal and overhead costs associated with the construction.

4.5.2 Economic Conductor Analysis

Consideration has been given to using the most economical conductor size for future tie lines and existing primary line changes and conversions. The techniques for performing this type of analysis are described in RUS Bulletins 60-9 and 1724D - 101B. It is important to recognize that the load levels shown on the following figure represent equivalent annual peak load over the life of a conductor. Since the load on a specific feeder does not remain constant over its entire life, the results of the economic conductor analysis often cannot be used directly. Furthermore, there are other factors such as voltage limits and reliability that must be considered in sizing a line. For this reason, the economic conductor analysis has been used only as a general guide. In evaluating major alternative plans, a more detailed annual and present worth cost analysis method is used.

For new tie lines, this analysis involves comparing the annual fixed costs (cost of capital, O&M, depreciation, taxes and insurance) of new construction with the variable cost of losses (demand and energy) at various loading levels.

For these analyses, the leveled annual cost of losses is calculated as per REA Bulletin 60-9. The cost of lost energy on a per-kilowatt-hour basis is calculated as:

$$Energy\ Charge + \frac{12 \times Demand\ Charge \times Demand\ Adjustment\ Factor}{8{,}760 \times Loss\ Factor}$$

The demand adjustment factor reflects the fact that the total of demand charges for a year is not equal to twelve times the demand charge for the peak month. The loss factor is calculated based on the average annual system load factor.

The kWh losses per mile of line per year for each conductor size at any particular load level are calculated as:

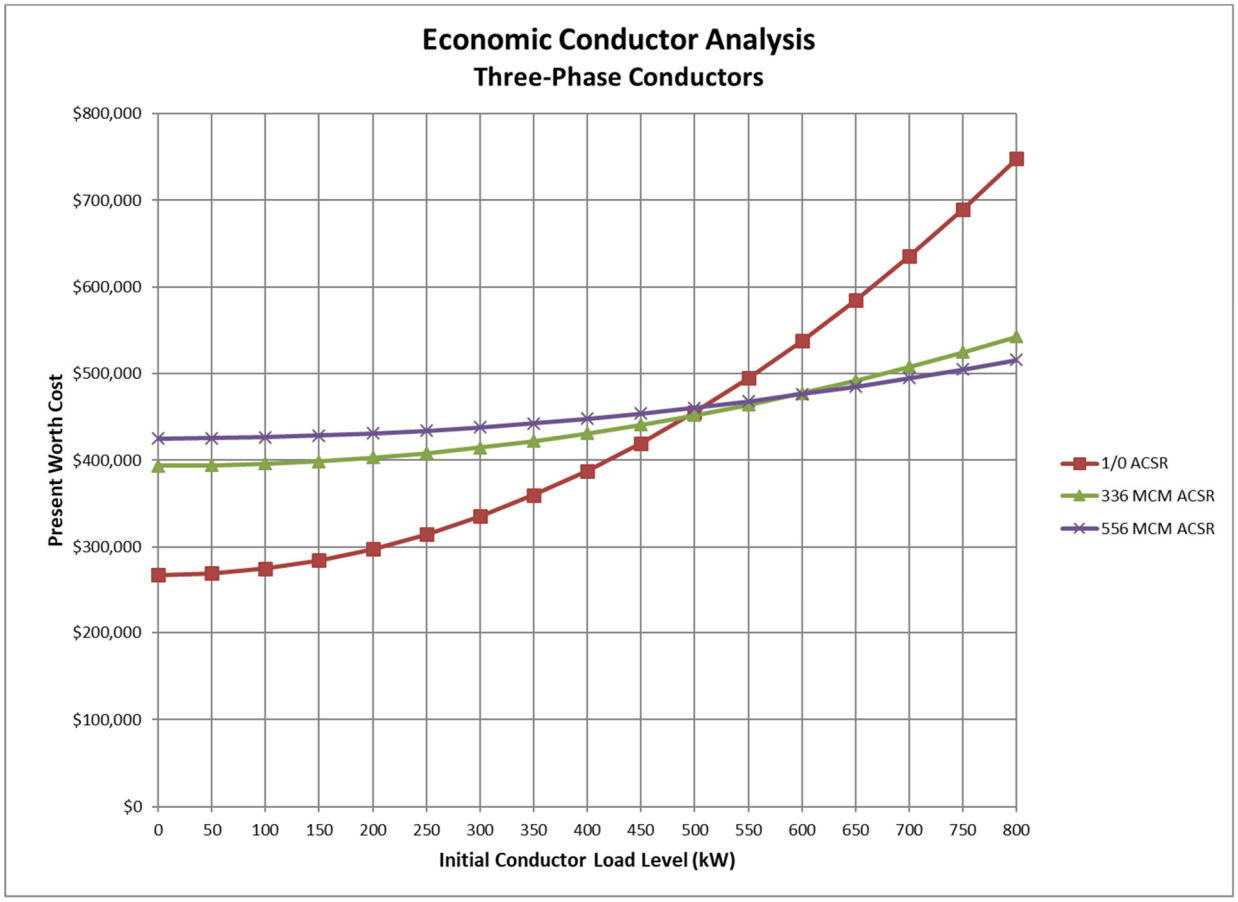
$$\frac{(Peak\ kW)^2 (Resistance\ per\ phase\ per\ mile)(Loss\ Factor)(8{,}760)}{(kV)^2 (Power\ Factor)^2 (No.\ of\ Phases)(1{,}000)}$$

From these equations, the annual cost of losses for each conductor at each loading level is calculated, also including a present worth factor that is based on the Cooperative's effective discount rate.

$$Annual\ Cost\ of\ Losses = kWh\ Lost\ per\ Mile\ per\ Year \times Cost\ of\ Lost\ Energy \times Present\ Worth\ Factor$$

Figure 4-1 indicates the economic conductor loading levels for three-phase line conversions. As can be seen in this figure for 7.2 kV distribution, 1/0 ACSR is the most economical conductor up to approximately 500 kW. Beyond this load level, 336 ACSR is the most economical up to approximately 575 kW, at which point 556 ACSR becomes the most economical conductor to use. For 14.4 kV distribution, these loads should be double. Many of Fleming-Mason's construction unit costs were estimated since historical values weren't available. As more accurate values are established by future construction, there may be significant differences from these values.

Figure 4-1 Three-Phase Conductor Economics



4.5.3 Economic Comparison Techniques

Construction projects in this plan result from economic comparisons between alternatives developed. Those economic comparisons were based on the present worth of the total annual costs for each alternative. The annual cost calculations include both the fixed costs associated with new investment (i.e. cost of capital, O&M, depreciation, taxes, and insurance as appropriate) and variable costs, including system losses and discounts for taking delivery at higher delivery voltages. Annual costs were discounted using a present worth interest factor to recognize the time value of money.

4.5.4 Distribution and Transmission Considerations

Delivery is provided to the Cooperative via the East Kentucky Power Cooperative (EKPC) transmission and distribution system. Since the cost of the EKPC transmission and distribution facilities are recovered through the Cooperative's transmission charges, the transmission and distribution requirements must be considered in planning and designing the Cooperative's distribution system. Therefore, the cost estimates used in the economic comparisons of the long-range plan include both transmission and distribution costs.

4.6 Substation Transformer Loading

The maximum amount that a transformer can be loaded and maintain "normal loss of life" is a function of temperature. Preloading of the transformer, ambient temperature conditions and the duration of the loading are all factors that must be considered. Figures 4-2 and 4-3 show substation transformer loading criteria based on ANSI/IEEE C57.92. These graphs can be used as a guide for determining acceptable loading of power transformers, although specific transformer thermal characteristics may limit loadability (ANSI/IEEE C57.91-1995 specifically speaks to the application of transient heating equations to determine loadability based on a transformer's specific thermal characteristics).

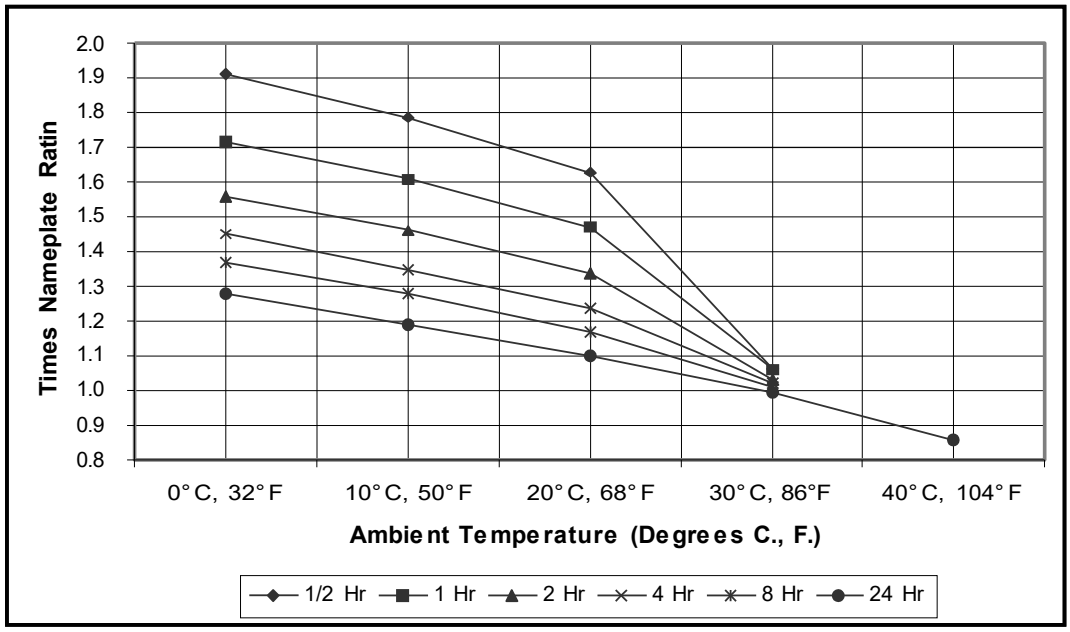
The duration of a potential overload during contingency conditions is typically in the range of 8 hours due to the load shape. Figure 4-3 indicates that for a transformer rated for a 65 ^{0}C rise and preloading of 70%, that at an ambient temperature of 40 ^{0}C (summer peak conditions) the transformer could be loaded to approximately 100% of its nameplate rating for 8 hours and maintain normal loss of life. The same figure indicates that for a transformer rated for a 65 ^{0}C rise and preloading of 70%, that at an ambient temperature of 0 ^{0}C (winter peak conditions) the transformer could be loaded to approximately 130% of its nameplate rating for 8 hours and maintain normal loss of life.

Transformer load limits are developed such that maximum use can be made of the equipment without damage or undue loss of life. In order to provide adequate backup to all transformers, a normal loading criterion of 70% of the nameplate rating of substation transformers has been established in this study to limit transformer overloads during contingencies. In this manner, transformer capacity is available to transfer load from a failed substation transformer to other available transformers (it is assumed that at least two transformers would be available to switch load to) through switching at the substation and/or through switching and ties on the distribution system.

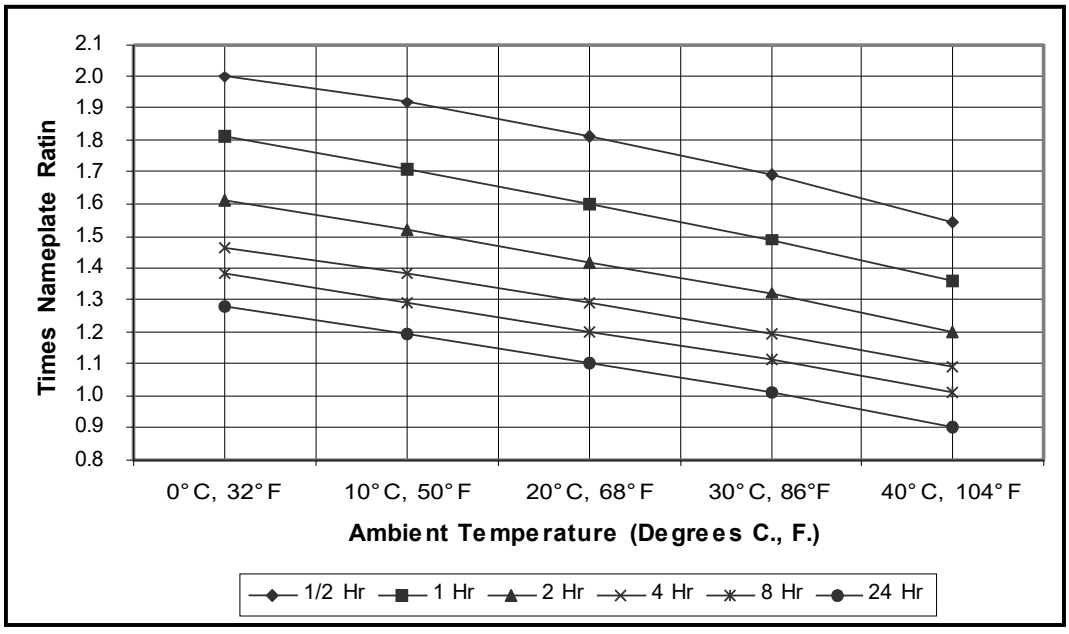
Table 4-6 lists substation transformer capacities at certain nameplate ratings during the summer and winter seasons. As previously discussed, the maximum load limit that a transformer can meet without any increase to normal loss of life varies considerably according to ambient air temperature and duration. In this study a derating of 7.5% was applied to the transformer nameplate ratings during the summer and an uprating of 25% was applied during the winter to capture the effects of ambient air temperature on available transformer capacity. These ratings can be compared to substation meter data and used as a guide to protect the transformer from overloads.

Figure 4-2 Transformer Loading -55°C

Transformer Loading - 55 Degree C. Rise, Forced-Air-Cooled (OA/FA/FA)
Preloading at 100%, Normal Loss of Life

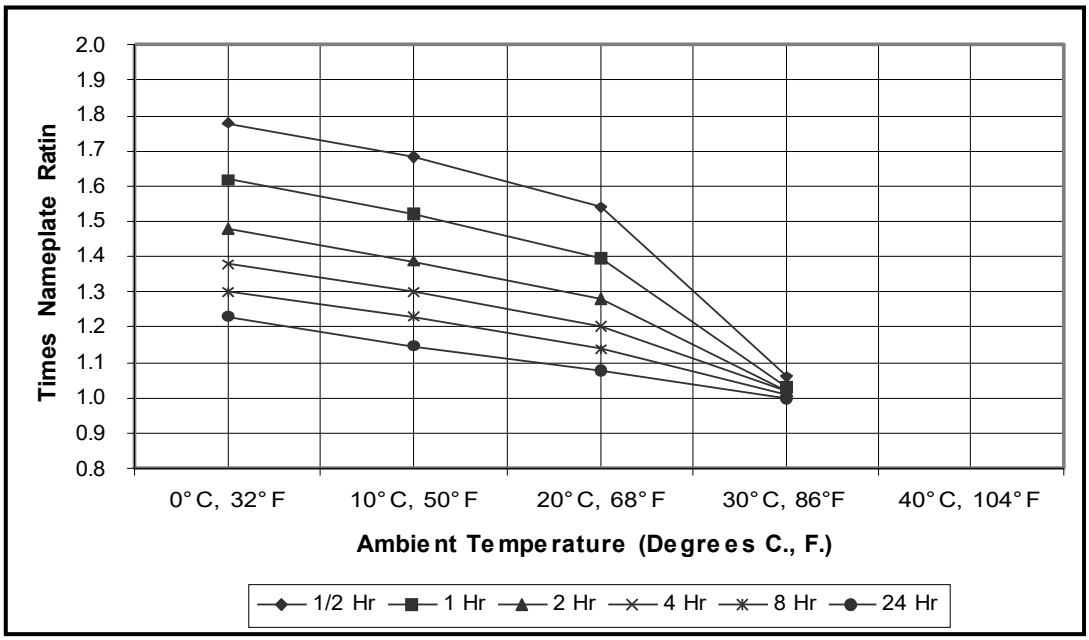


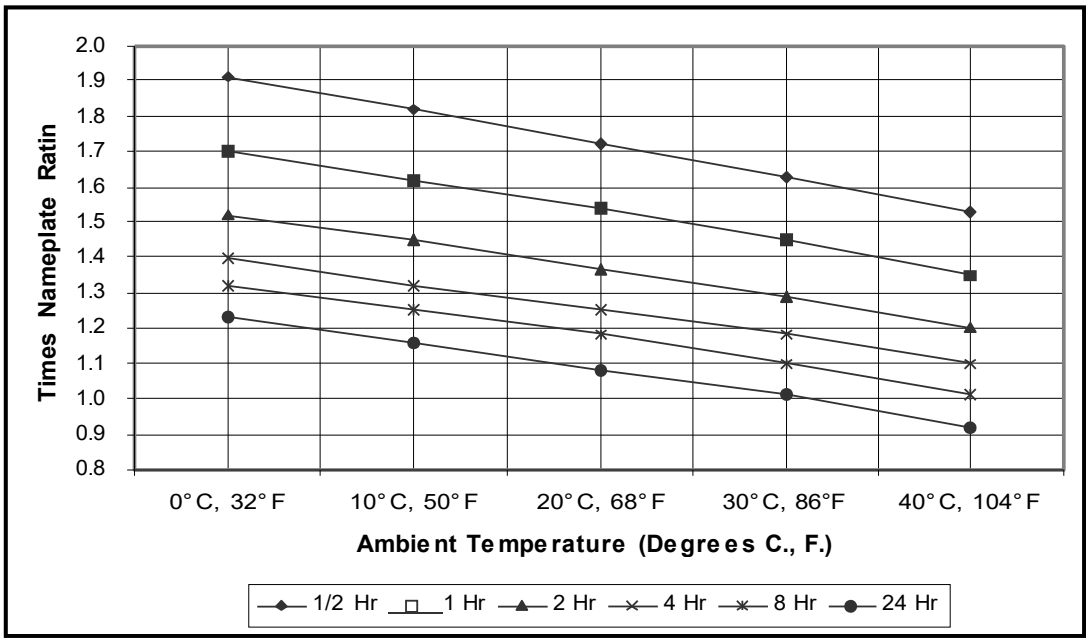
Transformer Loading - 55 Degree C. Rise, Forced-Air-Cooled (OA/FA/FA)
Preloading at 70%, Normal Loss of Life



Based on ANSI/IEEE C57.92-1981

Figure 4-3 Transformer Loading-65°C





Based on ANSI/IEEE C57.92-1981

Table 4-6 Substation Transformer Capacity

Transformer Nameplate Rating (kVA)							Summer Rating (-7.5% of Nameplate)		Winter Rating (+25% of Nameplate)	
Self-Cooled		Forced Air		Forced Air - Stage 2		Full Load				
OA,55°	OA,65°	FA,55°	FA,65°	FA,55°	FA,65°	(AMP)	(kVA)	(AMP)	(kVA)	(AMP)
1,500						69.5	1,388	64.2	1,875	86.8
2,500						115.8	2,313	107.1	3,125	144.7
3,750						173.6	3,469	160.6	4,688	217.0
5,000						231.5	4,625	214.1	6,250	289.4
	1,500					69.5	1,388	64.2	1,875	86.8
	2,500					115.8	2,313	107.1	3,125	144.7
	3,750					173.6	3,469	160.6	4,688	217.0
	5,000					231.5	4,625	214.1	6,250	289.4
3,750	4,200					194.5	3,885	179.9	5,250	243.1
5,000	5,600					259.3	5,180	239.8	7,000	324.1
2,500		3,125				144.7	2,891	133.8	3,906	180.8
3,750		4,687				217.0	4,335	200.7	5,859	271.2
5,000		6,250				289.4	5,781	267.7	7,813	361.7
	2,500		3,125			144.7	2,891	133.8	3,906	180.8
	3,750		4,687			217.0	4,335	200.7	5,859	271.2
	5,000		6,250			289.4	5,781	267.7	7,813	361.7
3,750	4,200	4,687	5,250			243.1	4,856	224.8	6,563	303.8
5,000	5,600	6,250	7,000			324.1	6,475	299.8	8,750	405.1
7,500	8,400	9,375	10,500			486.2	9,713	449.7	13,125	607.6
	10,000		12,500			578.8	11,563	535.3	15,625	723.4
10,000	11,200	12,500	14,000			648.2	12,950	599.5	17,500	810.2
OA,55°		FA,55°	FA/2,55°							
12,000	13,440	16,000	17,920	20,000	22,400	1037.0	20,720	959.0	28,000	1296.0
15,000	16,800	20,000	22,400	25,000	28,000	1298.0	25,900	1199.1	35,000	1620.4

4.7 Other Substation Equipment Loading

In addition to substation power transformers, loading criteria for other major substation equipment has also been established by the Cooperative. Substation bus regulators and feeder protection devices are not to be normally loaded more than 70%. During contingency situations, substation bus regulators can be loaded to 125% during the winter and 100% during the summer, while feeder protection devices can be loaded up to 100% regardless of the season.

4.8 Meter Points

The Cooperative presently utilizes no Metering Points where the Cooperative takes delivery from any utility other than EKPC.

4.9 Recloser Loading

The Cooperative has established the loading criteria in Table 4-7 relating to 12 kV protective devices.

Table 4-7 Protective Device Loading

	Normal Loading	Contingency Loading
1 ph Tap	70%	-
3 ph Tap	70%	-
1 ph Tie	50%	90%
3 ph Tie	50%	90%

Table 4-8 provides a guide for emergency loading of reclosers. Load currents above the continuous current rating of hydraulically controlled reclosers should only be applied to new reclosers. The following ratings allow some temperature rise in excess of that permitted under normal load.

Table 4-8 Recloser Emergency Loading

	Maximum Hours at		
Type (coil rating)	**125% of Rating**	**150% of Rating**	**175% of Rating**
H, 4H, V4H (all)	8	4	2
L (25-140)	8	4	2
RXE, WE	4	2	0

4.10 Contingency Analysis

The following planning criteria were used during the analysis:

1. The highest thermal loading limit of the substation transformer would not be exceeded (taking into account seasonal deratings / upratings). Refer to Table 4-6 for forced air rating and 55°/65° ratings.

2. Thermal loading limits of primary line would not be exceeded for the size of conductor, equipment, and condition of line, along with the emergency loading in Tables 4-4 and 4-5. The thermal loading limits of conductor are considered extreme, and therefore, the load currents were not allowed to exceed 300 amps.

3. Delivery point contingency loading at 80% of the projected non-coincident peak demand projections.

4. Maximum of two sets of line voltage regulators.

5. May use one set of line voltage regulators along with failed substation's regulators if the failed substation is configured for such use.

6. Substation bus voltage modelled at 124 V (on 120 V base). Assuming a voltage setting of 125 V with a 2 V bandwidth makes 124 volts the minimum.

7. Line voltage regulators can increase line voltage by 10% (output voltage of line voltage regulators set at 125 volts with a 2-volt bandwidth) set to step in the model.

8. Minimum of 114 volts on any single-phase line (ANSI Range B).

9. Minimum of 116 volts on any three-phase line.

10. Use of substation 7.2/12.47 or 14.4/24.94 kV low-side bus on failed substation to serve other circuits.

11. Voltage regulator thermal ratings not to be exceeded.

12. Overcurrent protection device review to be considered separately. The scope of the contingency analysis was to determine major project needs, not to review overcurrent protection needs during a contingency situation.

4.11 Operation and Maintenance

The Cooperative has adopted guidelines for operation and maintenance of electric distribution system facilities. A summary of these guidelines is included below.

4.11.1 Poles

Pole plant is inspected on an 8-year cycle. The inspection process includes visual inspection methods with a sound check if rot is suspected. Butt treatment is only done where the need is present.

4.11.2 Meters

The Cooperative has completed the deployment of Tantalus AMR on all meters. These meters will be tested on a case by case basis as needed in compliance with sample meter testing.

4.11.3 Reclosers

Recloser and sectionalizer equipment is maintained on a 6-year cycle. Oil-filled devices are checked every 6 years after installation. Oil-filled devices are removed for maintenance after a maximum of 12 years and replaced. Vacuum devices found with over 300 operations over the 6-year span are changed out for maintenance. Oil-filled and vacuum operated devices are removed for maintenance after a maximum of 18 years and replaced. The Cooperative intends to steadily shift from oil-filled devices to vacuum devices going forward to reduce the maintenance labor and improve device reliability in the future.

4.11.4 Voltage Regulators

Voltage regulators are inspected and adjusted semi-annually. Regulator service schedule is on an 8-year cycle. Oil samples are drawn to determine the need for maintenance on specific equipment. When service is necessary, all oil is replaced, and new non-PCB oil is used in the servicing program.

4.11.5 Distribution Transformers

Transformers are purchased with low loss design and non-PCB oil. A Total Cost of Ownership (TCO) analysis is completed for three-phase transformer purchases, while all single-phase transformers are simply purchased from United Utility Supply (UUS). Each transformer that is retired is tested for PCB content by a testing lab. Transformers determined to not be suitable for reuse are disposed of through an EPA approved disposal facility. All oil from oil filled devices that are to be disposed of are also sent to this facility. Disposal documents of destruction are provided by the facility.

4.11.6 Right-of-Way

Vegetation within the right-of-way is controlled on a 6-year cycle. Herbicide is applied on a 3-year cycle. The program begins with a survey of the scheduled area. Ground application of high volume herbicide as well as manual tree trimming is used. Any tree that can be removed that is within the right-of-way is suggested to be removed. Areas that can be maintained with brush-hog or mowing equipment are mowed.

4.11.7 Overhead Line

Patrol inspection of the entire electric distribution overhead line facilities is completed annually.

4.11.8 Underground Line

Padmount transformers have been inspected on a 2-year cycle.

4.11.9 Substations

Substations are owned by EKPC. Inspection and maintenance is performed by EKPC on their schedule.

4.12 Underground Cable

4.12.1 New Underground Construction

Minimum size conductor for underground primary facilities is 25 kV 1/0 solid aluminum, 220 mil insulation, jacketed with full neutral. Minimum size conductor for underground secondary facilities is 600 volts, 4/0 stranded aluminum with 2/0 aluminum neutral. Underground cable is installed in conduit.

4.12.2 Existing Underground Construction

Replacement of facilities is required for the following conditions:

- Underground line will be replaced after two faults in any 12-month time period. All bare concentric neutral underground cable will be replaced after two faults occur on the same line section within a 6-month time period.
- Concentric neutral conductors are exposed and determined to be severely deteriorated.
- Areas where earth has slipped or shifted, forcing stress on cables.
- Measured voltage between electrical facility metal enclosures and earth.
- Locations where land use has been altered over or near cable routes, such as excavations, buildings and other conditions.

4.13 Overhead Line Upgrades

Overhead lines that are determined to be in poor condition, which could adversely affect members' reliability, will be replaced as needed. Most of these replacements will be due to old 6A and 8A copper conductors.

4.13.1 New Overhead Construction

All construction will meet all NESC requirements. All new construction and rebuilds will be designed to at least NESC Grade C, Medium Loading construction.

Road crossings and railroad crossings are to be constructed using double support facilities, appropriate guying, no conductor splices in the crossing span, and to Grade B construction.

The minimum size conductor for overhead primary voltage facilities is #2 ACSR for single phase construction and 1/0 ACSR for three phase construction. Minimum size conductor for tie-lines between substations is 336 ACSR.

4.13.2 Existing Overhead Construction

Replacement of facilities is required for the following conditions:

- Broken, split, leaning, bowed, decayed, woodpecker damaged or other defect of wood poles.
- Broken, split, decayed, insect damaged or other defect of wood crossarm or braces.
- Attachments to poles that exceed the strength of the pole, such as numerous communication cables.

- Areas where earth has slipped or shifted, forcing stress on poles, guys and anchors.
- Areas where flood waters may severely reduce clearance to conductors and facilities attached to the pole.
- Locations where land use has been altered, such as use of large vehicles and equipment under or near electric facilities.
- Sagging conductors due to pole movement, conductor stress from ice or wind loading, change of land contours, and other similar circumstances (stressed conductor is defined as that found with at least twice normal sag).
- Where more than two splices in a span of ACSR conductor exists, replace the entire span. If more than ten splices per mile of conductor, per conductor, replace the entire mile section. Attachment of the new conductor is to be made with dead-end attachment facilities.
- Where reliability of a specific copper line section indicates a need for replacement, the line is replaced.
- When replacing a pole located on a tap of three spans or less of #4 ACSR, #6A or #8A copperweld conductor, the conductor is to be replaced on the entire tap length.

4.14 Feeder Load Balance

All loads will be balanced between phases for peak demands, where possible, by making necessary tap phasing changes. Proper load balancing improves line losses, voltage drop, and sectionalizing.

4.15 Reliability Indices

RUS Bulletin 1730A-119 requires that industry-accepted reliability indices SAIDI and SAIFI be calculated by Cooperatives and reported by all Borrowers. Therefore, it is recommended that the Cooperative calculate these indices. These indices have been defined in the IEEE 1366 and are shown below.

SAIFI: System Average Interruption Frequency Index

$$SAIFI = \frac{Total\ Number\ of\ Customer\ Interruptions}{Total\ Number\ of\ \ Customers\ Served}$$

SAIDI: System Average Interruption Duration Index

$$SAIDI = \frac{Sum of\ Customer\ Interruption\ Durations}{Total\ Number\ of\ \ Customers\ Served}$$

5 Recommended Plan

5.1 General

The recommended construction in this study is based on improving the present distribution system to provide adequate service through the end of 2022 according to forecasted non-coincident peak demands. The reasons for any recommended new substations, existing substation capacity upgrades, and distribution primary line improvements are explained in detail within this section.

5.2 New Substations

Two new substations are included in the plan for the 2019-2022 timeframe. These substations are being recommended to correct deficiencies in capacity, voltage and contingency capability.

Fleming-Mason has an arrangement with EKPC where EKPC pays the expenses for new transmission and substations. EKPC recovers the cost for their expenses through an ongoing maintenance fee to FME that would necessarily increase when new infrastructure is added. EKPC has provided a general project cost estimate for planning comparisons, but these estimates should be reduced by mitigating factors that are explained in the narrative. Also, it is important to note that these direct costs aren't incurred by FME and will only be utilized for comparison discussion in this narrative. Further investigation into specific cost impacts may be warranted.

5.2.1 Cranston Substation

Hilda 2 is projected to be loaded at 86.8% of winter capacity. This assumes a 125% capacity uprating for winter loading (20,605 kw of 23,750 kw capacity in winter). Hilda 2 is projected to be loaded at 74.3% of peak in the summer when applying the summer derating of 92.5% of nameplate capacity. There is a capacity issue for the Hilda 2 substation transformer and Hilda is considered a high growth area. According to the design criteria, additional capacity is recommended since the loading percentages are well above 70%. The Hilda 301 Cranston circuit is serving 7 MW of load on wire that is very close to capacity at peak. Portions of the circuit that do not have backfeed responsibility are loaded over the 70% capacity. Furthermore, low voltage is a significant issue on this circuit. Several options were considered.

Option A considers adding a new Cranston substation approximately 2/3 of the load distance on the Hilda 301 Cranston circuit. A transmission line exists at this location, so the tap cost would be minimal. In fact, a customer owned substation tap exists very close to the proposed location. An arrangement to add a new transformer at this location utilizing the existing tap and available substation land could financially benefit all stakeholders. A new substation would improve contingency options allowing service of the Hilda 301 Cranston circuit from the new substation or vice versa. Reliability would be inherently better since the distribution lines from the source to the customers are shortened.

Some circuit upgrades would still be necessary to upgrade some conductor near the new substation costing approximately $71,300. EKPC estimates that the cost of a new substation would be

approximately $1,550,000 for a 69-13.2 kV 12/16/20 MVA substation. If needed, a new 69 kV tap line would cost approximately $500,000 per mile. It may be possible to reduce costs by installing a smaller transformer since this amount of capacity need isn't projected to be needed until a much later time.

At winter peak, the remaining Hilda 2 substation projects a load of 15,419 kW after the load shift. The Cranston substation projects a load of 4,710 kW. The new substation would push out the need for a transformer capacity upgrade at Hilda 2 until roughly 2030. If at some point all of the remaining Hilda 301 Cranston load is shifted to the new Cranston substation, another conductor upgrade would be necessary costing an additional estimated $152,500. This would further defer the need for a transformer upgrade at Hilda 2 to roughly 2033. Additional options to shift load to the new substation may be available.

Option B involves upgrading 6.47 miles of 3ph conductor to 556 ACSR from 4/0 and 1/0 ACSR at a cost of $970,500. This resolves the issues with voltage drop and conductor capacity. But the continuing load growth projections suggest that a new transformer will be needed at Hilda 2 by 2025. This option does not provide a reasonable contingency means to feed this load if the Hilda 2 source is out.

Option C investigates the conversion of the Hilda 301 Cranston circuit to 25 kV at a cost of $2,006,000. This resolves the issues with voltage drop and conductor capacity. Similar to Option B, continuing load growth projections suggest that a new transformer will be needed at Hilda 2 by 2025. This option does not provide a reasonable contingency means to feed this load if the Hilda 2 source is out.

Option D pursues a plan to upgrade a long section of conductor to create a new feed from Plummers Landing 903. Plummers Landing is currently projected to be loaded at 53.9% of winter capacity assuming a 125% capacity uprating for winter loading (9,143 kw of 16,625 kw capacity in winter). The necessary projects would cost an estimated $1,520,000 if this were an average upgrade. However, this conversion would traverse difficult terrain that would elevate these costs and create ongoing significant maintenance cost for these lines. New loading on the Plummers Landing transformer would be approximately 11,200 kw of 16,625 kw capacity at winter peak (67.4%). New loading on the Hilda 2 transformer would be about 18,500 kw of 23,750 kw capacity at winter peak (77.9%). Growth projections suggest that a Hilda 2 transformer upgrade will be necessary by 2027. This option does not provide a reasonable contingency means to feed this load if the Hilda 2 source is out. A new tie to Plummers Landing would be established, but many more upgrade projects would be necessary to allow adequate contingency backfeeds between the substations. Reliability to a section of customers would be expected to be worse since they are added to the end of a very long line section with many miles of exposure to outages.

After consideration of each approach, **Option A is preferred**. Option A offers the best alternative for feeding a growing load center for the foreseeable future. Each alternative option involves significant investment that is comparable with Option A. The other alternative options also would require a transformer upgrade at Hilda 2 in the relatively near future. The cost of a transformer upgrade in addition to the expected project cost would be more than the cost of a new substation. Option A presents a solution that can improve reliability as well.

5.2.2 Stonewall Substation

During the process of designing distribution upgrade solutions to resolve low voltage issues identified on the Murphysville 603 Stonewall circuit, an alternative new substation was proposed for examination and comparison.

Option A resolves the projected voltage drop issues by adding a new Stonewall substation near the load center on the Murphysville 603 Stonewall circuit. There is currently a transmission line at this location, so the tap cost would be minimal. A new substation would provide contingency options to feed the Murphysville 603 Stonewall circuit from the new substation or vice versa. Reliability would be inherently better since the distribution lines from the source to the customers are shortened.

An additional $80,000 would be necessary for distribution upgrades to accommodate a new substation. EKPC estimates that the cost of a new substation would be approximately $1,575,000 for a 69-26.4 kV 12/16/20 MVA substation. If needed, a new 69 kV tap line would cost approximately $500,000 per mile. It may be possible to reduce costs by installing a smaller transformer since this amount of capacity need isn't projected for a long period of time. At winter peak, the Murphysville substation projected load is 4,699 kW after the load shift. The Stonewall substation projected load is 5,723 kW.

Option B looks into investment in significant distribution upgrades to improve the voltages. Distribution upgrades on this circuit that would be directly displaced with the addition of a substation would have costed an estimated $1,420,000.

After comparing both options, **Option A is preferred**. Examining costs identifies a comparable cost for both options. But Option A meets the immediate design criteria for some time into the future while offering a significant reliability improvement.

5.3 Substation and Regulator Upgrades

Table 5-1 shows the projected loads with the present system layout, along with substation transformer and regulator capacities for a winter peak. The shaded numbers indicate violations in planning criteria. Table 5-2 shows the projected loads with the recommended system improvements for a winter peak. As can be seen in this table, planning criteria have been satisfied or violations minimized for substation transformer capacity loading.

Exhibit 5 shows the feeder loading levels for the recommended system layout. Upgrades to meet the contingency study planning criteria are reviewed in Section 6 – Contingency Analysis but are being deferred to a future CWP.

5.3.1 Charters Substation

Charters substation circuit 105 had significant low voltage issues identified in the model requiring upgrade projects to resolve the problems. Project research eventually developed four different alternatives for consideration. To select a better overall solution, contingency criteria and resulting projects were considered in addition to voltage drop criteria even though these contingency related projects are being postponed to a later CWP. Also, expected costs for upgrades to the connecting Oak Ridge substation distribution lines are included for overall comparison.

Option A was initially considered as a means to resolve both voltage and contingency criteria. After an initial review, Option B was conceived as a potential alternative. During the resulting analysis for Option B, Options C and D were conceived and determined to be a viable means to serve the voltage and contingency criteria.

Charters is projected to be loaded at 93.8% of winter capacity. This assumes a 125% capacity uprating for winter loading (15,588kw of 16,625kw capacity in winter). Design criteria recommend that capacity upgrades or load shifting is employed to keep this loading below 70%. This criterion highlights a potential issue for resolution prior to an expensive transformer failure. It also reserves capacity such that contingency capacity may be available when needed. This study identified a real potential for overloading the transformer and an immediate lack of available capacity for alternative contingency feeds. Oak Ridge is projected to be loaded at 49.2% of winter capacity. This assumes a 125% capacity uprating for winter loading (8,176kw of 16,625kw capacity in winter). Only Option B addresses the capacity concern at Charters substation.

Option A is a means to resolve the immediate voltage issues for Charters 105 by upgrading a significant portion of 4/0 ACSR to 336 ACSR. There are significant concerns with this project since it would require a difficult conversion of a section of wire that is in relatively good shape and traverses extremely difficult terrain. The contingency feed to Charters 105 is from Oak Ridge 703, through Charters 102 and involves significant upgrades to the connecting three-phase distribution. Total project cost for construction upgrades is $2,229,800. Option A isn't a consideration as all issues can be resolved with less cost as indicated by the following options. Also, this option does not reduce the load on the Charters substation transformer which is over the 70% capacity criterion.

Option B involves projects to upgrade existing distribution and a load shift to feed most of Charters 105 from Oak Ridge 704. This option requires some 14.4 kV conversion, wire upgrades, and single-phase to three-phase conversions. Total project cost for construction upgrades is $1,875,300.

If this group of projects is completed, Charters would have an estimated peak winter load of 12,214 kW out of a 16,625 kW capacity (73.5%). Oak Ridge would have an estimated peak winter load of 11,343 kW out of a 16,625 kW capacity (68.2%). This puts both substations in a range of being efficiently used while still holding capacity in reserve for alternative contingency feeds.

Option C considers the possibility of continuing to feed the load from Charters 105 without the need for upgrading the significant portion of three-phase distribution from 4/0 ACSR to 336 ACSR. This option requires some 14.4 kV conversion, wire upgrades, and single-phase to three-phase conversions as described in Option B. Total project cost for construction upgrades is $1,875,300.

A contingency feed from Oak Ridge 704 to Charters 105 would require significant upgrades as described in Option B. Option C resolves the immediate voltage issues on Charters 105 but places the projects that connect Oak Ridge 704 in the contingency category which will be postponed to a later CWP. This option also puts off many of the projects that can be used to unload the Charters

substation transformer to a later CWP. Immediate expenses are minimized for this CWP. This option does not reduce the load on the Charters substation transformer which is over the 70% capacity criterion.

Option D considers the possibility of continuing to feed the load from Charters 105 without the need for upgrading the significant portion of three-phase distribution from 4/0 ACSR to 336 ACSR. This option requires some 14.4 kV conversion and wire upgrades. Total project cost for construction upgrades is $1,408,300.

A contingency feed from Oak Ridge 703 to Charters 102 and then to Charters 105 would require significant contingency upgrades as described in Option A. No new connection is made from Oak Ridge 704. Option D resolves the immediate voltage issues on Charters 105 but assumes that there will be no issue with overload on the Charters substation transformer. This option does not reduce the load on the Charters substation transformer which is over the 70% capacity criterion.

Option B is the preferred solution to resolve significant voltage issues while avoiding an upgrade on a relatively good section of three-phase distribution line and shifting a significant amount of load to Oak Ridge 704. Overall, Option B is less costly compared to Option A even though the Option B projects serve to revise both contingency and improvement projects within this CWP timeframe. The Charters substation transformer is close to overload. Option B is the only viable solution when compared with the cost of a lost transformer. Option C and D are the cheaper immediate options because they assume that the Charters substation transformer will not require replacement during this CWP period.

5.3.2 Flemingsburg Substation

The transformer load at the Flemingsburg substation is projected to be 73% of capacity at the 2022 winter peak. Design criteria recommend that capacity upgrades or load shifting is employed to keep this capacity below 70%. This criterion reserves capacity such that alternative contingency feeds may be used when needed. This study showed no immediate lack of available capacity for alternative contingency feeds. This design criteria violation should be monitored and considered in the next CWP study.

5.3.3 Hilda 2 Substation

The transformer capacity at the Hilda 2 substation is projected to be 86.8% loaded at the 2022 winter peak. Design criteria recommend that capacity upgrades or load shifting is employed to keep this capacity below 70%. This criterion is intended to give adequate time for the utility to implement measures circumventing a transformer overload problem. It also reserves capacity such that alternative contingency feeds may be established when needed. This study identified a potential for overloading the transformer in the near horizon and an immediate lack of available capacity for alternative contingency feeds. This violation is addressed through the addition of the Cranston substation described in Section 5.2.

5.3.4 Peasticks Substation

The bus voltage regulator capacity at the Peasticks substation is projected to be 77% loaded at the

2022 winter peak. Design criteria recommend that capacity upgrades or load shifting is employed to keep this capacity below 70%. This criterion reserves capacity such that alternative contingency feeds may be established when needed. This study showed no immediate lack of available capacity for alternative contingency feeds. This design criteria violation should be monitored and considered in the next CWP study.

Table 5-1 Substation Transformer and Regulator Loading – Unimproved System

UNIMPROVED SYSTEM AND NORMAL SYSTEM CONFIGURATION - WINTER						
		TRANSFORMER LOADING			VOLTAGE REGULATOR LOADING	
Delivery Point Name	Projected 2022 Winter Demand (kW)	Base kVA Rating (OA, 55°)	Max Winter Rating[1] (kW)	CWP Percent Loaded	Size (Amps)	CWP Percent Loaded [2]
BIG WOODS	8,211	12	19,000	43.2%	1307	26%
CHARTERS	15,588	-	16,625	93.8%	336	95%
FLEMINGSBURG	13,879	12	19,000	73.0%	500	57%
HILDA 2	20,605	15	23,750	86.8%	900	93%
HILLSBORO	8,847	12	23,750	37.3%	336	54%
MAYSVILLE INDUSTRIAL	7,465	12	23,750	31.4%	336	45%
MURPHYSVILLE	10,937	12	16,625	65.8%	500	45%
OAK RIDGE	8,176	-	16,625	49.2%	336	50%
PEASTICKS	12,744	-	24,500	52.0%	336	77%
PLUMMERS LANDING	9,143	-	16,625	55.0%	612	61%
RECTORVILLE	10,039	-	16,625	60.4%	614	67%
SHARKEY	16,273	-	24,500	66.4%	560	59%
SNOW HILL	8,320	12	16,625	50.0%	336	50%

[1] Based on 65^0 loading with fans (if installed), historical peak power factor, and a winter uprating of 25%.
[2] Calculated with an assumed 10% Load Unbalance

Greater than 70% design criteria
Greater than 100% capacity

Table 5-2 Substation Transformer and Regulator Loading – Improved System

IMPROVED SYSTEM AND NORMAL SYSTEM CONFIGURATION - WINTER						
		TRANSFORMER LOADING			VOLTAGE REGULATOR LOADING	
Delivery Point Name	Projected 2022 Winter Demand (kW)	Base kVA Rating (OA, 55°)	Max Winter Rating1 (kW)	CWP Percent Loaded	Size (Amps)	CWP Percent Loaded [2]
BIG WOODS	8,171	12	19,000	43.0%	1307	25%
CHARTERS	12,214	-	16,625	73.5%	336	74%
FLEMINGSBURG	13,856	12	19,000	72.9%	500	56%
HILDA 2	15,419	15	23,750	64.9%	900	70%
HILLSBORO	8,845	12	23,750	37.2%	336	54%
MAYSVILLE INDUSTRIAL	7,446	12	23,750	31.4%	336	45%
MURPHYSVILLE	4,699	12	16,625	28.3%	500	19%
OAK RIDGE	11,343	-	16,625	68.2%	336	69%
PEASTICKS	12,603	-	24,500	51.4%	336	76%
PLUMMERS LANDING	8,959	-	16,625	53.9%	612	60%
RECTORVILLE	9,888	-	16,625	59.5%	614	66%
SHARKEY	16,130	-	24,500	65.8%	560	59%
SNOW HILL	8,262	12	16,625	49.7%	336	50%
CRANSTON	4,710	-	16,625	28.3%	614	31%
STONEWALL	5,723	-	16,625	34.4%	336	35%

1 Based on 65° loading with fans (if installed), historical peak power factor, and a winter uprating of 25%.

2 Calculated with an assumed 10% Load Unbalance

Greater than 70% design criteria | Recommended Improvement

Greater than 100% capacity

5.4 Distribution Line Improvements

Construction projects are needed for capacity and voltage reasons to meet the established planning criteria. Line replacement and upgrades are also needed in areas where facilities are in poor condition to maintain adequate service reliability. Projects needed due to age and conditions of conductors were identified with the help of the Cooperative's staff familiar with the condition of the Cooperative's distribution facilities.

5.4.1 System Improvement Projects

Site- specific system improvement details are included on the following pages. This list does not include projects that will be completed strictly based on age and condition and identified through Fleming-Mason's normal prioritization process for age and condition projects.

BIG WOODS

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 4, 4/0 ACSR to 2-ph 1/0, 4/0 ACSR	313.01	0.67	$ 65,000	$ 43,600	2022	Current > 50 Amps	CO3331 to CO3054
3-ph 4/0 ACSR to 3-ph 336 ACSR	313.02	0.69	$ 125,000	$ 86,300	2021	Current > 50% Ampacity	CO3417 to CO3273
1-ph 2 ACSR to 3-ph 1/0 ACSR	313.03	0.63	$ 90,000	$ 56,700	2022	Voltage	CO3508 to CO4989
1-ph 2, 4 ACSR to 3-ph 1/0 ACSR	313.04	0.27	$ 90,000	$ 24,300	2022	Voltage	CO5000 to OH330879005
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
None							
Capacitors-605							
None							
TOTAL MILES		2.3					
TOTAL $				$ 210,900			

CHARTERS

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
Convert 1-ph to 14.4 kV	301.01	12.20	$ 12,000	$ 146,400	2022	Current > 50 Amps	CO23097 to CO22905
1-ph 2, 4 ACSR to 1-ph 1/0 ACSR	301.03	1.04	$ 55,000	$ 57,200	2021	Voltage	CO22561 to CO22668
Convert 1-ph to 14.4 kV	301.04	4.74	$ 12,000	$ 56,900	2020	Voltage, Current > 50% Ampacity	CO22559 to CO21698
Convert 3-ph to 14.4 kV	301.05	1.36	$ 22,000	$ 29,900	2020	Voltage, Current > 50% Ampacity	CO22559 to CO21698
1-ph 2 ACSR to 2-ph 1/0 ACSR	301.08	0.63	$ 65,000	$ 41,000	2021	Voltage	CO6963 to OH290554003
Convert 1-ph to 14.4 kV	301.09	6.77	$ 12,000	$ 81,200	2021	Voltage	ST220438001 downline
Convert 3-ph to 14.4 kV	301.10	0.73	$ 22,000	$ 16,100	2021	Voltage	ST220438001 downline
Convert 1-ph, 2-ph to 14.4 kV	301.11	13.01	$ 12,000	$ 156,100	2021	Voltage	ST230438001 downline
Convert 3-ph to 14.4 kV	301.12	0.36	$ 22,000	$ 7,900	2021	Voltage	ST230438001 downline
Convert 1-ph to 14.4 kV	301.13	10.00	$ 12,000	$ 120,000	2021	Voltage	ST230765002 downline
Convert 1-ph to 14.4 kV	301.15	17.78	$ 12,000	$ 213,400	2019	Voltage	AU55 to OC280437001 and CO7181
Convert 3-ph to 14.4 kV	301.16	2.75	$ 22,000	$ 60,500	2019	Voltage	AU55 downline
1-ph 2, 4 ACSR to 3-ph 336 ACSR	301.17	3.38	$ 125,000	$ 422,500	2019	Voltage	CO17761 to CO17952
3-ph 1/0 ACSR to 3-ph 336 ACSR	301.18	2.59	$ 125,000	$ 323,800	2019	Voltage	C17960 to CO17820
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Move regulator bank RG150878001 to CO22905	604.01A	0.00	$ -	*	2022	Voltage	
Install 3-200A regulators at CO30560	604.01B	0.00	$ -	$ 35,000	2020	Voltage, Contingency	
Move regulator bank RG230555001 to CO19548	604.01D	0.00	$ -	*	2019	Voltage	
Move regulator bank RG300397347 to CO7181	604.01E	0.00	$ -	*	2019	Voltage	
Capacitors-605							
None							
TOTAL MILES		77.3					
TOTAL $				$ 1,767,900			

FLEMINGSBURG

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
Convert 1-ph to 14.4 kV	302.01	7.65	$ 12,000	$ 91,800	2021	Voltage	ST270762001 downline
Convert 1-ph to 14.4 kV	302.02	5.78	$ 12,000	$ 69,400	2021	Voltage	ST270774001 downline
Convert 1-ph to 14.4 kV	302.03	11.97	$ 12,000	$ 143,600	2021	Voltage	AU45 downline
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
None							
Capacitors-605							
None							
TOTAL MILES		25.4					
TOTAL $				$ 304,800			

HILDA 2

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
3-ph 1/0 ACSR to 3-ph 336 ACSR	303.03	0.33	$ 125,000	$ 41,300	2022	Current > 50% Ampacity	CO4119 to OH340774023
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 3-100A regulators at CO4286	604.03A	0.00	$ -	$ 30,000	2019	Voltage	
Remove regulator RG26	604.03B	0.00	$ -	*	2019	Superseded by 414.01, 414.02	
Capacitors-605							
None							
TOTAL MILES		0.3					
TOTAL $				$ 71,300			

HILLSBORO

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
None							
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 1-50A regulator at OH330774027	604.04A	0.00	$ -	$ 7,000	2022	Voltage	
Install 3-100A regulators at OH320772008	604.04B	0.00	$ -	$ 30,000	2020	Voltage	
Capacitors-605							
None							
TOTAL MILES		0.0					
TOTAL $				$ 37,000			

MAYSVILLE

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 4, 1/0 ACSR to 2-ph 1/0 ACSR	305.01	4.30	$ 65,000	$ 279,500	2020	Current > 50 Amps	CO30702 to CO210142144
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 3-200A regulators at CO23905	604.05A	0.00	$ -	$ 35,000	2020	Voltage, Contingency	
Remove regulator REG34	604.05B	0.00	$ -	*	2020	Superseded by 604.05A, 305.01	
Capacitors-605							
None							
TOTAL MILES		4.3					
TOTAL $				$ 314,500			

MURPHYSVILLE

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 2 ACSR to 2-ph 1/0 ACSR	306.04	3.02	$ 65,000	$ 196,300	2022	Current > 50 Amps	CO29734 to CO29859
Convert 1-ph to 14.4 kV	306.05	6.95	$ 12,000	$ 83,400	2022	Current > 50 Amps	ST240429001 downline
1-ph 4 ACSR to 2-ph 1/0 ACSR	306.06	0.45	$ 65,000	$ 29,300	2022	Current > 50 Amps	CO27652 to OH240426006
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Move regulator RG634842757 to CO28663	604.06A	0.00	$ -	*	2019	Voltage	
Remove regulator RG240439001	604.06B	0.00	$ -	*	2019	Superseded by 415.1, 415.2	
Install 1-50A regulator at CO27673	604.06C	0.00	$ -	$ 7,000	2021	Voltage	
Capacitors-605							
None							
TOTAL MILES		10.4					
TOTAL $				$ 316,000			

OAK RIDGE

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
Convert 1-ph to 14.4 kV	307.01	4.83	$ 12,000	$ 58,000	2021	Voltage	ST210774001 downline
Convert 1-ph to 14.4 kV	307.02	6.64	$ 12,000	$ 79,700	2021	Voltage	AU59 downline
Convert 1-ph to 14.4 kV	307.03	2.51	$ 12,000	$ 30,100	2021	Voltage	AU40 to RG260649001
Convert 1-ph to 14.4 kV	307.04	0.52	$ 12,000	$ 6,200	2021	Voltage	ST260656001 downline
Convert 1-ph to 14.4 kV	307.05	16.65	$ 12,000	$ 199,800	2021	Voltage	AU8 downline
3-ph 2, 1/0 ACSR to 3-ph 336 ACSR	307.07	2.37	$ 125,000	$ 296,300	2019	Voltage	CO-82601623 to OH270649005
Convert 1-ph to 14.4 kV	307.08	8.75	$ 12,000	$ 105,000	2019	Voltage	AU7 downline
1-ph 4 ACSR to 3-ph 336 ACSR	307.09	3.63	$ 125,000	$ 453,800	2019	Voltage	CO7936 to CO17953
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 1-50A regulator at OH260216013	604.07A	0.00	$ -	$ 7,000	2021	Voltage	
Capacitors-605							
None							
TOTAL MILES		45.9					
TOTAL $				$ 1,235,900			

PEASTICKS

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 2, 4 ACSR to 2-ph 1/0 ACSR	308.01	0.77	$ 65,000	$ 50,100	2022	Current > 50 Amps	CO9354 to CO9508
1-ph 2 ACSR to 2-ph 1/0 ACSR	308.02	1.42	$ 65,000	$ 92,300	2022	Current > 50 Amps	CO8664 to CO8405
1-ph 4 ACSR to 2-ph 1/0 ACSR	308.03	1.94	$ 65,000	$ 126,100	2022	Current > 50 Amps	CO9134 to OH370878008
Convert 1-ph to 14.4 kV	308.04	6.97	$ 12,000	$ 83,600	2020	Voltage, Current > 50 Amps	AU11 downline
3-ph 2, 1/0 ACSR to 3-ph 336 ACSR	308.05	4.72	$ 125,000	$ 590,000	2020	Voltage, Current > 50% Ampacity	CO-689687084 to CO2372
Convert 1-ph to 14.4 kV	308.06	6.91	$ 12,000	$ 82,900	2021	Voltage	AU12 downline
1-ph 4 ACSR to 1-ph 1/0 ACSR	308.07	0.10	$ 55,000	$ 5,500	2021	Voltage	CO10685 to OH370878002
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 3-200A regulators at CO8524	604.08A	0.00	$ -	$ 35,000	2021	Voltage	
Install 3-200A regulators at CO8767	604.08B	0.00	$ -	$ 35,000	2022	Voltage	
Remove regulator RG29378565	604.08C	0.00	$ -	*	2019	Superseded by 604.08B	
Remove regulator REG57	604.08D	0.00	$ -	*	2019	Superseded by 604.08B	
Install 3-100A regulators at CO11195	604.08E	0.00	$ -	$ 30,000	2021	Voltage	
Install 1-50A regulators at CO9221	604.08G	0.00	$ -	$ 7,000	2021	Voltage	
Capacitors-605							
None							
TOTAL MILES		22.8					
TOTAL $				$ 1,137,500			

PLUMMERS LANDING

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 4, 1/0 ACSR to 2-ph 1/0 ACSR	309.01	1.13	$ 65,000	$ 73,500	2022	Current > 50 Amps	CO6370 to CO6683
1-ph 2 ACSR to 2-ph 1/0 ACSR	309.02	0.65	$ 65,000	$ 42,300	2022	Current > 50 Amps	CO6377 to CO6552
1-ph 2, 4 ACSR to 3-ph 1/0 ACSR	309.03	3.94	$ 90,000	$ 354,600	2021	Current >100 Amps	CO5877 to OH330206011
1-ph 2 ACSR to 2-ph 1/0 ACSR	309.04	1.53	$ 65,000	$ 99,500	2021	Current > 50 Amps	CO6339 to OH270876003
1-ph 4 ACSR, 6 ACWC to 2-ph 1/0 ACSR	309.05	1.49	$ 65,000	$ 96,900	2022	Current > 50 Amps	CO5885 to CO6249
1-ph 2 ACSR to 2-ph 1/0 ACSR	309.06	1.71	$ 65,000	$ 111,200	2022	Current > 50 Amps	CO5734 to CO6123
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Remove regulator REG330206001	604.09A	0.00	$ -	*	2019	Superseded by 604.09B, 309.03, 309.04	
Install 3-50A regulators at CO6221	604.09B	0.00	$ -	$ 21,000	2021	Voltage	
Install 3-100A regulators at CO5840	604.09C	0.00	$ -	$ 30,000	2022	Voltage	
Install 3-100A regulators at CO4885	604.09D	0.00	$ -	$ 30,000	2022	Voltage	
Capacitors-605							
None							
TOTAL MILES		10.5					
TOTAL $				$ 859,000			

RECTORSVILLE

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
None							
3-ph 4/0 ACSR, 1/0 CU to 3-ph 556 ACSR	310.01	4.33	$ 150,000	$ 649,500	2020	Voltage, Current > 50% Ampacity, Contingency	CO22364 to CO22457
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Move regulator bank RG13 to OH210555042	604.10A	0.00	$ -	*	2019	Voltage	
Install 1-50A regulator at CO22264	604.10B	0.00	$ -	$ 7,000	2019	Voltage	
Capacitors-605							
None							
TOTAL MILES		4.3					
TOTAL $				$ 656,500			

SHARKEY

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
1-ph 4 ACSR to 2-ph 1/0 ACSR	311.01	1.22	$ 65,000	$ 79,300	2022	Current > 50 Amps	CO2004 to OH390657017
1-ph 2 ACSR to 2-ph 1/0 ACSR	311.02	0.11	$ 65,000	$ 7,200	2022	Current > 50 Amps	CO-415726902 to OH390647015
1-ph 4 ACSR to 2-ph 1/0 ACSR	311.03	0.25	$ 65,000	$ 16,300	2022	Current > 50 Amps	CO1686 to OH390657022
3-ph 1/0 ACSR to 3-ph 336 ACSR	311.04	1.03	$ 125,000	$ 128,800	2022	Voltage, Current > 50% Ampacity, Contingency	CO2575 to OH390436022
Convert 1-ph to 14.4 kV	311.05	5.54	$ 12,000	$ 66,500	2021	Voltage, Current > 50 Amps	AU3 to CO1055634389
3-ph 1/0 ACSR to 3-ph 336 ACSR	311.06	1.21	$ 125,000	$ 151,300	2020	Current > 70% Ampacity	CO2579 to CO2019
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
None							
Capacitors-605							
None							
TOTAL MILES		9.4					
TOTAL $				$ 449,400			

SNOW HILL

Notes							
	Project Code	Miles / Poles	Future Cost Per Unit	Total Cost	Work Plan Year	Reason(s) for Project	Associated Line Sections / Poles
New Tie Lines-200							
None							
Line Conversions-300		Mi	Cost				
Convert 1-ph to 14.4 kV	312.01	8.54	$ 12,000	$ 102,500	2022	Voltage	AU26 to CO13608
Convert 1-ph to 14.4 kV	312.02	1.08	$ 12,000	$ 13,000	2022	Voltage	ST360429001 to CO17161
Substation Changes-500							
None							
Regulators-604		Qty	Cost				
Install 1-50A regulator at CO25061	604.12A	0.00	$ -	$ 7,000	2019	Voltage	
Install 3-100A regulators at OH360429010	604.12B	0.00	$ -	$ 30,000	2019	Voltage	
Install 1-50A regulator at CO14569	604.12C	0.00	$ -	$ 7,000	2019	Voltage	
Capacitors-605							
None							
TOTAL MILES		9.6					
TOTAL $				$ 159,500			

5.5 Distribution Equipment

601 - Transformers and Meters – See Tables 7-6 and 7-7
These costs are for all new transformers required to serve new members, as well as upgraded services and replacements, and meters for new services. Costs are based on recent historical Fleming-Mason expenditures.

602 – Service Upgrades – See Tables 7-8 and 7-9
These costs relate to service upgrades, conversions, and minor system improvements, as well as needs due to clearance and loading concerns. Projections are based on historical trends.

603 – Sectionalizing Equipment – See Tables 7-8 and 7-9
These costs are needed for continually updating the system with adequate overcurrent protection devices to maintain reliable service. Reclosers, fuses, and underground switchgear are some of the examples of devices within this group.

604 – Regulators – See Table 7-5
Strategically placed regulators will be needed throughout the plan for voltage support. These situations will develop when load grows more than anticipated in certain areas. Regulators will also be needed for contingency situations.

606 – Pole Replacements – See Tables 7-8 and 7-9
Pole replacements are needed as a result of the pole inspection program rejections (see section 4.11.1). Other miscellaneous replacements will be needed outside the inspection program. Poles damaged by vehicles, farm equipment, and weather-related items such as lightning and wind will be part of this category.

607 – Miscellaneous Replacements – See Tables 7-8 and 7-9
Miscellaneous equipment (crossarms, guy wires, anchors, etc.) replacement costs are included in this category.

608 – Conductor Replacements – See Tables 7-8 and 7-9
This category includes costs for miscellaneous conductor replacements around the system, generally for projects estimated at total cost of less than $100,000 each. Specific age & condition projects are not identified in this Construction Work Plan, but projects will be determined based on reliability needs.

5.6 Other Distribution Items

702 – Security Lights – See Tables 7-10 and 7-11
Security lights are installed by members around the system for lighting needs. FME is currently replacing all security lights with LED lights. Anytime there is construction on a pole with a non-LED light, the light is replaced with an LED light. This policy is increasing the immediate budget for lighting needs. However, as these lights are replaced, the overall maintenance and replacement costs are expected to decrease.

6 Contingency Analysis

6.1 Substation Load Duration

In general, planning methods use peak capacity to determine recommendations. Peak capacity planning is the evaluation of the ability of the system to carry the projected peak system load. However, the system will not always be experiencing peak conditions when a contingency situation arises. Generally, cooperatives may use an 80% peak loading level criterion and make upgrades when the system cannot adequately provide service in a contingency situation at this level. For the purpose of this study, an 80% peak loading was used to help identify any needed contingency projects. It should be noted, that using a peak load level less than 100% may result in the inability to backfeed all areas during a contingency situation that is experienced during peak loading conditions.

After any distribution investment, such as a new substation or circuit, there will always be excess capacity, or margin, in the immediate area. As those areas acquire additional demand, this margin diminishes, and new construction alternatives need to be explored. Therefore, after these upgrades, there may be more margin than is actually needed for all contingencies at 80% peak load levels. In fact, there will most likely be margin to cover contingency scenarios at 100% peak. As time progresses and more load growth occurs, the system will once again become incapable of providing adequate service restoration during peak load but will still be capable of serving 80% levels. This situation dealing with margin occurs during planning and construction for normal system configuration loads and is sometimes illustrated graphically as a "step" function as the years progress.

6.2 Contingency Capability

The system was analyzed at 80% of the 2022 peak load levels according to the contingency design criteria established in Section 4 to determine the system's ability to backfeed a substation area during an outage. A discussion of the results of this analysis is included in this section. Table 6-1 includes a summary of how a particular substation can be backfed during an outage. This table could be utilized to create a contingency switching order list. Table 6-2 shows the resulting loading of the substations backfeeding the load. Where voltage drop is a concern and remote SCADA access to regulator controls exist, consideration may be given to stepping the programmed voltage levels from to as high as 126.0 volts with a 2-volt bandwidth while still maintaining voltage levels within industry standards throughout the contingency.

These contingencies all assume that additional recommended projects are completed prior to the utilization of the contingency source and circuit. In fact, few of these contingency scenarios could meet design criteria without the completion of a significant list of projects. These projects would have added an estimated $4.5 million to the Construction Work Plan. Therefore, the decision was made to remove these projects from this CWP and include the list as a reference for a future Construction Work Plan. These projects are listed for reference in Table 6-3 and Table 6-4.

6.2.1 Big Woods Substation

Big Woods has ties to Hilda, Hillsboro, and Sharkey. Using the ties to Hilda and Sharkey, the entire Big Woods area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.2 Charters Substation

Charters has ties to Oak Ridge and Rectorville. Several projects in this CWP utilize upgrades to existing lines to create a new tie from Oak Ridge circuit 4 to Charters circuit 4. These projects are primarily justified to shift load from a heavily loaded Charters to an Oak Ridge transformer with available capacity. But, this does create the necessary lines for another contingency feed between the two substations. Using the ties to Rectorville and Oak Ridge, much of the Charters area can be backfed without any violations of the contingency design criteria after the contingency projects are completed. Charter feeder 4 cannot be picked up in a contingency scenario and meet contingency design criteria unless the demand is less than 40% of the peak. Feeder 3 cannot be picked up in a contingency scenario and meet contingency design criteria unless the demand is less than 60% of the peak.

6.2.3 Flemingsburg Substation

Flemingsburg has ties to Hillsboro, Murphysville, Oak Ridge, Plummers Landing, and Snow Hill. Using the ties to Hillsboro, Murphysville, Oak Ridge, and Plummers Landing, the entire Flemingsburg area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.4 Hilda Substation

Hilda has ties to Big Woods, a new Cranston substation, and Sharkey. Using the ties Big Woods, Cranston, and Sharkey the entire Hilda area can be adequately backfed with no violations of the contingency design criteria after the contingency projects are completed. It should be noted that it may be necessary to shift some load from Sharkey to Big Woods to prevent a transformer overload on Sharkey during a scenario where all of Hilda must be fed from elsewhere.

6.2.5 Hillsboro Substation

Hillsboro has ties to Big Woods, Flemingsburg, Peasticks, and Sharkey. Using the ties to Big Woods, Flemingsburg, and Peasticks, Hillsboro can be adequately backfed with no violations of the contingency design criteria after the contingency projects are completed.

6.2.6 Maysville Industrial Substation

Maysville Industrial has a tie to Murphysville. Using this tie, the entire Maysville Industrial area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.7 Murphysville Substation

Murphysville has ties to Flemingsburg, Maysville Industrial, Rectorville, Snow Hill and a new

Stonewall substation. Using the ties to Flemingsburg, Maysville Industrial, Rectorville, and Stonewall, the entire Murphysville area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.8 Oak Ridge Substation

Oak Ridge has ties to Charters, Flemingsburg, and Rectorville. Using the ties to Charters and Flemingsburg, the entire Oak Ridge area can be adequately backfed with no violations of the contingency design criteria after the contingency projects are completed.

6.2.9 Peasticks Substation

Peasticks has ties to Hillsboro and Sharkey. Using these ties, the entire Peasticks area can be adequately backfed with minor violations of the contingency design criteria after the contingency projects are completed. Backfeeding circuit 3 from Sharkey causes some low voltage on the three-phase lines before the new regulator near SW74. However, the model showed no affected customers with low voltage.

6.2.10 Plummers Landing Substation

Plummers Landing has ties to Flemingsburg and Hillsboro. Using these ties, the entire Plummers Landing area can be adequately backfed with no violations of the contingency criteria after the contingency projects are completed.

6.2.11 Rectorville Substation

Rectorville has ties to Charters, Murphysville, and Oak Ridge. Using the ties to Murphysville and Oak Ridge, the entire Rectorville area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.12 Sharkey Substation

Sharkey has ties to Big Woods, Hilda, Hillsboro, and Peasticks. Using the ties to Big Woods and Hilda, the entire Sharkey area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.13 Snow Hill Substation

Snow Hill has ties to Flemingsburg and Murphysville. Using these ties, the entire Snow Hill area can be adequately backfed without any violations of the contingency design criteria after the contingency projects are completed.

6.2.14 Cranston Substation

Cranston Substation is a new substation with a tie to Hilda. Using this tie, the entire Cranston area can be adequately backfed without any violation of the contingency design criteria after the contingency projects are completed.

6.2.15 Stonewall Substation

Stonewall Substation is a new substation with a tie to Murphysville. Using this tie, the entire Stonewall area can be adequately backfed without any violation of the contingency design criteria after the contingency projects are completed.

Table 6-1 Switching Order Recommendations

Substation Out of Service	Feeder	Transfer to		NOTES
		Substation	Feeder	
BIG WOODS	1	HILDA 2	4	Close OC400322001. Open SW330878001. Close SW400102001.
	2	HILDA 2	4	Close SW390209004.
	3	SHARKEY	4	Close N.O. pt. at OH390216012.
CHARTERS	2	OAK RIDGE	3	Close SW220772001.
	3	RECTORVILLE	3	Close SW210555001.1. Voltage issues before RG13 and before new reg at CO30560 over 60% peak.
	4	-		Capacity to carry this is unavailable at 80% peak. 704 can carry this at 39% of peak.
	5	OAK RIDGE	4	Close N.O. pt. at CO17990.
FLEMINGSBURG	1	HILLSBORO	3	Close SW944
	2	MURPHYSVILLE	2	Close SW250657004.
	3	OAK RIDGE	5	Close SW260656004.
	4	MURPHYSVILLE	2	Feed via transfer bus.
	5	PLUMMERS LANDING	2	Close SW330102003.
HILDA 2	1	CRANSTON	1	Close N.O. pt. at CO1110.
	2	SHARKEY	3	Feed via transfer bus. Shed Sharkey circuit 4 load to Big Woods. Open Feeder 1104. Close N.O. pt. at OH390216012.
	3	SHARKEY	3	Close N.O. pt. at CO2022.
	4	BIG WOODS	1	Close OC400322001.
	G1	BIG WOODS	1	Connect by new switch near CO672.
	G2	BIG WOODS	1	Connect by new switch near CO672.
HILLSBORO	1	PEASTICKS	2	Close SW260.
	2	FLEMINGSBURG	1	Feed via transfer bus.
	3	FLEMINGSBURG	1	Close SW944.
	4	BIG WOODS	3	Close SW390216001.
MAYSVILLE INDUSTRIAL	2	MURPHYSVILLE	4	Feed via transfer bus.
	3	MURPHYSVILLE	4	Feed via transfer bus.
	4	MURPHYSVILLE	4	Close SW751.

Substation Out of Service	Feeder	Transfer to Substation	Transfer to Feeder	NOTES
MURPHYSVILLE	2	FLEMINGSBURG	2	Close SW250657004.
	3	STONEWALL	2	Close N.O. pt. at CO29661.
	4	MAYSVILLE INDUSTRIAL	4	Close SW751.
	5	RECTORVILLE	4	Close SW868.
OAK RIDGE	3	CHARTERS	2	Close SW220772001.
	4	CHARTERS	5	Close N.O. pt. at CO17990.
	5	FLEMINGSBURG	3	Close SW260656005.
PEASTICKS	2	HILLSBORO	1	Close SW260. Sub regulators are within constraints when considering winter 125% uprate.
	3	SHARKEY	4	Close SW74. Slight low voltage near SW74. No customers affected.
	4	HILLSBORO	1	Close SW268. Sub regulators are within constraints when considering winter 125% uprate.
	5	SHARKEY	4	Close SW440208002.
PLUMMERS LANDING	2	FLEMINGSBURG	5	Close SW330102003.
	3	FLEMINGSBURG	5	Feed via transfer bus.
	5	HILLSBORO	4	Close SW330552001.
RECTORVILLE	2	MURPHYSVILLE	5	Feed via transfer bus.
	3	OAK RIDGE	5	Close N.O. pt. at CO21357.
	4	MURPHYSVILLE	5	Close SW868.
SHARKEY	2	BIG WOODS	3	Feed via transfer bus.
	3	HILDA 2	3	Close SW390649001. Sub regulators are within constraints when considering winter 125% uprate.
	4	BIG WOODS	3	Close N.O. pt. at OH390216012.
	5	BIG WOODS	3	Feed via transfer bus.
SNOW HILL	2	FLEMINGSBURG	2	Close N.O. pt. at CO14421.
	3	MURPHYSVILLE	2	Close SW250426001.
	4	FLEMINGSBURG	2	Feed via transfer bus.
	5	MURPHYSVILLE	2	Close SW250206002.
CRANSTON	1	HILDA 2	1	Close N.O. pt. at CO1110.
	2	HILDA 2	1	Feed via transfer bus.
STONEWALL	1	MURPHYSVILLE	3	Feed via transfer bus.
	2	MURPHYSVILLE	3	Close N.O. pt. at CO29661.
	3	MURPHYSVILLE	3	Feed via transfer bus.

Table 6-2 Contingency Analysis

Substation Out of Service	Feeder	Feeder Demand (kW)	Transfer to		Substation Backfeeding Load			
			Substation	Feeder	Total Demand (kW)	Max Capacity (kW) [1]	Max Amps (Amps)	Max Reg Capacity (Amps)
BIG WOODS	1	3,360	HILDA 2	4	17,362	23,750	820	900
	2	1,589	HILDA 2	4	17,362	23,750	820	900
	3	1,575	SHARKEY	4	14,477	19,000	160	560
CHARTERS	2	339	OAK RIDGE	3	9,465	16,625	226	336
	3	3,541	RECTORVILLE	3	11,744	16,625	592	614
	4	5,727	-		-	-	-	-
	5	102	OAK RIDGE	4	9,465	16,625	226	336
FLEMINGSBURG	1	2,043	HILLSBORO	3	9,178	23,750	223	336
	2	2,215	MURPHYSVILLE	2	8,106	19,000	197	500
	3	1,187	OAK RIDGE	5	10,265	16,625	241	336
	4	1,701	MURPHYSVILLE	2	8,106	19,000	197	500
	5	3,905	PLUMMERS LANDING	2	11,087	16,625	125	612
HILDA 2	1	1,466	CRANSTON	1	5,257	16,625	250	614
	2	3,804	SHARKEY	3	16,179	19,000	389	560
	3	3,965	SHARKEY	3	16,179	19,000	389	560
	4	3,040	BIG WOODS	1	14,655	19,000	710	1,307
	G1	0	BIG WOODS	1	14,655	19,000	710	1,307
	G2	7	BIG WOODS	1	14,655	19,000	710	1,307
HILLSBORO	1	2,416	PEASTICKS	2	12,514	24,500	321	336
	2	2,074	FLEMINGSBURG	1	14,977	19,000	373	500
	3	1,574	FLEMINGSBURG	1	14,977	19,000	373	500
	4	958	BIG WOODS	3	7,499	19,000	358	1,307
MAYSVILLE INDUSTRIAL	2	623	MURPHYSVILLE	4	10,493	19,000	270	500
	3	3,527	MURPHYSVILLE	4	10,493	19,000	270	500
	4	1,876	MURPHYSVILLE	4	10,493	19,000	270	500
MURPHYSVILLE	2	2,029	FLEMINGSBURG	2	13,183	19,000	324	500
	3	523	STONEWALL	2	5,088	16,625	136	336
	4	744	MAYSVILLE INDUSTRIAL	4	6,787	16,625	164	336
	5	451	RECTORVILLE	4	8,330	16,625	436	614

Substation Out of Service	Feeder	Feeder Demand (kW)	Transfer to		Substation Backfeeding Load			
			Substation	Feeder	Total Demand (kW)	Max Capacity (kW) [1]	Max Amps (Amps)	Max Reg Capacity (Amps)
OAK RIDGE	3	1,035	CHARTERS	2	13,894	16,625	325	336
	4	3,115	CHARTERS	5	13,894	16,625	325	336
	5	4,864	FLEMINGSBURG	3	16,062	19,000	404	500
PEASTICKS	2	1,795	HILLSBORO	1	13,559	23,750	339	336
	3	2,838	SHARKEY	4	17,028	19,000	439	560
	4	4,308	HILLSBORO	1	13,559	23,750	339	336
	5	1,101	SHARKEY	4	17,028	19,000	439	560
PLUMMERS LANDING	2	2,536	FLEMINGSBURG	5	15,815	19,000	385	500
	3	1,966	FLEMINGSBURG	5	15,815	19,000	385	500
	5	2,579	HILLSBORO	4	9,658	23,750	237	336
RECTORVILLE	2	1,224	MURPHYSVILLE	5	8,268	19,000	213	500
	3	3,439	OAK RIDGE	5	12,790	16,625	308	336
	4	3,209	MURPHYSVILLE	5	8,268	19,000	213	500
SHARKEY	2	1,176	BIG WOODS	3	12,761	19,000	620	1,307
	3	6,788	HILDA 2	3	19,195	23,750	907	900
	4	4,912	BIG WOODS	3	12,761	19,000	620	1,307
	5	0	BIG WOODS	3	12,761	19,000	620	1,307
SNOW HILL	2	3,100	FLEMINGSBURG	2	14,308	19,000	346	500
	3	1,847	MURPHYSVILLE	2	6,549	19,000	164	500
	4	501	FLEMINGSBURG	2	14,308	19,000	346	500
	5	1,127	MURPHYSVILLE	2	6,549	19,000	164	500
CRANSTON	1	1,793	HILDA 2	1	16,283	23,750	780	900
	2	1,958	HILDA 2	1	16,283	23,750	780	900
STONEWALL	1	871	MURPHYSVILLE	3	8,589	19,000	204	500
	2	827	MURPHYSVILLE	3	8,589	19,000	204	500
	3	2,861	MURPHYSVILLE	3	8,589	19,000	204	500

[1] Based on 65^0 loading with fans (if installed) and a power factor of 95% . Winter rating.

Contingency Planning Criteria

1. Loading = 80% of projected peak load
2. Allowable voltage levels = 116 V on 3-ph, 114 V on 1-ph
3. Allowable Capacity = 100%
4. Two sets of voltage regulators allowed

Table 6-3 Contingency Analysis Projects – Distribution Lines

Delivery Point	Year	CFR Code	2018 Cost Per Unit	Total (Rounded to $100)	Description	Location / Span Numbers	Miles/ Units	Reason
CHARTERS	2023	301.19	$125,000	$30,000	3-ph 6 ACWC to 3-ph 336 ACSR	OH210555034 to CO21973	0.24	Contingency
HILDA 2	2023	303.01	$12,000	$78,000	Convert 1-ph to 14.4 kV	CO495 downline	6.50	Contingency
HILDA 2	2023	303.02	$22,000	$109,800	Convert 3-ph to 14.4 kV	CO495 downline	4.99	Contingency
HILLSBORO	2023	304.01	$125,000	$898,800	3-ph 1/0, 2/0 ACSR to 3-ph 336 ACSR	CO5567 to CO9939	7.19	Contingency
MAYSVILLE INDUSTRIAL	2023	305.02	$95,000	$15,200	3-ph 2 ACSR to 3-ph 1/0 ACSR	CO24729 to OH29	0.16	Contingency
MURPHYSVILLE	2023	306.07	$95,000	$28,500	3-ph 2 ACSR to 3-ph 1/0 ACSR	CO30511 to OH190438001	0.30	Contingency
MURPHYSVILLE	2023	306.08	$95,000	$10,500	3-ph 2 ACSR to 3-ph 1/0 ACSR	CO-804599953 to CO511904266	0.11	Contingency
MURPHYSVILLE	2023	306.09	$95,000	$400,900	3-ph 2 ACSR to 3-ph 1/0 ACSR	CO29804 to CO24945	4.22	Contingency
MURPHYSVILLE	2023	306.10	$125,000	$242,500	3-ph 1/0 CU to 3-ph 336 ACSR	CO29460 to OH190659018	1.94	Contingency
MURPHYSVILLE	2023	306.11	$125,000	$481,300	3-ph 1/0 CU, 6 ACWC, 2 ACSR to 3-ph 336 ACSR	CO28600 to CO277846335	3.85	Contingency
PLUMMERS LANDING	2023	309.08	$12,000	$490,100	Convert 1-ph to 14.4 kV	CO-1952292198 downline	40.84	Contingency
PLUMMERS LANDING	2023	309.09	$22,000	$156,600	Convert 3-ph to 14.4 kV	CO-1952292198 downline	7.12	Contingency
RECTORVILLE	2023	310.02	$125,000	$717,500	3-ph 1/0 CU, 4/0 ACSR to 3-ph 336 ACSR	OH210542002 to CO28400	5.74	Contingency
SHARKEY	2023	311.08	$125,000	$83,800	3-ph 2 ACSR to 3-ph 336 ACSR	CO2059 to CO2373	0.67	Contingency

CWP Year	Total Line Conversion Costs	Total Line Conversion Miles
2023	$3,743,500	83.87
TOTALS (Site Specific Work)	**$3,743,500**	**83.87**

Table 6-4 Contingency Analysis Projects – Regulators

Delivery Point	Description	Estimated Cost
FLEMINGSBURG	Install 3-100A regulators at SW944	$30,000
FLEMINGSBURG	Install 3-200A regulators at CO16106	$35,000
FLEMINGSBURG	Install 3-231A regulators at OH260878022	$35,000
FLEMINGSBURG	Install 3-200A regulators at OH250866003	$35,000
HILDA 2	Install 3-200A regulators at OH390439014	$35,000
HILDA 2	Install 3-200A regulators at OH400104018	$35,000
HILLSBORO	Install 3-100A regulators at OH320648006	$30,000
HILLSBORO	Install 3-50A regulator at CO5135	$21,000
HILLSBORO	Install 3-200A regulators at OH380427008	$35,000
MURPHYSVILLE	Install 3-200A regulators at OH250428001	$35,000
MURPHYSVILLE	Install 3-200A regulators at CO194944442	$35,000
MURPHYSVILLE	Install 3-200A regulators at CO28649	$35,000
MURPHYSVILLE	Install 3-200A regulators at CO29661	$35,000
OAK RIDGE	Install 3-100A regulators at CO18313	$30,000
OAK RIDGE	Install 3-200A regulators at CO21428	$35,000
PEASTICKS	Install 3-200A regulators at CO9935	$35,000
PLUMMERS LANDING	Install 3-200A regulators at OH330765012	$35,000
RECTORVILLE	Install 3-200A regulators at CO28566	$35,000
SHARKEY	Install 3-328A regulators at CO2130	$50,000
SHARKEY	Install 3-200A regulators at CO2398	$35,000
BIG WOODS	Install 3-200A regulators at OH390217002	$35,000
TOTALS		$721,000

7 Construction Costs

This section shows all relevant costs over the planning period, broken down by RUS loan application codes. The following tables provide additional details and support. Exhibit 6 contains graphs depicting the historical and projected costs.

7.1 Cost Estimate Summary

A summary of the cost estimate by RUS loan application code for 2019 through 2022 is found in Table 7-1 below.

Table 7-1 Cost Estimate Summary

PROJECTIONS	2019	2020	2021	2022	Work Plan Totals
New Construction (Net CIAC)					
New URD and OVHD Service - 100	$939,600	$969,400	$999,000	$1,028,600	$3,936,600
System Improvements					
New Tie Lines - 200 series	$0	$0	$0	$0	$0
Line Conversions (Site-Specific) - 300 series	$1,875,300	$1,840,700	$1,853,400	$1,560,800	$7,130,200
New Substations - 400 series	$0	$0	$0	$0	$0
Existing Substations - 500 series	$0	$0	$0	$0	$0
New Transmission - 800 series	$0	$0	$0	$0	$0
Transformers & Meters - 601	$508,200	$526,400	$542,900	$561,900	$2,139,400
Service Upgrades - 602	$94,400	$97,200	$100,150	$103,150	$394,900
Sectionalizing Equip - 603	$51,200	$52,800	$54,400	$56,000	$214,400
Regulators - 604	$81,000	$100,000	$107,000	$102,000	$390,000
Capacitors - 605	$0	$0	$0	$0	$0
Pole Replacements - 606	$639,600	$657,650	$678,000	$698,350	$2,673,600
Misc. Replacements - 607	$0	$0	$0	$0	$0
Misc. Conductor Replacements - 608 [1]	$97,000	$99,900	$102,900	$106,000	$405,800
Other					
Security Lights - 702	$255,350	$265,100	$270,500	$281,300	$1,072,250
AMI Equipment (excl meters in 601) - 705		$0	$0	$0	$0
TOTAL (NET CIAC)	$4,541,650	$4,609,150	$4,708,250	$4,498,100	$18,357,150
[1] Code 608 includes age & condition replacement projects (primarily replacing aging CWC & URD)					
		Average Per Year			$4,589,300

7.2 New Line Extensions (Code 100)

Table 7-2 New Line Extensions (Code 100)

HISTORICAL (NET CIAC)	2013	2014	2015	2016	2017	5-YR AVG.
Overhead & Underground - 100						
Consumers	362	354	376	370	387	370
Miles: Primary + Secondary	14.1	14.75	17.8	15.36	15.95	15.6
Total Cost	$876,197	$967,655	$1,041,467	$854,211	$955,989	$939,104
Cost/Consumer	$2,420	$2,733	$2,770	$2,309	$2,470	$2,539
Total Cost - New Services	**$876,197**	**$967,655**	**$1,041,467**	**$854,211**	**$955,989**	**$939,104**

PROJECTED (NET CIAC)	2019	2020	2021	2022	Work Plan Totals
Overhead & Underground - 100					
Consumers	370	370	370	370	1480
Miles: Primary + Secondary	15.6	15.6	15.6	15.6	62.4
Total Cost	$939,612	$969,400	$999,000	$1,028,600	$3,936,612
Cost/Consumer	$2,539	$2,620	$2,700	$2,780	$2,660
Total Cost - New Services	**$939,612**	**$969,400**	**$999,000**	**$1,028,600**	**$3,936,612**

7.3 Site Specific System Improvements

Table 7-3 Code 300 Projects by Substation

Delivery Point	Year	CFR Code	2018 Cost Per Unit	Total (Rounded to $100)	Description	Location / Span Numbers	Miles/ Units	Reason
BIG WOODS	2022	313.01	$65,000	$43,600	1-ph 4, 4/0 ACSR to 2-ph 1/0, 4/0 ACSR	CO3331 to CO3054	0.67	Current > 50 Amps
BIG WOODS	2021	313.02	$125,000	$86,300	3-ph 4/0 ACSR to 3-ph 336 ACSR	CO3417 to CO3273	0.69	Current > 50% Ampacity
BIG WOODS	2022	313.03	$90,000	$56,700	1-ph 2 ACSR to 3-ph 1/0 ACSR	CO3508 to CO4989	0.63	Voltage
BIG WOODS	2022	313.04	$90,000	$24,300	1-ph 2, 4 ACSR to 3-ph 1/0 ACSR	CO5000 to OH330879005	0.27	Voltage
CHARTERS	2022	301.01	$12,000	$146,400	Convert 1-ph to 14.4 kV	CO23097 to CO22905	12.20	Current > 50 Amps
CHARTERS	2021	301.03	$55,000	$57,200	1-ph 2, 4 ACSR to 1-ph 1/0 ACSR	CO22561 to CO22668	1.04	Voltage
CHARTERS	2020	301.04	$12,000	$56,900	Convert 1-ph to 14.4 kV	CO22559 to CO21698	4.74	Voltage, Current > 50% Ampacity
CHARTERS	2020	301.05	$22,000	$29,900	Convert 3-ph to 14.4 kV	CO22559 to CO21698	1.36	Voltage, Current > 50% Ampacity
CHARTERS	2021	301.08	$65,000	$41,000	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO6963 to OH290554003	0.63	Voltage
CHARTERS	2021	301.09	$12,000	$81,200	Convert 1-ph to 14.4 kV	ST220438001 downline	6.77	Voltage
CHARTERS	2021	301.10	$22,000	$16,100	Convert 3-ph to 14.4 kV	ST220438001 downline	0.73	Voltage
CHARTERS	2021	301.11	$12,000	$156,100	Convert 1-ph, 2-ph to 14.4 kV	ST230438001 downline	13.01	Voltage
CHARTERS	2021	301.12	$22,000	$7,900	Convert 3-ph to 14.4 kV	ST230438001 downline	0.36	Voltage
CHARTERS	2021	301.13	$12,000	$120,000	Convert 1-ph to 14.4 kV	ST230765002 downline	10.00	Voltage
CHARTERS	2019	301.15	$12,000	$213,400	Convert 1-ph to 14.4 kV	AU55 to OC280437001 and CO7181	17.78	Voltage
CHARTERS	2019	301.16	$22,000	$60,500	Convert 3-ph to 14.4 kV	AU55 downline	2.75	Voltage
CHARTERS	2019	301.17	$125,000	$422,500	1-ph 2, 4 ACSR to 3-ph 336 ACSR	CO17761 to CO17952	3.38	Voltage
CHARTERS	2019	301.18	$125,000	$323,800	3-ph 1/0 ACSR to 3-ph 336 ACSR	C17960 to CO17820	2.59	Voltage
FLEMINGSBURG	2021	302.01	$12,000	$91,800	Convert 1-ph to 14.4 kV	ST270762001 downline	7.65	Voltage
FLEMINGSBURG	2021	302.02	$12,000	$69,400	Convert 1-ph to 14.4 kV	ST270774001 downline	5.78	Voltage
FLEMINGSBURG	2021	302.03	$12,000	$143,600	Convert 1-ph to 14.4 kV	AU45 downline	11.97	Voltage
HILDA 2	2022	303.03	$125,000	$41,300	3-ph 1/0 ACSR to 3-ph 336 ACSR	CO4119 to OH340774023	0.33	Current > 50% Ampacity

Delivery Point	Year	CFR Code	2018 Cost Per Unit	Total (Rounded to $100)	Description	Location / Span Numbers	Miles/ Units	Reason
MAYSVILLE INDUSTRIAL	2020	305.01	$65,000	$279,500	1-ph 4, 1/0 ACSR to 2-ph 1/0 ACSR	CO30702 to CO210142144	4.30	Current > 50 Amps
MURPHYSVILLE	2022	306.04	$65,000	$196,300	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO29734 to CO29859	3.02	Current > 50 Amps
MURPHYSVILLE	2022	306.05	$12,000	$83,400	Convert 1-ph to 14.4 kV	ST240429001 downline	6.95	Current > 50 Amps
MURPHYSVILLE	2022	306.06	$65,000	$29,300	1-ph 4 ACSR to 2-ph 1/0 ACSR	CO27652 to OH240426006	0.45	Current > 50 Amps
OAK RIDGE	2021	307.01	$12,000	$58,000	Convert 1-ph to 14.4 kV	ST210774001 downline	4.83	Voltage
OAK RIDGE	2021	307.02	$12,000	$79,700	Convert 1-ph to 14.4 kV	AU59 downline	6.64	Voltage
OAK RIDGE	2021	307.03	$12,000	$30,100	Convert 1-ph to 14.4 kV	AU40 to RG260649001	2.51	Voltage
OAK RIDGE	2021	307.04	$12,000	$6,200	Convert 1-ph to 14.4 kV	ST260656001 downline	0.52	Voltage
OAK RIDGE	2021	307.05	$12,000	$199,800	Convert 1-ph to 14.4 kV	AU8 downline	16.65	Voltage
OAK RIDGE	2019	307.07	$125,000	$296,300	3-ph 2, 1/0 ACSR to 3-ph 336 ACSR	CO-82601623 to OH270649005	2.37	Voltage
OAK RIDGE	2019	307.08	$12,000	$105,000	Convert 1-ph to 14.4 kV	AU7 downline	8.75	Voltage
OAK RIDGE	2019	307.09	$125,000	$453,800	1-ph 4 ACSR to 3-ph 336 ACSR	CO7936 to CO17953	3.63	Voltage
PEASTICKS	2022	308.01	$65,000	$50,100	1-ph 2, 4 ACSR to 2-ph 1/0 ACSR	CO9354 to CO9508	0.77	Current > 50 Amps
PEASTICKS	2022	308.02	$65,000	$92,300	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO8664 to CO8405	1.42	Current > 50 Amps
PEASTICKS	2022	308.03	$65,000	$126,100	1-ph 4 ACSR to 2-ph 1/0 ACSR	CO9134 to OH370878008	1.94	Current > 50 Amps
PEASTICKS	2020	308.04	$12,000	$83,600	Convert 1-ph to 14.4 kV	AU11 downline	6.97	Voltage, Current > 50 Amps
PEASTICKS	2020	308.05	$125,000	$590,000	3-ph 2, 1/0 ACSR to 3-ph 336 ACSR	CO-689687084 to CO2372	4.72	Voltage, Current > 50% Ampacity
PEASTICKS	2021	308.06	$12,000	$82,900	Convert 1-ph to 14.4 kV	AU12 downline	6.91	Voltage
PEASTICKS	2021	308.07	$55,000	$5,500	1-ph 4 ACSR to 1-ph 1/0 ACSR	CO10685 to OH370878002	0.10	Voltage

Delivery Point	Year	CFR Code	2018 Cost Per Unit	Total (Rounded to $100)	Description	Location / Span Numbers	Miles/ Units	Reason
PLUMMERS LANDING	2022	309.01	$65,000	$73,500	1-ph 4, 1/0 ACSR to 2-ph 1/0 ACSR	CO6370 to CO6683	1.13	Current > 50 Amps
PLUMMERS LANDING	2022	309.02	$65,000	$42,300	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO6377 to CO6552	0.65	Current > 50 Amps
PLUMMERS LANDING	2021	309.03	$90,000	$354,600	1-ph 2, 4 ACSR to 3-ph 1/0 ACSR	CO5877 to OH330206011	3.94	Current >100 Amps
PLUMMERS LANDING	2021	309.04	$65,000	$99,500	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO6339 to OH270876003	1.53	Current > 50 Amps
PLUMMERS LANDING	2022	309.05	$65,000	$96,900	1-ph 4 ACSR, 6 ACWC to 2-ph 1/0 ACSR	CO5885 to CO6249	1.49	Current > 50 Amps
PLUMMERS LANDING	2022	309.06	$65,000	$111,200	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO5734 to CO6123	1.71	Current > 50 Amps
RECTORVILLE	2020	310.01	$150,000	$649,500	3-ph 4/0 ACSR, 1/0 CU to 3-ph 556 ACSR	CO22364 to CO22457	4.33	Voltage, Current > 50% Ampacity, Contingency
SHARKEY	2022	311.01	$65,000	$79,300	1-ph 4 ACSR to 2-ph 1/0 ACSR	CO2004 to OH390657017	1.22	Current > 50 Amps
SHARKEY	2022	311.02	$65,000	$7,200	1-ph 2 ACSR to 2-ph 1/0 ACSR	CO-415726902 to OH390647015	0.11	Current > 50 Amps
SHARKEY	2022	311.03	$65,000	$16,300	1-ph 4 ACSR to 2-ph 1/0 ACSR	CO1686 to OH390657022	0.25	Current > 50 Amps
SHARKEY	2022	311.04	$125,000	$128,800	3-ph 1/0 ACSR to 3-ph 336 ACSR	CO2575 to OH390436022	1.03	Voltage, Current > 50% Ampacity, Contingency
SHARKEY	2021	311.05	$12,000	$66,500	Convert 1-ph to 14.4 kV	AU3 to CO1055634389	5.54	Voltage, Current > 50 Amps
SHARKEY	2020	311.06	$125,000	$151,300	3-ph 1/0 ACSR to 3-ph 336 ACSR	CO2579 to CO2019	1.21	Current > 70% Ampacity
SNOW HILL	2022	312.01	$12,000	$102,500	Convert 1-ph to 14.4 kV	AU26 to CO13608	8.54	Voltage
SNOW HILL	2022	312.02	$12,000	$13,000	Convert 1-ph to 14.4 kV	ST360429001 to CO17161	1.08	Voltage

CWP Year	Total Line Conversion Costs	Total Line Conversion Miles
2019	$1,875,300	41.25
2020	$1,840,700	27.63
2021	$1,853,400	107.80
2022	$1,560,800	45.86
TOTALS (Site Specific Work)	**$7,130,200**	**222.54**

Table 7-4 Substation Costs (Code 400, 500 & 800)

Substation	CWP Year	CWP Project Code	Description	[1] CWP Cost 2018 $s
Cranston	2019	414.1	New 138-13.2 kV 12/16/20 MVA Sub ($1,725,000)	$0
Cranston	2019	414.2	New 138 kV Tap Line	$0
Stonewall	2019	415.1	New 138-26.4 kV 12/16/20 MVA Sub ($1,775,000)	$0
Stonewall	2019	415.2	New 138 kV Tap Line	$0
			SUBSTATION WORK TOTALS (2018 $)	**$0**

[1] All cost associated with substations and transmission investment is immediately absorbed by EKPC. Maintenance cost paid by FME to EKPC will increase, but no immediate costs are incurred by FME.

Table 7-5 Code 604 Voltage Regulator Projects

Code	Delivery Point	Description	Primary Justification	Year	Estimated Cost
604.01A	CHARTERS	Move regulator bank RG150878001 to CO22905	Voltage	2022	*
604.01B	CHARTERS	Install 3-200A regulators at CO30560	Voltage, Contingency	2020	$35,000
604.01D	CHARTERS	Move regulator bank RG230555001 to CO19548	Voltage	2019	*
604.01E	CHARTERS	Move regulator bank RG300397347 to CO7181	Voltage	2019	*
604.03A	HILDA 2	Install 3-100A regulators at CO4286	Voltage	2019	$30,000
604.03B	HILDA 2	Remove regulator RG26	Superseded by 414.01, 414.02	2019	*
604.04A	HILLSBORO	Install 1-50A regulator at OH330774027	Voltage	2022	$7,000
604.04B	HILLSBORO	Install 3-100A regulators at OH320772008	Voltage	2020	$30,000
604.05A	MAYSVILLE IND	Install 3-200A regulators at CO23905	Voltage, Contingency	2020	$35,000
604.05B	MAYSVILLE IND	Remove regulator REG34	Superseded by 604.05A, 305.01	2020	*
604.06A	MURPHYSVILLE	Move regulator RG634842757 to CO28663	Voltage	2019	*
604.06B	MURPHYSVILLE	Remove regulator RG240439001	Superseded by 415.1, 415.2	2019	*
604.06C	MURPHYSVILLE	Install 1-50A regulator at CO27673	Voltage	2021	$7,000
604.07A	OAK RIDGE	Install 1-50A regulator at OH260216013	Voltage	2021	$7,000
604.08A	PEASTICKS	Install 3-200A regulators at CO8524	Voltage	2021	$35,000
604.08B	PEASTICKS	Install 3-200A regulators at CO8767	Voltage	2022	$35,000
604.08C	PEASTICKS	Remove regulator RG29378565	Superseded by 604.08B	2019	*
604.08D	PEASTICKS	Remove regulator REG57	Superseded by 604.08B	2019	*
604.08E	PEASTICKS	Install 3-100A regulators at CO11195	Voltage	2021	$30,000
604.08G	PEASTICKS	Install 1-50A regulators at CO9221	Voltage	2021	$7,000
604.09A	PLUMMERS LANDING	Remove regulator REG330206001	Superseded by 604.09B, 309.03, 309.04	2019	*
604.09B	PLUMMERS LANDING	Install 3-50A regulators at CO6221	Voltage	2021	$21,000
604.09C	PLUMMERS LANDING	Install 3-100A regulators at CO5840	Voltage	2022	$30,000
604.09D	PLUMMERS LANDING	Install 3-100A regulators at CO4885	Voltage	2022	$30,000
604.10A	RECTORVILLE	Move regulator bank RG13 to OH210555042	Voltage	2019	*
604.10B	RECTORVILLE	Install 1-50A regulator at CO22264	Voltage	2019	$7,000
604.12A	SNOW HILL	Install 1-50A regulator at CO25061	Voltage	2019	$7,000
604.12B	SNOW HILL	Install 3-100A regulators at OH360429010	Voltage	2019	$30,000
604.12C	SNOW HILL	Install 1-50A regulator at CO14569	Voltage	2019	$7,000
TOTALS				2019	$81,000
TOTALS				2020	$100,000
TOTALS				2021	$107,000
TOTALS				2022	$102,000

*** These jobs represent operational items and therefore the dollars are not included as capital improvements in the CWP dollars.**

7.4 Code 600 Items

Table 7-6 Historical Data - Code 601 Transformers and Meters

HISTORICAL	2013	2014	2015	2016	2017	5-YR AVG.
Transformers - 601						
PADMOUNT						
Number	26	23	36	17	26	26
Total Cost	63,461	85,682	95,599	86,626	94,584	$85,190
Cost/Padmount Transformer	$2,441	$3,725	$2,656	$5,096	$3,638	$3,328
OVERHEAD						
Number	314	153	260	313	152	238
Total Cost	$360,880	$193,195	$308,426	$352,055	$171,199	$277,151
Cost/Overhead Transformer	$1,149	$1,263	$1,186	$1,125	$1,126	$1,163
Meters & Meter Bases - 601						
METERS						
Number	6,247	11,669	8,367	560	1,006	5570
Total Cost	$758,733	$1,556,563	$1,041,480	$154,669	$172,653	$736,820
Cost/Meter	$121	$133	$124	$276	$172	$132
Total Transformers & Meters - 601	$1,183,074	$1,835,440	$1,445,505	$593,350	$438,436	$1,099,161

Table 7-7 Projections — Code 601 Transformers & Meters

PROJECTED	2019	2020	2021	2022	Work Plan Totals
Transformers - 601					
PADMOUNT					
Number	26	26	26	26	104
Total Cost	$86,580	$89,180	$91,780	$94,640	$362,180
Cost/Padmount Transformer	$3,330	$3,430	$3,530	$3,640	$3,483
OVERHEAD					
Number	238	238	238	238	952
Total Cost	$276,080	$283,220	$292,740	$302,260	$1,154,300
Cost/Overhead Transformer	$1,160	$1,190	$1,230	$1,270	$1,213
Meters & Meter Bases - 601					
METERS [1]					
Number	1,100	1,100	1,100	1,100	4400
Total Cost	$145,517	$154,000	$158,400	$165,000	$622,917
Cost/Meter	$132	$140	$144	$150	$142
Total Transformers & Meters - 601	$508,177	$526,400	$542,920	$561,900	$2,139,397

[1] The annual number of new meters is expected to decrease significantly compared to 2013 to 2015 numbers. Those historical numbers were inflated during an AMI deployment.

Table 7-8 Historical Data – Other Code 600 Items

HISTORICAL	2013	2014	2015	2016	2017	5-YR AVG.
Service Upgrades - 602						
Number						-
Cost	$192,738	$104,965	$38,525	$80,199	$55,465	$94,378
Cost/Upgrade	-	-	-	-	-	-
Sectionalizing Equipment - 603						
SECTIONALIZING DEVICES						
Number	26	13	30	13	0	16
Cost	$40,004	$66,680	$102,024	$53,553	$0	$52,452
Cost/Sectionalizing Device	$1,539	$5,129	$3,401	$4,119	-	$3,198
Total Sectionalizing Equipment - 603	$40,004	$66,680	$102,024	$53,553	$0	$52,452
Pole Replacement - 606						
Number	192	180	168	315	275	226
Cost	$393,121	$525,562	$408,678	$877,918	$997,422	$640,540
Cost/Pole	$2,048	$2,920	$2,433	$2,787	$3,627	$2,834
Misc. Conductor Replacements - 608						
Miles	2.84	3.01	0.001	0	5.39	2.2482
Cost	$177,282	$21,609	$2,426	$0	$294,677	$99,199
Cost/Mile	$62,423	$7,179	$2,426,000	-	$54,671	$44,124

Table 7-9 Projections – Other 600 Code Items

PROJECTED	2019	2020	2021	2022	Work Plan Totals
Service Upgrades - 602					
Number					
Cost	$94,378	$97,210	$100,126	$103,130	$394,844
Cost/Upgrade					
Sectionalizing Equipment - 603 (non-site-specific)					
SECTIONALIZING DEVICES					
Number	16	16	16	16	64
Cost	$51,200	$52,800	$54,400	$56,000	$214,400
Cost/Sectionalizing Device	$3,200	$3,300	$3,400	$3,500	$3,350
Total Sectionalizing Equipment - 603	$51,200	$52,800	$54,400	$56,000	$214,400
Pole Replacement - 606					
Number	226	226	226	226	904
Cost	$639,580	$657,660	$678,000	$698,340	$2,673,580
Cost/Pole	$2,830	$2,910	$3,000	$3,090	$2,958
Misc. Conductor Replacements - 608					
Miles	2.2	2.2	2.2	2.2	8.8
Cost	$97,020	$99,924	$102,916	$105,996	$405,856
Cost/Mile	$44,100	$45,420	$46,780	$48,180	$46,120

7.5 Code 700 Items

Table 7-10 Code 700 Historical Data

HISTORICAL	2013	2014	2015	2016	2017	5-YR AVG.
Security Lights - 702						
Number	132	103	427	723	1318	541
Cost	$90,675	$91,853	$184,386	$284,082	$624,713	$255,142
Cost/Light	$687	$892	$432	$393	$474	$472

Table 7-11 Code 700 Projections

PROJECTED	2019	2020	2021	2022	Work Plan Totals
Security Lights - 702					
Number	541	541	541	541	2164
Cost	$255,331	$265,090	$270,500	$281,320	$1,072,241
Cost/Light	$472	$490	$500	$520	$495

8 Exhibits

Exhibit 1 System Load Data

Year	Energy Requirements		Energy Losses		Energy Usage			Non-Coincident Peak Demand			Annual
	Total Req.	% Chng	Amount	% Loss	Own Use	Cons. Sales	% Chng	Amount	Month	% Chng	Load Factor
	(MWh)	(%)	(MWh)	(%)	(MWh)	(MWh)	(%)	(KW)		(%)	(%)
2008	1,003,258	---	24,803	2.5	663	977,792	---	199,900		---	57.29
2009	935,441	(6.8)	26,639	2.8	647	908,155	(7.1)	202,900		1.5	52.63
2010	891,006	(4.8)	24,945	2.8	661	865,400	(4.7)	171,600		(15.4)	59.27
2011	892,251	0.1	26,428	3.0	595	865,228	(0.0)	2,064,000		1,102.8	4.93
2012	849,667	(4.8)	24,660	2.9	525	824,482	(4.7)	179,100		(91.3)	54.16
2013	863,239	1.6	23,790	2.8	623	838,826	1.7	164,700		(8.0)	59.83
2014	958,271	11.0	27,422	2.9	677	930,172	10.9	215,000		30.5	50.88
2015	881,817	(8.0)	23,046	2.6	577	858,194	(7.7)	213,600		(0.7)	47.13
2016	1,004,335	13.9	21,605	2.2	567	982,163	14.4	190,000		(11.0)	60.34
2017	1,003,316	(0.1)	25,128	2.5	542	977,646	(0.5)	185,300		(2.5)	61.81
2008 - 2012 ACGR		(4.1)		(0.1)			(4.2)			(2.7)	
2012 - 2017 ACGR		3.4		0.4			3.5			0.7	
2008 - 2017 ACGR		0.0		0.1			(0.0)			(0.8)	
AVERAGE				2.7							

CONSUMER DATA

Year	Number of Consumers				Average kWh per Consumer			Cons. Sales Rev ($)	Avg $/KWh	% Chng
	Annual Avg	% Chng	Dec. 31	% Chng	Annual	Monthly	% Chng			
2008	23,804	---	23,824	---	41,077	3,423	---	74,200,183	0.076	---
2009	23,792	(0.1)	23,721	(0.4)	38,171	3,181	(7.1)	68,352,833	0.075	(0.8)
2010	23,822	0.1	23,747	0.1	36,328	3,027	(4.8)	66,194,937	0.076	1.6
2011	23,827	0.0	23,789	0.2	36,313	3,026	(0.0)	69,485,874	0.080	5.0
2012	23,758	(0.3)	23,730	(0.2)	34,703	2,892	(4.4)	68,416,925	0.083	3.3
2013	23,833	0.3	23,790	0.3	35,196	2,933	1.4	70,450,477	0.084	1.2
2014	23,885	0.2	23,868	0.3	38,944	3,245	10.6	75,176,455	0.081	(3.8)
2015	24,010	0.5	24,023	0.6	35,743	2,979	(8.2)	68,469,116	0.080	(1.3)
2016	24,219	0.9	24,266	1.0	40,553	3,379	13.5	71,748,267	0.073	(8.4)
2017	24,355	0.6	24,366	0.4	40,141	3,345	(1.0)	70,144,346	0.072	(1.8)
2008 - 2012 ACGR		(0.0)		(0.1)			(4.1)			2.3
2012 - 2017 ACGR		0.5		0.5			3.0			(2.9)
2008 - 2017 ACGR		0.3		0.3			(0.3)			(0.6)

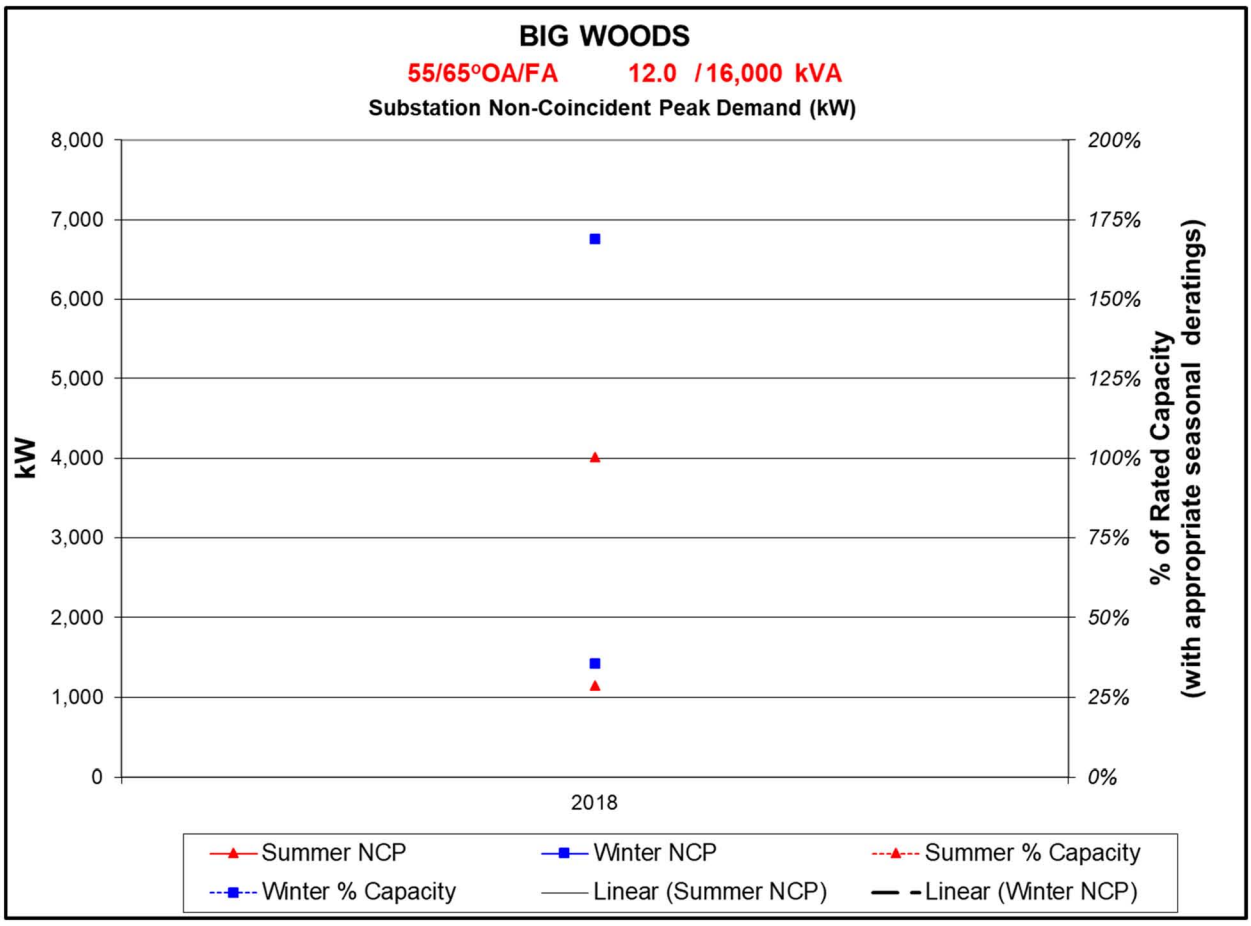
NOTES:

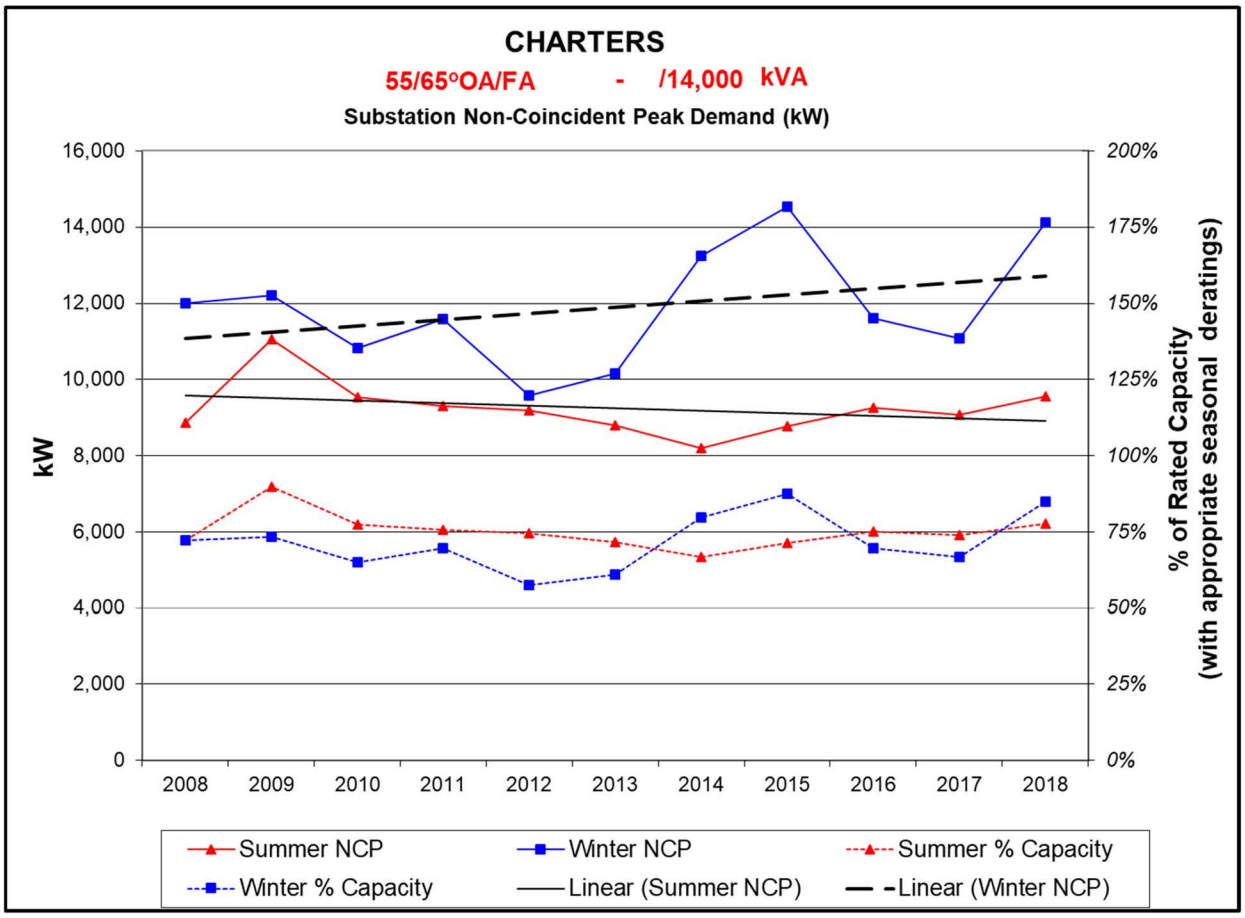
1) Data compiled from RUS Form 7 records.

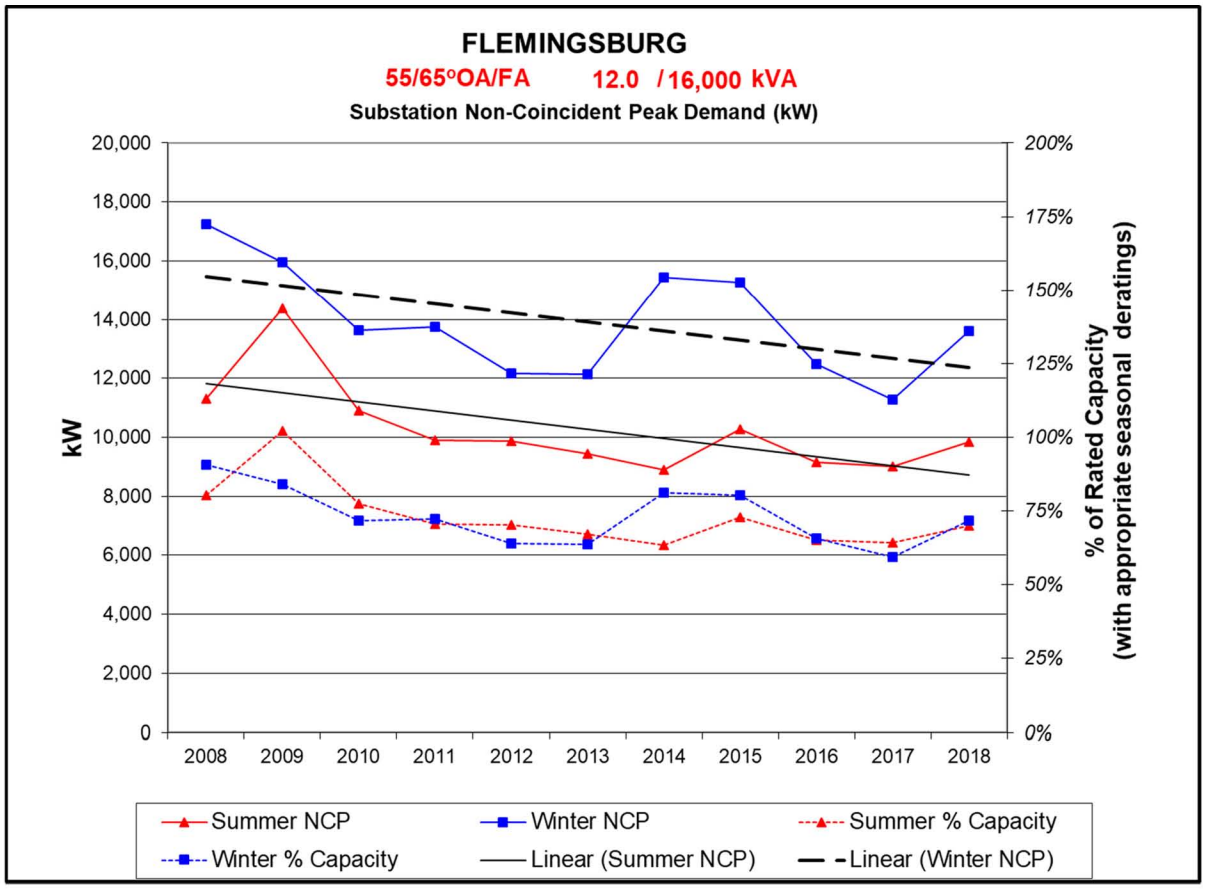
2) The peak demand represents the sum of the coincident metered peak demands of each delivery point for the peak month.

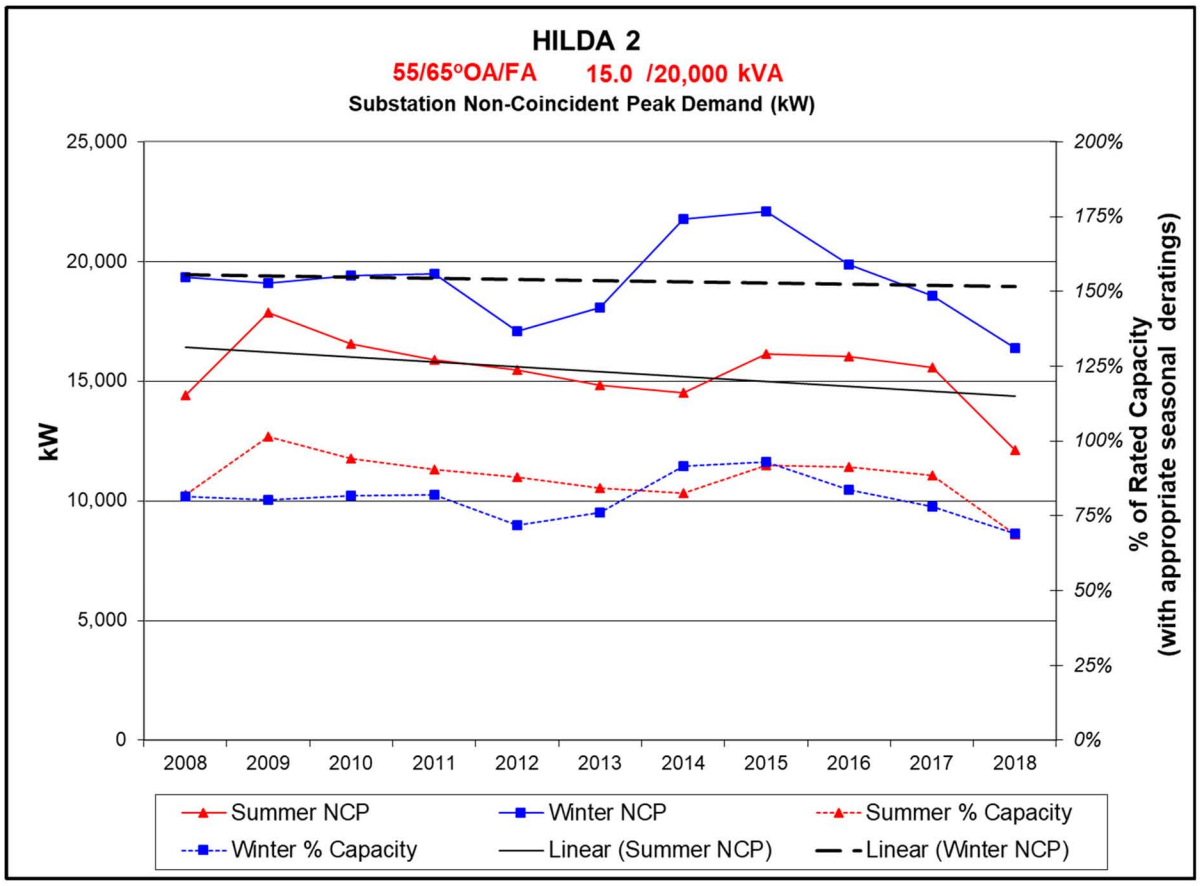
3) ACGR is Annual Compound Growth Rate

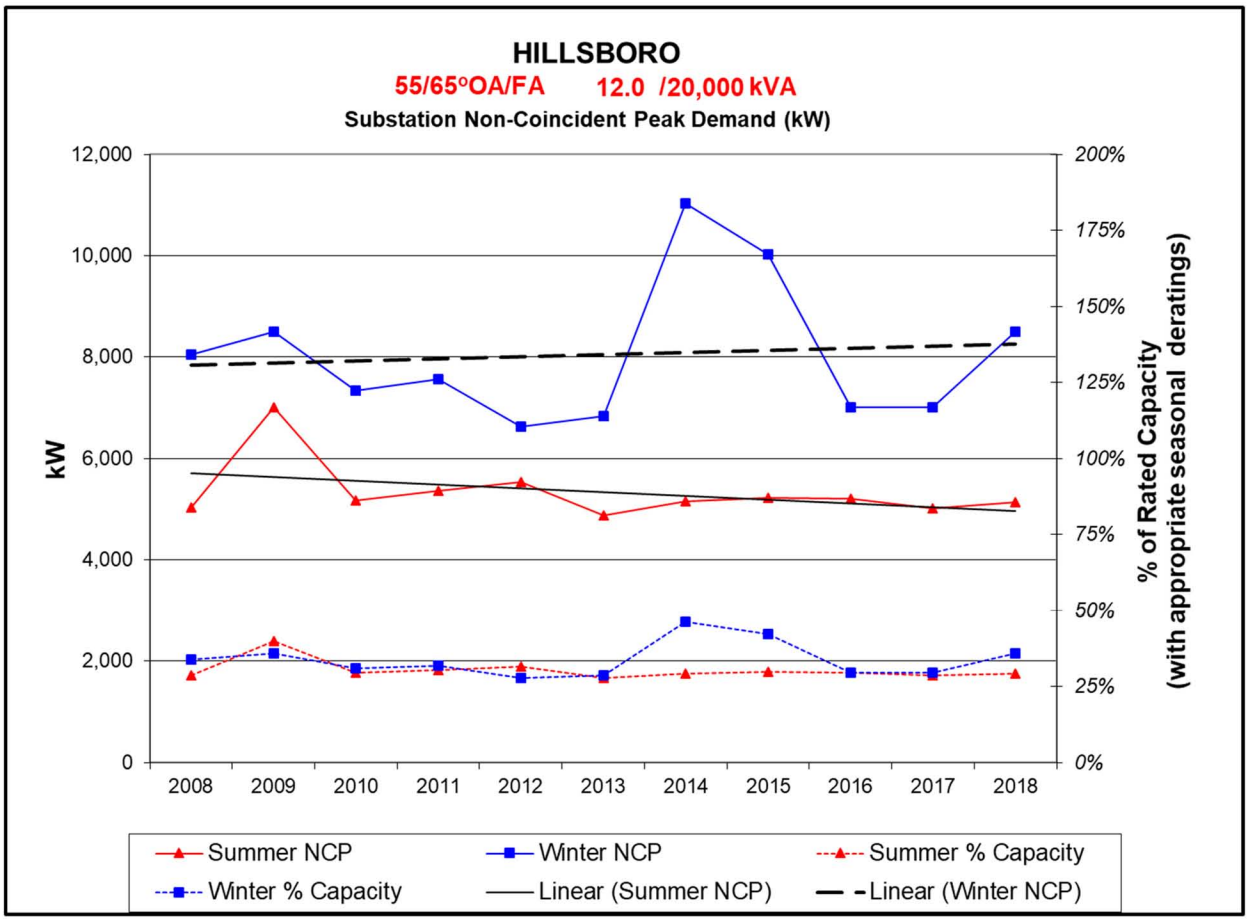
Exhibit 2 Historical Substation Load Data

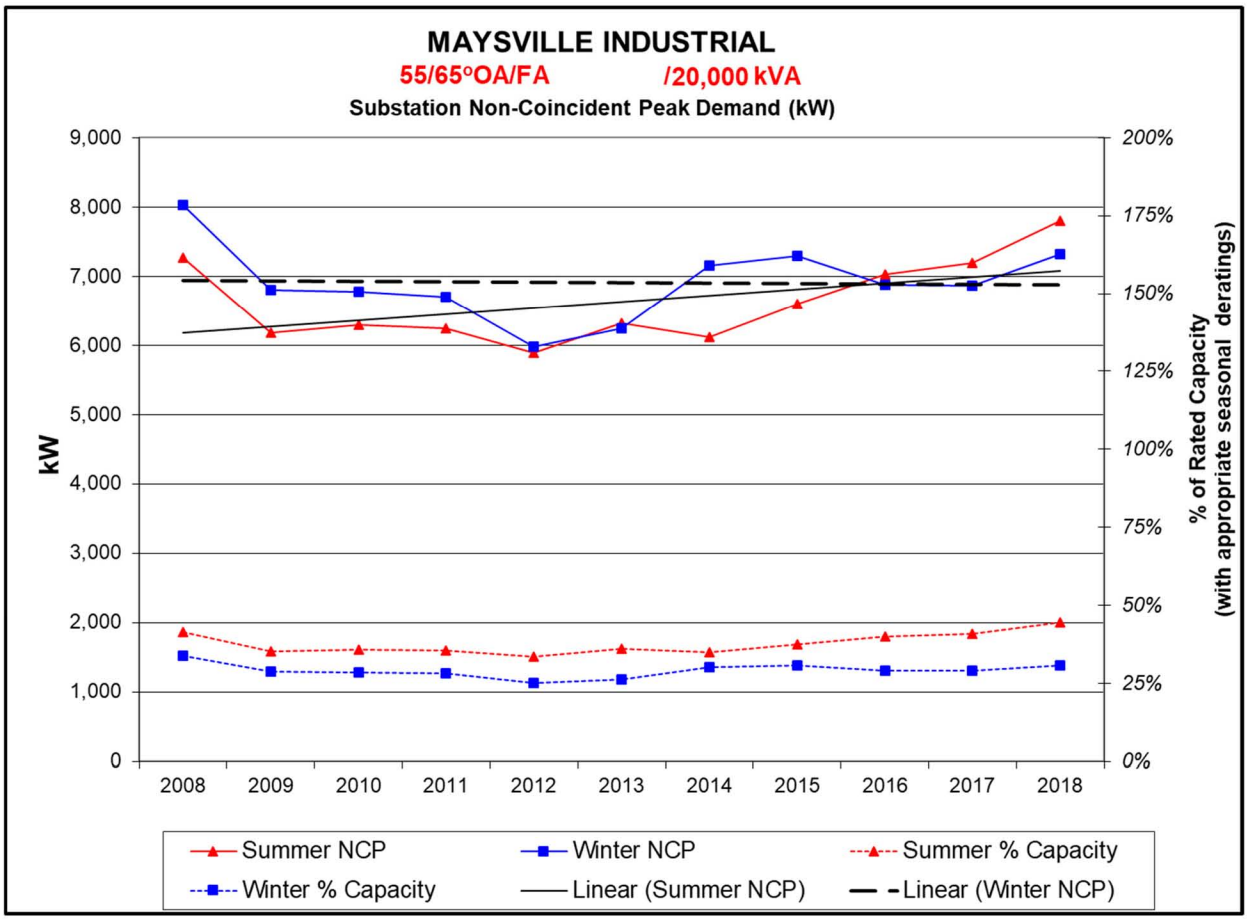


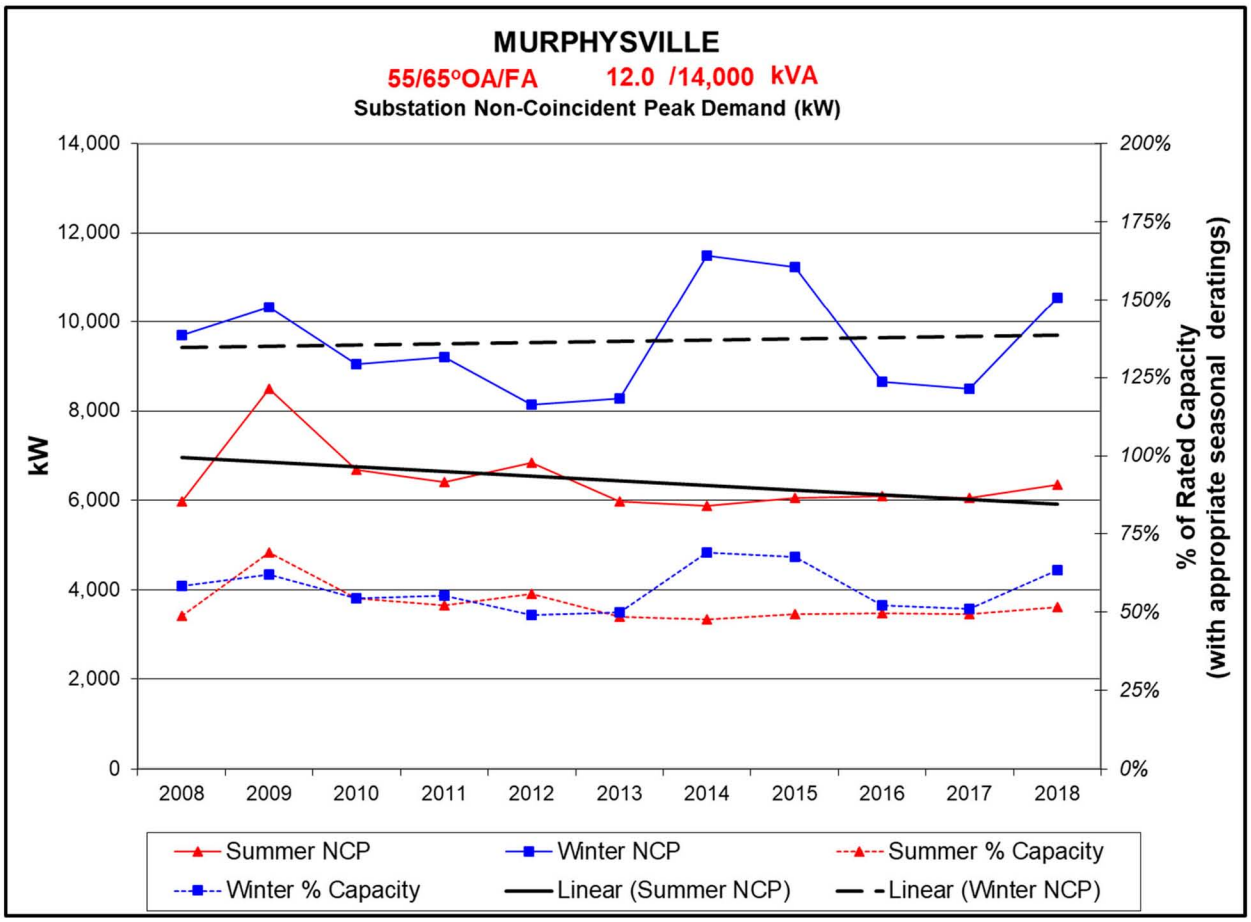

CHARTERS
55/65°OA/FA - /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

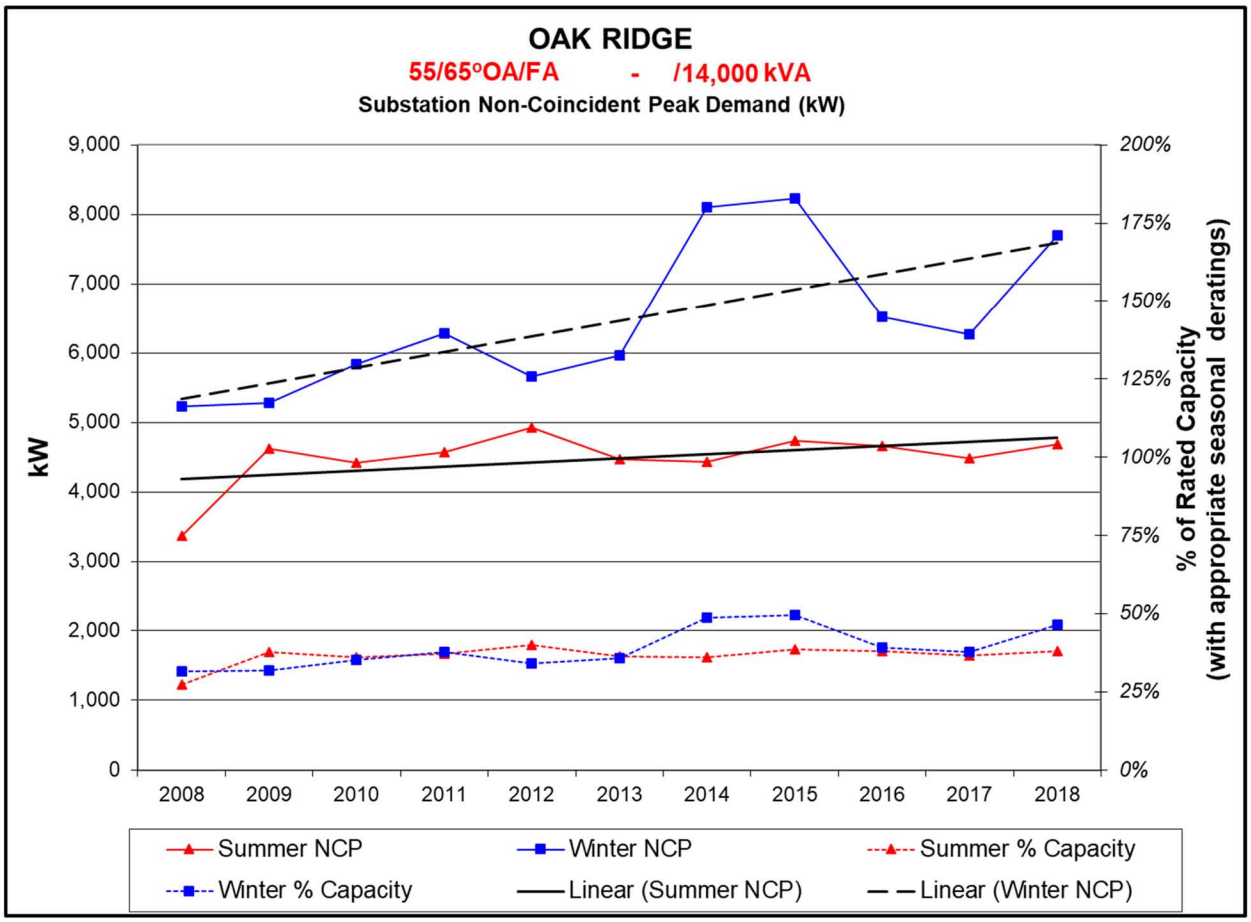

FLEMINGSBURG
55/65°OA/FA 12.0 /16,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

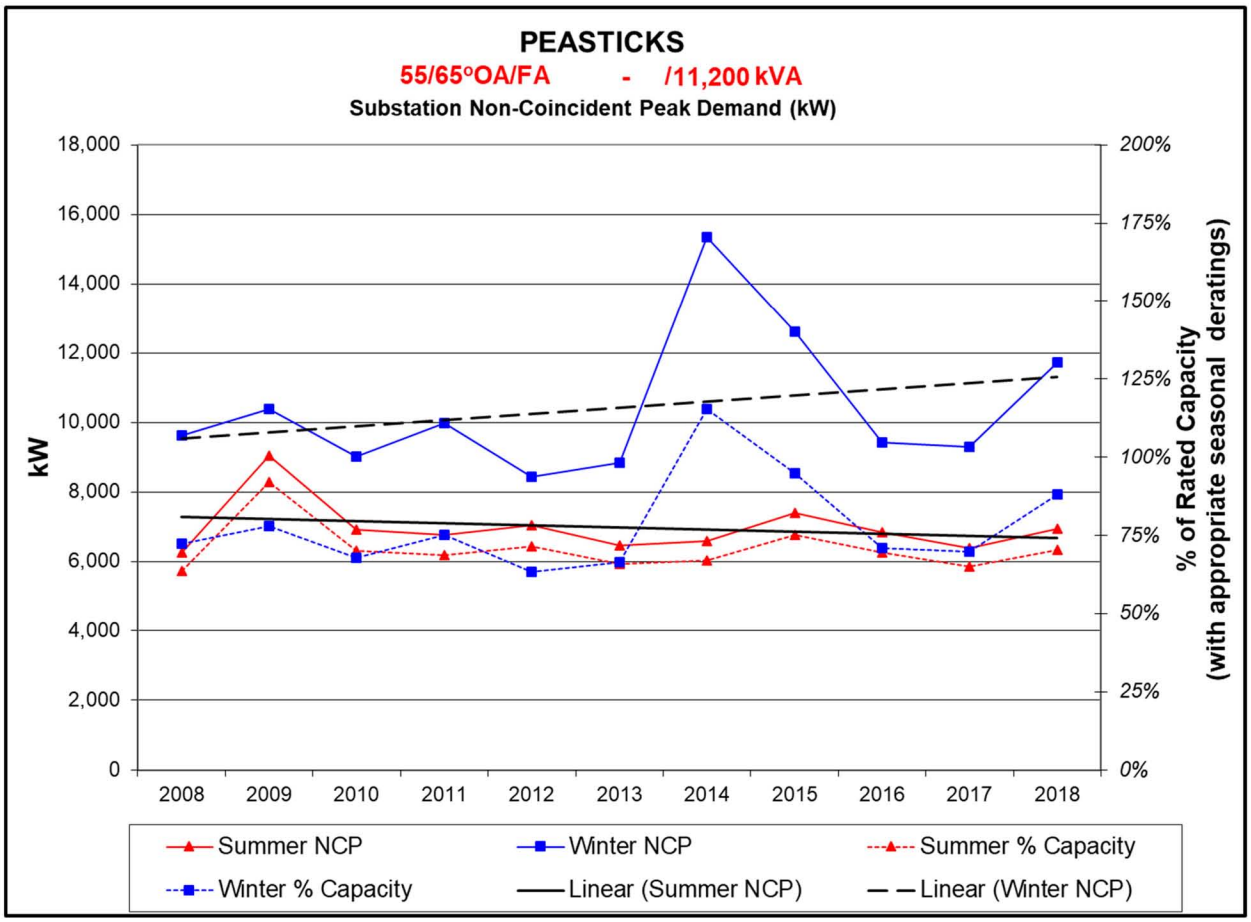

HILDA 2
55/65°OA/FA 15.0 /20,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
25,000
20,000
15,000
10,000
5,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

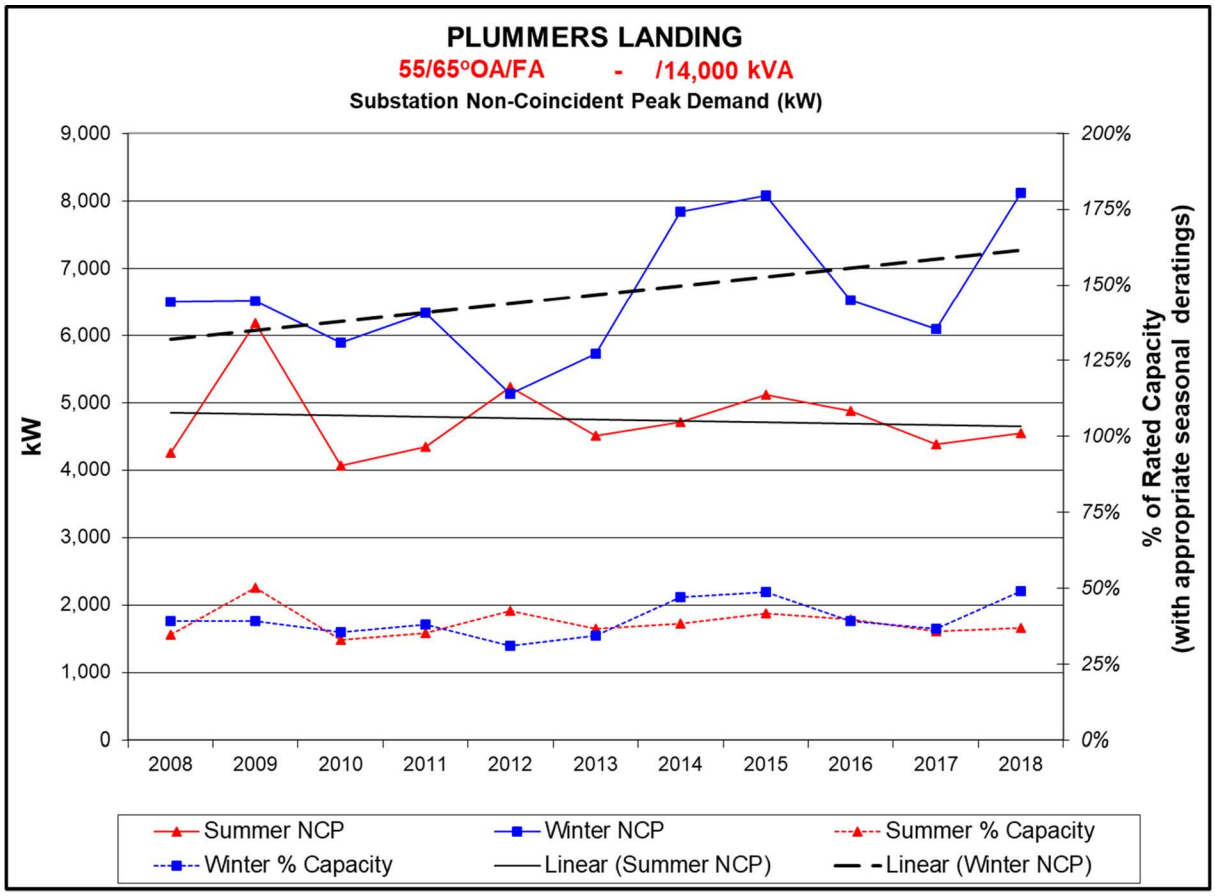

HILLSBORO
55/65°OA/FA 12.0 /20,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

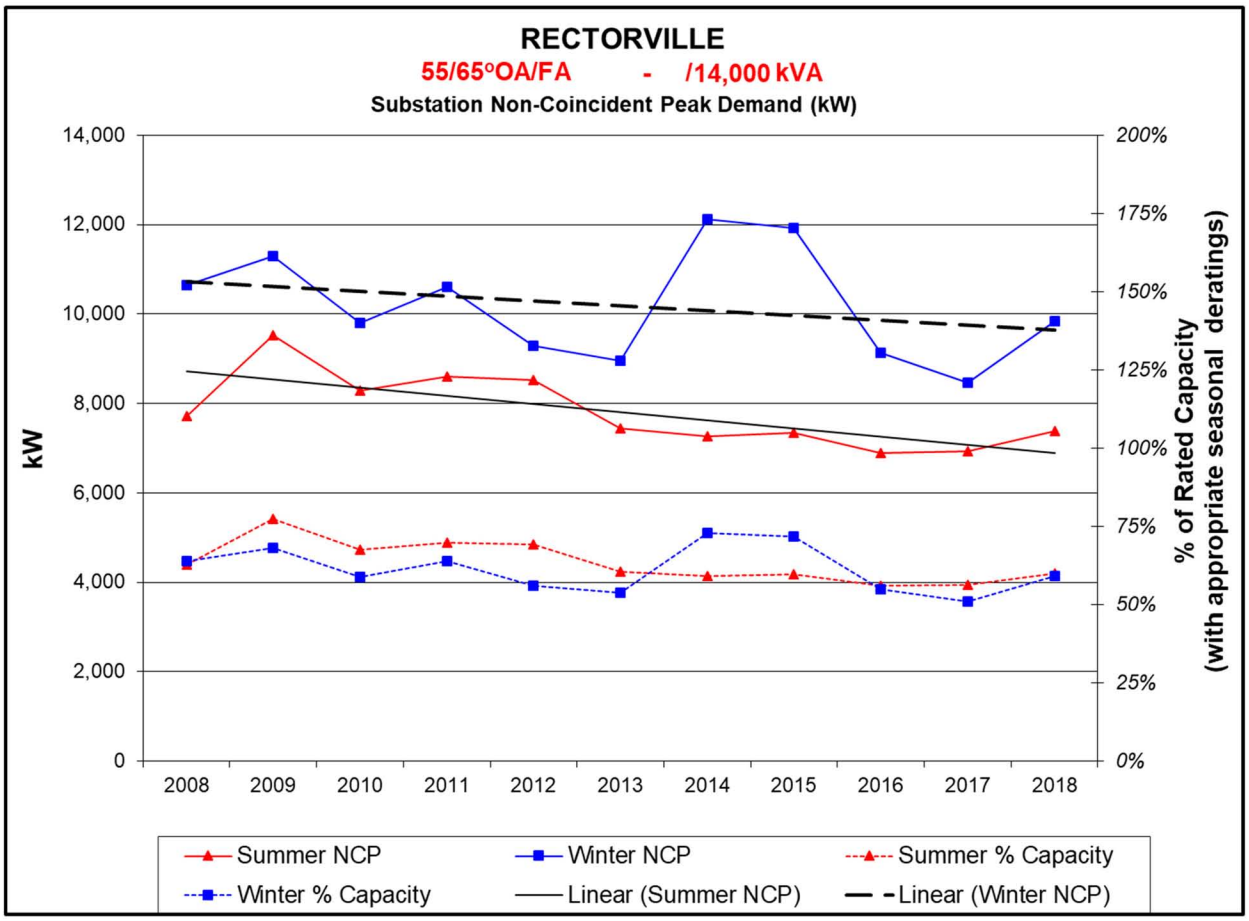

MAYSVILLE INDUSTRIAL
55/65°OA/FA /20,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

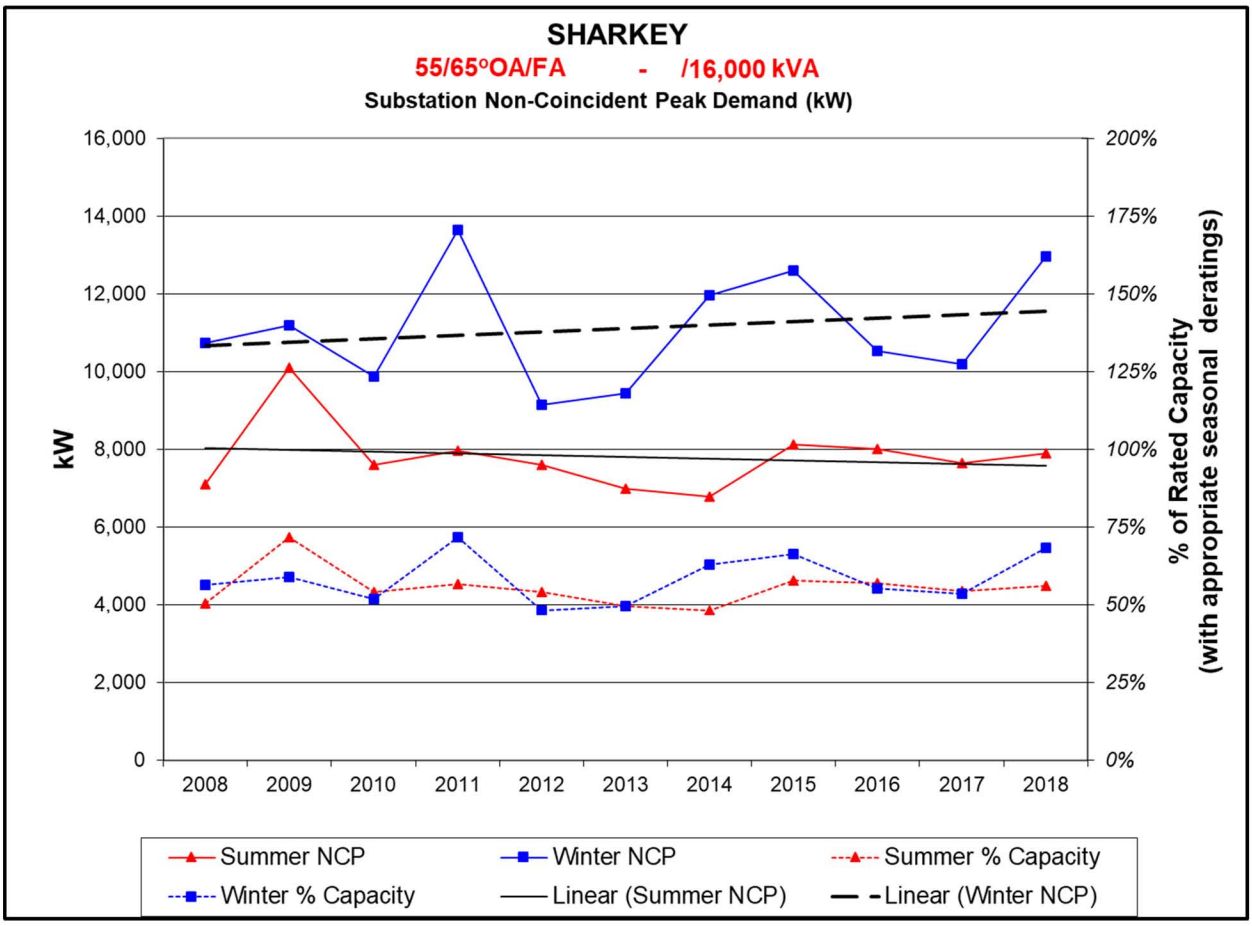

MURPHYSVILLE
55/65°OA/FA 12.0 /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

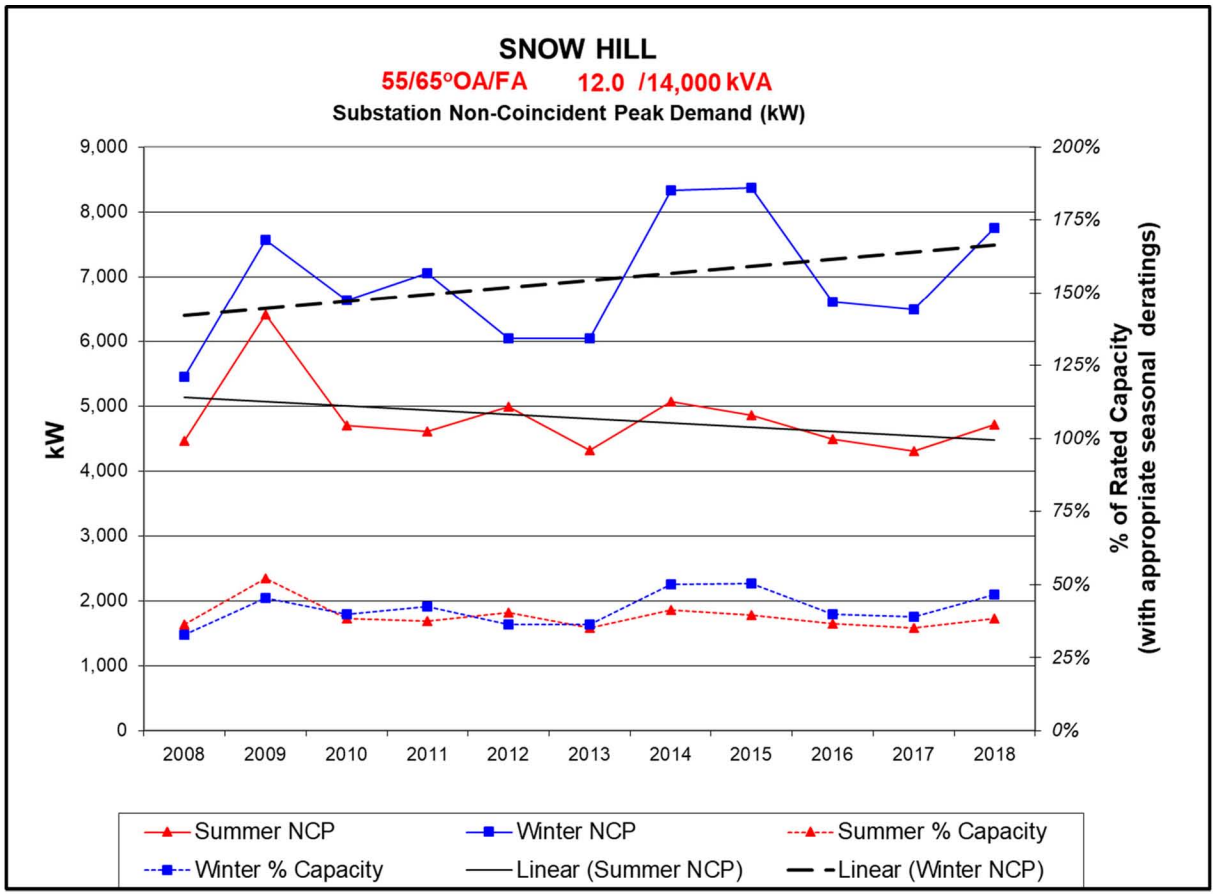

OAK RIDGE
55/65°OA/FA - /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

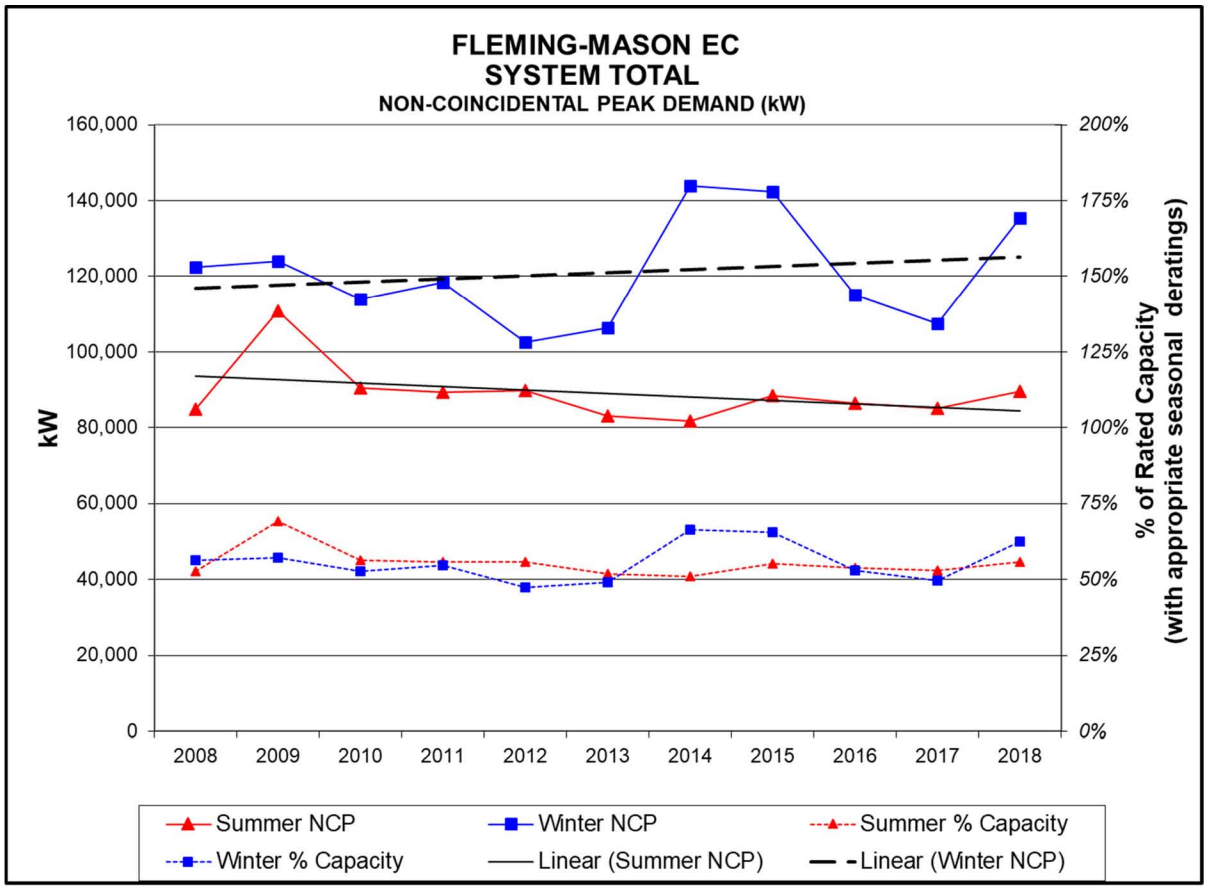

PEASTICKS
55/65°OA/FA - /11,200 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity (with appropriate seasonal deratings)
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)


PLUMMERS LANDING
55/65°OA/FA - /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)


RECTORVILLE
55/65°OA/FA - /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)


SHARKEY
55/65°OA/FA - /16,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
% of Rated Capacity
(with appropriate seasonal deratings)
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)


SNOW HILL
55/65°OA/FA 12.0 /14,000 kVA
Substation Non-Coincident Peak Demand (kW)
kW
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)


FLEMING-MASON EC
SYSTEM TOTAL
NON-COINCIDENTAL PEAK DEMAND (kW)
kW
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
200%
175%
150%
125%
100%
75%
50%
25%
0%
% of Rated Capacity
(with appropriate seasonal deratings)
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
Summer NCP
Winter NCP
Summer % Capacity
Winter % Capacity
Linear (Summer NCP)
Linear (Winter NCP)

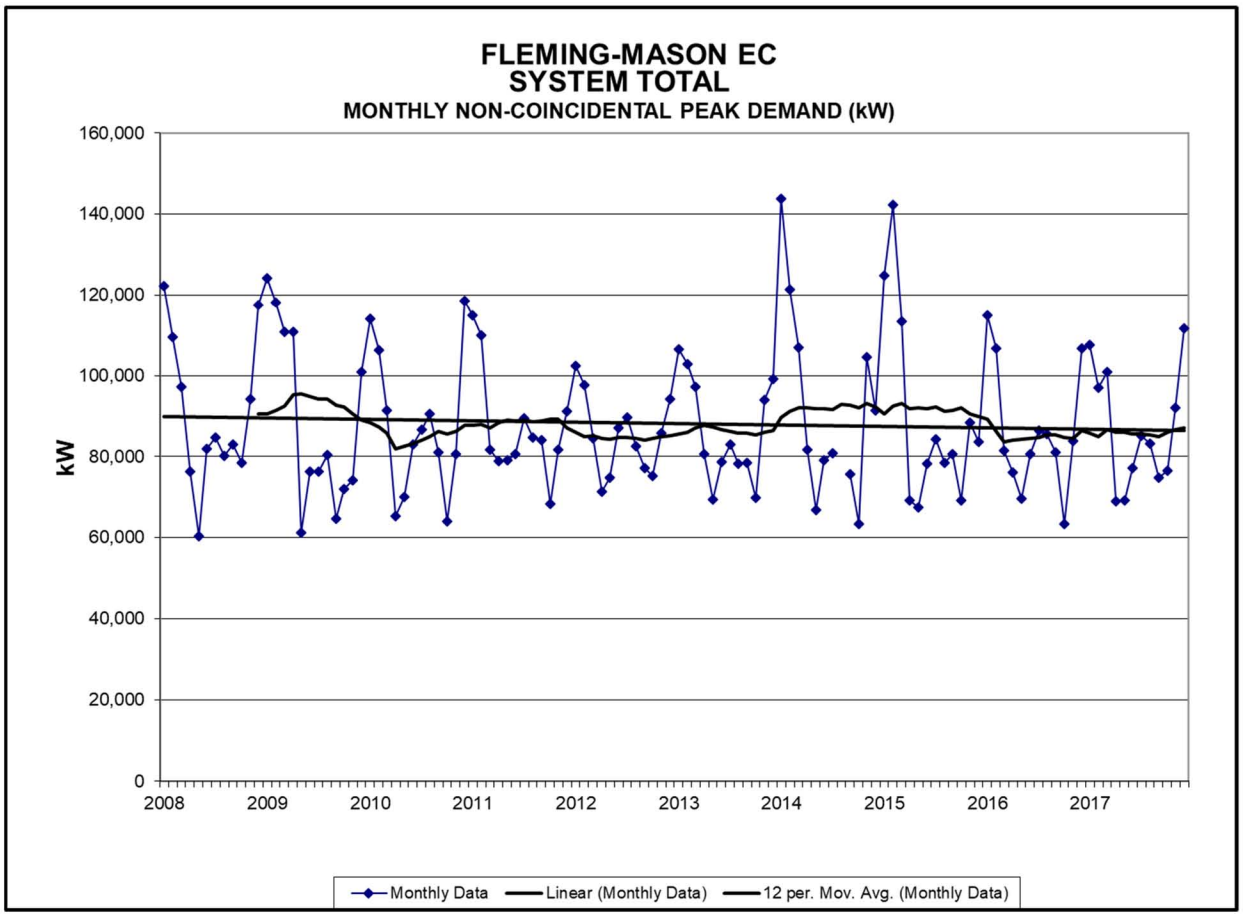

FLEMING-MASON EC
SYSTEM TOTAL
MONTHLY NON-COINCIDENTAL PEAK DEMAND (kW)
kW
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Monthly Data
Linear (Monthly Data)
12 per. Mov. Avg. (Monthly Data)

Exhibit 3 Unit Cost Estimates

Description	YR 2019
1 PH to 1 PH 1/0 ACSR ($ / mi)	$55,000
1 PH to 2 PH 1/0 ACSR ($ / mi)	$65,000
1 PH to 3 PH 1/0 ACSR ($ / mi)	$90,000
3 PH to 3 PH 1/0 ACSR ($ / mi)	$95,000
1 PH to 3 PH 336 ACSR ($ / mi)	$125,000
3 PH to 3 PH 336 ACSR ($ / mi)	$125,000
3 PH to 3 PH 556 ACSR ($ / mi)	$150,000
3 PH to 3 PH DBL CKT 356 ACSR ($ / mi)	$180,000
CONVERT 1PH OR 2PH TO 14.4 KV ($ / mi)	$12,000
CONVERT 3PH TO 14.4 KV ($ / mi)	$22,000
BUILD NEW 1PH 1/0 ACSR ($ / mi)	$50,000
BUILD NEW 3PH 1/0 ACSR ($ / mi)	$85,000
BUILD NEW 3PH 336 ACSR ($ / mi)	$125,000
BUILD NEW 3PH 556 ACSR ($ / mi)	$135,000
BUILD NEW 1PH 1/0 URD ($ / mi)	$105,600
1-50 AMP REGULATOR (7.2kV or 14.4kV)	$7,000
1-100 AMP REGULATOR (7.2kV or 14.4kV)	$10,000
3-100 AMP REGULATOR BANK (7.2kV or 14.4kV)	$30,000
3-200 AMP REGULATOR BANK (14.4kV)	$35,000
3-219 AMP REGULATOR BANK (7.2kV)	$35,000
3-231 AMP REGULATOR BANK (14.4kV)	$40,000
3-328 AMP REGULATOR BANK (7.2kV)	$50,000
1- HYDRAULIC OCR	$3,500
AIR BREAK SWITCH	$3,000

Exhibit 4 Unimproved Feeder Loading

SUBSTATION NAME Existing Capacity	Ckt.	2022 Projected Winter Peak Load Level (kW) Present System Layout Thru kW	Thru Amps A	 B	 C	Thru No. of Consumers From Windmil
BIG WOODS	1301	5,294	210	303	249	904
	1302	942	41	68	28	208
	1303	1,972	156	43	90	338
	TOTAL	8,208	407	414	367	1,450
CHARTERS	102	423	5	14	9	89
	103	4,521	126	111	82	910
	104	7,226	165	175	170	1,348
	105	3,400	107	51	75	828
	TOTAL	15,570	403	351	336	3,175
FLEMINGSBURG	201	2,566	68	82	32	645
	202	2,780	70	59	61	691
	203	1,484	31	35	35	88
	204	2,127	49	59	44	165
	205	4,917	76	164	111	886
	TOTAL	13,874	294	399	283	2,475
HILDA 2	301	6,998	286	345	369	771
	302	4,786	155	276	221	591
	303	4,993	174	277	252	248
	304	3,807	196	210	159	194
	Guardian1	0	0	0	0	0
	Guardian2	8	0	0	1	1
	TOTAL	20,592	811	1,108	1,002	1,805
HILLSBORO	401	3,058	60	79	81	505
	402	2,612	70	51	58	574
	403	1,977	38	23	78	427
	404	1,206	34	17	34	253
	TOTAL	8,853	202	170	251	1,759
MAYSVILLE INDUSTRIAL	502	779	13	14	25	68
	503	4,313	106	108	106	18
	504	2,370	73	51	36	619
	TOTAL	7,462	192	173	167	705

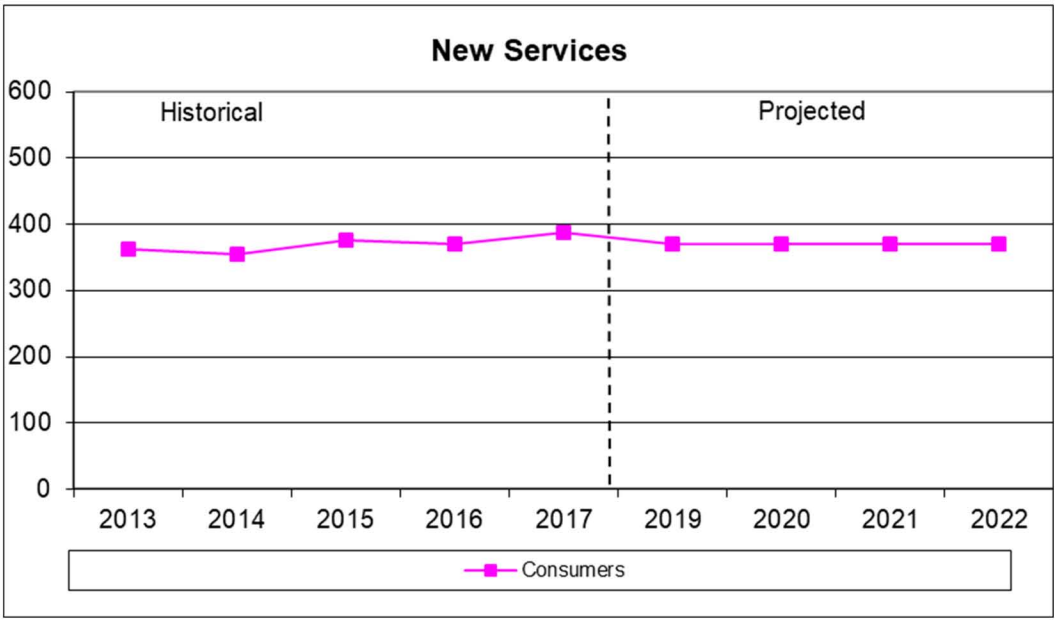
SUBSTATION NAME Existing Capacity	Ckt.	2022 Projected Winter Peak Load Level (kW) Present System Layout Thru kW	Thru Amps A	 B	 C	Thru No. of Consumers From Windmil
MURPHYSVILLE	602	2,543	47	60	72	476
	603	6,901	155	140	193	1,447
	604	932	10	28	26	170
	605	569	2	2	35	103
	TOTAL	10,945	214	230	326	2,196
OAK RIDGE	703	1,301	27	16	45	332
	704	723	32	3	16	166
	705	6,150	102	160	176	1,295
	TOTAL	8,174	161	179	237	1,793
PEASTICKS	802	2,253	53	41	62	402
	803	3,643	62	91	105	569
	804	5,441	139	137	107	940
	805	1,394	14	39	45	223
	TOTAL	12,731	268	308	319	2,134
PLUMMERS LANDING	902	3,259	177	117	160	484
	903	2,566	115	130	122	476
	905	3,311	115	79	275	321
	TOTAL	9,136	407	326	557	1,281
RECTORVILLE	1002	1,536	94	69	55	296
	1003	4,456	241	188	204	980
	1004	4,044	246	97	223	945
	TOTAL	10,036	581	354	482	2,221
SHARKEY	1102	1,470	37	34	35	9
	1103	8,615	143	231	234	766
	1104	6,195	93	124	218	575
	1105	0	0	0	0	0
	TOTAL	16,280	273	389	487	1,350
SNOW HILL	1202	3,927	79	59	140	665
	1203	2,325	89	27	45	450
	1204	653	4	7	36	168
	1205	1,413	49	11	42	276
	TOTAL	8,318	221	104	263	1,559
SYSTEM TOTAL		**150,179**				**23,903**

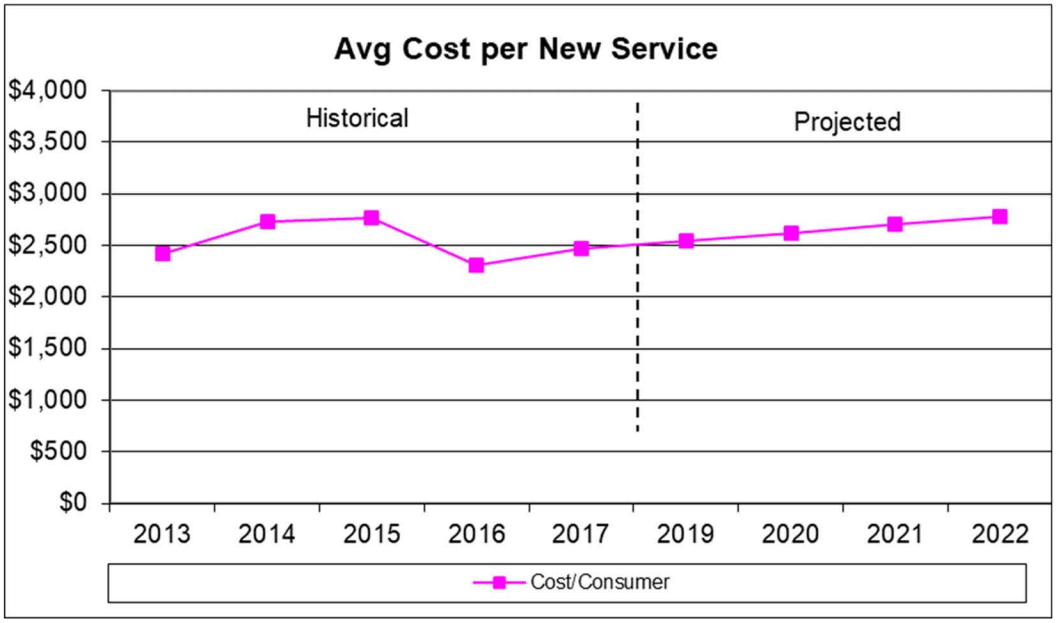
Exhibit 5 Improved Feeder Loading

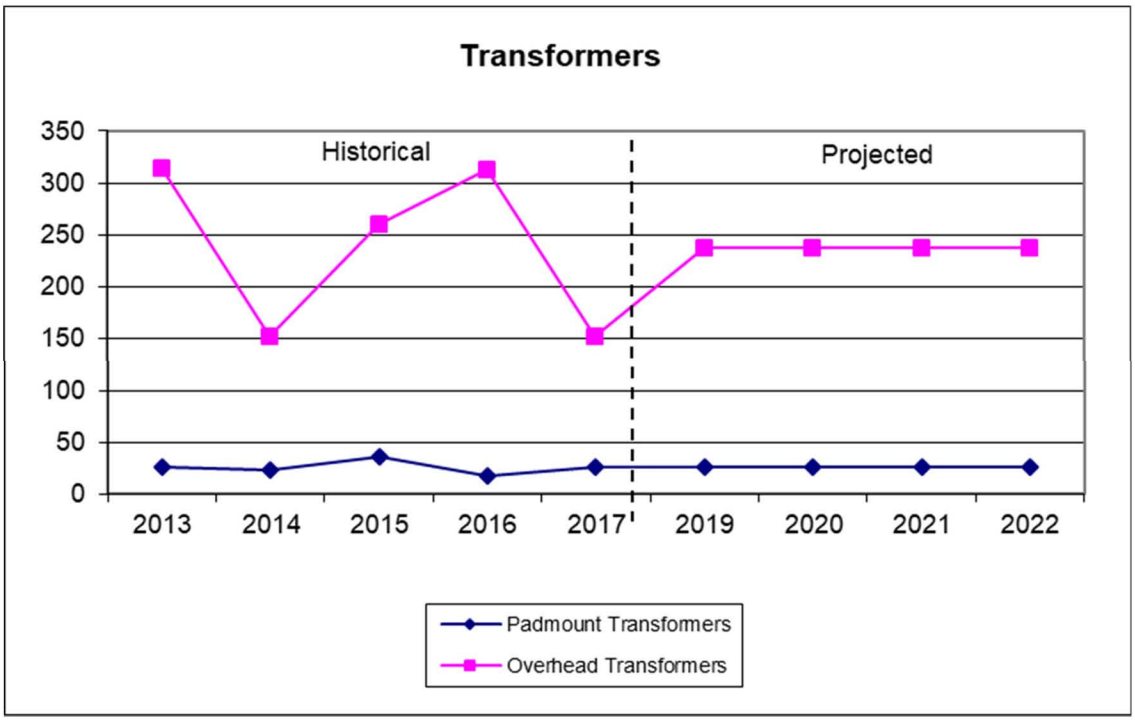
SUBSTATION NAME Existing Capacity	Ckt.	2022 Projected Winter Peak Load Level (kW) Present System Layout Thru kW	Thru Amps A	 B	 C	Thru No. of Consumers From Windmil
BIG WOODS	1301	4,205	195	209	196	734
	1302	1,994	84	81	105	378
	1303	1,971	104	94	90	338
	TOTAL	8,170	383	384	391	1,450
CHARTERS	102	423	5	14	9	89
	103	4,454	93	109	111	910
	104	7,207	168	173	165	1,348
	105	128	2	4	2	46
	TOTAL	12,212	268	300	287	2,393
FLEMINGSBURG	201	2,561	67	59	54	645
	202	2,777	71	59	61	691
	203	1,484	31	35	35	88
	204	2,127	49	59	44	165
	205	4,903	110	133	106	886
	TOTAL	13,852	328	345	300	2,475
HILDA 2	301	1,834	92	83	80	229
	302	4,779	195	252	204	591
	303	4,990	249	222	232	248
	304	3,804	196	184	184	194
	Guardian1	0	0	0	0	0
	Guardian2	8	1	0	0	1
	TOTAL	15,415	733	741	700	1,263
HILLSBORO	401	3,058	60	79	81	505
	402	2,609	58	63	57	574
	403	1,973	45	49	44	427
	404	1,203	34	27	23	253
	TOTAL	8,843	197	218	205	1,759
MAYSVILLE INDUSTRIAL	502	779	13	14	25	68
	503	4,313	106	108	106	18
	504	2,352	55	51	52	619
	TOTAL	7,444	174	173	183	705

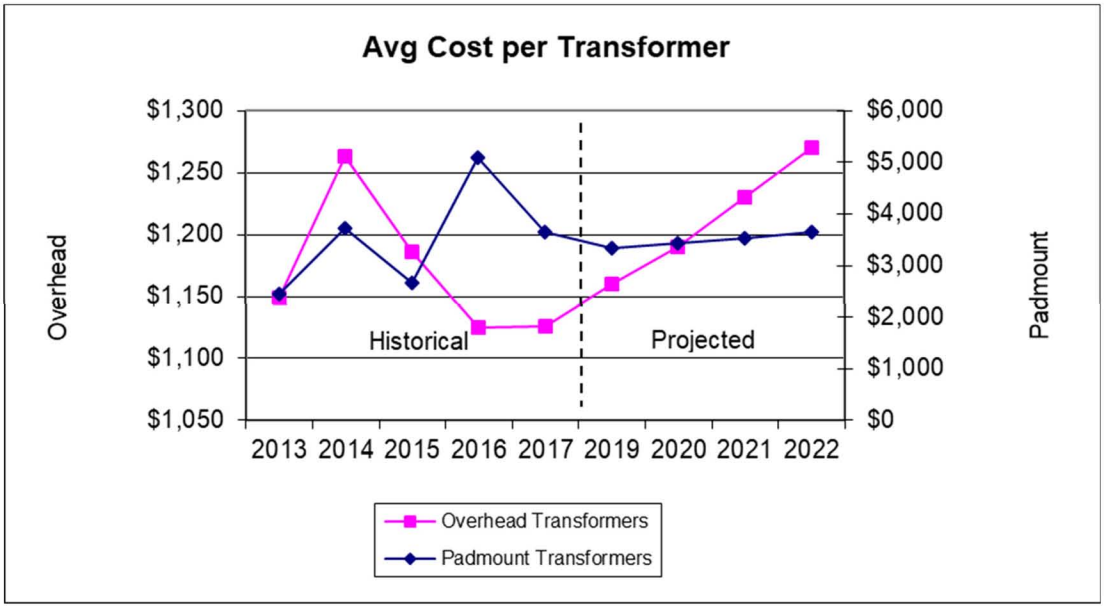
SUBSTATION NAME Existing Capacity	Ckt.	2022 Projected Winter Peak Load Level (kW) Present System Layout Thru kW	Thru Amps A	 B	 C	Thru No. of Consumers From Windmil
MURPHYSVILLE	602	2,543	58	60	60	476
	603	654	27	9	8	144
	604	932	10	28	26	170
	605	569	2	2	35	103
	TOTAL	4,698	97	99	129	893
OAK RIDGE	703	1,302	27	36	24	332
	704	3,924	106	75	87	948
	705	6,115	135	157	141	1,295
	TOTAL	11,341	268	268	252	2,575
PEASTICKS	802	2,247	53	57	46	402
	803	3,559	71	89	91	569
	804	5,412	111	130	139	940
	805	1,383	28	23	45	223
	TOTAL	12,601	263	299	321	2,134
PLUMMERS LANDING	902	3,242	142	157	152	484
	903	2,476	121	109	123	321
	905	3,239	143	153	159	476
	TOTAL	8,957	406	419	434	1,281
RECTORVILLE	1002	1,535	71	69	77	296
	1003	4,315	212	188	212	980
	1004	4,035	198	176	189	945
	TOTAL	9,885	481	433	478	2,221
SHARKEY	1102	1,470	37	34	35	9
	1103	8,508	198	182	220	766
	1104	6,150	133	153	145	575
	1105	0	0	0	0	0
	TOTAL	16,128	368	369	400	1,350
SNOW HILL	1202	3,900	91	84	99	665
	1203	2,316	59	55	45	450
	1204	631	16	18	10	168
	1205	1,412	21	39	41	276
	TOTAL	8,259	187	196	195	1,559
CRANSTON	1401	2,245	106	119	103	142
	1402	2,464	107	111	115	400
	TOTAL	4,709	213	230	218	542
STONEWALL	1501	1,092	11	30	34	794
	1502	1,036	40	14	17	253
	1503	3,593	91	90	66	256
	TOTAL	5,721	142	134	117	1,303
SYSTEM TOTAL		**148,235**				**23,903**

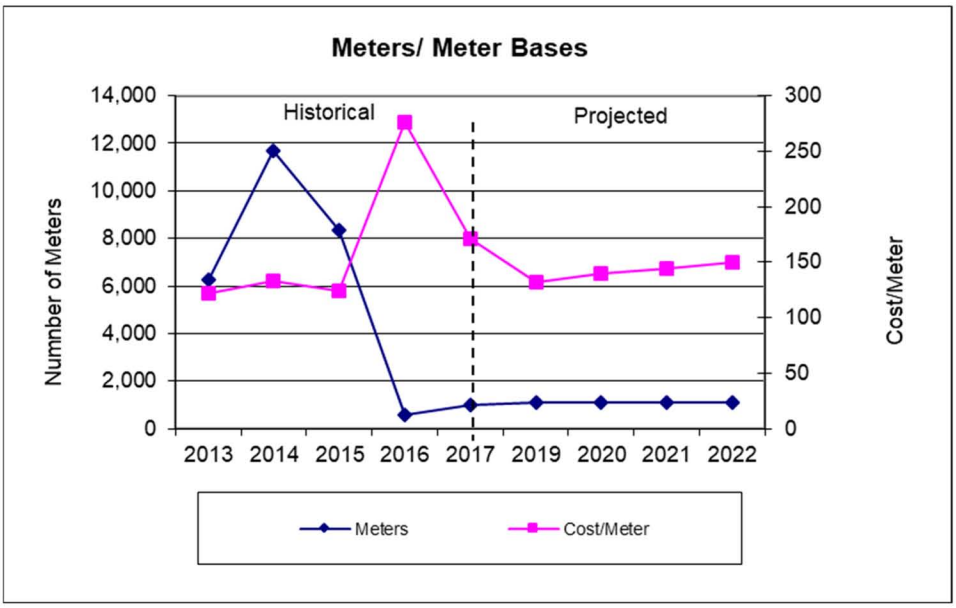
Exhibit 6 Projected Cost Graphs by RUS Code

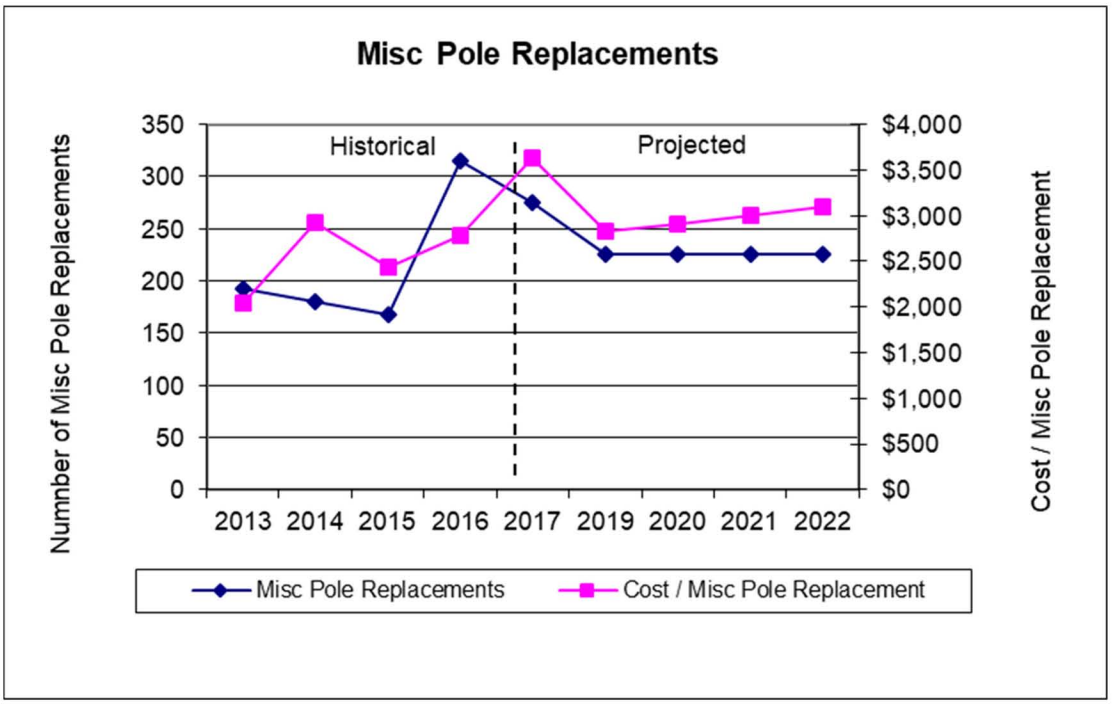





Transformers
350
300
250
200
150
100
50
0
Historical
Projected
2013
2014
2015
2016
2017
2019
2020
2021
2022
Padmount Transformers
Overhead Transformers


Avg Cost per Transformer
Overhead
$1,300
$1,250
$1,200
$1,150
$1,100
$1,050
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Padmount
Historical
Projected
2013 2014 2015 2016 2017 2019 2020 2021 2022
Overhead Transformers
Padmount Transformers


Meters/ Meter Bases
Historical
Projected
Numnber of Meters
Cost/Meter
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
300
250
200
150
100
50
0
2013
2014
2015
2016
2017
2019
2020
2021
2022
Meters
Cost/Meter


Misc Pole Replacements
Historical
Projected
Numnber of Misc Pole Replacements
Cost / Misc Pole Replacement
350
300
250
200
150
100
50
0
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
2013 2014 2015 2016 2017 2019 2020 2021 2022
Misc Pole Replacements
Cost / Misc Pole Replacement

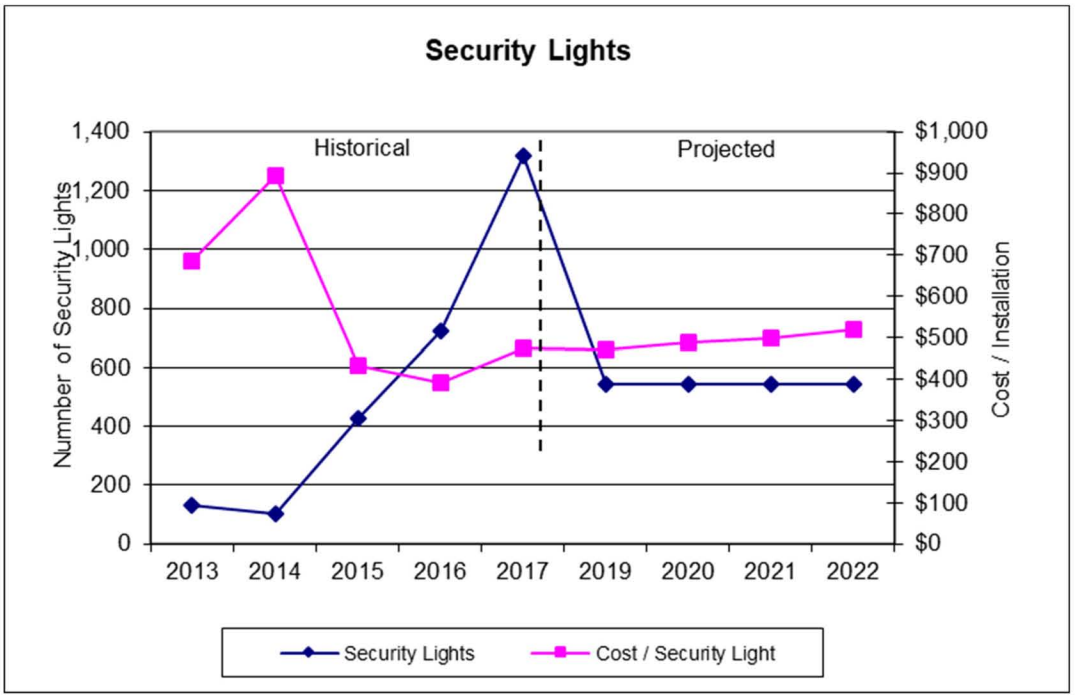

Security Lights
Historical
Projected
Numnber of Security Lights
Cost / Installation
1,400
1,200
1,000
800
600
400
200
0
$1,000
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
2013 2014 2015 2016 2017 2019 2020 2021 2022
Security Lights
Cost / Security Light

Exhibit 7 Suggested Load Balancing and Load Transfers

SUGGESTED LOAD BALANCING

Delivery Point	Feeder	Line Section*	TAP FROM	TAP TO	Cons on Tap Moved	AMPS on Tap Moved **	Notes
BIG WOODS	114	CO3751	C	A	16	16	
	114	CO4748	B	A	22	16.8	
	114	CO966	AB	BC	18	19.5	A PH LOAD TO C PH
	114	CO3331	B	AB			313.01
	114	CO3387	B	A	8	11.6	AFTER 313.01
	114	CO3383	B	A	3	9.7	
	124	CO3834	B	C	87	50.7	
	124	CO3045	C	B	15	10.9	
	134	CO3589	A	B	53	25.5	
CHARTERS	103	CO22896	A	C	81	22.7	
	103	CO21922	A	C	28	21.5	
	103	CO20229	C	A	27	9	
	103	CO21752	A	C	9	8.5	
	104	CO20819	C	A	23	19.1	
	104	CO1132037426	A	C	60	14.8	
	104	CO20821	B	A	44	24.1	
	104	CO20531	A	B	29	10.8	
	105	CO19924	B	A	58	15	
	105	CO6963	A	AB			301.08
	105	CO7007	A	B	171	40	AFTER 301.08
FLEMINGSBURG	201	CO12922	B	C	110	35.1	
	201	OH260876020	C	B	31	12.9	
	202	OH310114013	B	A	39	9.5	
	202	CO15516	A	B	24	9.2	
	205	CO14898	C	A	69	19.7	
	205	CO7438	B	C	60	21.4	
	205	CO7785	C	B	19	6.6	
	205	CO6846	B	A	41	14.6	
HILDA 2	301	CO4435	C	A	79	40.1	AFTER 414.1, 414.2
	301	CO4295	A	C	22	22.9	AFTER 414.1, 414.2
	301	CO1044	B	A	13	23.3	AFTER 414.1, 414.2
	301	CO4196	A	C	12	9.5	AFTER 414.1, 414.2
	301	OC40013001	A	B	35	28.4	AFTER 414.1, 414.2
	301	CO719	C	A	42	34.4	AFTER 414.1, 414.2
	302	CO244	B	A	26	21.4	
	302	CO129	A	C	20	10.4	
	302	CO17	C	A	41	28.4	
	303	CO8216	C	A	19	29	
	303	CO734	B	A	22	26.4	
	303	OH400332030	B	C	10	8.5	
	304	CO2604	B	C	25	26	

SUGGESTED LOAD BALANCING

Delivery Point	Feeder	Line Section*	TAP FROM	TAP TO	Cons on Tap Moved	AMPS on Tap Moved **	Notes
HILLSBORO	402	OH310868002	A	B	44	18.5	
	402	CO12126	B	A	17	7	
	403	CO17271	C	A	18	7.3	
	403	CO13142	C	B	40	14.4	
	403	CO12682	C	B	41	12.1	
	404	CO3856	C	B	26	20.2	
MAYSVILLE INDUSTRIAL	504	CO30702	A	AC			305.01
	504	CO24570	A	C	135	25.3	AFTER 305.01
	504	CO24322	C	A	41	9.8	
MURPHYSVILLE	602	CO29303	C	A	21	11.7	
	603	CO29734	C	AC			306.04
	603	CO29857	C	A	108	37.8	AFTER 306.04
	603	CO27652	C	AC			306.06
	603	CO30402	C	A	43	18.6	AFTER 306.06
	603	CO30278	A	B	48	15.5	AFTER OPEN AT CO27830
OAK RIDGE	703	CO23804	C	B	43	26.1	
	705	CO18484	C	A	57	15.3	
	705	CO1394043038	B	A	43	19.5	
	705	CO15847	C	B	37	16.5	
	705	CO26042	A	B	53	18.6	
	705	CO26047	B	A	70	17.2	
PEASTICKS	802	CO9354	C	BC			308.01
	802	CO9494	C	B	34	31.9	AFTER 308.01
	803	CO1494	C	A	15	19.6	
	804	CO9134	B	BC			308.03
	804	CO17046	B	C	50	33.2	AFTER 308.03
	804	CO11160	A	B	39	26.7	
	805	CO8664	B	AB			308.02
	805	CO8590	B	A	17	29.1	AFTER 308.02
PLUMMERS LANDING	902	CO6370	B	BC			309.01
	902	CO6782	B	C	48	40.3	AFTER 309.01
	902	CO6377	A	AB			309.02
	902	CO6553	A	B	26	32.3	AFTER 309.02
	902	CO6692	C	B	41	44.6	
	903	CO5877	A	ABC			309.03
	903	CO6270	A	B	18	23.2	AFTER 309.03
	903	CO6339	A	B			309.04
	903	CO6339	B	BC			309.04
	903	CO8369	B	C	46	39.5	AFTER 309.04
	903	CO5885	B	AB			309.05
	903	CO6116	B	A	68	31.2	AFTER 309.05
	903	CO5734	C	AC			309.06
	903	CO6196	C	A	37	29.7	AFTER 309.06
	903	CO5485	B	A	32	27.5	
	903	CO5882	C	B	12	8.5	
	905	CO4751	C	B	14	19.1	
	905	CO4930	C	A	15	14.3	
	905	CO5286	C	A	19	14	
	905	CO5399	C	B	41	49.9	
	905	CO4953	C	B	7	9.5	

SUGGESTED LOAD BALANCING

Delivery Point	Feeder	Line Section*	TAP FROM	TAP TO	Cons on Tap Moved	AMPS on Tap Moved **	Notes
RECTORVILLE	1002	CO-1949781245	A	C	37	21.3	
	1003	CO21513	A	C	67	42.5	
	1003	CO22510	B	C	46	18.2	
	1003	CO22263	C	A	93	47.2	
	1003	CO22216	A	B	34	22.3	
	1004	CO28592	A	B	65	23.3	
	1004	CO22491	C	B	20	7.7	
	1004	CO29074	C	B	28	8.5	
SHARKEY	1103	CO2004	C	AC			311.01
	1103	CO1945	C	A	33	28.5	AFTER 311.01
	1103	CO-415726902	B	AB			311.02
	1103	CO-1908617053	B	A	28	28	AFTER 311.02
	1103	CO1382010372	C	B	17	14.3	
	1103	CO1686	B	BC			311.03
	1103	CO1549	B	C	47	30.9	AFTER 311.03
	1104	CO2064	C	A	79	41.7	
	1104	CO2790	C	B	26	29.8	
SNOW HILL	1202	CO14569	C	B	71	26	
	1202	CO11704	C	A	19	10.1	
	1203	CO17252	A	B	83	29.5	
	1204	CO25002	C	A	33	50	
	1205	CO26555	A	B	86	28.3	

*** Indicated line section is first line section off of 3-phase line where the indicated phase change is recommended to occur. All downline line sections will of course reflect the change as well.**

**** Amps indicated represent historical peak winter loading.**

NOTE: If the recommended phase changes would create any type of safety hazard due to jumper lengths / safety clearancess, etc. then the phase change should NOT be made. Alternate load balancing schemes can be developed as needed.

LOAD TRANSFERS

Delivery Point	New Open Line Section	Description
BIG WOODS	CO931	AFTER CONVERSIONS, CLOSE AT SW330878001 FEEDING FROM BIG WOODS KY158
OAK RIDGE	CO21188	CLOSE SW1852930236
SNOW HILL	CO25273	CLOSE SW757
CHARTERS	CO17990	AFTER CONVERSIONS, CLOSE AT CO17952 FEEDING FROM OAK RIDGE 704
HILDA	CO1110	AFTER 414.1, 414.2, MOVE LOAD TO CRANSTON SUBSTATION
MURPHYSVILLE	CO29661	AFTER 415.1, 415.2, MOVE LOAD TO STONEWALL SUBSTATION
MURPHYSVILLE	C027830	ADD AUTOTRANSFORMER AT CO27977 (A PHASE)

Exhibit 8 Ten-Year Load Projections

DELIVERY POINT	2017 - 2018 Winter Peak Demand	Projected Winter ACGR[1]	2018 - 2019 Projected Winter Peak	2019 - 2020 Projected Winter Peak	2020 - 2021 Projected Winter Peak	2021 - 2022 Projected Winter Peak	2022 - 2023 Projected Winter Peak	2023 - 2024 Projected Winter Peak	2024 - 2025 Projected Winter Peak	2025 - 2026 Projected Winter Peak	2026 - 2027 Projected Winter Peak	2027 - 2028 Projected Winter Peak
BIG WOODS	6,755	5.0%	7,093	7,447	7,820	8,211	8,621	9,052	9,505	9,980	10,479	11,003
CHARTERS	14,122	2.5%	14,475	14,837	15,207	15,588	15,977	16,377	16,786	17,206	17,636	18,077
FLEMINGSBURG	13,605	0.5%	13,673	13,741	13,810	13,879	13,949	14,018	14,088	14,159	14,230	14,301
HILDA 2	16,376	5.0%	17,894	18,754	19,657	20,605	21,600	22,645	23,742	24,894	26,104	27,374
HILLSBORO	8,502	1.0%	8,587	8,673	8,759	8,847	8,935	9,025	9,115	9,206	9,298	9,391
MAYSVILLE INDUSTRIAL	7,317	0.5%	7,354	7,390	7,427	7,465	7,502	7,539	7,577	7,615	7,653	7,691
MURPHYSVILLE	10,552	0.9%	10,647	10,743	10,840	10,937	11,036	11,135	11,235	11,336	11,438	11,541
OAK RIDGE	7,703	1.5%	7,819	7,936	8,055	8,176	8,298	8,423	8,549	8,677	8,808	8,940
PEASTICKS	11,727	2.1%	11,974	12,225	12,482	12,744	13,012	13,285	13,564	13,849	14,139	14,436
PLUMMERS LANDING	8,123	3.0%	8,367	8,618	8,876	9,143	9,417	9,699	9,990	10,290	10,599	10,917
RECTORVILLE	9,841	0.5%	9,890	9,940	9,989	10,039	10,089	10,140	10,191	10,242	10,293	10,344
SHARKEY	12,976	5.0%	13,625	14,806	15,522	16,273	17,061	17,889	18,759	19,672	20,631	21,637
SNOW HILL	7,747	1.8%	7,887	8,029	8,173	8,320	8,470	8,622	8,778	8,936	9,097	9,260
TOTAL SYSTEM [2]	135,347	2.6%	139,285	143,139	146,617	150,227	153,967	157,849	161,879	166,062	170,405	174,912
2018 PRS System Peak Projections [3]			**131,750**	**136,250**	**138,140**	**140,900**	**144,143**	**146,397**	**147,130**	**148,270**	**149,590**	**151,600**

[1] ACGR = Annual Compound Growth Rate
[2] NOTE: The "System" demand represent the greatest month's sum of each individual delivery point's NCP for the month
[3] NOTE: PRS reflects the FME system coincident peak demand growth, not the individual substation NCP

DELIVERY POINT	2018 Summer Peak Demand	Projected Summer ACGR[1]	2019 Projected Summer Peak	2020 Projected Summer Peak	2021 Projected Summer Peak	2022 Projected Summer Peak	2023 Projected Summer Peak	2024 Projected Summer Peak	2025 Projected Summer Peak	2026 Projected Summer Pea	2027 Projected ummer Pea	2028 Projected Summer Peak
BIG WOODS	4,014	0.5%	4,034	4,054	4,074	4,095	4,115	4,136	4,156	4,177	4,198	4,219
CHARTERS	9,562	0.5%	9,609	9,657	9,706	9,754	9,803	9,852	9,901	9,951	10,001	10,051
FLEMINGSBURG	9,838	0.5%	10,830	10,880	10,929	10,979	11,030	11,080	11,131	11,182	11,233	11,284
HILDA 2	12,110	0.5%	12,871	12,932	12,993	13,054	13,116	13,178	13,241	13,303	13,366	13,430
HILLSBORO	5,130	0.5%	5,156	5,182	5,208	5,234	5,260	5,286	5,312	5,339	5,366	5,393
MAYSVILLE INDUSTRIAL	7,803	0.7%	7,858	7,913	7,968	8,024	8,080	8,136	8,193	8,251	8,308	8,367
MURPHYSVILLE	6,351	0.5%	6,383	6,415	6,447	6,479	6,512	6,544	6,577	6,610	6,643	6,676
OAK RIDGE	4,679	0.7%	4,712	4,745	4,778	4,811	4,845	4,879	4,913	4,948	4,982	5,017
PEASTICKS	6,929	0.5%	6,964	6,999	7,034	7,069	7,104	7,140	7,175	7,211	7,247	7,284
PLUMMERS LANDING	4,550	0.5%	4,573	4,596	4,619	4,642	4,665	4,689	4,712	4,736	4,759	4,783
RECTORVILLE	7,373	0.5%	7,410	7,447	7,484	7,521	7,559	7,597	7,635	7,673	7,711	7,750
SHARKEY	7,901	0.5%	7,940	8,480	8,520	8,560	8,600	8,641	8,682	8,723	8,764	8,805
SNOW HILL	4,710	0.5%	4,733	4,757	4,781	4,805	4,829	4,853	4,877	4,902	4,926	4,951
TOTAL SYSTEM [2]	90,951	0.8%	93,073	94,057	94,541	95,027	95,518	96,011	96,505	97,006	97,504	98,010
2018 PRS System Peak Projections [3]			**89,500**	**91,750**	**95,950**	**97,440**	**98,200**	**99,430**	**100,550**	**102,000**	**102,970**	**104,270**

[1] ACGR = Annual Compound Growth Rate
[2] NOTE: The "System" demand represent the greatest month's sum of each individual delivery point's NCP for the month
[3] NOTE: PRS reflects the FME system coincident peak demand growth, not the individual substation NCP

Exhibit 9 Voltage Drop Diagrams

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 6
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 6. Concerning the Fleming-Mason Energy's construction projects, for each project started in 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.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 7
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

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 historical test year and the historical test year.

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

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 8
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 8. Provide, in the format provided in Schedule E, an analysis of Fleming-Mason Energy's Construction Work in Progress (CWIP) as defined in the Uniform System of Accounts for each project identified in Schedule D.

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

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 9
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

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. Fleming-Mason Energy does not typically record capitalized interest as projects are typically short-term in nature.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 10
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

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

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

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

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

d. Computation and development of minimum cash requirements;

e. Balance in accounts payable applicable to amounts included in utility plant in service;

f. Balance in accounts payable applicable to amounts included in plant under construction; and

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

Response 10 (a) through (c) and (e) through (g). Please see attachment.

Response 10(d). Minimum cash requirement is adjusted on a daily and weekly basis depending on the needs of the cooperative. Fleming-Mason Energy utilizes its lines of credit with CFC and CoBank for liquidity purposes. The typical cash balance is usually between $1-1.2 million.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 11
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 11. 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 11. There have been no acquisitions of an operating unit or system since our last rate case.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 12
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 12. Provide Fleming-Mason Energy'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 12. Please see attached.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 13
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 13. Provide the average number of customers on Fleming-Mason Energy's system by rate schedule for the test year and two most recent calendar years.

Response 13. Please see attached.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 14
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 14. 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 14. Please see attached schedule.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 15
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 15. Provide the comparative operating statistics for total company as shown in Schedule G.

Response 15. Please see attached schedule.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 16
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 16. Provide the information requested in Schedule H 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, by month, for the test year and three most recent calendar years preceding the test year. Explain any variance exceeding five percent. Complete the information requested in Schedule H1.

Response 16. 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

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 17
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 17. State whether Fleming-Mason Energy, 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 Fleming-Mason Energy's last base rate case.

Response 17. Fleming-Mason Energy is working with an outside consultant to perform a salary study. The salary study is currently being prepared and is anticipated to be completed within the next one to two weeks. Upon completion, it will be provided under seal pursuant to a Motion for Confidential Treatment.

Request 17a. 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 17a. Please see the response to 17 above.

Request 17b. If comparisons were not performed, explain why not.

Response 17b. Please see the response to 17 above.

ATTACHMENT FILED UNDER SEAL PURSANT TO A MOTION FOR CONFIDENTIAL TREATMENT

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 18
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 18. Provide the most recent wage, compensation, and employee benefits studies, analyses, or surveys conducted since Fleming-Mason Energy's last base rate case or that are currently utilized by Fleming-Mason Energy.

Response 18. Please see the response to 17.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 19
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 19. 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 19. The following general wage increases were granted for all employee groups – exempt, non-exempt, supervisors, and managers:

2022 Cost of Living (effective 11/25/22) - 4% or $1.00 per hour increase to rate, whichever was greater (included CEO)

2021 Cost of Living (effective 11/26/21) - $0.50 per hour increase to rate with 2% lump sum payable to employee (excluded CEO)

2020 Cost of Living (effective 11/27/20) - 1% increase to rate with 2% lump sum payable to employee (included CEO)

Fleming-Mason Energy does not have a unionized employee group.

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 20
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 20. Provide a schedule reflecting the salaries and other compensation of each executive officer for the base period 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 officer status since the test year in the utility's most recent rate case, provide the salaries for the persons they replaced.

Response 20. 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

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 21
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 21. Provide a listing of all health care plan categories, dental plan categories, and vision plan categories available to corporate officers individually and to groups defined as Directors, Managers, Supervisors, Exempt, Non-Exempt, Union, and Non-Union Hourly employees (e.g., single, family). 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 21. Please see attached.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 22
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 22. Provide all current labor contracts and the most recent labor contracts previously in effect.

Response 22. Fleming-Mason Energy is not unionized. Therefore, there is no labor contract in effect.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 23
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 23. Provide each medical insurance policy that the utility currently maintains.

Response 23. Please see attached.

Kentucky Rural Electric Cooperative

Kentucky Rural Electric Cooperative Employers Benefit Plan
Fleming-Mason Energy
Summary Plan Description

Effective
January 1, 2023

TABLE OF CONTENTS

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.

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
Maternal Health Program	Baby Steps 1-800-388-3193 www.MyAmeriBen.com	

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

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

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* 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 or a child placed with the *employee* for adoption

   c. lawfully placed *foster child* for whom health coverage is not provided by the state

   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.

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 or foster care, 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 or foster care.

In the case of the birth or adoption of a child or placement for foster care, 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 eligible *dependents*
Divorce or annulment	Last day of the month	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	thirty (30) days of birth	Enroll yourself Enroll the newborn child and all other eligible dependents
Adoption, placement for adoption, *foster child*, or legal guardianship of a child	Date of event	thirty (30) days of adoption	Enroll yourself Enroll the newly adopted child and all other eligible dependents
Your *dependent* child reaches maximum age for coverage	Last day of the month	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
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	First of the month following the date of the 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	First of the month following the date of the 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 last day of the calendar month a covered spouse loses coverage due to loss of dependency

4. the last day of the calendar month that 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

A terminated *employee* who is rehired will be treated as a new hire and required to satisfy all eligibility and enrollment requirements to the extent permitted by the terms of the *Plan* and applicable law.

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.

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, placement for foster care) 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*.

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. Schedule of Medical Benefits - PPO Option

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Deductible, per Calendar Year The *network* and *non-network deductible* amounts do not accumulate towards each other. *Co-payments* and *co-insurance* do not apply to the *deductible*. When applicable, *claims* for a common accident will be credited to the covered *employee* and their *deductible*. When this *Plan* is secondary, the *deductible* will be waived for all covered services on the *claim*.		
Per *plan participant*	$600	$1,200
Per *family unit*	$1,800	$3,600
Family Unit - Embedded Deductible If you are enrolled in the family option, your *Plan* contains two (2) components: an individual *deductible* and a *family unit deductible*. Having two (2) components to the *deductible* allows for each member of your *family unit* the opportunity to have your *Plan* cover medical expenses prior to the entire dollar amount of the *family unit deductible* being met. The individual *deductible* is embedded in the family *deductible*. **For example,** if you, your spouse, and child are on a family plan with a $1,800 *family unit* embedded *deductible*, and the individual *deductible* is $600, and your child *incurs* $600 in medical bills, their *deductible* is met, and your *Plan* will help pay subsequent medical bills for that child during the remainder of the *calendar year*, even though the *family unit deductible* of $1,800 has not been met yet.		
Co-Insurance Out-of-Pocket Limit, per Calendar Year This *out-of-pocket limit* includes *co-insurance*.		
Per *plan participant*	$1,900	$4,500
Per *family unit*	$3,800	$9,000
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*	$7,150	Unlimited
Per *family unit*	$14,300	Unlimited
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 *the maximum allowable charges* 3. charges not covered under the *Plan* 4. *balanced billed* charges		

Benefits shown as *co-payments* are listed for what the *plan participant* will pay. The *deductible* is waived with all *co-payments* unless otherwise indicated within the schedule.

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 Services			
Allergy Testing	No charge	70% *co-insurance* after *deductible*	
Allergy Injection and Serum	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Ambulance Service	90% *co-insurance* after *network deductible*		Please refer to the **Medical Benefits** section, **Covered Medical Charges**, Ambulance, for a further description and limitations of this benefit. ***Pre-certification*** **is required** for non-emergent air ambulance and chartered flights.
Anesthetics and Hospital Charges for Routine Dental Procedures	**Professional Services:** No charge **Other:** 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.**

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Chiropractic Treatment	$30 *co-payment*	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	**Office Visit:** $30 *co-payment* **Inpatient/Outpatient:** 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*.
Diagnostic Testing	**Inpatient/Outpatient Professional Services:** 90% *co-insurance* after *deductible* **Office Visit/ Independent Lab:** No charge	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			
Facility Services	$100 *co-payment*		The emergency room *co-payment* applies to the facility charges only. The emergency room *co-payment* is waived if admitted.
Physician Services	No charge		If placed in observation, the emergency room *co-payment* will apply.
Foot Care (Routine)	No charge	70% *co-insurance* after *deductible*	For treatment of metabolic or peripheral vascular disease only.
Genetic/Genomic Counseling and 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)	No charge	70% *co-insurance* after *deductible*	
Implantable Hearing Devices	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
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*	
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 or 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.**
Lab and X-Ray	No charge	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.**
Male Sterilization	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Maternity			
Initial Visit	$30 *co-payment*	70% *co-insurance* after *deductible*	
All Other 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			
Office Visit	$30 *co-payment*	70% *co-insurance* after *deductible*	
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*	Includes residential treatment. ***Pre-certification*** **is required.**

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Nutritional Therapy/ Counseling	**Office Visit:** $30 *co-payment* **Outpatient Services:** 90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Office Visit			
Primary Care Physician	$30 *co-payment*	70% *co-insurance* after *deductible*	The *co-payment* applies to the office visit plus surgeries and injections billed by the *physician* for the same date of service. All other services rendered during the *physician's* office visit are paid at the applicable benefit level.
Specialist	$30 *co-payment*	70% *co-insurance* after *deductible*	Office visits when a *physician's* office is located inside a hospital facility will also apply the *co-payment* benefit level. Home visits are covered.
Oral Surgery	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Orthotic Appliances/ Prosthetics	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Outpatient Observation Stays	**Facility Services:** $100 *co-payment* **Physician Services:** No charge		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 is 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.
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.**

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COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
Sleep Disorders/Sleep Studies	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Telehealth Services			
LiveHealth Online	$30 *co-payment*	Not covered	Telemedicine benefit provided through Anthem at www.livehealthonline.com or call 1-855-603-7985.
Other Telehealth Providers	$30 *co-payment*	70% *co-insurance* after *deductible*	
Temporomandibular Joint Syndrome (TMJ)/Occlusion Treatment Services	90% *co-insurance* after *deductible*	70% *co-insurance* after *deductible*	
Therapy Services			
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	**Blue Distinction Center:** 90% *co-insurance*, *deductible* waived **Other Network:** 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.**
Urgent Care	$30 *co-payment*	70% *co-insurance* after *deductible*	The urgent care visit *co-payment* will apply to the urgent care visit and all other services, including lab and x-rays, performed and billed by the *physician* for the same date of service. Includes retail/walk-in clinics.
Vision Exam (Medical)	No charge	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.

L. Schedule of Prescription Drug Benefits - PPO 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 not apply to the medical *deductible*.

Prescription drug charges do apply to the medical *out-of-pocket* maximum.

Benefits shown as *co-payments* are listed for what the *plan participant* will pay.

Network Retail Pharmacy Option (34 to 90-Day Supply)	Network Mail Order Pharmacy Option (90-Day Supply)
Preventive Rx No charge	**Preventive Rx** No charge
Generic Drugs $15 *co-payment*	**Generic Drugs** $30 *co-payment*
Formulary Brand Name Drugs $30 *co-payment*	**Formulary Brand Name Drugs** $60 *co-payment*
Non-Formulary Brand Name Drugs $60 *co-payment*	**Non-Formulary Brand Name Drugs** $120 *co-payment*
Specialty Drugs 20% *co-insurance* up to $100	**Specialty Drugs** Limited to a thirty-four (34) day supply
Over-the-Counter Non-Sedating Anti-Histamines 80% *co-insurance* **Over-the-Counter Proton Pump Inhibitors** No charge	
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 websites 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 Pillar Rx 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.**

M. 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.

N. 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.**

O. 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.

P. 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	**Preventive Rx** No charge
Generic Drugs 90% *co-insurance* after Medical *Plan deductible* is met	**Generic Drugs** 90% *co-insurance* after Medical *Plan deductible* is met
Formulary Brand Name 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	**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	**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
4. maternal health program

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*.

F. Maternal Health Program

Your *employer* has contracted with Baby Steps, AmeriBen's maternal health program, as part of your healthcare coverage through the Kentucky Rural Electric Cooperative Employers Benefit Plan. This program provides education, support, and a specially trained maternal health nurse who will help you and your baby stay healthy and avoid complications—before, during, and after your *pregnancy*.

How the Maternal Health Program Works

Upon enrolling, your nurse will contact you and ask you a few questions about your *pregnancy*, and you can start receiving the following benefits:

1. a registered nurse (R.N.), who will schedule regular telephone appointments to check on you and your baby
2. access to call your registered nurse with any questions or concerns as often as you like
3. helpful informational and educational *pregnancy* materials
4. help in setting goals, finding a doctor, understanding prenatal tests, and following a safe nutrition and exercise program
5. Upon enrollment, you will receive a FREE copy of the book *What to Expect When You're Expecting*.

Covered *employees* and spouses may enroll in the program by contacting Baby Steps directly as shown in the Quick Reference Information Chart.

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 or foster care 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 or foster care 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 or foster care 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 or foster care.
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. Accountant/Human Resources

   b. Office Manager

   c. President & Chief Executive Officer

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*.

Foster Child

A child under the limiting age shown in the **Eligibility, Effective Date, and Termination Provisions** section of this *Plan* for whom a covered *employee* has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered foster child is not a child temporarily living in the covered *employee's* home; one placed in the covered *employee's* home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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*.

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.

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.

DocuSigned by:
By: Lauren Fritz
28F987F905794EF...

Date: 6/20/2023

Title: Chief Financial Officer

If you have questions about your *Plan* benefits, please contact the *Third Party Administrator* at 1-844-209-0071.

AmeriBen

P.O. Box 7186
Boise ID 83707

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.

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* 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.

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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$600	$1,200	
	Per family:	$1,800	$3,600	
Are there services covered before you meet your deductible?	Yes. Preventive care services when performed in network and benefits where a co-payment applies.			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:	$1,900	$4,500	
	Per family:	$3,800	$9,000	
	Overall Out-of-Pocket Maximum			
		Network	**Non-Network**	
	Per participant:	$7,150	Unlimited	
	Per family:	$14,300	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			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	allowed amounts, pre-certification penalties, and non-medically necessary services.	
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-833-835-2714 for 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	$30 co-payment, deductible waived	30% co-insurance, deductible waived	Co-payment applies to the office visit only. All other services performed will apply to their applicable benefit level.
	Specialist visit	$30 co-payment, deductible waived	30% co-insurance, deductible waived	
	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)	**Diagnostic Inpatient/Outpatient Professional Services:** 10% co-insurance after deductible **Lab and X-Ray Inpatient Professional Services:** 10% co-insurance after deductible **Lab and X-Ray Outpatient Professional Services:**	30% co-insurance after deductible	——————————none——————————

* 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)	
		No charge **Office Visit/Independent Lab:** No charge		
	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):** $15 co-payment, deductible waived **Mail Order (90-Day Supply):** $30 co-payment, deductible waived **OTC Non-Sedating Anti-Histamines:** 20% co-payment **OTC Proton Pump Inhibitors and 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	**Retail (34-Day Supply):** $30 co-payment, deductible waived **Mail Order (90-Day Supply):** $60 co-payment, deductible waived	Not Covered	
	Non-preferred brand drugs	**Retail (34-Day Supply):** $60 co-payment, deductible waived **Mail Order (90-Day Supply):** $120 co-payment, deductible waived	Not Covered	
	Specialty drugs	**Retail (30-Day Supply):** 20% co-insurance up to	Not Covered	

* 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)	
		a $100 maximum **Retail/Mail Order (90-Day Supply):** 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:** $100 co-payment deductible waived for facility, no charge for physician **Non-Emergency Care:** $100 co-payment, deductible waived		Co-payment is waived if admitted.
	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 benefits by $100 per occurrence.
	Urgent care	$30 co-payment, deductible waived	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	

* 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 mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit:** $30 co-payment, deductible waived **All Other 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	$30 co-payment, deductible waived	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 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)	
	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 the 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	$600
Specialist co-payment	$30
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	$600
Copayments	$30
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,730**

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

The plan's overall deductible	$600
Specialist co-payment	$30
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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$800**

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

The plan's overall deductible	$600
Specialist co-payment	$30
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	$600
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

New Case Document (NCD)

Effective date

Humana.

Humana.com

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New Case Document (NCD)

NCD completed by: Account Installation Manager **Date:** 9/13/2022
Account Executive: Gabe Hellinger
Account Installation Manager: Anna Lawyer

Authorization

By signing below, the plan sponsor:

Acknowledges it is the sponsor's responsibility to review and verify that the NCD and all document drafts are correct and, if not correct, to make necessary corrections in a timely manner. This authorizes Humana to build product, plan benefits, process claims and draft mandated communications (i.e., Evidence of Coverage) based on the final approved NCD.

This authorization and agreement is made and entered into by
Fleming Mason Energy Coop Inc.

and Humana, effective 1/1/2023

After the exchange of the NCD, any changes to the documents describing the plan for these purposes must be in writing, state the effective date and must be communicated to and accepted by Humana claims administration in a timely fashion.

Renewing plan for existing client **Effective date of plan:** 1/1/2023

Plan Sponsor signature: Brandon Hunt
Print name: Brandon Hunt
Title: President/CEO
Date: 9/14/22

Humana signature: Anna Lawyer
Print name: Anna Layer
Title: Account Installation Manager
Date: 9/13/2022

The client and Humana have caused this agreement to be executed by their respective officers or representatives as duly authorized.

1. Plan Sponsor

Legal name of plan sponsor:	Fleming Mason Energy Coop Inc.
Plan sponsor DBA name:	Fleming Mason Energy
Common name of plan sponsor:	Fleming Mason Energy
Federal Tax ID Number: Name provided must match the tax ID number reported to the IRS.	61-0193917
Location address: (No P.O. boxes)	1449 Elizaville Rd. Flemingsburg, KY. 41041
County:	Fleming
Mailing address:	PO Box 328 Flemingsburg, KY. 41041
County:	Fleming
Management contact: (Primary plan decision maker)	Joni Hazelrigg
Title:	President & CEO
Mailing address:	1449 Elizaville Rd. Flemingsburg, KY. 41041
Telephone:	606-464-3144
Fax number:	N/A
Email address:	jhazelrigg@fme.coop
Administrative contact: (Day-to-day administrative contact)	Lauren Fritz
Title:	Office Manager
Mailing address:	1449 Elizaville Rd. Flemingsburg, KY. 41041
Telephone:	606-845-2661
Fax number:	N/A
Email address:	lfritz@fme.coop
Third-party Administrator:	N/A
Contact name:	
Mailing address:	
Telephone:	
Fax number:	
Email address:	

The account is sponsored by:
Employer

Organization type:
Privately Held Corporation

2. Product

The product type offered:

MAPD (Medical with Rx Rider)

The plan(s) design available:

Plan Type	Plan Number	Option Number	Rx Option	Medical Plan Design Exhibit	Rx Plan Design Exhibit
LPPO	079	060	1	See Attached	See Attached

3. Enrollment

Plan Year: 2023

Duration of the plan: 1/1/2023-12/31/2023

Estimated eligible enrollees: 38

Initial Open Enrollment Period: N/A

Annual Enrollment Period: N/A

Other insurance options offered through the plan sponsor:

No – Full Replacement

Humana is the only Medicare Advantage carrier offered to retirees. Medicare-eligible retirees are expected to move to the Humana plan unless the plan sponsors' rules allow retirees to remain on the active employee plan.

Other Medical and/or Prescription drug insurance options offered through the plan sponsor:

Note: Enrollees **may not** enroll into an individual MAPD or PDP plan and remain on this plan. If Humana plan is MA only, enrollees may enroll in a plan-sponsored PDP plan and remain on this plan. If Humana plan is a PDP only, enrollees may enroll in a plan-sponsored MA plan and remain on this plan.

Dental and/or Vision insurance options offered through the plan sponsor outside of Humana:

Initial enrollment method to be used:

Paper applications

Ongoing enrollment method to be used:

Paper applications

Paper applications will be sent to:

Humana

Note: Applications will need to be received by Humana prior to the effective date or within seven days of the signature date. Enrollment effective date is always the first of the month after the receipt date or a future effective month specified by the group.

Humana updates demographics for:

All

Note: For plan sponsors that use paper enrollment method, Humana is required to process an address change when a member contacts Humana with this information. If the plan sponsor contacts Humana with a demographic change, Humana must reach out to the member to confirm the change only if the member moves out of his or her current service area.

Additional enrollment comments:

4. Eligibility

Acceptance of ongoing Medicare Age-In Enrollments:
Aging-in retirees can enroll at any time

New enrollments received after the Open Enrollment Period: (Other than retirees aging-in to Medicare)
Yes, Humana can accept enrollments throughout the plan year

Acceptance of Medicare-eligible Spouses and/or Dependents:
Yes, Medicare eligible spouses and dependents may enroll

Split coverage is allowed if multiple plan options are offered:
N/A

Acceptance of Surviving Spouses at implementation:
Yes

The Spouse or Dependent will be able to remain on the plan if the retiree passes away:
Yes

Note: If an individual is eligible for or entitled to Medicare based solely on ESRD (end stage renal disease), Medicare Secondary Payer laws require that the Employer Group health plan offered by Employer Group be the primary payer for the first 30 months of the individual's Medicare eligibility or entitlement. The Employer Group agrees to confirm whether individuals seeking to enroll in the Plan are within this 30-month coordination period and also agrees not to seek enrollment in the Plan of any individuals during their 30-month coordination period.

Additional Eligibility comments:

Age-In Process:

Enrollment kits can be requested by emailing GroupMedicareSalesKitRequest@humana.com

5. Opt-out and Terminations

Opportunity for re-enrollment when a retiree opts out or terminates coverage from the plan:

No, retirees cannot elect back into the plan at a later date

The spouse or dependent will be able to remain on the plan if the retiree terminates coverage:

Yes

Note: If time limit is set that allows the spouse or dependent to remain on the plan, the plan sponsor is responsible for informing Humana **30 days before** the desired termination date.

Note:

- **Voluntary terminations** are initiated by the member. Requests for terminations must be made by a signed and dated letter submitted by the member specifically requesting a termination date. The request must be received prior to the requested end date.
- **Involuntary terminations** are initiated by the plan sponsor. These requests must be made in enough time for Humana to provide the member with 30 days notice of termination. Terminations must be submitted 30 days in advance of the requested end date. Requests submitted late will be processed for the next available end date per CMS regulation.

Additional opt-out/termination comments:

Consequences to a retiree if he or she opts out or terminates coverage from the plan:

No coverage on any other service.

6. ID Card

Name will be on the ID card:

No

If yes, the naming convention will be displayed as: (26 characters; M and W count as 1.5)

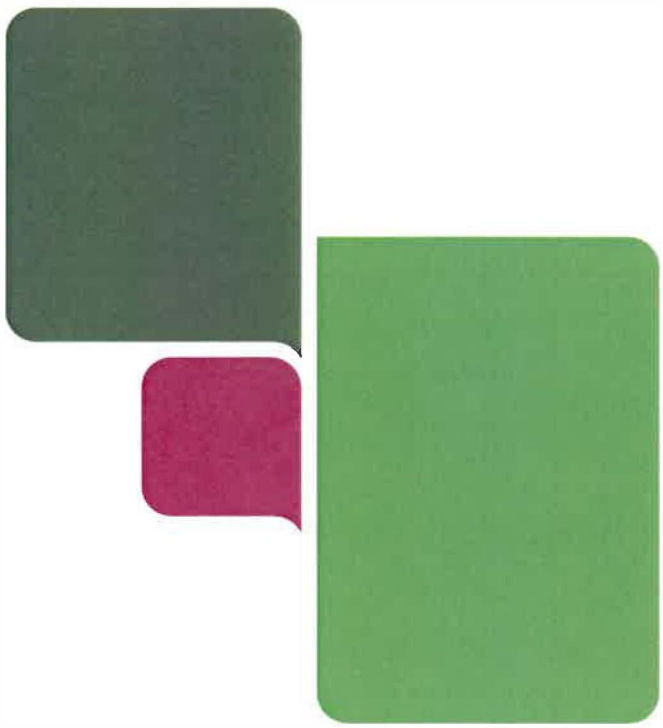
Customer Service number displayed on the ID card: 1-866-396-8810

The benefits selected below will appear on the ID cards:

- ☑ Office visit
- ☑ Specialist
- ☑ Hospital emergency

Note: • Coinsurances do not display on the ID card • Not applicable for **PDP** only

Plan sponsor logo will appear on ID card:



7. Billing Setup

The Billing Type will be:

Employer Billed

The plan sponsor pays full premium to Humana and coordinates payment from the member, if applicable. Members will be referred back to the designated contact and phone number provided by the group for questions related to premium information.

Customer Service will provide premium information to the members:

No, members can be referred to: Name: Kristy Turner

Phone: 606-845-2661

Plan sponsor will make a contribution to the premium: **If yes, the contribution amount will be**

Yes 100%

The plan sponsor will be:

Pay as billed Plan Sponsor will receive monthly invoice; Plan Sponsor group numbers will be combined unless requested otherwise.

Monthly payment method: (Payment is due at the first of the month. Example: January premium is due Jan. 1.)

Check

Type of premium:

Blended

If blended, the composite rate is:

Plan type/option	Blended rate
LPPO 079/060 w/ Rx 1	$334.74 PMPM

Separate billing address for the invoices:

No

Billing contact information:

Billing contact:

Mailing address:

Telephone:

Email address:

Additional billing setup comments:

The plan sponsor receives the retiree drug subsidy (RDS) or has an employer plan sponsor waiver plan (EGWP):
Neither

The plan sponsor will attest that all of the retirees enrolling in our plan(s) have had creditable prescription drug coverage before enrolling:
No

Note: Medicare requires continuous prescription drug coverage at or above the Original Medicare level since the member became Medicare eligible. Continuous coverage means going no more than 63 consecutive days without coverage.

The plan sponsor will pay late enrollment penalties (LEP) assessed by CMS for members who did not have creditable drug coverage:
No

Note: If the plan sponsor does not pay for the member's LEP, Humana will send the member a coupon booklet to pay for the LEP portion of the premium.

8. Renewals

Each year Humana must conduct a renewal process for plan-sponsored Medicare plans. In the interest of protecting the member's coverage, Humana will automatically term the Medicare Advantage plan if the plan sponsor does not respond to its renewal before 11/30/2023

1. Renewal date for next plan year: 01/01/2024

9. Member Communications

Coordination of Benefits (COB)
Humana's standard is to obtain coordination of benefit information at time of enrollment , and then annually thereafter if Medicare indicates the member could have other coverage. This information is collected in compliance with the Medicare Secondary Payer Act to ensure that Medicare should be the primary payer for the member.

Evidence of Coverage (EOC)
All new members receive a detailed description of their specific benefits through the EOC, which will arrive within 30 days of the effective date.

ID Card
All new members will receive an ID card prior to their effective date.

Acceptance/Acknowledgment Letter
Once the member is enrolled in the plan, they will receive a combined letter confirming their enrollment has been accepted by CMS.

Annual Notice of Change (ANOC)/EOC
Renewing members will receive a copy of the upcoming year's Annual Notice of Change (ANOC), which includes information on how to obtain the EOC.

Contact List

Fleming Mason Energy

Mailing Address: 1449 Elizaville Rd, Flemingsburg, KY 41041

Name	Title	Phone Number	Email
Brandon Hunt	President & CEO	606-845-2661	bhunt@fme.coop
Lauren Fritz	Office Manager	606-845-2661	lfritz@fme.coop
Kristy Turner	Accounting/HR	606-845-2661	kturner@fme.coop

Brown & Brown of KY, Inc.

Mailing Address: 4605 Lincoln Rd, Louisville, KY 40220

Name	Title	Phone Number	Email
Pat Morrison	Broker	(502) 241-7072	pmorrison@bblouisville.com
Tricia Gatrost	Account Manager	(502) 814-0645	Trish.gatrost@bbrown.com

Humana Account Management Team

Mailing Address: 500 West Main Street, WFP 19E, Louisville, KY 40202

Name	Title	Phone Number	Email
Gabriel Hellinger	Account Executive	502-476-1477	ghellinger@humana.com

Humana Operations Team

Mailing Address: 101 East Main Street, Louisville, KY 40202

Name	Title	Phone Number	Email
Anna Lawyer	Account Installation Manager	502.580.5115	apendley@humana.com
Michelle Smith	Communication Consultant	502-580-6946	GMCCMailbox@humana.com
Courtney Bell	Account Concierge	502-580-8049	groupmedicareacs@humana.com
Zac Greene	Bill Representative	502-476-7049	zgreene@humana.com
Jason Hall	Enrollment Analyst	502-710-7999x1140314	generalgrpmedicare@humana.com

Frequently Used Contacts

Member Customer Service:	(866) 396-8810
Enrollment Kit Requests:	GroupMedicareSalesKitRequest@humana.com
Telephonic Applications:	1-800-824-8242
Completed Enrollment Application Fax Line:	1-877-889-9936

Contact List

Group Medicare Resource List

Account Executive (AE)	Overall responsibility for the clients and members experience with Humana, which includes the client relationship, all aspects of account strategy development, and renewal delivery.	•Plan Performance /Plan Compass •Renewal rates •Commission questions •Schedule A requests
Consumer Engagement Professional (CEP)	Assists in day to day account management functions along with coordinating member education/engagement, open enrollment activity, reporting and monitors escalated inquiries.	•Humana Clinical mailing campaigns •BH2U •Community event sponsorships
Account Installation Manager (AIM)	Main point of contact for new and annual plan implementation. Responsible for managing day-to-day implementation details, plan setup and the internal account implementation team. Serves as your ongoing point of contact for all operational areas.	•Enrollment and Billing setup •Renewal system setup •ID card Issuance •ANOC/EOC Issuance •Benefit and claim administration
Communication Consultant (CC)	Responsible for pre-enrollment communications, coordinates seminars, provides ongoing communication support for select post-enrollment communications, ensures all CMS compliance regulations are met and members receive information timely.	•Announcement Letters •Enrollment Kits •Seminars
Account Concierge Specialist (ACS)	Direct point of contact for any member service related questions or issues. Works directly with you and the member to bring issues to full resolution.	•Escalated member concerns pertaining to Customer Service, claims and billing •Enrollment discrepancies •Member billing/premium discrepancies •Letters/phone calls that are of concern • Coverage/benefit issues
Dedicated Group Medicare Customer Care	A direct point of contact and resource for members to call with questions and issues. Provides immediate assistance for inquires.	•ID Card requests •Request for member materials such as enrollment kit, Summary of Benefits, Evidence of Coverage, Provider Directory •Address updates (if Humana handles) •Claim status questions and explanation • Enrollment verification • Requests for Humana ID/ Group numbers • Premium/billing inquiries (if Humana handles)

Let's talk about the **Humana Group Medicare Advantage PPO** Plan.

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact Humana, your employer/union group, or your employer group benefits plan administrator.	
Medical deductible	This plan does not have a deductible.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$2,500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$2,500** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$175** per admit	**$175** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$50** copay or **5%** of the cost	**$0** to **$50** copay or **5%** of the cost
Ambulatory surgical center	**$15** copay	**$15** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$5** copay	**$5** copay
Specialists	**$15** copay	**$15** copay
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	**$65** copay for Medicare-covered emergency room visit(s)	**$65** copay for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$5** to **$15** copay	**$5** to **$15** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$5** to **$50** copay	**$5** to **$50** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** to **$50** copay	**$0** to **$50** copay
Outpatient X-rays	**$5** to **$50** copay	**$5** to **$50** copay
Radiation therapy	**$15** to **$50** copay	**$15** to **$50** copay
HEARING SERVICES		
Medicare-covered hearing	**$15** copay	**$15** copay
DENTAL SERVICES		
Medicare-covered dental	**$15** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	**$15** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
VISION SERVICES		
Medicare-covered vision services	**$15** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$15** copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility	**$175** per admit	**$175** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$5** to **$40** copay **Partial Hospitalization:** **$15** copay	**Outpatient therapy visit:** **$5** to **$40** copay **Partial Hospitalization:** **$15** copay
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days	**$0** copay per day for days 1-20 **$50** copay per day for days 21-100	**$0** copay per day for days 1-20 **$50** copay per day for days 21-100
PHYSICAL THERAPY		
	$15 copay	**$15** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$50** copay	**$50** copay
PART B PRESCRIPTION DRUGS		
	20% of the cost	**20%** of the cost

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain **20** combined In & Out-of-Network visit limit per plan year Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$15** copay	**$15** copay
ALLERGY		
Allergy shots & serum	**$5** to **$15** copay	**$5** to **$15** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$15** copay	**$15** copay
COVID-19		
Testing and Treatment	Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.	
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$15** copay	**$15** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**20%** of the cost	**20%** of the cost
Medical supplies	**20%** of the cost	**20%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**20%** of the cost
Diabetes monitoring supplies	**0%** of the cost	**0%** of the cost

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**$5** to **$40** copay	**$5** to **$40** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$15** copay	**$15** copay
Cardiac rehabilitation	**$15** copay	**$15** copay
Pulmonary rehabilitation	**$15** copay	**$15** copay
RENAL DIALYSIS		
Renal dialysis	**$15** copay	**$15** copay
Kidney disease education services	**$0** copay	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$15** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
	SilverSneakers® is a total health and physical activity program that provides access to exercise equipment, group fitness classes, and social events.	
HEALTH EDUCATION SERVICES		
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	
MEAL BENEFIT		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.	
POST-DISCHARGE PERSONAL HOME CARE		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.	
POST-DISCHARGE TRANSPORTATION SERVICES		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by car, van or wheelchair accessible vehicle at no cost.	
SMOKING CESSATION (ADDITIONAL)		
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.		

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Let's talk about the **Humana Group Medicare Advantage Rx** Plan.

Find out more about the Humana Group Medicare Advantage Rx plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

Deductible

Pharmacy (Part D) deductible This plan does not have a deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$10** copay	**$10** copay
2 (Preferred Brand)	**$20** copay	**$20** copay
3 (Non-Preferred Drug)	**$40** copay	**$40** copay
4 (Specialty Tier)	**25%** of the cost	**25%** of the cost
90-day supply		
1 (Generic or Preferred Generic)	**$30** copay	**$0** copay
2 (Preferred Brand)	**$60** copay	**$40** copay
3 (Non-Preferred Drug)	**$120** copay	**$80** copay
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit **www.humana.com/SearchResources**, locate Prescription Drug section, select **www.humana.com/MedicareDrugList** link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP**2**.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on (even if you haven't paid your deductible, if applicable).

ADDITIONAL DRUG COVERAGE

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,660**.
You will continue to pay the same amount as when you were in the initial coverage stage.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay the greater of either:

- **$4.15** for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs, OR
- **5%** coinsurance

Notes

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 24
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 24. Provide detailed descriptions of all early retirement plans or other staff reduction programs Fleming-Mason Energy has offered or intends to offer its employees during the test year. Include all cost-benefit analyses associated with these programs.

Response 24. Fleming-Mason Energy employees may elect to retire on attaining early retirement date (age 55) at a reduced benefit with the defined benefit retirement plan. Fleming-Mason Energy did not offer a staff reduction plan in the test period and does not intend to in the future.

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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 25
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 25. Provide a complete description of Fleming-Mason Energy's other post-employment benefit package(s) provided to its employees.

Response 25. Upon retirement at age 55 or older, and with twenty or more years of employment, employees hired prior to March 4, 1993, have the privilege to continue in Fleming-Mason's group medical coverage at the level they had at date of retirement. The employee shall pay fifty percent of the cost with Fleming-Mason paying fifty percent until such time that the retired employee or spouse is eligible for Medicare. Fleming-Mason shall pay 100% of the cost of the Medicare supplement until the retired employee's death. Upon the retired employee's death, spousal coverage may be continued with the spouse paying 100% of the cost. Upon retirement at age 55 or older, with twenty or more years of employment, employees hired after March 4, 1993, shall have the privilege of continuing in Fleming-Mason's group medical coverage at the level they had on the date of retirement. The employee shall pay fifty percent of the cost with Fleming-Mason paying fifty percent until such time that the retired employee or spouse is eligible for Medicare. Upon reaching Medicare eligibility, all coverage ceases. Upon the retired employee's death, spousal coverage may be continued with the spouse paying 100% of the cost. The Medicare supplemental policy is with Humana, please see listed in Request 23.

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COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 26
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 26. Provide a complete description of the financial reporting and ratemaking treatment of Fleming-Mason Energy's pension costs.

Response 26. 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.

FLEMING-MASON ENERGY COOPERATIVE, INC.
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COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 27
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 27. Regarding Fleming-Mason Energy's employee compensation policy:

Request 27a. Provide Fleming-Mason Energy's written compensation policy as approved by the board of directors.

Response 27a. The Board of Directors maintains Policy 502. A copy of this policy is attached.

Request 27b. Provide a narrative description of the compensation policy, including the reasons for establishing the policy and Fleming-Mason Energy's objectives for the policy.

Response 27b. The employee compensation policy (502) is objectively written to establish a governing document on the pay period, reporting of time worked, and rate under which employees of the cooperative shall be paid. The purpose of the plan is to establish competitive compensation and employee retention. The key objectives of the plan include:

- attracting and retaining quality personnel to support Fleming Mason Energy
- ensuring pay administration is fair and equitable for all employees.
- ensuring pay opportunities for employees reflect changes in competitive compensation trends and economic conditions.

Request 27c. 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.

Response 27c. The compensation policy was developed in-house by senior management with the assistance of an outside consultant. A full compensation study is currently being prepared and will be filed under seal pursuant to a Motion for Confidential Treatment with Request 17 when complete.

Request 27d. Explain when Fleming-Mason Energy's compensation policy was last reviewed or given consideration by the board of directors.

Response 27d. The compensation policy was last reviewed by the board of directors in June of 2023.

POLICY NO. 502

EMPLOYEE'S PAY / COMPENSATION

I. OBJECTIVE

To establish a policy governing the pay period, reporting of time worked, work week and rate under which employees of the Cooperative shall be paid.

II. CONTENT

A. Pay Period:

Pay periods shall be on a bi-weekly basis with periods beginning at 12:01pm Friday and ending two weeks later on the following Friday at 12:00 pm. The pay period will consist of eight - 9-hour days and one – 8-hour day. Nine-hour days begin at 7:00 a.m. and end at 4:30 p.m. with ½ hour lunch period. Eight-hour day (every Friday) will begin at 7:30 a.m. and end at 4:30 p.m. with ½ hour lunch period. One-half of the full-time employees will work the first Friday of the pay period, the other one-half will work the second Friday of the pay period. Checks shall be issued during the week immediately following such pay period.

B. Reporting of Time Worked:

Each Supervisor shall prepare daily time sheets for himself or herself as well as all employees under his or her direct supervision. Time sheets shall show as accurately as possible all hours worked with time and mileage charged to the proper account, work order, and/or job.

C. Work Week:

Regular work week will begin at 12:01 p.m. on Friday and end the following Friday at 12:00 p.m. Each work week will consist of 40 hours regular time.

D. Temporary Remote Work:

Short-term remote working arrangements may be available for employees who require a temporary telecommuting arrangement for such things as recovery from an illness or injury, personal needs related to caring for family members, or short-term accommodations for other valid reasons. Remote work may be appropriate for some employees and jobs but not for others. Temporary remote work arrangements are granted at FME's sole discretion and can be revoked at any time and for any nondiscriminatory reason. Temporary remote work will not exceed six months.

E. Rate of Pay:

1. Regular Time - Rates of pay for the regular 40-hour work week shall be established in accordance with the job description and classification of the work to be performed.
2. Overtime – Hourly and non-exempt employees shall be paid at the rate of time and one half for all time worked in excess of forty (40) hours per regular work week.

Fleming-Mason Energy Cooperative, Inc.

3. Out-Of-State Storm Assistance - Employees working out-of-state for other utilities for storm restoration will be paid double time for all time worked in excess of forty (40) hours per regular work week. Employees working out-of-state will be guaranteed 16 hours per workday.
4. On Call Time - An hourly employee who is required to make him/herself available for duty by leaving instructions where he or she can be located shall receive:

Primary Person:	2 Hours per day
Two (2) Secondary Persons:	1 Hour per day

5. Holidays – In addition to receiving holiday time at the regular rate of pay, an hourly employee shall be paid double time for either/or On Call Time or actual time worked on FME holidays: New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving Day, Christmas (2 days). Personal Days do not qualify as a Holiday for purposes of this policy.
6. Sundays - An hourly employee shall be paid double time when called out to work on a Sunday. On-call time on Sundays does not qualify for double time.
7. Call Out Time - An hourly employee who is called out for duty after regular working hours shall receive a minimum of two (2) hours' pay in the event that employee is out less than two (2) hours. In the event such call out is more than two (2) hours in length that employees shall be paid for the entire time worked.

F. Competitive Pay

The FME compensation plan emulates the Kentucky average among electric cooperatives. All non-bargaining unit positions are internally evaluated and assigned to a salary grade, based on internal organizational equity. Each grade is defined by an entry, target (Kentucky/Local average) and maximum rate. As salary information becomes available (annually), all ranges will be updated to reflect changes and maintain pace with the Kentucky, National, and local labor market. Each position should reflect the pay range for the appropriate market. For instance, more skilled positions may have to reflect ranges outside of local and/or state levels.

FME will generally provide a standard wage increase (percentage) to employees on an annual basis to maintain competitiveness. This increase will be based on labor market changes and/or local cost of living.

FME salary increases may be based on individual performance and where current pay is relative to the position grade target. FME's competitive philosophy is to migrate all employees (who are proficient in their roles) to their plan target rate in no longer than an appropriate timeframe. Individual performance can accelerate progression to and above the target rate. Competitive pressure and the ability to attract and retain qualified human resources can also influence range positioning for employees.

G. Bonus Pay for Salaried Employees

Salaried employees will not receive hourly compensation for hours worked outside of a normal workday under normal conditions. Salaried employees will be eligible for compensation for bonus hours worked under the following conditions.

1. Storm restoration has lasted a consecutive 24-hour period. Multiple meters have been without power during this time and outage restoration efforts have went above the 24-hour period.

Fleming-Mason Energy Cooperative, Inc.

2. Employee must work consistently longer than 2 hours and conditions of 1). above must be met.
3. Any hours work over the minimum 2 hour trigger and meeting conditions 1) and 2). will be based on the following pay rate:
    a. Bonus Pay will be based on hours worked at normal rate of pay. Example 1 – outage event lasting 12 hours, salaried employees work on normal pay structure. Example 2 – outage event lasting over 24 hours, salaried employees will work the first 2 hours at normal pay structure (no hourly compensation). Any consecutive hours worked after that time period; bonus pay may be paid to those individuals meeting the criteria above. Justification for bonus pay will be at the discretion of the CEO. Pay will be structured around number of hours worked (minus 2 minimum hours) at a rate based off normal rate of pay.
    b. Employee goes home for mandatory rest during an outage event that is lasting over 24 hours. When the salaried employee returns to the same outage restoration, the first 2 consistently worked hours are again at a normal pay structure (no hourly compensation). Any consecutive hours after that will be paid with bonus pay based off the same condition above in (a).

III. RESPONSIBILITY

It shall be the responsibility of each supervisor to accurately report time worked on daily time sheets. It shall be the duty of each Department Head to review time sheets for proper accounting of time, mileage, leave, reporting time, etc. before signing and passing on to the payroll section.

Approved by Board of Directors: 9/02/2021; 05/04/2023;06/28/23

Last Revised: 10/01/2019; 05/04/2023; 06/28/23

Replaces: Operating Policy 29-3 Employee's Pay (Last Revised June 9, 2011)

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 28
RESPONSIBLE PERSON: Brandon Hunt
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 28. State whether Fleming-Mason Energy's expenses for wages, salaries, benefits, and other compensation included in the test year, and any adjustments to the test year, are compliant with the board of director's compensation policy.

Response 28. Fleming-Mason Energy's expenses for wages, salaries, benefits, and other compensation are compliant with the policies and procedures of Fleming-Mason Energy and its board of directors. The board delegates authority to the CEO to make hiring and salary decisions while following the guidelines for wages and salaries.

FLEMING-MASON ENERGY COOPERATIVE, INC.
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COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 29
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 29. Provide, in the format provided in Schedule I, the following information for Fleming-Mason Energy'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 of deferred compensation.

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

h. Healthcare benefit cost.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by the employee.

i. Dental benefits cost.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by employee.

j. Vision benefits cost.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by employee.

k. Life insurance cost.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by employee

l. Accidental death and disability benefits.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by employee

m. Defined Benefit Retirement.

(1) Amount paid by Fleming-Mason Energy.
(2) Amount paid by employee

n. Defined Contribution – 401(k) or similar plan cost. Provide the amount paid by Fleming-Mason Energy.

o. Cost of any other benefit available to an employee (specify).

Response 29. 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

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 30
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 30. For each item of benefits listed in Item 29 above where an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate was determined.

Response 30. The requested information was generally discussed in Ms. Fritz's testimony filed in support of the Application (Exhibit 9, page 8-10) Greater detail is provided below:

Healthcare/Medical Benefits: The employee is required to pay 20% of the cost of the premium. This contribution rate was determined in looking at local, state, and national benchmarks with the KREC plan.

Dental Insurance: The employee is required to pay 50% of the cost of the premium. This contribution rate was determined reasonable due to the lower cost in premium.

Vision Insurance: The employee is required to pay 50% of the cost of the premium. This contribution rate was determined reasonable due to the lower cost in premium.

Long-term & Short-Term Disability Insurance: The employee is required to pay 20% of the cost of the premium. This is required of full-time employees after ninety days of employment. This contribution rate was determined reasonable due to the low cost of premiums. Fleming-Mason switched from NRECA to One America in 2022 to create cost savings to both employer and employee.

AD&D Coverage: The employee is required to pay the full cost of the premium. This benefit is optional and deemed reasonable due to the low cost with NRECA.

Supplemental Life Insurance: The employee is required to pay full cost of the premium. This benefit is optional and deemed reasonable due to the low cost with NRECA.

Cancer, Heart, Accident Supplemental Insurance: The employee is required to pay full cost of the premium. This benefit is optional to the employee and is offered through Washington National Insurance Group.

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COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 31
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 31. Provide a listing of all healthcare plan categories, dental plan categories, and vision 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). 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 31. Please refer to Fleming-Mason Energy's responses to Request numbers 21 and 30.

FLEMING-MASON ENERGY COOPERATIVE, INC.
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FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 32
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 32. 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 32. Fleming-Mason Energy provides basic life insurance of two-times the salary for each employee. Fleming-Mason Energy pays 100% of the premiums for all employees for basic life insurance. An employee may, at his or her own expense, choose to purchase up to five-times his or her salary in supplemental life insurance. Additional AD&D insurance, spouse, and/or child life insurance may also be purchased at the employee's expense. This applies to all employees. Fleming-Mason Energy also provides AD&D insurance to all directors at no cost to the directors.

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COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 33
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 33. 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 33.

Defined Benefit		
	Employee Contribution Rate	Employer Contribution Rate
CEO	0%	100%
Directors	NOT OFFERED	
Managers	0%	100%
Supervisors	0%	100%
Exempt	0%	100%
Non-Exempt	0%	100%
Union	n/a	n/a
Non-Union Hourly	0%	100%
401(k)/Roth 401(k)		
	Employee Contribution Rate	Employer Contribution Rate
CEO	100%	1% after Employee 1%
Directors	NOT OFFERED	
Managers	100%	1% after Employee 1%
Supervisors	100%	1% after Employee 1%
Exempt	100%	1% after Employee 1%
Non-Exempt	100%	1% after Employee 1%
Union	n/a	n/a
Non-Union Hourly	100%	1% after Employee 1%

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 34
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 34. Provide an analysis of Fleming-Mason Energy's expenses for research and development activities for the test year and the three preceding calendar years. For the test year include the following:

Response 34. Fleming-Mason Energy has no research and development activities.

Request 34a. The basis of fees paid to research organizations and Fleming-Mason Energy's portion of the total revenue of each organization. Where the contribution is monthly, provide the current rate and the effective date.

Response 34a. Fleming-Mason Energy has no research and development activities.

Request 34b. Details of the research activities conducted by each organization.

Response 34b. Fleming-Mason Energy has no research and development activities.

Request 34c. Details of services and other benefits provided to Fleming-Mason Energy by each organization during the test year and the preceding calendar year.

Response 34c. Fleming-Mason Energy has no research and development activities.

Request 34d. Total expenditures of each organization including the basic nature of costs incurred by the organization.

Response 34d. Fleming-Mason Energy has no research and development activities.

Request 34e. Details of the expected benefits to Fleming-Mason Energy.

Response 34e. Fleming-Mason Energy has no research and development activities.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 35
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 35. Provide a running total of the following information concerning the cost of preparing this case:

Request 35a. 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).

Response 35a. Please see the attached schedule.

Request 35b. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in Item 35.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.

Response 35b. Please see the attached schedule.

Request 35c. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in Item 35.a. above. Updates will be due when Fleming-Mason Energy files its monthly financial statements with the Commission, through the month of the public hearing.

Response 35c. Fleming-Mason Energy will provide the requested monthly updates of the actual costs incurred in conjunction with the rate case.

CATAYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: August 1, 2023	**Invoice #:** 230708
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2022 COS & Rate Review Case No. 2023-00223 For Services Provided in July 2023

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Complete COS & Rate Design. Prepare testimony and exhibits for filing. Calls and/or emails with staff on same.	6.0 hours	$225.00	$1,350.00
				TOTAL	**$ 1,350.00**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 8/10/23
Ck No. 96204
Vnd No. 13770 Acct. Mo. 8
Acct No. 923.00 Item ID MSAD04 Amt. 1350.00
Rec'v Rpt

CATAYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: July 1, 2023	**Invoice #:** 230608
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2022 COS & Rate Review Case No. 2023-00223 For Services Provided in June 2023

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Complete COS & Rate Design. Present to BOD. Calls and/or emails with staff on same.	19.5 hours	$225.00	$ 4,387.50
				TOTAL	**$ 4,387.50**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 7/6/23
Ck No. 95974
Vnd No. 13770 Acct. Mo. 7

Acct No.	Item ID	Amt.
923.00	MSAD04	4387.50

Rec'v Rpt

CATAYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: June 1, 2023	**Invoice #:** 230512
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2022 COS & Rate Review Case No. _____ For Services Provided in May 2023

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Continue COS and rate design modeling. Calls and/or emails with staff on same.	18.0 hours	$225.00	$ 4,050.00
				TOTAL	**$ 4,050.00**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 6/15/23
Ck No. 95848
Vnd No. 13720 Acct. Mo. 6
Acct No. Item ID Amt.
923.00 MSAD04 4050.00
Rec'v Dept

CATALYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: April 1, 2023	**Invoice #:** 230308
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2022 COS & Rate Review Case No. _____ For Services Provided in March 2023

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Continue COS and rate design modeling. Calls and/or emails with staff on same.	7.0 hours	$225.00	$ 1,575.00
				TOTAL	**$ 1,575.00**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Brenda Hunt

Fleming - Mason Energy
Ck Date 4/20/23
Ck No. 95408
Vnd No. 13770 Acct. Mo. 4

Acct No.	Item ID	Amt.
923.00	MSADDL	1575.00

Rec'v Rpt

CATAYST
CONSULTING LLC
3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: May 1, 2023	**Invoice #:** 230406
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2022 COS & Rate Review Case No. _____ For Services Provided in April 2023

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Continue COS and rate design modeling. Calls and/or emails with staff on same.	8.5 hours	$225.00	$ 1,912.50
				TOTAL	**$ 1,912.50**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 5/4/23
Ck No. 95570
Vnd No. 13770 Acct. Mo. 5

Acct No.	Item ID	Amt.
923.00	MSAP 04	1912.50

Rec'v Ref: _____

CATAYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: March 1, 2023	**Invoice #:** 230211
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2021 Rate Review For Services Provided in February 2023

923.00 MSAD 04

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Process initial data request responses to populate COS model. Calls and/or emails with staff on same.	7.5 hours	$225.00	$ 1,687.50
				TOTAL	**$ 1,687.50**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 3/9/23
Ck No. 95203
Vnd No. 13770 Acct. Mo. 3

Acct No.	Item ID	Amt.
923.00	MSAD 04	1687.50

Receipt

CATAYST
CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

INVOICE

Date: October 1, 2022	**Invoice #:** 220906
Client: Fleming-Mason Energy 1449 Elizaville Rd Flemingsburg, KY 41041 Attn: Lauren Fritz	**Project:** 2021 Rate Review For Services Provided in September, 2022

923.00 MSAD 04

	Item	Description	Qty	Rate	Amt
1	Consulting Services	John Wolfram – consulting support. Prepare initial revenue requirement model. Calls and/or emails with staff on same.	2.0 hours	$225.00	$ 450.00
				TOTAL	**$ 450.00**

Please remit payment to Catalyst Consulting LLC at the address listed above. Thank you.

Fleming - Mason Energy
Ck Date 10/6/22
Ck No. 94273
Vnd No. 13770 Acct. Mo. 10

Acct No.	Item ID	Amt.
923.00	MSAD 04	450.00

Rec'v By

CAMPBELL ROGERS & STACY PLLC

INVOICE

Invoice # 3445
Date: 07/03/2023
Due Upon Receipt

154 Flemingsburg Road
Morehead, Kentucky 40351

Fleming - Mason Energy
Ck Date 7/6/23
Ck No. 95973
Vnd No. 13432 Acct. Mo. 7

Acct No.	Item ID	Amt.
923.00	MSADD2	4490.00

Rec'v Rpt

Fleming-Mason Energy
1449 Elizaville Road
P.O. Box 328
Flemingsburg, Kentucky 41041

02647-Fleming-Mason Energy-18-General

General

Type	Date	Notes	Quantity	Rate	Total
Service	04/10/2023	Review proposed AppHarvest modifications to contract	0.25	$200.00	$50.00
Service	04/18/2023	Review proposed policy changes.	0.50	$200.00	$100.00
Service	04/25/2023	Prep opinion letter re Tim Eldridge EKPC qualifications.	0.25	$200.00	$50.00
Service	05/02/2023	Nominating Comittee meeting at FME	0.50	$200.00	$100.00
Expense	05/03/2023	Reimbursable expenses: Software Management- login charge for Fleming County Clerk	1.00	$15.00	$15.00
Expense	05/03/2023	Reimbursable expenses: Software Management- Robertson County Clerk login charge	1.00	$15.00	$15.00
Service	05/03/2023	Deed research re easements	1.25	$200.00	$250.00
Expense	05/05/2023	Recording Fees: Robertson County Clerk recording fee for easement	1.00	$50.00	$50.00
Expense	05/05/2023	Recording Fees: Bath County Clerk recording fee for easement	1.00	$50.00	$50.00
Expense	05/05/2023	Recording Fees: Mason County Clerk recording fee for easement	1.00	$50.00	$50.00
Expense	05/05/2023	Recording Fees: Fleming County Clerk recording fee for 2 easements	1.00	$100.00	$100.00
Service	05/18/2023	Receive and respond to capital credit question from Financial Officer	0.10	$200.00	$20.00
Service	05/23/2023	Research capital credit bankruptcy issue.	0.75	$200.00	$150.00

Service	05/29/2023	Receive and respond to email to General Manager re rate case information.	0.50	$200.00	$100.00
Service	05/29/2023	Review proposed Easement re underground line Rowan County. Deed research	0.50	$200.00	$100.00
Service	06/05/2023	Email exchange with Tim Lowe re easement	0.25	$200.00	$50.00
Service	06/06/2023	Receive and respond to emails with CEO. Review insurance documents.	0.50	$200.00	$100.00
Service	06/14/2023	Receive email from CEO. Review ROW contract. Draft email to CEO	0.50	$200.00	$100.00
Service	06/28/2023	Annual Membership meeting	1.50	$200.00	$300.00
Service	06/29/2023	Deed research re Easements: Bath, Fleming, and Lewis	1.00	$200.00	$200.00
Expense	06/29/2023	Reimbursable expenses: Online deed research fee-Fleming County	1.00	$15.00	$15.00
				Subtotal	**$1,965.00**

05067-Fleming-Mason Energy-22-PSC Environmental Surcharge Review PSC 2022-00141

PSC Environmental Surcharge Review PSC 2022-00141

Type	Date	Notes	Quantity	Rate	Total
Service	06/20/2023	Receive and review entry of appearance and Motion	0.25	$200.00	$50.00
				Subtotal	**$50.00**

05325-Fleming-Mason Energy-22-PSC Investigation of Fuel Adjustment Clause 2022-00190

PSC Investigation of Fuel Adjustment Clause 2022-00190

Type	Date	Notes	Quantity	Rate	Total
Service	06/13/2023	Receive and review Order	0.10	$200.00	$20.00
Service	06/14/2023	Receive and review filing and Order	0.10	$200.00	$20.00
				Subtotal	**$40.00**

05326-Fleming-Mason Energy-22-PSC Investigation of Demand Practices 2022-00370

PSC Investigation of Demand Practices 2022-00370

Type	Date	Notes	Quantity	Rate	Total
Service	06/14/2023	Receive and review order	0.10	$200.00	$20.00
			Subtotal		**$20.00**

05573-Fleming-Mason Energy-23-John Luhrman easement issue, Fleming County

John Luhrman easement issue, Fleming County

Type	Date	Notes	Quantity	Rate	Total
Service	04/10/2023	Receive and review emails and phone conf with CEO	0.25	$200.00	$50.00
Expense	04/11/2023	Reimbursable expenses: Software Management-Online research fee Mason County Clerk.	1.00	$15.00	$15.00
Service	04/11/2023	Review docs. Deed research. Prep letter to attorney. Email CEO	1.00	$200.00	$200.00
			Subtotal		**$265.00**

05684-Fleming-Mason Energy-23-Public Service Commission Rate Case

Public Service Commission Rate Case

Type	Date	Notes	Quantity	Rate	Total
Service	05/30/2023	Phone conf with CEO and Office Manager and Consultant to review study and discuss timeline	1.50	$200.00	$300.00
Service	05/30/2023	Receive and respond to emails from CEO and consultant	0.25	$200.00	$50.00
Service	06/05/2023	File work: shephardizing KAR, KRS, prior rate cases referenced in recent rate case one PSC Order referenced was miscited - think I foudn the order talked about - copy provided to Earl	3.00	$150.00	$450.00

Service	06/19/2023	Phone conf w CEO	0.25	$200.00	$50.00
Service	06/20/2023	Receive and review emails from consultant and CEO	0.25	$200.00	$50.00
Service	06/21/2023	Review drafts from consultant	0.50	$200.00	$100.00
Service	06/27/2023	Review final Cost of Service Study Draft resolution for Board of Directors.	2.00	$200.00	$400.00
Service	06/29/2023	Research. Draft Election and Notice of Intent. Phone conf with CEO and PSC Review Draft of public notice	3.50	$200.00	$700.00
Service	06/29/2023	Phone contact with PSC. Finalize Notice of Intent and file.	0.25	$200.00	$50.00
				Subtotal	**$2,150.00**
				Total	**$4,490.00**

Detailed Statement of Account

Current Invoice

Invoice Number	Due On	Amount Due	Payments Received	Balance Due
3445	07/03/2023	$4,490.00	$0.00	$4,490.00
			Outstanding Balance	**$4,490.00**
			Total Amount Outstanding	**$4,490.00**

Please make all amounts payable to: Campbell Rogers & Stacy PLLC

Payment is due upon receipt.

7/5/23

Jennifer McRoberts

From: Lauren Fritz
Sent: Monday, August 28, 2023 9:55 AM
To: Jennifer McRoberts
Subject: FW: Fleming-Mason rate case

From: Earl Rogers <earl@campbellrogers.com>
Sent: Monday, August 28, 2023 9:54 AM
To: Lauren Fritz <lfritz@fme.coop>
Subject: Fleming-Mason rate case

Lauren
At this stage I would estimate my fees for the remainder of this rate case to be $45,000.
Obviously this is an estimate and the final amount will depend on the hours required.

EARL ROGERS III

CAMPBELL ROGERS & STACY PLLC

154 Flemingsburg Road

Morehead, Kentucky 40351

(606)-783-1012

(606)-784-8926 fax

Proposal for Consulting Services For

Fleming Mason Energy Cooperative, Inc.

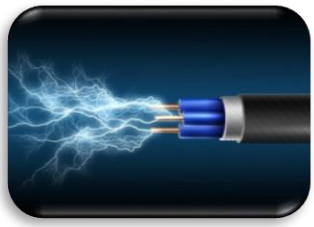
Cost of Service Study & Rate Design

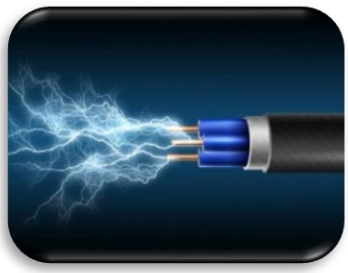
August 31, 2022

Submitted By

CATALYST

CONSULTING LLC





CATALYST

CONSULTING LLC

3308 Haddon Road
Louisville, KY 40241
(502) 599-1739
johnwolfram@catalystcllc.com

August 31, 2022

Brandon Hunt, P.E.
President/CEO
Fleming Mason Energy Cooperative, Inc.
1449 Elizaville Road
Post Office Box 328
Flemingsburg, KY 41041

Dear Brandon,

Thank you for giving Catalyst Consulting LLC the opportunity to submit a proposal to assist Fleming Mason Energy Cooperative Inc. in performing a cost of service and rate design study.

Please let me know if you have any questions about this proposal. I look forward to assisting you on this initiative.

Sincerely,

John Wolfram
Principal

Enclosure

Table of Contents

Executive Summary

This proposal provides a quote for consulting services to assist Fleming Mason Energy Cooperative, Inc. ("Fleming Mason") by

1) collecting the data necessary to perform a cost of service and rate study;

2) determining the target annual revenue requirement;

3) preparing a fully allocated, embedded cost of service analysis which will utilize a cost of service model that functionally assigns, classifies, and allocates all the utility's accounting costs and plant for a twelve-month test period;

4) determining and/or reviewing pro forma adjustments to reflect any known and measurable changes to the test period values;

5) calculating a rate of return for each rate class;

6) calculating per-unit costs which reflect unbundled cost-based rates for each rate class;

7) evaluating how well each rate component in the current rates reflects cost causation and recommending alternatives for rate modifications that would better reflect cost causation;

8) designing electric rates;

9) delivering a presentation to the Board of Directors regarding cost of service study results;

10) preparing and supporting a rate filing before the Kentucky Public Service Commission ("Commission").

To make the cost of service study more useful, Catalyst Consulting will provide Fleming Mason with all the cost of service models, consumption analyses, and rate design models electronically in Microsoft Excel® format at the end of the study.

Scope of Work

Catalyst Consulting will perform the following services on this project.

1. Data Collection & Review

Catalyst Consulting will provide Fleming Mason with a list of information required to conduct the studies. Additional items and/or discussion around the data required for filing a rate case may follow initial review. Catalyst Consulting will review the data provided and may assist with preparing the filing requirements for a rate case.

2. Revenue Requirement

a) Catalyst Consulting will work with Fleming Mason staff to prepare the estimated annual target margins for electric operations.

b) Catalyst Consulting will work with Fleming Mason to develop pro forma adjustments, based on information provided by the utility, to ensure that the cost of service study reflects revenues and expenses that will be incurred when the new rates become effective.

3. Cost of Service Study

a) Catalyst Consulting will develop a fully-allocated, embedded cost-of-service study to identify the relative responsibility of each electric rate classification for the recovery of the costs of service.

b) The cost of service study will utilize a standardized Microsoft Excel® model that functionally assigns, classifies, and allocates all of the utility's accounting costs for the twelve month test period. The first step will be to ***functionalize*** all of the utility's costs into major functional groups. Functionalizing costs in this manner will permit the study to be used to develop unbundled rates, as described below. The second step will be to ***classify*** all functionalized costs as energy-related, demand-related, customer-related. The third step will be to ***allocate*** the functionalized and classified costs to the classes of customers identified by the utility. The classes of customers will generally correspond to the utility's rate schedules and special contract customers (if any). The methods used to functionally assign, classify, and allocate costs adhere to industry-accepted practices and have been accepted by regulators in numerous formal rate proceedings.

c) Catalyst Consulting will identify the revenue requirement associated with each functional (unbundled) category. The revenue requirement will be expressed both in dollars and on a per unit cost basis. Catalyst Consulting will allocate Fleming Mason's functionalized revenue requirement to the rate classes as appropriate.

d) Catalyst Consulting will calculate a rate of return for each rate class and for the overall system.

e) Catalyst Consulting will develop per-unit costs for customer, energy, and demand cost components from the cost of service study ("cost-based rates").

f) Catalyst Consulting will provide a copy of the cost of service model and related schedules in electronic format so that Fleming Mason can use the models to perform further analysis on detailed cost information, evaluate management decisions, or explore additional rate options.

4. Rate Design

a) In consultation with management, Catalyst Consulting will develop an appropriate set of rate design criteria and objectives.

b) Catalyst Consulting will review the current Fleming Mason rate structure and identify any differences between the current rates and the cost-based rates from the cost of service study.

c) Catalyst Consulting will work with Fleming Mason to design the appropriate utility rate schedules that provide revenue recovery sufficient to cover the total system revenue requirement, taking into consideration the revenue responsibility indicated by the cost of service study and Fleming Mason's rate design policies and objectives. The rate design will include any proposed revisions to existing rate structures and classifications desired by Fleming Mason's management team or Board of Directors.

d) Catalyst Consulting will develop analyses for each existing rate class served by Fleming Mason that show the billing determinants for each rate component and the revenue derived from each component and show the same billing units applied to the new proposed rate design. This shows the revenue that will be generated from the new rate design versus the old rate design and helps to ensure that the utility will receive the revenue that it needs from the new rates.

e) Catalyst Consulting will explore other rate alternatives as directed by Fleming Mason's

management and/or Board of Directors.

5. Board Presentation(s)

Catalyst Consulting will deliver presentation(s) to Fleming Mason's Board and management team regarding the results of the cost of service and rate studies, as desired.

6. Support Rate Filing

a) Catalyst Consulting will prepare testimony and exhibits for a rate filing before the Commission to implement the rates approved by Fleming Mason's Board.

b) Catalyst Consulting will assist Fleming Mason with developing filing requirements, exhibits or other schedules as desired.

c) Catalyst Consulting will participate fully in the rate proceeding and provide broad support to the utility. This includes providing strategic guidance on the development of the filing, drafting direct testimony, preparing exhibits and schedules, drafting written responses to data requests, reviewing intervenor testimony, developing data requests, sponsoring rebuttal testimony, contributing to possible settlement negotiations, assisting in witness preparation, participating in formal hearings, preparing responses to post-hearing data requests, and assisting in the development of post-hearing briefs if applicable. The approach is to fully partner with Fleming Mason on the filing, from start to finish, and to help in every way desired, to help achieve the most favorable ruling possible from the Commission.

7. Financial Assessment

Catalyst Consulting will prepare high-level analysis of current revenue requirements, on a monthly basis, to serve as an initial assessment of the financial health of the utility. This will be on an unadjusted basis using the most recent 12 months of financial data. These assessments can be repeated monthly until such time as the management team and/or Board of Directors elect to proceed with the other proposed items in the Scope of Work.

Study Schedule

Catalyst Consulting will complete this study in a timely manner and will work with Fleming Mason's staff to meet the desired deadlines. Studies ordinarily require approximately three months. The critical path item for achieving this target is the timely provision of test period data and company information noted in Scope of Work Item 1.

Pricing & Fee Schedules

For all activities on this project, Catalyst Consulting will charge for services at the following hourly rates:

Member	John Wolfram	$225 per hour

The hourly rates quoted are effective through December 31, 2022.

The cost of the work described in the Scope of Work Items 1 and 3 for the cost of service study is fixed at $10,000. The cost estimate for the work described in Scope of Work Item 2 is $2,000. The cost estimate for each Presentation described in Scope of Work Item 5 is $1,500 plus travel. The cost for the work described in the Scope of Work Item 4 will vary based on the extent of necessary rate revisions and for Scope of Work Item 6 will vary based on the type of rate filing, the number of data requests and the overall complexity of the formal proceeding before the Commission. These items are challenging to estimate accurately. The cost estimate for the work described in the Scope of Work Item 7 is up to $1,000.

Based on the nature of the filing, the entire project in total is estimated to cost as follows:

1) Traditional cost of service study and rate filing: $45,000
2) Streamlined rate filing with cost of service study, revenue increase and rate changes: $20,000
3) Streamlined rate filing with cost of service study and revenue neutral rate changes: $18,000

For all travel (if any) Catalyst Consulting will bill the actual reasonable cost of transportation, meals, lodging, and incidentals. Mileage reimbursement will be in accordance with rates allowed by the IRS. Catalyst Consulting may also bill for other ad hoc expenses, including printing, shipping, etc., if incurred. Reasonable efforts will be made to minimize expenses and obtain advantageous pricing.

For any activities that are not expressly provided for in the Scope of Work, Catalyst Consulting will bill for its services based on the time spent performing the requested services, for the actual costs of travel, accommodations, and ad hoc expenses reasonably incurred.

Company Information

Contact Information

Company contact information for Catalyst Consulting LLC is as follows:

Catalyst Consulting LLC
John Wolfram, Principal
3308 Haddon Road
Louisville, Kentucky 40241
Phone： (502) 599-1739
Email: johnwolfram@catalystcllc.com
Web: www.catalystcllc.com
Linkedin: www.linkedin.com/in/johnwolfram

Initial Data Request

To perform the activities outlined in the Scope of Work, Catalyst Consulting will require the following information.

1) RUS Financial and Operating Report Electric Distribution report (formerly known as RUS Form 7) for the test year to be used in the cost of service study.

2) Trial Balance – showing operating revenues, expenses, and plant balances by RUS account number (consistent with RUS Bulletin 1767B-1) for the twelve month test period.

3) Year-End Accumulated Depreciation (depreciation reserve) by primary Plant Account Number. If not available, please provide by major functional group (i.e., Distribution, Transmission).

4) Annual Depreciation Expenses by primary Plant Account Number. If not available, please provide by major functional group.

5) Labor expenses by primary O&M account (i.e., labor dollars that have been expensed).

6) Monthly Billing Determinants for the test year by rate schedule. This includes all information necessary to reproduce the test period billings. As much detail as possible is desired. Billing determinants include the following, by month and by rate schedule:
   a. Number of customers,
   b. kWh sales,
   c. kW billing demand (CP or NCP as billed, or both if possible)
   d. Revenue for each rate schedule.
   e. For Seasonal and TOU rate schedules, if any, please provide data by each rate block or On-Peak/Off-Peak period.

7) Monthly unit charges billed under all rate tracking mechanisms by rate class. Also please include any other monthly charges that are billed in the monthly revenue.

8) Load data for individual customers within various rate classes. As much information about load as possible is desired. Data showing estimated load at the time of the system peak is desired or any other customer load data that would permit a more

accurate estimate of customer demands by rate class at the time of the system peak. This includes monthly class maximum demands (NCP), monthly class coincident peak demands (CP), and monthly sum of the individual customer maximum demands for each class. Hourly system loads are also desired if available.

9) Hourly load data by rate class for 12 months for all classes for which a Time Of Use Rate is required, if available. If not available, any estimation of on-peak/off-peak differential based on experience or other data would be useful.

10) Monthly Purchased Power Detail for the 12-month test year. This includes invoices for wholesale power supply purchases, other transmission costs billed to Fleming Mason if any, or any other billed amounts & invoices related to monthly purchased power expenses.

11) Copy of the Wholesale Supplier's Rate Schedule (including any riders or power cost adjustments) applicable to the test year and any announced or projected schedules on a prospective basis.

12) Estimate of installed cost of meters by rate schedule (i.e., meter installation and equipment cost for a typical customer served under each rate schedule.) This information would typically be provided by the utilities' engineering department and would be based on the *best engineering estimate* of what it currently costs to install a meter for a typical customer served under each major rate schedule (including the cost of the meter and installation costs that are booked in Account 370).

13) Estimate of installed cost of services by rate schedule (i.e., service installation and equipment cost for a typical customer served under each rate schedule.) This information would typically be provided by the utilities' engineering department and would be based on the *best engineering estimate* of what it currently costs to install a service for a typical customer served under each major rate schedule (including the cost of the service and installation costs that are booked in Account 369).

14) Continuing Property Records – CPR plant detail for the following accounts (including number of units and investment by type of equipment):

    a. Account 364 – Poles, Towers and Fixtures
    b. Account 365 – Overhead Conductors and Devices
    c. Account 367 – Underground Conductors

d. Account 368 – Line Transformers (if account includes station transformers, then differentiate between line transformers and station transformers)

15) Number of streetlights and outdoor lights under each lighting schedule by month by rate schedule.

16) Copy of all special contracts, if any.

17) Any information from previous rate adjustments or studies that may be pertinent to this study.

Catalyst Consulting will require frequent interaction with members of the Fleming Mason staff during this project, especially with employees from the finance and accounting area.

Additional information may be required after review of the data or policies requested above.

Please feel free to ask any questions regarding these data requirements.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 36
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 36. Provide the following information for the most recent calendar year concerning Fleming-Mason Energy and any affiliated service corporation or corporate service division/unit:

Request 36a. A schedule detailing the costs charged, either directly or allocated by Fleming-Mason Energy to the service company. Indicate Fleming-Mason Energy's accounts where these costs were originally recorded. For costs that are allocated, include a description of the allocation factors utilized.

Response 36a. Please see attached.

Request 36b. A schedule detailing the costs charged, either directly or allocated, by the service company to Fleming-Mason Energy. Indicate Fleming-Mason Energy's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

Response 36b. Please see attached.

INVOICE	DATE	PO NO	INVOICE DESCRIPTION	REF NUM	PAYDTE	AMOUNT	TAX	PAID	CKDATE/ VOID	CHECK/ ACH SEQ
VENDOR: 14236 FM UTILITY RESOURCES										
1054	011022		ROW 1/3-1/9		011322	6205.70	.00	6205.70	011322	515
1055	011722		ROW 1/10-1/16		012022	6909.15	.00	6909.15	012022	518
1056	012422		ROW 1/17-1/23		012722	6566.30	.00	6566.30	012722	521
1058	013122		ROW 1/24-1/30		021022	6891.60	.00	6891.60	021022	531
1059	020722		ROW 1/31-2/6		021022	5383.06	.00	5383.06	021022	531
1060	021422		ROW 2/7/22-2/13/22		021722	6891.60	.00	6891.60	021722	541
1062	022122		ROW 2/14/22-2/203/22		022422	7052.98	.00	7052.98	022422	544
1063	022822		ROW 2/21/22-2/27/22		030322	6923.80	.00	6923.80	030322	546
1064	030722		ROW 2/28/22-3/6/22		031022	6451.60	.00	6451.60	031022	556
1065	031422		ROW 3/7/22-3/13/22		031722	4656.22	.00	4656.22	031722	559
1066	032122		ROW 3/14/22-3/30/22		032422	6891.60	.00	6891.60	032422	561
1067	032822		ROW 3/21/22-3/27/22		033122	6891.60	.00	6891.60	033122	570
1068	040422		ROW 3/28/22-4/3/22		040722	6891.60	.00	6891.60	040722	574
1069	041122		ROW 4/4/22-4/10/22		041422	6105.82	.00	6105.82	041422	584
1070	041822		ROW 4/11/22-4/17/22		042122	6627.85	.00	6627.85	042122	586
1071	042522		ROW 4/18/22-4/24/22		042822	6469.06	.00	6469.06	042822	587
1072	050222		ROW 4/25/22-5/1/22		050522	6603.74	.00	6603.74	050522	591
1073	050922		ROW 5/2/22-5/8/22		051222	6877.97	.00	6877.97	051222	600
1074	051622		ROW 5/9/22-5/15/22		051922	7371.30	.00	7371.30	051922	602
1075	052322		ROW 5/16/22-5/22/22		052622	6891.60	.00	6891.60	052622	604
1076	053122		ROW 5/23/22-5/29/22		060222	5111.65	.00	5111.65	060222	606
1077	060622		ROW 5/30/22-6/5/22		060922	4552.00	.00	4552.00	060922	616
1078	061322		ROW 6/6/22-6/12/22		061622	5144.40	.00	5144.40	061622	618
1079	062022		ROW 6/13/22-6/19/22		062322	8920.88	.00	8920.88	062322	620
1080	062722		ROW 6/20/22-6/26/22		063022	5230.43	.00	5230.43	063022	628

VENDOR: 14236 FM UTILITY RESOURCES

INVOICE	DATE	PO NO	INVOICE DESCRIPTION	REF NUM	PAYDTE	AMOUNT	TAX	PAID	CKDATE/ VOID	CHECK/ ACH SEQ
1081	070522		ROW 6/27/22-07/03/22		070722	4806.30	.00	4806.30	070722	632
1082	071122		ROW 07/04/22-07/10/22		071422	4670.00	.00	4670.00	071422	634
1083	071822		ROW 07/11/22-07/17/22		072122	5131.60	.00	5131.60	072122	636
1084	072522		ROW 07/18/22-07/24/22		072822	3927.46	.00	3927.46	072822	639
1085	080122		ROW 07/25/22-07/31/22		080422	5254.19	.00	5254.19	080422	642
1086	080822		ROW 08/01/22-08/07/22		081122	5906.60	.00	5906.60	081122	652
1087	081522		ROW 08/08/22-08/15/22		081822	7134.06	.00	7134.06	081822	654
1088	082222		ROW 08/15/22-08/21/22		082522	7397.63	.00	7397.63	082522	656
1089	082922		ROW 08/22/22-08/28/22		090122	6790.15	.00	6790.15	090122	658
1090	090522		ROW 08/29/22-09/04/22		090822	4183.54	.00	4183.54	090822	668
1091	091222		ROW 09/05/22-09/11/22		091522	7121.90	.00	7121.90	091522	672
1092	091922		ROW 09/12/22-09/18/22		092222	7844.64	.00	7844.64	092222	674
1093	092622		ROW 09/19/22-09/25/22		092922	6810.41	.00	6810.41	092922	675
1094	100322		ROW 09/26/22-10/02/22		100622	7840.81	.00	7840.81	100622	676
1095	101022		ROW 10/03/22-10/09/22		101322	6021.70	.00	6021.70	101322	686
1096	101722		ROW 10/10/22-10/16/22		102022	6918.70	.00	6918.70	102022	690
1097	102422		ROW 10/17/22-10/23/22		102722	8452.18	.00	8452.18	102722	692
1098	103122		ROW 10/24/22-10/30/22		110322	6252.78	.00	6252.78	110322	701
1099	110722		ROW 10/31/22-11/06/22		111022	6872.54	.00	6872.54	111022	703
1100	111422		ROW 11/07/22-11/13/22		111722	7347.78	.00	7347.78	111722	706
1101	112122		ROW 11/14/22-11/20/22		112322	6659.30	.00	6659.30	112322	709
1102	112822		ROW 11/21/22-11/27/22		120122	7120.90	.00	7120.90	120122	710
1103	120522		ROW 11/28/22-12/04/22		120822	6281.30	.00	6281.30	120822	719
1104	121222		ROW 12/05/22-12/11/22		121522	6228.90	.00	6228.90	121522	720
1105	121922		ROW 12/12/22-12/18/22		122222	7938.47	.00	7938.47	122222	724

INVOICE	DATE	PO NO	INVOICE DESCRIPTION	REF NUM	PAYDTE	AMOUNT	TAX	PAID	CKDATE/ VOID	CHECK/ ACH SEQ
VENDOR: 14236	FM UTILITY RESOURCES									
1106	122622		ROW 12/19/22-12/25/22		122922	7028.22	.00	7028.22	122922	726
1112	123122		2022 SURCHARGE		020223	20761.66	.00	20761.66	020223	743

VENDOR TOTAL: 349217.23

INVOICE	DATE	PO NO	INVOICE DESCRIPTION	REF NUM	PAYDTE	AMOUNT	TAX	PAID	CKDATE/ VOID	CHECK/ ACH SEQ

GRAND TOTAL: 349217.23

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 37
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 37. Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 36:

a. Provide the names of affiliates that provided some form of service to Fleming-Mason Energy and the type of service Fleming-Mason Energy received from each affiliate.

b. Provide the names of affiliates to whom Fleming-Mason Energy provided some form of service and the type of service Fleming-Mason Energy 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 37a. FM Utility Resources, LLC is a subsidiary of Fleming-Mason Energy, and provides Right-of-Way Services to the cooperative.

Response 37b. Fleming-Mason Energy does not provide services to any affiliate.

Response 37c. No service agreement with the affiliate described in 37a has been previously filed with the Commission.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 38
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 38. Describe the utility's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involved lobbying on the local, state, or national level.

Response 38. Fleming-Mason Energy has not engaged in lobbying activities.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 39
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 39. Regarding demand-side management, conservation, and energy-efficiency programs, provide the following:

Request 39a. A list of all programs currently offered by Fleming-Mason Energy.

Response 39a.

SimpleSaver- AC- This program allows for the installation of utility-provided switches on air conditioners 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.

CARES – Community Assistance Resources for Energy Savings - The program provides an incentive to enhance weatherization and energy efficiency services.

Request 39b. The total cost incurred for these programs by Fleming-Mason Energy in each of the three most recent calendar years.

Response 39b.

Costs related to demand-side management, conservation, and energy-efficiency programs

	2020	2021	2022
Revenues from EKPC			
Incentive to member	$ 40,915.54	$ 27,510.00	$ 25,065.00
Lost Revenue	$ 54,082.60	$ 28,802.00	$ 26,905.00
Administrative Cost	$ 5,610.00	$ 3,470.00	$ 3,290.00
	$ 100,608.14	$ 59,782.00	$ 55,260.00
Expenses			
Incentive to member	$ 40,915.54	$ 27,510.00	$ 25,065.00
Labor, benefits, uniforms, transportation, phone	$ 43,902.98	$ 43,594.00	$ 42,442.72
	$ 84,818.52	$ 71,104.00	$ 67,507.72
Net Income/(Expense)	$ (15,789.62)	$ 11,322.00	$ 12,247.72

Request 39c. The total energy and demand reductions realized through these programs in each of the three most recent calendar years.

Response 39c.

January 01, 2020 to December 31, 2020

Owner-Member	Fleming-Mason Energy	Totals YTD by Program	MWh / kWh and MW Saved through Dec 31, 2020			
Group / Program		Qty	MWh	kWh	Winter MW	Summer MW
⊟ Residential	2,051	2,051	314	314,018	0.042	0.024
CFL	0	0	0	0	0.000	0.000
Energy Audit - Billing Insights Audit	6	6	3	3,138	0.000	0.000
Heat Pump Retrofit (14 SEER)	22	22	166	165,726	0.000	0.007
Heat Pump Retrofit (15 SEER & up / Geo)	7	7	56	55,846	0.000	0.003
LED	2,000	2,000	48	48,000	0.008	0.005
LED-Promotional	3	3	0	72	0.000	0.000
TSE Home (Performance) (HERS 79 or below)	6	6	19	19,032	0.016	0.004
TSE Home (Prescriptive)	7	7	22	22,204	0.018	0.005
⊟ Switches	-6	-6	0	-30	0.000	-0.006
DLC AC	-6	-6	0	-30	0.000	-0.006
DLC WH	0	0	0	0	0.000	0.000
Total	2,045	2,045	314	313,988	0.042	0.018
MWh	314					
Winter MW	0.042					
Summer MW	0.018					

January 01, 2021 to December 31, 2021

Owner-Member	Fleming-Mason Energy	Totals YTD by Program	MWh / kWh and MW Saved through Dec 31, 2021			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
⊟ Residential	7,532	7,532	373	372,928	0.049	0.031
ENERGY STAR MANUFACTURED HOME	1	1	4	4,060	0.001	0.000
Heat Pump Retrofit (14 SEER)	20	20	151	150,660	0.000	0.006
Heat Pump Retrofit (15 SEER & up / Geo)	2	2	16	15,956	0.000	0.001
LED	7,500	7,500	180	180,000	0.030	0.018
LED-Promotional	2	2	0	48	0.000	0.000
TSE Home (Performance) (HERS 79 or below)	5	5	16	15,860	0.013	0.004
TSE Home (Prescriptive)	2	2	6	6,344	0.005	0.001
⊟ Switches	-4	-4	0	-25	-0.001	-0.003
DLC AC	-3	-3	0	-15	0.000	-0.003
DLC WH	-1	-1	0	-10	-0.001	0.000
Total	7,528	7,528	373	372,903	0.049	0.027
MWh	373					
Winter MW	0.049					
Summer MW	0.027					

January 01, 2022 to December 31, 2022

Owner-Member	Fleming-Mason Energy	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2022			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
⊟ Residential	5,530	5,530	314	313,972	0.040	0.025
Heat Pump Retrofit (14 SEER)	20	20	151	150,660	0.000	0.006
Heat Pump Retrofit (15 SEER & up / Geo)	1	1	9	9,060	0.000	0.001
LED	5,500	5,500	132	132,000	0.022	0.013
LED-Promotional	2	2	0	48	0.000	0.000
TSE Home (Performance) (HERS 79 or below)	7	7	22	22,204	0.018	0.005
⊟ Switches	-4	-4	0	-25	-0.001	-0.003
DLC AC	-3	-3	0	-15	0.000	-0.003
DLC WH	-1	-1	0	-10	-0.001	0.000
Total	5,526	5,526	314	313,947	0.040	0.022
MWh	314					
Winter MW	0.040					
Summer MW	0.022					

Request 39d. The total cost for these programs included in the historical test period and expected energy reductions to be realized from these programs.

Response 39d.

Costs related to demand-side management, conservation, and energy-efficiency programs

		2022
Revenues from EKPC		
	Incentive to member	$ 25,065.00
	Lost Revenue	$ 26,905.00
	Administrative Cost	$ 3,290.00
		$ 55,260.00
Expenses		
	Incentive to member	$ 25,065.00
	Labor, benefits, uniforms, transportation, phone	$ 42,442.72
		$ 67,507.72
	Net Income/(Expense)	$ 12,247.72

January 01, 2022 to December 31, 2022

Owner-Member	Fleming-Mason Energy	*Totals YTD by Program*	MWh / kWh and MW Saved through Dec 31, 2022			
Group / Program		**Qty**	**MWh**	**kWh**	**Winter MW**	**Summer MW**
⊟ Residential	5,530	5,530	314	313,972	0.040	0.025
Heat Pump Retrofit (14 SEER)	20	20	151	150,660	0.000	0.006
Heat Pump Retrofit (15 SEER & up / Geo)	1	1	9	9,060	0.000	0.001
LED	5,500	5,500	132	132,000	0.022	0.013
LED-Promotional	2	2	0	48	0.000	0.000
TSE Home (Performance) (HERS 79 or below)	7	7	22	22,204	0.018	0.005
⊟ Switches	-4	-4	0	-25	-0.001	-0.003
DLC AC	-3	-3	0	-15	0.000	-0.003
DLC WH	-1	-1	0	-10	-0.001	0.000
Total	5,526	5,526	314	313,947	0.040	0.022
MWh	314					
Winter MW	0.040					
Summer MW	0.022					

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 40
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 40. 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 40. Please see attached.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 41
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 41. Provide an analysis of Other Operating Taxes as shown in Schedule J for the most recent calendar year.

Response 41. Please see attached schedule.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 42
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 42. 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 Fleming-Mason Energy according to each invoice, and a description of the services provided.

Response 42. Please see attached.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 43
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 43. Provide the following information for Fleming-Mason Energy. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

Request 43a. A detailed analysis of all charges booked during the test 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.

Response 43a. Fleming-Mason Energy did not have advertising expenses in Account 913 but did have in 930 and those are shown in Schedule L1. Please see attached.

Request 43b. 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.

Response 43b. Please see attached.

Request 43c. 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 43c. Please see attached.

ACCOUNT ANALYSIS
FOR ACCT: 930.20 MISC GENERAL EXPENSE
DATE RANGE FROM 01/01/22 TO 12/31/22

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	MSAD 11	10		2095	01/06/22	VN 14919	.00	300.00	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR 00	30		112	01/13/22		3.00	111.81	.00	LABOR REGULAR
PY	20	131.60	LABR 06	30		112	01/13/22		1.00	37.27	.00	PERSONAL DAY
PY	20	131.60	LABR 00	30		122	01/27/22		7.00	260.82	.00	LABOR REGULAR
PY	20	131.60	LABR 02	30		122	01/27/22		1.00	37.26	.00	SICK LEAVE
PY	10	242.21	ACLB 01	30		212	01/31/22		5.00	186.30	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU 02	30		1	01/31/22		.00	10.22	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF 01	30		1	01/31/22		.00	121.44	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX 17	30		1	01/31/22		.00	14.83	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF 02	30		1	01/31/22		.00	138.70	.00	RETIREMENT 2%
JE	44	242.99	ACCU 01	30		1	01/31/22		.00	36.01	.00	VACATION ACCRUAL
JE	44	408.20	EMBF 04	30		1	01/31/22		.00	3.66	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF 06	30		1	01/31/22		.00	44.86	.00	EMPLOYER FICA
JE	44	408.30	EMBF 07	30		1	01/31/22		.00	10.49	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF 03	30		1	01/31/22		.00	3.71	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF 19	30		1	01/31/22		.00	5.27	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU 01	10		1	01/31/22	V FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS 06	30		1	01/31/22	V FJ28	.00	18.00	.00	STATE SALES AND USE TAX
AP	1	232.10	MPRL 10	50		2095	02/01/22	VN 1222	1500.00	2,226.00	.00	LED BULBS
AP	1	232.10	MSAD 11	10		2095	02/01/22	VN 1221	.00	176.38	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR 00	30		212	02/10/22		3.00	111.81	.00	LABOR REGULAR
PY	20	131.60	LABR 00	30		222	02/24/22		5.00	186.30	.00	LABOR REGULAR
PY	20	131.60	LABR 06	30		222	02/24/22		1.00	37.26	.00	PERSONAL DAY
PY	10	242.21	ACLB 01	30		312	02/28/22		5.00	186.30	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU 02	30		1	02/28/22		.00	7.06	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF 01	30		1	02/28/22		.00	111.96	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX 17	30		1	02/28/22		.00	12.71	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF 02	30		1	02/28/22		.00	118.91	.00	RETIREMENT 2%
JE	44	242.99	ACCU 01	30		1	02/28/22		.00	30.87	.00	VACATION ACCRUAL
JE	44	408.20	EMBF 04	30		1	02/28/22		.00	.31	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF 06	30		1	02/28/22		.00	31.13	.00	EMPLOYER FICA
JE	44	408.30	EMBF 07	30		1	02/28/22		.00	7.28	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF 03	30		1	02/28/22		.00	1.20	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF 19	30		1	02/28/22		.00	4.72	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU 01	10		1	02/28/22	V FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
AP	1	232.10	MSAD 11	10		2095	03/03/22	VN 14919	.00	300.00	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR 00	30		312	03/10/22		3.00	111.81	.00	LABOR REGULAR
AP	1	232.10	MPRL 10	50		2095	03/15/22	VN 13503	1500.00	6,428.48	.00	ANNUAL MTG - RAIN GAUGE
AP	1	232.10	MPRL 10	50		2095	03/15/22	VN 13503	1500.00	2,424.92	.00	ANNUAL MTG - KEY CHAIN LIGHT
AP	1	232.10	MPRL 10	50		2095	03/15/22	VN 13503	1500.00	2,913.16	.00	ANNUAL MTG - SPIRAL NOTEBOOK
AP	1	232.10	MPRL 10	50		2095	03/15/22	VN 13503	2000.00	1,627.46	.00	ANNUAL MTG - HAND SANITIZER
AP	1	232.10	MSAD 11	10		2095	03/21/22	VN 2844	.00	52.59	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR 00	30		322	03/24/22		8.00	298.08	.00	LABOR REGULAR
AP	1	232.10	MSAD 11	30		2095	03/25/22	VN 14251	.00	113.50	.00	MISC OFFICE EXP-SP BOARD MTG FOO
AP	1	232.10	MSAD 11	10		2095	03/25/22	VN 14251	.00	79.29	.00	MISC OFFICE EXP-KEC BD MTG LUNCH
AP	1	232.10	MSAD 11	50		2095	03/28/22	VN 1104	3500.00	2,328.70	.00	MEMBER HANDBOOKS
AP	1	232.10	MSAD 11	50		2095	03/28/22	VN 1104	3500.00-	.00	2,328.70-	MEMBER HANDBOOKS
AP	1	232.10	MSAD 11	50		2095	03/31/22	VN 12918	3500.00	2,328.70	.00	MEMBER HANDBOOKS
AP	1	232.10	MSAD 11	20		2095	03/31/22	VN 12426	.00	14.00	.00	MISCELLANEOUS OFFICE EXPENSES
PY	10	242.21	ACLB 01	30		412	03/31/22		6.00	223.56	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB 01	30		412	03/31/22		2.00	74.52	.00	ACCRUED LABOR - REGULAR

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	10	50		2095	03/31/22	VN 11081	43.00	508.22	.00	SHORT SLEEVE S-XL
AP	1	232.10	MPRL	10	50		2095	03/31/22	VN 11081	6.00	80.39	.00	SHORT SLEEVE 2XL
AP	1	232.10	MPRL	10	50		2095	03/31/22	VN 11081	2.00	29.91	.00	SHORT SLEEVE 3XL
AP	1	232.10	MPRL	10	50		2095	03/31/22	VN 11081	3.00	36.51	.00	SHORT SLEEVE LARGE TALL
AP	1	232.10	MPRL	10	50		2095	03/31/22	VN 11081	4.00	57.62	.00	SHORT SLEEVE XL TALL
AP	1	232.10	MPRL	10	50		2095	03/31/22	VN 11081	2.00	29.70	.00	SHORT SLEEVE 2XL TALL
JE	44	165.10	INSU	02	30		1	03/31/22		.00	9.46	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	03/31/22		.00	125.67	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	03/31/22		.00	15.26	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	03/31/22		.00	142.80	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	03/31/22		.00	37.08	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	03/31/22		.00	.05	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	03/31/22		.00	36.85	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	03/31/22		.00	8.62	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	03/31/22		.00	.00	2.06-	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	03/31/22		.00	5.67	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	03/31/22	V FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS	06	30		1	03/31/22	V FJ28	.00	821.64	.00	STATE SALES AND USE TAX
PY	20	131.60	LABR	00	30		412	04/07/22		.00	.13	.00	LABOR REGULAR
AP	1	232.10	MPRL	14	10		2095	04/11/22	VN 3475	.00	50.00	.00	ANNUAL MTG-NOMINATING COMMITTEE
AP	1	232.10	MPRL	14	10		2095	04/11/22	VN 15025	.00	50.00	.00	ANNUAL MTG-NOMINATING COMMITTEE
AP	1	232.10	MPRL	14	10		2095	04/11/22	VN 15026	.00	50.00	.00	ANNUAL MTG-NOMINATING COMMITTEE
AP	1	232.10	MPRL	14	50		2095	04/11/22	VN 13942	.00	50.00	.00	ANNUAL MTG-NOMINATING COMMITTEE
AP	1	232.10	MPRL	14	10		2095	04/11/22	VN 15027	.00	50.00	.00	ANNUAL MTG-NOMINATING COMMITTEE
AP	1	232.10	MSED	07	10		2095	04/17/22	VN 2844	.00	48.70	.00	MISCELLANEOUS
PY	20	131.60	LABR	00	30		422	04/21/22		8.00	298.08	.00	LABOR REGULAR
AP	1	232.10	MPRL	08	20		2095	04/21/22	VN 14459	.00	65.00	.00	MISC SERVICES EXPENSES
AP	1	232.10	MSAD	11	30		2095	04/25/22	VN 14251	.00	168.28	.00	MISC OFFICE EXP-BD MTG FOOD
AP	1	232.10	MPRL	15	50		2095	04/28/22	VN 11804	.00	381.60	.00	ANNUAL MTG-MISCELLANEOUS
PY	10	242.21	ACLB	01	30		512	04/29/22		7.00	260.82	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	04/30/22		.00	8.91	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	04/30/22		.00	118.97	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	04/30/22		.00	14.24	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	04/30/22		.00	133.26	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	04/30/22		.00	34.60	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	04/30/22		.00	.02	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	04/30/22		.00	34.72	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	04/30/22		.00	8.12	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	04/30/22		.00	.04	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	04/30/22		.00	5.31	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	04/30/22	V FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
AP	1	232.10	MPRL	10	50		2095	05/05/22	VN 1222	5500.00	8,745.00	.00	LED BULBS
AP	1	232.10	MPRL	10	50		2095	05/05/22	VN 1222	1600.00	3,392.00	.00	BLUE BUCKETS
PY	20	131.60	LABR	00	30		522	05/19/22		6.00	223.56	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		522	05/19/22		2.00	74.52	.00	SICK LEAVE
AP	1	232.10	MPRL	15	50		2095	05/23/22	VN 10638	.00	809.99	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MSAD	11	10		2095	05/25/22	VN 14251	.00	74.60	.00	MISC OFFICE EXP-KEC MTG
AP	1	232.10	MPRL	15	50		2095	05/25/22	VN 14251	.00	303.25	.00	ANNUAL MTG-MISC-SHIRTS
PY	10	242.21	ACLB	01	30		612	05/27/22		4.00	149.04	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		612	05/27/22		1.00	37.26	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		622	05/31/22		1.00	37.26	.00	ACCRUED LABOR - REGULAR

ACCOUNT ANALYSIS
FOR ACCT: 930.20 MISC GENERAL EXPENSE
DATE RANGE FROM 01/01/22 TO 12/31/22

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
PY	10	242.21	ACLB	01	30		622	05/31/22			1.00	37.26	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	05/31/22			.00	8.00	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	05/31/22			.00	105.49	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	05/31/22			.00	12.78	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	05/31/22			.00	119.58	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	05/31/22			.00	31.05	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	05/31/22			.00	31.24	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	05/31/22			.00	7.31	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	05/31/22			.00	.01	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	05/31/22			.00	4.77	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	05/31/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
AP	1	232.10	MSAD	11	10		2095	06/02/22	VN	12187	.00	375.00	.00	MISCELLANEOUS OFFICE EXPENSES
AP	1	232.10	MPRL	15	60		2095	06/14/22	VN	15073	.00	500.00	.00	ANNUAL MTG-MISCELLANEOUS
PY	20	131.60	LABR	00	30		622	06/16/22			4.00	149.08	.00	LABOR REGULAR
PY	20	131.60	LABR	05	30		622	06/16/22			2.00	74.54	.00	PERMISSION LEAVE
AP	1	232.10	MPRL	15	50		2095	06/26/22	VN	11123	.00	115.00	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15099	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15100	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15101	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15102	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15103	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15104	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15105	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15106	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15107	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	07	50		2095	06/27/22	VN	15108	.00	1,000.00	.00	ANNUAL MEETING-SCHOLARSHIPS
AP	1	232.10	MPRL	15	30		2095	06/27/22	VN	14251	.00	700.00	.00	ANNUAL MTG-MISC GIFT CARDS
AP	1	232.10	MPRL	15	50		2095	06/27/22	VN	14251	.00	34.90	.00	ANNUAL MTG-MISC-SHIRTS
AP	1	232.10	MPRL	15	50		2095	06/28/22	VN	1137	.00	42.40	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	15	50		2091	06/28/22	VN	3402	.00	200.00	.00	ANNUAL MTG-MISCELLANEOUS
PY	20	131.60	LABR	00	30		632	06/30/22			8.00	298.08	.00	LABOR REGULAR
AP	1	232.10	MPRL	15	50		2091	06/30/22	VN	9540	.00	156.00	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	15	50		2091	06/30/22	VN	10026	.00	270.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	15	50		2091	06/30/22	VN	1395	.00	125.00	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	15	50		2091	06/30/22	VN	1239	.00	149.00	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	15	50		2091	06/30/22	VN	14459	.00	25.92	.00	ANNUAL MTG-MISCELLANEOUS
PY	10	242.21	ACLB	01	10		712	06/30/22			18.00	1,145.02	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	20		712	06/30/22			174.00	6,780.63	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		712	06/30/22			120.00	3,643.11	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	40		712	06/30/22			27.00	1,102.91	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	60		712	06/30/22			45.00	1,423.89	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	02	30		712	06/30/22			2.00	93.38	.00	ACCRUED LABOR - OVERTIME
PY	10	242.21	ACLB	02	40		712	06/30/22			1.00	44.78	.00	ACCRUED LABOR - OVERTIME
JE	44	165.10	INSU	02	10		1	06/30/22			.00	24.11	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.10	INSU	02	20		1	06/30/22			.00	142.75	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.10	INSU	02	30		1	06/30/22			.00	89.64	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.10	INSU	02	40		1	06/30/22			.00	24.16	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.10	INSU	02	60		1	06/30/22			.00	29.98	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	10		1	06/30/22			.00	193.41	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	165.30	EMBF	01	20		1	06/30/22			.00	1,145.34	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	165.30	EMBF	01	30		1	06/30/22			.00	719.26	.00	EMPLOYEE'S GROUP INSURANCE

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	165.30	EMBF	01	40		1	06/30/22			.00	193.86	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	165.30	EMBF	01	60		1	06/30/22			.00	240.51	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	10		1	06/30/22			.00	23.43	.00	RETIRED EMPLOYEES EXPENSES
JE	44	228.30	EMEX	17	20		1	06/30/22			.00	138.77	.00	RETIRED EMPLOYEES EXPENSES
JE	44	228.30	EMEX	17	30		1	06/30/22			.00	87.14	.00	RETIRED EMPLOYEES EXPENSES
JE	44	228.30	EMEX	17	40		1	06/30/22			.00	23.49	.00	RETIRED EMPLOYEES EXPENSES
JE	44	228.30	EMEX	17	60		1	06/30/22			.00	29.14	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	10		1	06/30/22			.00	219.23	.00	RETIREMENT 2%
JE	44	242.53	EMBF	02	20		1	06/30/22			.00	1,298.27	.00	RETIREMENT 2%
JE	44	242.53	EMBF	02	30		1	06/30/22			.00	815.30	.00	RETIREMENT 2%
JE	44	242.53	EMBF	02	40		1	06/30/22			.00	219.75	.00	RETIREMENT 2%
JE	44	242.53	EMBF	02	60		1	06/30/22			.00	272.63	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	10		1	06/30/22			.00	56.92	.00	VACATION ACCRUAL
JE	44	242.99	ACCU	01	20		1	06/30/22			.00	337.08	.00	VACATION ACCRUAL
JE	44	242.99	ACCU	01	30		1	06/30/22			.00	211.68	.00	VACATION ACCRUAL
JE	44	242.99	ACCU	01	40		1	06/30/22			.00	57.05	.00	VACATION ACCRUAL
JE	44	242.99	ACCU	01	60		1	06/30/22			.00	70.78	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	10		1	06/30/22			.00	96.63	.00	EMPLOYER FICA
JE	44	408.30	EMBF	06	20		1	06/30/22			.00	572.21	.00	EMPLOYER FICA
JE	44	408.30	EMBF	06	30		1	06/30/22			.00	359.35	.00	EMPLOYER FICA
JE	44	408.30	EMBF	06	40		1	06/30/22			.00	96.85	.00	EMPLOYER FICA
JE	44	408.30	EMBF	06	60		1	06/30/22			.00	120.16	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	10		1	06/30/22			.00	22.60	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.30	EMBF	07	20		1	06/30/22			.00	133.82	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.30	EMBF	07	30		1	06/30/22			.00	84.04	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.30	EMBF	07	40		1	06/30/22			.00	22.65	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.30	EMBF	07	60		1	06/30/22			.00	28.10	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	10		1	06/30/22			.00	12.95	.00	EMPLOYER 401K PLAN MATCH
JE	44	926.20	EMBF	19	20		1	06/30/22			.00	76.70	.00	EMPLOYER 401K PLAN MATCH
JE	44	926.20	EMBF	19	30		1	06/30/22			.00	48.17	.00	EMPLOYER 401K PLAN MATCH
JE	44	926.20	EMBF	19	40		1	06/30/22			.00	12.98	.00	EMPLOYER 401K PLAN MATCH
JE	44	926.20	EMBF	19	60		1	06/30/22			.00	16.11	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	06/30/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS	06	30		1	06/30/22	V	FJ28	.00	22.50	.00	STATE SALES AND USE TAX
AP	1	232.10	MPRL	15	50		2095	07/07/22	VN	15117	.00	400.00	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MPRL	15	50		2095	07/07/22	VN	13691	.00	1,500.00	.00	ANNUAL MTG-MISCELLANEOUS
PY	20	131.60	LABR	00	20		712	07/14/22			.00	.00	.01-	LABOR REGULAR
PY	20	131.60	LABR	00	30		712	07/14/22			3.00	111.81	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		712	07/14/22			1.00	37.17	.00	HOLIDAY
PY	20	131.60	LABR	00	40		712	07/14/22			.00	.00	.01-	LABOR REGULAR
AP	1	232.10	MPRL	15	50		2095	07/21/22	VN	1221	.00	636.00	.00	ANNUAL MTG-MISC-PHOTOSHOOT
AP	1	232.10	MPRL	15	50		2095	07/25/22	VN	14251	.00	292.27	.00	ANNUAL MTG-MISC-WATER/ICE
PY	20	131.60	LABR	00	30		722	07/28/22			8.00	298.08	.00	LABOR REGULAR
AP	1	232.10	MPRL	15	50		2095	07/31/22	VN	3402	.00	150.00	.00	ANNUAL MTG-MISCELLANEOUS
PY	10	242.21	ACLB	01	30		812	07/31/22			4.00	149.04	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	15	50		2095	07/31/22	VN	1395	.00	125.00	.00	ANNUAL MTG-MISCELLANEOUS
JE	44	165.10	INSU	02	30		1	07/31/22			.00	9.89	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	07/31/22			.00	124.23	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	07/31/22			.00	15.35	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	07/31/22			.00	143.62	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	07/31/22			.00	37.29	.00	VACATION ACCRUAL

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	408.30	EMBF	06	30		1	07/31/22			.00	37.96	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	07/31/22			.00	8.88	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	07/31/22			.00	5.57	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	07/31/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
PY	20	131.60	LABR	00	30		812	08/11/22			4.00	149.08	.00	LABOR REGULAR
PY	20	131.60	LABR	00	30		822	08/25/22			7.00	260.82	.00	LABOR REGULAR
AP	1	232.10	MPRL	15	50		2095	08/25/22	VN	1104	.00	46.80	.00	ANNUAL MTG-MISCELLANEOUS
AP	1	232.10	MSAD	11	10		2095	08/29/22	VN	12187	.00	375.00	.00	MISCELLANEOUS OFFICE EXPENSES
PY	10	242.21	ACLB	01	30		912	08/31/22			6.00	223.56	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	08/31/22			.00	9.05	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	08/31/22			.00	114.80	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	08/31/22			.00	14.44	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	08/31/22			.00	135.14	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	08/31/22			.00	35.09	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	08/31/22			.00	.01	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	08/31/22			.00	34.19	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	08/31/22			.00	8.00	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	08/31/22			.00	5.12	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	08/31/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS	06	30		1	08/31/22	V	FJ28	.00	22.50	.00	STATE SALES AND USE TAX
PY	20	131.60	LABR	00	30		912	09/08/22			1.00	37.28	.00	LABOR REGULAR
PY	20	131.60	LABR	00	30		922	09/22/22			7.00	260.82	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		922	09/22/22			1.00	37.26	.00	HOLIDAY
AP	1	232.10	MSAD	11	30		2095	09/26/22	VN	14251	.00	94.29	.00	MISC OFFICE EXP-STRATEGIC PLAN
AP	1	232.10	EMEX	14	30		2095	09/26/22	VN	14251	.00	21.94	.00	MISC-TABLECLOTH CLEANING
AP	1	232.10	MSAD	11	10		2095	09/28/22	VN	1093	.00	165.00	.00	MISCELLANEOUS OFFICE EXPENSES
JE	40	123.10	INVS	04	10		2091	09/30/22	V	GJ#807	.00	795.30	.00	PATRONAGE CAPITAL - CFC
PY	10	242.21	ACLB	01	30		1012	09/30/22			8.00	298.08	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	09/30/22			.00	9.62	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	09/30/22			.00	124.48	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	09/30/22			.00	15.37	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	09/30/22			.00	143.82	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	09/30/22			.00	37.34	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	09/30/22			.00	.04	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	09/30/22			.00	36.33	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	09/30/22			.00	8.50	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	09/30/22			.00	.02	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	09/30/22			.00	5.38	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU	01	10		1	09/30/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS	06	30		1	09/30/22	V	FJ28	.00	9.90	.00	STATE SALES AND USE TAX
AP	1	232.10	MSAD	11	10		2095	10/09/22	VN	12187	.00	750.00	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR	00	30		1022	10/20/22			7.00	260.82	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		1022	10/20/22			1.00	37.26	.00	SICK LEAVE
AP	1	232.10	MSAD	11	50		2095	10/25/22	VN	14251	.00	10.27	.00	MISC OFFICE EXP-STRATEGIC PLANNI
AP	1	232.10	MSAD	11	30		2095	10/25/22	VN	14251	.00	93.97	.00	MISC OFFICE EXP-STRATEGIC PLAN
PY	10	242.21	ACLB	01	30		1112	10/28/22			7.00	260.82	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1112	10/28/22			1.00	37.26	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MSAD	11	10		2095	10/31/22	VN	12187	.00	375.00	.00	MISCELLANEOUS OFFICE EXPENSES
AP	1	232.10	MSAD	11	20		2095	10/31/22	VN	14459	.00	6.40	.00	MISCELLANEOUS OFFICE EXPENSES
PY	10	242.21	ACLB	01	30		1122	10/31/22			1.00	37.26	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	10/31/22			.00	10.09	.00	AMORTIZ OF PREPAID INSURANCE-W.C

SO	TR	RACCT	ITEM ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	165.30	EMBF 01	30		1	10/31/22			.00	133.65	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX 17	30		1	10/31/22			.00	16.32	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF 02	30		1	10/31/22			.00	.00	58.30-	RETIREMENT 2%
JE	44	242.99	ACCU 01	30		1	10/31/22			.00	39.64	.00	VACATION ACCRUAL
JE	44	408.20	EMBF 04	30		1	10/31/22			.00	.04	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF 06	30		1	10/31/22			.00	38.17	.00	EMPLOYER FICA
JE	44	408.30	EMBF 07	30		1	10/31/22			.00	8.93	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF 03	30		1	10/31/22			.00	.02	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF 19	30		1	10/31/22			.00	5.71	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU 01	10		1	10/31/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS 06	30		1	10/31/22	V	FJ28	.00	67.50	.00	STATE SALES AND USE TAX
AP	1	232.10	MPRL 10	50		2095	11/10/22	VN	10447	2000.00	2,739.64	.00	2023 SCENIC CALENDAR
JE	46	0.00	MPRL 10	10		2091	11/14/22	V	00054389	.00	.00	4,125.00-	EKPC- LED BULB REIMB
PY	20	131.60	LABR 00	30		1122	11/17/22			6.00	223.56	.00	LABOR REGULAR
PY	10	242.21	ACLB 01	30		1212	11/25/22			5.00	186.30	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB 01	30		1212	11/25/22			1.00	37.26	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MSAD 11	30		2095	11/25/22	VN	14251	.00	73.48	.00	MISC OFFICE EXP-BOARD RM SUPPLIE
PY	10	242.21	ACLB 01	30		1222	11/30/22			3.00	116.28	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU 02	30		1	11/30/22			.00	8.68	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF 01	30		1	11/30/22			.00	163.15	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX 17	30		1	11/30/22			.00	14.31	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF 02	30		1	11/30/22			.00	.00	51.14-	RETIREMENT 2%
JE	44	242.99	ACCU 01	30		1	11/30/22			.00	34.77	.00	VACATION ACCRUAL
JE	44	408.20	EMBF 04	30		1	11/30/22			.00	.01	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF 06	30		1	11/30/22			.00	32.86	.00	EMPLOYER FICA
JE	44	408.30	EMBF 07	30		1	11/30/22			.00	7.69	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF 03	30		1	11/30/22			.00	.02	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF 19	30		1	11/30/22			.00	5.06	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU 01	10		1	11/30/22	V	FJ14	.00	596.00	.00	AMORTIZ. OR PREPAID INSURANCE
AP	1	232.10	MSAD 11	10		2095	12/01/22	VN	12187	.00	375.00	.00	MISCELLANEOUS OFFICE EXPENSES
AP	1	232.10	MSAD 11	10		2095	12/09/22	VN	1221	.00	95.02	.00	MISCELLANEOUS OFFICE EXPENSES
PY	20	131.60	LABR 00	30		1222	12/15/22			4.00	155.00	.00	LABOR REGULAR
AP	1	232.10	EMEX 14	50		2095	12/26/22	VN	14251	.00	21.94	.00	MISC-TABLECLOTH CLEANING
PY	20	131.60	LABR 00	30		1232	12/29/22			5.00	193.80	.00	LABOR REGULAR
PY	10	242.21	ACLB 01	30		113	12/31/22			2.00	77.52	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB 01	30		113	12/31/22			2.00	77.52	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU 02	30		1	12/31/22			.00	11.93	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF 01	30		1	12/31/22			.00	90.27	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX 17	30		1	12/31/22			.00	11.77	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF 02	30		1	12/31/22			.00	.00	41.98-	RETIREMENT 2%
JE	44	242.99	ACCU 01	30		1	12/31/22			.00	27.86	.00	VACATION ACCRUAL
JE	44	408.30	EMBF 06	30		1	12/31/22			.00	46.17	.00	EMPLOYER FICA
JE	44	408.30	EMBF 07	30		1	12/31/22			.00	10.80	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF 19	30		1	12/31/22			.00	6.24	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.10	INSU 01	10		1	12/31/22	V	FJ14	.00	946.82	.00	AMORTIZ. OR PREPAID INSURANCE
JE	41	0.00	TAXS 06	30		1	12/31/22	V	FJ28	.00	22.50	.00	STATE SALES AND USE TAX

NUMBER OF RECORDS FOUND - 301

TOTAL QTY 21,236.00

TOTAL DEBIT 99,902.87
TOTAL CREDIT 6,607.20-

NET BALANCE 93,295.67

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
PY	20	131.60	LABR	00	30		112	01/13/22			11.50	298.17	.00	LABOR REGULAR
PY	20	131.60	LABR	05	30		112	01/13/22			1.00	23.71	.00	PERMISSION LEAVE
PY	20	131.60	LABR	00	30		122	01/27/22			20.00	510.21	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		212	01/31/22			15.00	385.65	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	01/31/22			.00	19.64	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	01/31/22			.00	233.46	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	01/31/22			.00	28.50	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	01/31/22			.00	266.64	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	01/31/22			.00	69.23	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	01/31/22			.00	7.03	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	01/31/22			.00	86.23	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	01/31/22			.00	20.17	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	01/31/22			.00	7.13	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	01/31/22			.00	10.14	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	01/31/22	V	FJ922	.00	4,555.55	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		212	02/10/22			7.00	177.97	.00	LABOR REGULAR
PY	20	131.60	LABR	00	30		222	02/24/22			23.00	593.33	.00	LABOR REGULAR
PY	20	131.60	LABR	05	30		222	02/24/22			1.00	23.71	.00	PERMISSION LEAVE
PY	10	242.21	ACLB	01	30		312	02/28/22			11.00	278.81	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	02/28/22			.00	14.53	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	02/28/22			.00	230.47	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	02/28/22			.00	26.16	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	02/28/22			.00	244.77	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	02/28/22			.00	63.55	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	02/28/22			.00	.64	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	02/28/22			.00	64.09	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	02/28/22			.00	14.99	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	02/28/22			.00	2.47	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	02/28/22			.00	9.71	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	02/28/22	V	FJ922	.00	677.47	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		312	03/10/22			9.00	231.39	.00	LABOR REGULAR
PY	20	131.60	LABR	00	30		322	03/24/22			22.00	563.62	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		412	03/31/22			20.00	510.20	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	02	30		412	03/31/22			.50	20.04	.00	ACCRUED LABOR - OVERTIME
PY	10	242.21	ACLB	01	30		412	03/31/22			2.00	53.42	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	03/31/22			.00	18.43	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	03/31/22			.00	244.72	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	03/31/22			.00	29.72	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	03/31/22			.00	278.08	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	03/31/22			.00	72.20	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	03/31/22			.00	.09	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	03/31/22			.00	71.76	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	03/31/22			.00	16.78	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	03/31/22			.00	.00	4.01-	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	03/31/22			.00	11.04	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	03/31/22	V	FJ922	.00	979.97	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		422	04/21/22			22.00	565.13	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		512	04/29/22			22.00	563.62	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	04/30/22			.00	17.99	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	04/30/22			.00	240.22	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	04/30/22			.00	28.76	.00	RETIRED EMPLOYEES EXPENSES

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH			QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	242.53	EMBF	02	30		1	04/30/22				.00	269.06	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	04/30/22				.00	69.86	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	04/30/22				.00	.04	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	04/30/22				.00	70.10	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	04/30/22				.00	16.40	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	04/30/22				.00	.08	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	04/30/22				.00	10.72	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	04/30/22	V		FJ922	.00	1,593.38	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		522	05/19/22				20.00	510.20	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		612	05/27/22				22.00	563.62	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		622	05/31/22				3.00	77.13	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		622	05/31/22				1.00	23.71	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	05/31/22				.00	16.81	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	05/31/22				.00	221.72	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	05/31/22				.00	26.86	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	05/31/22				.00	251.32	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	05/31/22				.00	65.25	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	05/31/22				.00	65.65	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	05/31/22				.00	15.35	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	05/31/22				.00	.03	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	05/31/22				.00	10.02	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	05/31/22	V		FJ922	.00	901.80	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		622	06/16/22				8.00	195.68	.00	LABOR REGULAR
PY	20	131.60	LABR	06	30		622	06/16/22				2.00	53.42	.00	PERSONAL DAY
PY	20	131.60	LABR	00	30		632	06/30/22				16.00	403.36	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		712	06/30/22				7.00	177.97	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	06/30/22				.00	17.48	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	06/30/22				.00	140.27	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	06/30/22				.00	16.99	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	06/30/22				.00	159.00	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	06/30/22				.00	41.28	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	06/30/22				.00	70.08	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	06/30/22				.00	16.39	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	06/30/22				.00	9.39	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	06/30/22	V		FJ922	.00	918.40	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		712	07/14/22				7.00	177.97	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		712	07/14/22				1.00	23.71	.00	HOLIDAY
PY	20	131.60	LABR	00	30		722	07/28/22				14.50	369.30	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		812	07/31/22				10.00	255.10	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	07/31/22				.00	13.70	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	07/31/22				.00	172.16	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	07/31/22				.00	21.27	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	07/31/22				.00	199.03	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	07/31/22				.00	51.68	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	07/31/22				.00	52.60	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	07/31/22				.00	12.30	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	07/31/22				.00	7.72	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	07/31/22	V		FJ922	.00	2,012.18	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		822	08/25/22				6.00	142.26	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		912	08/31/22				7.00	165.97	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	08/31/22				.00	4.40	.00	AMORTIZ OF PREPAID INSURANCE-W.C

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	165.30	EMBF	01	30		1	08/31/22		.00	55.86	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	08/31/22		.00	7.03	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	08/31/22		.00	65.76	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	08/31/22		.00	17.07	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	08/31/22		.00	16.64	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	08/31/22		.00	3.89	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	08/31/22		.00	2.49	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	08/31/22	V FJ922	.00	2,016.53	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		912	09/08/22		1.00	23.71	.00	LABOR REGULAR
PY	20	131.60	LABR	00	30		922	09/22/22		7.00	170.87	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		922	09/22/22		1.00	24.41	.00	HOLIDAY
PY	10	242.21	ACLB	01	30		1012	09/30/22		8.00	195.28	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	09/30/22		.00	6.29	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	09/30/22		.00	81.41	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	09/30/22		.00	10.05	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	09/30/22		.00	94.06	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	09/30/22		.00	24.42	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	09/30/22		.00	.02	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	09/30/22		.00	23.76	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	09/30/22		.00	5.56	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	09/30/22		.00	.01	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	09/30/22		.00	3.52	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	09/30/22	V FJ922	.00	1,753.05	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		1022	10/20/22		8.00	195.28	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		1112	10/28/22		6.00	146.46	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1122	10/31/22		2.00	48.17	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	10/31/22		.00	6.21	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	10/31/22		.00	82.27	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	10/31/22		.00	10.05	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	10/31/22		.00	.00	35.89-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	10/31/22		.00	24.40	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	10/31/22		.00	.02	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	10/31/22		.00	23.50	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	10/31/22		.00	5.49	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	10/31/22		.00	.01	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	10/31/22		.00	3.52	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	10/31/22	V FJ922	.00	1,509.04	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		1122	11/17/22		13.00	312.78	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		1122	11/17/22		1.00	24.41	.00	SICK LEAVE
PY	10	242.21	ACLB	01	30		1212	11/25/22		13.00	313.43	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1212	11/25/22		2.00	48.17	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MSAD	01	30		2095	11/25/22	VN 14251	.00	24.35	.00	GEN OFFICE SUPPLIES-FILE ORGANIZ
PY	10	242.21	ACLB	01	30		1222	11/30/22		3.00	76.23	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	11/30/22		.00	11.93	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	11/30/22		.00	224.43	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	11/30/22		.00	19.69	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	11/30/22		.00	.00	70.35-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	11/30/22		.00	47.83	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	11/30/22		.00	.01	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	11/30/22		.00	45.21	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	11/30/22		.00	10.57	.00	EMPLOYER FICA-MEDICARE PORTION

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	EMBF	03	30		1	11/30/22		.00	.03	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	11/30/22		.00	6.96	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	11/30/22	V FJ922	.00	730.98	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		1222	12/15/22		7.00	175.27	.00	LABOR REGULAR
PY	20	131.60	LABR	06	30		1222	12/15/22		3.00	75.58	.00	PERSONAL DAY
AP	1	232.10	MSAD	01	30		2095	12/26/22	VN 14251	.00	51.84	.00	GEN OFFICE SUPPLIES-FILE ORGANIZ
PY	20	131.60	LABR	00	30		1232	12/29/22		14.00	351.19	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		1232	12/29/22		1.00	25.41	.00	SICK LEAVE
PY	20	131.60	LABR	06	30		1232	12/29/22		1.00	24.76	.00	PERSONAL DAY
PY	10	242.21	ACLB	01	30		113	12/31/22		4.00	100.34	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		113	12/31/22		4.00	100.34	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	12/31/22		.00	20.20	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	12/31/22		.00	152.80	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	12/31/22		.00	19.92	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	12/31/22		.00	.00	71.07-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	12/31/22		.00	47.16	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	12/31/22		.00	78.15	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	12/31/22		.00	18.28	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	12/31/22		.00	10.56	.00	EMPLOYER 401K PLAN MATCH
JE	41	921.30	OVHD	04	30		1	12/31/22	V FJ922	.00	1,038.54	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR

NUMBER OF RECORDS FOUND - 173

TOTAL QTY	410.50
TOTAL DEBIT	34,984.94
TOTAL CREDIT	181.32-
NET BALANCE	34,803.62

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	04	50		2095	01/01/22	VN 1144	.00	1,000.00	.00	DUES - CHAMBER OF COMMERCE
AP	1	232.10	MPRL	22	50		2095	01/04/22	VN 1239	.00	73.50	.00	PUBLICATION EXPENSES
PY	20	131.60	LABR	00	30		112	01/13/22		9.00	335.40	.00	LABOR REGULAR
PY	20	131.60	LABR	06	30		112	01/13/22		3.00	111.80	.00	PERSONAL DAY
AP	1	232.10	MPRL	01	50		2095	01/13/22	VN 1221	.00	2,381.64	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	01/13/22	VN 1221	.00	697.57	.00	RURAL LIGHT INSERT
AP	1	232.10	MPRL	03	50		2095	01/19/22	VN 9954	.00	250.00	.00	CIVIC DUES & EXPENSES
JE	42	0.00	MPRL	43	10		2091	01/21/22	V 00044734	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
JE	42	0.00	MPRL	43	10		2091	01/24/22	V 00044802	.00	20.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	41	50		2095	01/25/22	VN 14251	.00	5.00	.00	UCC FILING FEES FOR HOW$SMART
PY	20	131.60	LABR	00	30		122	01/27/22		26.00	968.85	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		122	01/27/22		6.00	223.58	.00	SICK LEAVE
AP	1	232.10	MPRL	22	50		2095	01/31/22	VN 3402	.00	388.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	36	50		2095	01/31/22	VN 11402	.00	9.02	.00	HOW$MART/MACED PROGRAM
PY	10	242.21	ACLB	01	30		212	01/31/22		16.50	614.85	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		212	01/31/22		3.50	130.42	.00	ACCRUED LABOR - REGULAR
JE	40	142.40	MPRL	36	50		2091	01/31/22	V GJ#799	.00	.00	54.31-	SPIVEY FEES
JE	44	165.10	INSU	02	30		1	01/31/22		.00	38.46	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	01/31/22		.00	457.22	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	01/31/22		.00	55.82	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	01/31/22		.00	522.20	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	01/31/22		.00	135.58	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	01/31/22		.00	13.77	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	01/31/22		.00	168.88	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	01/31/22		.00	39.50	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	01/31/22		.00	13.97	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	01/31/22		.00	19.85	.00	EMPLOYER 401K PLAN MATCH
JE	41	929.00	UTIL	01	10		1	01/31/22	V FJ921	.00	.71	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	01/31/22	V FJ922	.00	6,833.33	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
JE	42	0.00	MPRL	43	10		2091	02/07/22	V 00045287	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		212	02/10/22		9.00	335.40	.00	LABOR REGULAR
AP	1	232.10	MPRL	01	50		2095	02/10/22	VN 1221	.00	2,388.45	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	02/10/22	VN 1221	.00	699.55	.00	RURAL LIGHT INSERT
JE	42	0.00	MPRL	43	10		2091	02/18/22	V 00045667	.00	30.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	DUES	04	50		2095	02/18/22	VN 1221	.00	320.23	.00	DUES - CHAMBER OF COMMERCE
JE	42	0.00	MPRL	43	10		2091	02/21/22	V 00045723	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		222	02/24/22		23.00	857.06	.00	LABOR REGULAR
PY	20	131.60	LABR	06	30		222	02/24/22		3.00	111.79	.00	PERSONAL DAY
AP	1	232.10	MPRL	22	50		2095	02/24/22	VN 12801	.00	80.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	41	50		2095	02/25/22	VN 14251	.00	15.00	.00	UCC FILING FEES FOR HOW$SMART
AP	1	232.10	MPRL	22	50		2095	02/25/22	VN 14251	.00	7.11	.00	PUBLICATION EXPENSES-FB AD
AP	1	232.10	MPRL	22	50		2095	02/26/22	VN 1395	.00	50.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	02/27/22	VN 3402	.00	119.00	.00	PUBLICATION EXPENSES
PY	10	242.21	ACLB	01	30		312	02/28/22		23.00	857.06	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	36	50		2095	02/28/22	VN 11402	.00	4.69	.00	HOW$MART/MACED PROGRAM
JE	44	165.10	INSU	02	30		1	02/28/22		.00	29.24	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	02/28/22		.00	463.88	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	02/28/22		.00	52.66	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	02/28/22		.00	492.65	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	02/28/22		.00	127.91	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	02/28/22		.00	1.29	.00	EMPLOYER FEDERAL UNEMPLOYMENT

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	408.30	EMBF	06	30		1	02/28/22		.00	128.99	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	02/28/22		.00	30.17	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	02/28/22		.00	4.97	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	02/28/22		.00	19.54	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	02/28/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	02/28/22	V FJ921	.00	.52	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	02/28/22	V FJ922	.00	1,016.20	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	DUES	03	50		2095	03/01/22	VN 10334	.00	475.00	.00	DUES - MISCELLANEOUS
AP	1	232.10	DUES	04	50		2095	03/07/22	VN 1589	.00	100.00	.00	DUES - CHAMBER OF COMMERCE
PY	20	131.60	LABR	00	30		312	03/10/22		9.00	335.38	.00	LABOR REGULAR
AP	1	232.10	MPRL	22	50		2095	03/10/22	VN 1447	.00	30.00	.00	ADVERTISING
AP	1	232.10	MPRL	01	50		2095	03/10/22	VN 1221	.00	2,329.60	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	03/10/22	VN 1221	.00	682.29	.00	RURAL LIGHT INSERT
JE	42	0.00	MPRL	43	10		2091	03/21/22	V 00046627	.00	50.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		322	03/24/22		32.00	1,192.43	.00	LABOR REGULAR
AP	1	232.10	MPRL	41	50		2095	03/25/22	VN 14251	.00	5.00	.00	UCC FILING FEES FOR HOW$SMART
AP	1	232.10	MPRL	22	50		2095	03/25/22	VN 14251	.00	23.19	.00	PUBLICATION EXPENSES-FB AD
AP	1	232.10	MPRL	06	50		2095	03/25/22	VN 14251	.00	513.35	.00	SCHOOL PROGRAMS-YOUTH TOUR
JE	42	0.00	MPRL	43	10		2091	03/28/22	V 00046817	.00	20.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	22	50		2095	03/30/22	VN 12801	.00	40.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	08	50		2095	03/31/22	VN 12426	.00	25.62	.00	MISC SERVICES EXPENSES
AP	1	232.10	MPRL	36	50		2095	03/31/22	VN 11402	.00	5.19	.00	HOW$MART/MACED PROGRAM
PY	10	242.21	ACLB	01	30		412	03/31/22		29.00	1,080.64	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		412	03/31/22		3.00	111.79	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	03/31/22		.00	36.36	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	03/31/22		.00	482.85	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	03/31/22		.00	58.65	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	03/31/22		.00	548.68	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	03/31/22		.00	142.46	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	03/31/22		.00	.19	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	03/31/22		.00	141.58	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	03/31/22		.00	33.11	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	03/31/22		.00	.00	7.91-	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	03/31/22		.00	21.79	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	03/31/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	03/31/22	V FJ921	.00	.56	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	03/31/22	V FJ922	.00	1,469.95	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
JE	42	0.00	MPRL	43	10		2091	04/01/22	V 00047027	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	01	50		2095	04/07/22	VN 1221	.00	2,330.00	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	04/07/22	VN 1221	.00	682.41	.00	RURAL LIGHT INSERT
JE	46	0.00	MPRL	22	10		2091	04/12/22	V 00047394	.00	.00	250.00-	EKPC- ADVERTISING
AP	1	232.10	MPRL	06	50		2095	04/15/22	VN 2278	.00	245.70	.00	SCHOOL PROGRAMS
AP	1	232.10	MPRL	06	50		2095	04/15/22	VN 2278	.00	266.18	.00	SCHOOL PROGRAMS
PY	20	131.60	LABR	00	30		422	04/21/22		32.00	1,192.43	.00	LABOR REGULAR
AP	1	232.10	UTIL	07	50		2095	04/22/22	VN 1153	.00	50.75	.00	WATER/SEWER/TRASH COLL/MISC SER
PY	10	242.21	ACLB	01	30		512	04/29/22		29.00	1,080.64	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	36	50		2095	04/30/22	VN 11402	.00	5.02	.00	HOW$MART/MACED PROGRAM
JE	44	165.10	INSU	02	30		1	04/30/22		.00	36.22	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	04/30/22		.00	483.75	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	04/30/22		.00	57.91	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	04/30/22		.00	541.84	.00	RETIREMENT 2%

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH		QTY	DEBIT	CREDIT	DESCRIPTION
JE	44	242.99	ACCU	01	30		1	04/30/22			.00	140.68	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	04/30/22			.00	.08	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	04/30/22			.00	141.18	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	04/30/22			.00	33.02	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	04/30/22			.00	.16	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	04/30/22			.00	21.58	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	04/30/22	V	FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	04/30/22	V	FJ921	.00	1.50	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	04/30/22	V	FJ922	.00	2,390.08	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	UTIL	07	50		2095	05/09/22	VN	1153	.00	50.75	.00	WATER/SEWER/TRASH COLL/MISC SER
AP	1	232.10	MPRL	01	50		2095	05/10/22	VN	1221	.00	2,335.43	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	05/10/22	VN	1221	.00	684.02	.00	RURAL LIGHT INSERT
JE	42	0.00	MPRL	43	10		2091	05/16/22	V	00048484	.00	20.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	22	50		2095	05/16/22	VN	11123	.00	30.00	.00	PUBLICATION EXPENSES
PY	20	131.60	LABR	00	30		522	05/19/22			26.00	968.85	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		522	05/19/22			6.00	223.58	.00	SICK LEAVE
AP	1	232.10	MPRL	08	20		2095	05/23/22	VN	14459	.00	120.00	.00	MISC SERVICES EXPENSES
JE	42	0.00	MPRL	43	10		2091	05/23/22	V	00048691	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	08	50		2095	05/25/22	VN	14251	.00	55.64	.00	MISC SVCS EXP-SCHOLARSHIP COMM
AP	1	232.10	MPRL	06	50		2095	05/26/22	VN	2278	.00	286.65	.00	SCHOOL PROGRAMS
JE	42	0.00	MPRL	43	10		2091	05/27/22	V	00048851	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	10	242.21	ACLB	01	30		612	05/27/22			21.00	782.53	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		612	05/27/22			3.00	111.79	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	36	50		2095	05/31/22	VN	11402	.00	5.02	.00	HOW$MART/MACED PROGRAM
AP	1	232.10	MPRL	36	50		2095	05/31/22	VN	11402	.00	.00	5.02-	HOW$MART/MACED PROGRAM
AP	1	232.10	MPRL	36	50		2095	05/31/22	VN	11402	.00	5.19	.00	HOW$MART/MACED PROGRAM
PY	10	242.21	ACLB	01	30		622	05/31/22			3.00	111.79	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		622	05/31/22			3.00	111.79	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	05/31/22			.00	33.07	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	05/31/22			.00	436.08	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	05/31/22			.00	52.83	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	05/31/22			.00	494.31	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	05/31/22			.00	128.34	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	05/31/22			.00	129.12	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	05/31/22			.00	30.20	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	05/31/22			.00	.05	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	05/31/22			.00	19.70	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	05/31/22	V	FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	05/31/22	V	FJ921	.00	8.03	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	05/31/22	V	FJ922	.00	1,352.71	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
PY	20	131.60	LABR	00	30		612	06/02/22			.00	.08	.00	LABOR REGULAR
AP	1	232.10	MPRL	22	50		2095	06/08/22	VN	1395	.00	145.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	06/08/22	VN	12801	.00	80.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	06/08/22	VN	3402	.00	99.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	06/08/22	VN	1447	.00	475.00	.00	ADVERTISING
AP	1	232.10	MPRL	01	50		2095	06/09/22	VN	1221	.00	2,009.44	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	06/09/22	VN	1221	.00	1,849.70	.00	RURAL LIGHT INSERT
AP	1	232.10	UTIL	07	50		2095	06/09/22	VN	1153	.00	50.75	.00	WATER/SEWER/TRASH COLL/MISC SER
JE	42	0.00	MPRL	43	10		2091	06/13/22	V	00049342	.00	20.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		622	06/16/22			12.00	447.20	.00	LABOR REGULAR
PY	20	131.60	LABR	05	30		622	06/16/22			14.00	521.72	.00	PERMISSION LEAVE

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	06	50		2095	06/27/22	VN 15109	.00	500.00	.00	SCHOOL PROGRAMS
AP	1	232.10	MPRL	06	50		2095	06/27/22	VN 15110	.00	500.00	.00	SCHOOL PROGRAMS
AP	1	232.10	MPRL	06	50		2095	06/27/22	VN 15111	.00	500.00	.00	SCHOOL PROGRAMS
AP	1	232.10	MPRL	06	50		2095	06/27/22	VN 15112	.00	500.00	.00	SCHOOL PROGRAMS
JE	42	0.00	MPRL	43	10		2091	06/28/22	V 00049772	.00	70.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	22	50		2095	06/29/22	VN 10334	.00	100.00	.00	PUBLICATION EXPENSES
PY	20	131.60	LABR	00	30		632	06/30/22		32.00	1,192.43	.00	LABOR REGULAR
AP	1	232.10	MPRL	22	50		2091	06/30/22	VN 1395	.00	95.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	36	50		2091	06/30/22	VN 11402	.00	5.02	.00	HOW$MART/MACED PROGRAM
PY	10	242.21	ACLB	01	30		712	06/30/22		9.00	335.37	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	06/30/22		.00	52.56	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	06/30/22		.00	421.74	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	06/30/22		.00	51.10	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	06/30/22		.00	478.06	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	06/30/22		.00	124.12	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	06/30/22		.00	210.70	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	06/30/22		.00	49.28	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	06/30/22		.00	28.24	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	06/30/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	06/30/22	V FJ921	.00	6.82	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	06/30/22	V FJ922	.00	1,377.60	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	UTIL	07	50		2095	07/11/22	VN 1153	.00	50.75	.00	WATER/SEWER/TRASH COLL/MISC SER
AP	1	232.10	DUES	04	50		2095	07/13/22	VN 1466	.00	525.00	.00	DUES - CHAMBER OF COMMERCE
JE	42	0.00	MPRL	43	10		2091	07/13/22	V 00050242	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		712	07/14/22		17.00	633.52	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		712	07/14/22		3.00	111.80	.00	HOLIDAY
AP	1	232.10	MPRL	01	50		2095	07/14/22	VN 1221	.00	2,390.27	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	07/14/22	VN 1221	.00	700.07	.00	RURAL LIGHT INSERT
AP	1	232.10	MPRL	08	50		2095	07/21/22	VN 1221	.00	148.40	.00	MISC SERVICES EXPENSES
AP	1	232.10	MPRL	22	50		2095	07/27/22	VN 10334	.00	100.00	.00	PUBLICATION EXPENSES
PY	20	131.60	LABR	00	30		722	07/28/22		26.00	968.85	.00	LABOR REGULAR
AP	1	232.10	MPRL	36	50		2095	07/31/22	VN 11402	.00	5.19	.00	HOW$MART/MACED PROGRAM
AP	1	232.10	MPRL	22	50		2095	07/31/22	VN 3402	.00	299.00	.00	PUBLICATION EXPENSES
PY	10	242.21	ACLB	01	30		812	07/31/22		20.00	745.27	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	22	50		2095	07/31/22	VN 1395	.00	95.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	07/31/22	VN 10334	.00	.00	100.00-	PUBLICATION EXPENSES
JE	44	165.10	INSU	02	30		1	07/31/22		.00	40.81	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	07/31/22		.00	512.54	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	07/31/22		.00	63.30	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	07/31/22		.00	592.61	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	07/31/22		.00	153.84	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	07/31/22		.00	156.60	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	07/31/22		.00	36.67	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	07/31/22		.00	23.01	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	07/31/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	07/31/22	V FJ921	.00	7.77	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	07/31/22	V FJ922	.00	3,018.27	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	DUES	04	50		2095	08/03/22	VN 2782	.00	100.00	.00	DUES - CHAMBER OF COMMERCE
AP	1	232.10	MPRL	01	50		2095	08/04/22	VN 1221	.00	2,390.27	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	08/04/22	VN 1221	.00	700.07	.00	RURAL LIGHT INSERT
AP	1	232.10	UTIL	07	50		2095	08/09/22	VN 1153	.00	276.80	.00	WATER/SEWER/TRASH COLL/MISC SER

SO	TR	RACCT	ITEM	ID	DEPT	WH	BH	DATE	CK/JOB/REC/TSK PJ/VHR/VND/VEH	QTY	DEBIT	CREDIT	DESCRIPTION
PY	20	131.60	LABR	00	30		812	08/11/22		9.00	335.40	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		812	08/11/22		3.00	111.80	.00	SICK LEAVE
AP	1	232.10	MPRL	01	50		2095	08/16/22	VN 1221	.00	9.54	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	08/16/22	VN 1221	.00	2.79	.00	RURAL LIGHT INSERT
JE	42	0.00	MPRL	43	10		2091	08/17/22	V 00051421	.00	30.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		822	08/25/22		29.00	1,080.64	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		912	08/31/22		26.00	968.85	.00	ACCRUED LABOR - REGULAR
AP	1	232.10	MPRL	36	50		2091	08/31/22	VN 11402	.00	5.19	.00	HOW$MART/MACED PROGRAM
JE	44	165.10	INSU	02	30		1	08/31/22		.00	35.67	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	08/31/22		.00	452.47	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	08/31/22		.00	56.93	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	08/31/22		.00	532.64	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	08/31/22		.00	138.29	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	08/31/22		.00	.03	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	08/31/22		.00	134.75	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	08/31/22		.00	31.51	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	08/31/22		.00	.02	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	08/31/22		.00	20.18	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	08/31/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	08/31/22	V FJ921	.00	9.78	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	08/31/22	V FJ922	.00	3,024.80	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	MPRL	22	50		2095	09/07/22	VN 1447	.00	151.00	.00	ADVERTISING
AP	1	232.10	MPRL	22	50		2095	09/07/22	VN 1395	.00	109.00	.00	PUBLICATION EXPENSES
PY	20	131.60	LABR	00	30		912	09/08/22		3.00	111.83	.00	LABOR REGULAR
AP	1	232.10	MPRL	01	50		2095	09/08/22	VN 1221	.00	2,406.83	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	09/08/22	VN 1221	.00	704.92	.00	RURAL LIGHT INSERT
AP	1	232.10	MPRL	22	50		2095	09/08/22	VN 3402	.00	119.00	.00	PUBLICATION EXPENSES
AP	1	232.10	UTIL	07	50		2095	09/09/22	VN 1153	.00	74.51	.00	WATER/SEWER/TRASH COLL/MISC SER
AP	1	232.10	MPRL	06	50		2095	09/15/22	VN 1221	.00	75.90	.00	SCHOOL PROGRAMS
PY	20	131.60	LABR	00	30		922	09/22/22		29.00	1,080.64	.00	LABOR REGULAR
PY	20	131.60	LABR	04	30		922	09/22/22		3.00	111.79	.00	HOLIDAY
AP	1	232.10	MSAD	08	50		2095	09/26/22	VN 1395	.00	217.30	.00	SUBSCRIPTIONS
AP	1	232.10	MPRL	22	50		2095	09/27/22	VN 3402	.00	238.00	.00	PUBLICATION EXPENSES
PY	10	242.21	ACLB	01	30		1012	09/30/22		26.00	968.85	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1012	09/30/22		3.00	111.79	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	09/30/22		.00	36.22	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	09/30/22		.00	468.66	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	09/30/22		.00	57.88	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	09/30/22		.00	541.48	.00	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	09/30/22		.00	140.59	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	09/30/22		.00	.13	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	09/30/22		.00	136.78	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	09/30/22		.00	31.99	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	09/30/22		.00	.07	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	09/30/22		.00	20.25	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	09/30/22	V FJ15	.00	1,831.58	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	09/30/22	V FJ921	.00	9.68	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	09/30/22	V FJ922	.00	2,629.58	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	MPRL	22	50		2095	10/04/22	VN 12801	.00	80.00	.00	PUBLICATION EXPENSES
AP	1	232.10	UTIL	07	50		2091	10/10/22	VN 1153	.00	70.19	.00	WATER/SEWER/TRASH COLL/MISC SER
AP	1	232.10	MPRL	01	50		2095	10/11/22	VN 1221	.00	2,416.63	.00	KENTUCKY LIVING MAGAZINE

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	02	50		2095	10/11/22	VN 1221	.00	707.81	.00	RURAL LIGHT INSERT
AP	1	232.10	MPRL	06	50		2095	10/13/22	VN 1221	.00	9,400.00	.00	SCHOOL PROGRAMS
JE	42	0.00	MPRL	43	10		2091	10/17/22	V 00053427	.00	40.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		1022	10/20/22		29.00	1,080.64	.00	LABOR REGULAR
PY	20	131.60	LABR	02	30		1022	10/20/22		3.00	111.79	.00	SICK LEAVE
PY	10	242.21	ACLB	01	30		1112	10/28/22		32.00	1,192.43	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1122	10/31/22		3.00	111.79	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	10/31/22		.00	39.77	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	10/31/22		.00	526.78	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	10/31/22		.00	64.32	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	10/31/22		.00	.00	229.81-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	10/31/22		.00	156.24	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	10/31/22		.00	.15	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	10/31/22		.00	150.44	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	10/31/22		.00	35.18	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	10/31/22		.00	.08	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	10/31/22		.00	22.52	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	10/31/22	V FJ15	.00	522.03	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	10/31/22	V FJ921	.00	7.30	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	10/31/22	V FJ922	.00	2,263.56	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	MPRL	01	50		2095	11/04/22	VN 1221	.00	2,427.83	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	11/04/22	VN 1221	.00	711.09	.00	RURAL LIGHT INSERT
AP	1	232.10	MPRL	08	30		2091	11/07/22	VN 7756	.00	275.00	.00	LEADERSHIP HORIZONS CLASS '17-18
AP	1	232.10	MPRL	22	50		2095	11/08/22	VN 1395	.00	95.00	.00	PUBLICATION EXPENSES
JE	46	0.00	MPRL	22	10		2091	11/14/22	V 00054390	.00	.00	250.00-	EKPC- ADVERTISING
AP	1	232.10	MPRL	22	50		2095	11/15/22	VN 3402	.00	119.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	06	50		2095	11/15/22	VN 2278	.00	532.35	.00	SCHOOL PROGRAMS
AP	1	232.10	MPRL	06	50		2095	11/15/22	VN 2278	.00	573.30	.00	SCHOOL PROGRAMS
JE	42	0.00	MPRL	43	10		2091	11/16/22	V 00054462	.00	20.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		1122	11/17/22		29.00	1,080.64	.00	LABOR REGULAR
JE	42	0.00	MPRL	43	10		2091	11/22/22	V 00054655	.00	30.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	10	242.21	ACLB	01	30		1212	11/25/22		20.00	745.27	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1212	11/25/22		3.00	111.79	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1212	11/25/22		3.00	111.79	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		1222	11/30/22		9.00	348.81	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	11/30/22		.00	36.93	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	11/30/22		.00	694.49	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	11/30/22		.00	60.93	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	11/30/22		.00	.00	217.70-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	11/30/22		.00	148.01	.00	VACATION ACCRUAL
JE	44	408.20	EMBF	04	30		1	11/30/22		.00	.03	.00	EMPLOYER FEDERAL UNEMPLOYMENT
JE	44	408.30	EMBF	06	30		1	11/30/22		.00	139.89	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	11/30/22		.00	32.72	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	408.40	EMBF	03	30		1	11/30/22		.00	.08	.00	EMPLOYER STATE UNEMPLOYMENT
JE	44	926.20	EMBF	19	30		1	11/30/22		.00	21.53	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	11/30/22	V FJ15	.00	522.03	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	11/30/22	V FJ921	.00	3.89	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	11/30/22	V FJ922	.00	1,096.46	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR
AP	1	232.10	MPRL	22	50		2095	12/05/22	VN 1447	.00	151.00	.00	ADVERTISING
AP	1	232.10	MPRL	22	50		2095	12/05/22	VN 1395	.00	95.00	.00	PUBLICATION EXPENSES
AP	1	232.10	MPRL	22	50		2095	12/05/22	VN 3402	.00	119.00	.00	PUBLICATION EXPENSES

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	50		2095	12/09/22	VN 1221	.00	2,390.13	.00	KENTUCKY LIVING MAGAZINE
AP	1	232.10	MPRL	02	50		2095	12/09/22	VN 1221	.00	700.05	.00	RURAL LIGHT INSERT
JE	46	0.00	MPRL	22	10		2091	12/12/22	V 00055350	.00	.00	125.00-	EKPC- ADVERTISING
PY	20	131.60	LABR	00	30		1222	12/15/22		20.00	775.06	.00	LABOR REGULAR
JE	42	0.00	MPRL	43	10		2091	12/15/22	V 00055464	.00	10.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
AP	1	232.10	MPRL	06	50		2095	12/15/22	VN 2278	.00	491.40	.00	SCHOOL PROGRAMS
AP	1	232.10	DUES	04	50		2095	12/15/22	VN 1589	.00	100.00	.00	DUES - CHAMBER OF COMMERCE
AP	1	232.10	MSML	02	50		2095	12/15/22	VN 15212	.00	36.73	.00	POSTAGE - GENERAL
JE	42	0.00	MPRL	43	10		2091	12/20/22	V 00055607	.00	30.00	.00	SIMPLE SAVER SIGN ON INCENTIVE
PY	20	131.60	LABR	00	30		1232	12/29/22		23.00	891.39	.00	LABOR REGULAR
PY	10	242.21	ACLB	01	30		113	12/31/22		14.00	542.58	.00	ACCRUED LABOR - REGULAR
PY	10	242.21	ACLB	01	30		113	12/31/22		6.00	232.54	.00	ACCRUED LABOR - REGULAR
JE	44	165.10	INSU	02	30		1	12/31/22		.00	57.82	.00	AMORTIZ OF PREPAID INSURANCE-W.C
JE	44	165.30	EMBF	01	30		1	12/31/22		.00	437.42	.00	EMPLOYEE'S GROUP INSURANCE
JE	44	228.30	EMEX	17	30		1	12/31/22		.00	57.02	.00	RETIRED EMPLOYEES EXPENSES
JE	44	242.53	EMBF	02	30		1	12/31/22		.00	.00	203.44-	RETIREMENT 2%
JE	44	242.99	ACCU	01	30		1	12/31/22		.00	134.99	.00	VACATION ACCRUAL
JE	44	408.30	EMBF	06	30		1	12/31/22		.00	223.72	.00	EMPLOYER FICA
JE	44	408.30	EMBF	07	30		1	12/31/22		.00	52.32	.00	EMPLOYER FICA-MEDICARE PORTION
JE	44	926.20	EMBF	19	30		1	12/31/22		.00	30.22	.00	EMPLOYER 401K PLAN MATCH
JE	41	165.20	PRPY	00	10		1	12/31/22	V FJ15	.00	522.04	.00	AMORTIZATION OF PREPAID EXPENSES
JE	41	929.00	UTIL	01	10		1	12/31/22	V FJ921	.00	15.18	.00	ELECTRIC SERVICE
JE	41	921.30	OVHD	04	30		1	12/31/22	V FJ922	.00	1,557.82	.00	OFFC&COMP EXP/EMP WELFARE-CLEAR

NUMBER OF RECORDS FOUND - 329

TOTAL QTY 776.00

TOTAL DEBIT 149,988.68
TOTAL CREDIT 1,443.19-
NET BALANCE 148,545.49

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 08	10		2095	01/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	01/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	01/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	01/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	01/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	01/01/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/18/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/24/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/24/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	01/24/22	VN 3464	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 06	10		2095	01/24/22	VN 3464	.00	212.77	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX 08	10		2095	01/24/22	VN 3464	.00	197.73	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	01/24/22	VN 12417	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 06	10		2095	01/24/22	VN 12417	.00	207.04	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX 08	10		2095	01/24/22	VN 12417	.00	231.66	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 03	10		2095	01/31/22	VN 1287	.00	3.24	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	02/01/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	02/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES

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	08	10		2095	02/07/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	02/07/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	02/07/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	02/07/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	02/07/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	02/11/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	02/25/22	VN 14251	.00	1,006.71	.00	DIR LODGING/TRAVEL EXP-POWERXCHG
AP	1	232.10	BDEX	03	10		2095	02/28/22	VN 1287	.00	4.32	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/01/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	03/09/22	VN 1657	.00	671.14	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	01	10		2095	03/09/22	VN 1657	.00	1,500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	03/09/22	VN 12417	.00	1,500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	03/09/22	VN 12417	.00	804.55	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	08	10		2095	03/09/22	VN 12417	.00	290.16	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/21/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/21/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/21/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/21/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	03/21/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	03/21/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE

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	10		2095	03/21/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	03/21/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	03/21/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	03/22/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	03/22/22	VN 3464	.00	191.30	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 06	10		2095	03/25/22	VN 14251	.00	.00	335.57-	DIR LODGING/TRAVEL EXP-RM CANCEL
AP	1	232.10	BDEX 03	10		2095	03/29/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 07	10		2095	03/30/22	VN 10260	.00	.00	450.00-	REGISTRATION FEES - MEETINGS
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	04/01/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	04/22/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 03	10		2095	04/30/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 09	10		2095	04/30/22	VN 14657	.00	43.61	.00	DIRECTORS' MISCELLANEOUS EXP
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/01/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	05/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES

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	10		2095	05/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	05/17/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	05/17/22	VN 3464	.00	73.13	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 03	10		2095	05/31/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/01/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 1657	.00	17.55	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 12022	.00	1.17	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 12417	.00	15.80	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 3464	.00	42.12	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 13992	.00	5.85	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 1626	.00	23.40	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	06/27/22	VN 14917	.00	31.59	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	06/27/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 03	10		2091	06/30/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 01	10		2095	07/19/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	07/19/22	VN 3464	.00	203.13	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 06	10		2095	07/28/22	VN 10260	.00	2,229.06	.00	HOTEL - NRECA LEGAL SEMINAR

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	03	10		2095	07/31/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/01/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 3464	.00	750.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 3464	.00	213.13	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 3464	.00	212.32	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 14917	.00	197.32	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 14917	.00	143.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 14917	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 12417	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 12417	.00	214.58	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 12417	.00	188.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 12022	.00	2,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 12022	.00	168.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 12022	.00	922.50	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 1657	.00	212.32	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 1657	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 1657	.00	171.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 13992	.00	1,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 13992	.00	197.32	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	08	10		2095	08/16/22	VN 1626	.00	177.50	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	08/16/22	VN 1626	.00	2,000.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	08/16/22	VN 1626	.00	888.67	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	03	10		2095	08/29/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 1657	.00	18.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES

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	08	10		2095	09/01/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/01/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/14/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	09/20/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/20/22	VN 3464	.00	202.50	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	05	10		2095	09/20/22	VN 3464	.00	10.26	.00	DIRECTORS' MEALS
AP	1	232.10	MSAD	08	10		2095	09/20/22	VN 1288	.00	301.00	.00	SUBSCRIPTIONS
AP	1	232.10	BDEX	03	10		2095	09/27/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 1657	.00	18.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	09/29/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	09/29/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	08	10		2095	10/06/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	01	10		2095	10/06/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES

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	10		2095	10/06/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/17/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 03	10		2095	10/26/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 07	10		2095	10/28/22	VN 10260	.00	1,890.00	.00	REGISTRATION FEES - MEETINGS
AP	1	232.10	BDEX 06	10		2095	10/28/22	VN 10260	.00	516.32	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 1657	.00	18.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	10/31/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	10/31/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	11/04/22	VN 14917	.00	15.63	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	11/04/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	11/17/22	VN 3464	.00	250.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 03	10		2095	11/30/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 1657	.00	18.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 1657	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 1657	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 12022	.00	1.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 12022	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 12022	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 12417	.00	16.88	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 12417	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 12417	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 3464	.00	45.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 3464	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 3464	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 13992	.00	6.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 13992	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 13992	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 1626	.00	25.00	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 1626	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 1626	.00	500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 08	10		2095	12/01/22	VN 14917	.00	33.75	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 14917	.00	600.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX 01	10		2095	12/01/22	VN 14917	.00	500.00	.00	DIRECTORS' FEES

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	10		2095	12/09/22	VN 12417	.00	1,500.00	.00	DIRECTORS' FEES
AP	1	232.10	BDEX	06	10		2095	12/09/22	VN 12417	.00	905.01	.00	DIRECTORS' LODGING/TRAVEL EXP
AP	1	232.10	BDEX	08	10		2095	12/09/22	VN 12417	.00	371.25	.00	DIRECTORS' MILEAGE
AP	1	232.10	BDEX	05	10		2095	12/15/22	VN 1221	.00	1,909.00	.00	DIRECTORS' MEALS-ALL 7
AP	1	232.10	BDEX	07	10		2095	12/15/22	VN 1221	.00	560.00	.00	REGISTRATION FEES - SG, TS
AP	1	232.10	BDEX	09	10		2095	12/26/22	VN 14251	.00	1,282.60	.00	DIRECTORS' MISC EXP-XMAS
AP	1	232.10	BDEX	03	10		2095	12/28/22	VN 1287	.00	3.78	.00	DIRECTORS' INSURANCE
AP	1	232.10	BDEX	07	10		2095	12/28/22	VN 10260	.00	2,475.00	.00	REGISTRATION FEES - MEETINGS

NUMBER OF RECORDS FOUND - 365

TOTAL QTY .00

TOTAL DEBIT	145,141.58
TOTAL CREDIT	785.57-
NET BALANCE	144,356.01

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 44
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 44. Provide the name and personal mailing address of each member of Fleming-Mason Energy'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 44.

Tom Saunders, Chairman – 5736, US 62, Mays Lick, KY 41055

John Roe, Vice-Chairman & **KEC Representative** – 7690 Lower Kinney Rd., Vanceburg, KY 41179

Sandina Gooding, Secretary/Treasurer – 185 Country Lane, Flemingsburg, KY 41041

Timothy Eldridge, Director & **NRECA / EKPC Representative** – 55 Big Elm Estates, Morehead, KY 40351

Rick Hord, Director – 6091 Ribolt Epworth Rd., Tollesboro, KY 41189

Regina Rose, Director – 6173 Morehead Rd., Flemingsburg, KY 41041

Shane Smoot, Director – 3632 W Hwy 60, Owingsville, KY 40360

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 45
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 45. 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 the utility's board members for serving on EKPC's board of directors. If any of the listed expenses in this analysis include the costs for a director's spouse, list expenses for the directors' spouses separately.

Response 45.

	Monthly Fee	Meeting Fee	Mileage	AD&D Insurance (NRECA)	NRECA Rural Electric Magazine Subscription	Lodging/Travel/ Meal Expenses	Registration Fees	Misc Expense
Tim Eldridge	$7,200.00	$10,000.00	$404.20	$6.48	$43.00	$2,570.88		$226.83
Sandina Gooding, Secretary/Treasurer	$7,200.00	$9,500.00	$185.61	$6.48	$43.00	$1,449.35	$280.00	$183.22
Rick Hord	$7,200.00	$12,500.00	$1,325.30	$6.48	$43.00	$6,224.92		$183.22
John Roe, Vice-Chairman	$7,200.00	$12,000.00	$1,730.00	$6.48	$43.00	$1,787.20		$183.22
Regina Rose	$7,200.00	$9,000.00	$84.30	$6.48	$43.00	$724.28		$183.28
Tom Saunders, Chairman	$7,200.00	$10,000.00	$514.70	$6.48	$43.00	$1,415.52	$280.00	$183.22
Shane Smoot	$7,200.00	$9,000.00	$583.01	$6.48	$43.00	$724.17		$183.22
	$50,400.00	$72,000.00	$4,827.12	$45.36	$301.00	$14,896.32	$560.00	$1,326.21

Please see the following description of the type of meetings and board members in attendance.

CFC Financial Workshop- January 24-25

Tom Saunders
Rick Hord
Regina Rose
John Roe

NRECA PowerExchange-March 6-9

Timothy Eldridge
Rick Hord

KEC Annual Meeting – August 13-26

Sandina Gooding
Timothy Eldridge
Tom Saunders
Rick Hord
Regina Rose
Shane Smoot
John Roe

KEC Board Orientation -Nov 4

Shane Smoot

Director Winter School- December 15

Rick Hord

John Roe served as the Kentucky Electric Cooperative board member representing Fleming-Mason Energy. Mr. Roe attended 11 board/committee meetings at a per diem of $250. Tim Eldridge serves as the East Kentucky Power Cooperative board member representing Fleming-Mason Energy. No compensation was paid to Mr. Eldridge for serving on this board. No costs were incurred for director spouses.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 46
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 46. Provide Fleming-Mason Energy'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 46. Please see Board Policy 105 included in Response 47 below for the attorney compensation policy. See attached Board Policy 109 as well as Fleming-Mason Energy's current General Counsel Agreement. General Counsel is paid for additional work at the rate of $200 per hour. Fleming-Mason Energy does not have a written policy on the compensation of auditors or other professional service providers. See attached for the most recent annual audit engagement letter.

Fleming-Mason Energy Cooperative, Inc.

POLICY NO. 109

LEGAL REPRESENTATION AND USE OF ATTORNEYS

I. OBJECTIVE

The Board of Directors of Fleming-Mason Energy Cooperative, Inc. ("Board") recognizes that competent legal representation and effective use of attorneys are critical to the successful operation of Fleming-Mason. Although an attorney or law firm retained or employed by Fleming-Mason are governed by rules of professional conduct and other local, state, and federal law, the objective of this policy is to provide additional guidance for, and emphasize important aspects of, the Attorney's representation of Fleming-Mason and Fleming-Mason's use of the Attorney. To the extent this policy is inconsistent with rules of professional conduct or similar requirements governing attorneys, the rules or requirements govern.

II. POLICY

A. General Counsel. Fleming-Mason shall retain or employ an Attorney to continually provide general legal services to the Cooperative. General legal services include, but are not limited to: (1) attending and reviewing minutes of all meetings of the Board and all annual and special meetings of Fleming-Mason Energy's members; (2) negotiating, drafting, and reviewing contracts; (3) providing legal services for the disposition or acquisition of real property and interests in real property; (4) providing legal services for the borrowing or lending of money; (5) providing legal services regarding general business, cooperative, tax, and electric utility law; and, (6) providing legal services for matters involving the Kentucky Public Service Commission.

B. Special Counsel. As reasonably necessary, and following consultation with the General Counsel, Fleming-Mason may retain or employ an Attorney to provide special legal services to the Cooperative ("Special Counsel"). Special legal services require competence in a particular field of law and include, but are not limited to: (1) representing the Cooperative in state or federal court, or before a local, state, or federal agency; and (2) providing legal services regarding labor, employment, tax, antitrust, environmental, or intellectual property law. In providing special legal services to the Cooperative, a Special Counsel shall provide the General Counsel copies of all communications, memoranda, briefs, notices, motions, and other documents prepared, filed, received, or sent by the Special Counsel. As determined by the Board, the General Counsel may provide special legal services to the Cooperative.

C. Competent Legal Representation and Conflicts of Interest. An Attorney shall provide competent legal representation to the Cooperative, and shall have or acquire the appropriate knowledge, skills, time, and qualifications necessary to provide competent legal representation. No Attorney, however, guarantees, promises, or warrants a successful or favorable outcome regarding legal services provided to the Cooperative. An Attorney shall comply with conflict of interest requirements prescribed in applicable local, state, and federal law and rules of professional conduct. An Attorney may provide legal services to an entity in which the Cooperative owns an interest ("Affiliated Entity") only if the Attorney complies with these conflict of interest requirements. An Attorney shall inform the Cooperative's chief executive officer, or person authorized by the chief executive officer ("CEO") in writing of any other entity engaged in

generating, transmitting, distributing, marketing, or selling electric energy to which the Attorney provides legal services.

D. Retaining, Employing, and Discharging Attorney. The Board shall make decisions regarding retaining, employing, and discharging the General Counsel. Following consultation with the General Counsel, the CEO shall make decisions regarding retaining, employing, and discharging any other Attorney. By providing written notice to an Attorney, the Cooperative may discharge the Attorney, and terminate any attorney engagement agreement, at any time for any reason. By providing written notice to the Cooperative, and as required or allowed by applicable law and rules of professional conduct, an Attorney shall or may withdraw from representing the Cooperative and terminate any attorney engagement agreement.

E. Third Party. As part of providing legal services to the Cooperative, and with the CEO's prior consent, an Attorney may retain another attorney or may use an attorney or paraprofessional associated with the Attorney in a law firm. As reasonably necessary or helpful in providing legal services to the Cooperative, and subject to any limitations stated in an attorney engagement agreement, an Attorney may contract for a non-attorney and non-paraprofessional third party to provide goods or services.

F. Directing Attorney. Only the Board or the CEO may request that an Attorney provide legal services to the Cooperative. As requested by an Attorney, and as reasonably necessary or helpful in providing legal services to the Cooperative, the Cooperative shall provide the Attorney reasonable access to its directors, officers, employees, consultants, agents, representatives, records, and documents. The CEO and an Attorney shall keep the Board reasonably informed regarding any matter for which the Attorney is providing legal services to the Cooperative. In consultation with the Board or as directed by the Board, the CEO shall direct an Attorney. In providing legal services to the Cooperative, and subject to the Board or CEO's direction, an Attorney may act on the Cooperative's behalf in any manner reasonably believed to be in the Cooperative's best interest. Unless the CEO gives his or her prior consent, an Attorney may not make a statement outside of a tribunal regarding the Attorney's provision of legal services to the Cooperative, which statement the Attorney knows or reasonably should know will be disseminated by means of public communication. No Cooperative director, officer, employee, consultant, agent, or representative may interfere with the Attorney's ability to exercise independent professional judgment and render candid advice.

G. Attorney Fees and Expenses. The Cooperative Attorney will be hired on an annual basis and the Cooperative shall pay the Attorney a monthly retainer to be agreed on between the parties which will commence at the beginning of the month in which hired. The Attorney may bill the Cooperative an additional amount for additional services rendered outside normal retainer business.

H. Unauthorized Practice of Law. No Fleming-Mason Energy director, officer, employee, consultant, agent, or representative may provide legal services to the Cooperative unless the individual is an attorney admitted to practice law in an appropriate jurisdiction.

I. Cooperative as Client. In providing legal services to the Cooperative, an Attorney represents the Cooperative as client, acting through its authorized directors, officers, employees, and members. In representing the Cooperative, an Attorney does not represent the Cooperative's directors, officers, employees, or members. If the Board gives its informed, written, and prior consent, and

if an Attorney complies with applicable conflict of interest requirements, then the Attorney may represent an Affiliated Entity and the Attorney may represent individual Cooperative directors, officers, employees, and members in matters related to the Attorney's representation of the Cooperative.

J. Attorney-Client Privilege. Confidential communications between Fleming-Mason Energy, or its agent or representative, and the Attorney, or the Attorney's agent or representative, made to facilitate the Attorney's provision of legal services to the Cooperative are protected by the attorney-client privilege. Cooperative directors, officers, employees, consultants, agents, and representatives shall not disclose these communications to third parties, other than those to whom disclosure is made in furtherance of this provision of legal services, or those reasonably necessary for transmitting the communications. To the extent these communications are disclosed to Cooperative employees, consultants, agents, or representatives, they must only be disclosed to individuals who reasonably need to know of the communications.

K. Attorney's Duty to Inform and Consult. An Attorney shall keep the Board and the CEO reasonably informed regarding a matter for which the Attorney is providing legal services to the Cooperative. For decisions regarding the matter to be made by the Cooperative, the Attorney shall explain the matter to the Board and the CEO to the extent reasonably necessary to permit the Cooperative to make an informed decision. An Attorney shall promptly comply with the Cooperative's reasonable request for information.

L. Reliance. In providing legal services to the Cooperative, an Attorney may rely upon information provided by the Cooperative, unless the Attorney knows that the reliance is unwarranted. In performing his or her duties, a Cooperative director, officer, or employee may rely upon information, opinions, reports, and statements prepared or presented by an Attorney. A director, officer, or employee's reliance, however, is only permitted regarding matters involving skills or expertise that he or she reasonably believes are within the Attorney's professional or expert competence. Further, this reliance is only permitted if the director, officer, or employee acts in good faith and reasonably believes that the reliance is warranted and that the Attorney merits confidence.

M. Legal Programs, Publications, and Memberships. Fleming-Mason shall encourage the General Counsel to: (1) attend legal programs sponsored by, and to subscribe to legal publications published by, the National Rural Electric Cooperative Association and any association of electric cooperatives located within the state; and (2) be a member of, and attend programs sponsored by, the Electric Cooperative Bar Association and any association of attorneys representing electric cooperatives located within the state. The payment of any fees and expenses related to a General Counsel retained by Fleming-Mason Energy attending these legal programs, subscribing to these legal publications, or being a member of these associations must be specified in an attorney engagement agreement.

III. RESPONSIBILITY

The Board is responsible for compliance with this policy. The CEO is responsible for communicating with an Attorney regarding the Attorney's provision of legal services to Fleming-Mason Energy.

Approved by Board of Directors: 2/02/2017
Reviewed by Board of Directors: 10/01/2019; 08/03/23

Fleming-Mason Energy Cooperative, Inc.

Attorney Engagement Agreement

Fleming-Mason Energy Cooperative, Inc. ("Cooperative") and Earl Rogers, III ("Attorney") enter this Attorney Engagement Agreement ("Agreement") on October 1, 2019, with the Agreement being effective on January 1, 2020.

1. General Agreement. Pursuant to this Agreement, Attorney shall provide legal services to Cooperative, and Cooperative shall pay Attorney. In entering this Agreement, Cooperative and Attorney have formed or continue an attorney-client relationship for the provision of the legal services stated in this Agreement.

2. Policy. Attorney and Cooperative, respectively, shall comply with applicable provisions of Fleming-Mason Energy Cooperative, Inc. Policy No. 109, entitled "Legal Representation and Use of Attorneys" ("Policy"), which Policy is incorporated in this Agreement by reference.

3. General or Special Counsel. As described in the Policy, and as indicated below, Attorney shall provide legal services to Cooperative as:

   _X_ General Counsel and, as requested by Cooperative, provide Electric Cooperative general legal services and any special legal services determined by the Board of Directors of Cooperative ("Board")

   ____ Special Counsel and provide Cooperative the following special legal services, with Attorney's representation of Cooperative being limited to providing these special legal services: _____

4. General Retainer. If Attorney provides legal services to Cooperative as General Counsel, then Cooperative shall pay the Attorney $ 1,060.00 per month for attending and reviewing minutes of all regular and special meetings of the Board and for providing general legal services.

5. Payment. Cooperative shall pay Attorney on a monthly basis.

6. Publications. Memberships, Meetings, and Seminars. If Attorney provides legal services to Cooperative as General Counsel the Cooperative shall pay for annual subscriptions to publications issued by NRECA and shall pay and reimburse for the Attorney to attend NRECA and KAEC annual legal seminars and annual member meetings.

7. Governing Law. This Agreement will be governed by, and interpreted under, the law of Kentucky.

FLEMING-MASON ENERGY COOPERATIVE, INC.

Joni Hazelrigg
Printed Name: Joni Hazelrigg
Title: President / CEO
Date: 10/1/19

[NAME OF ATTORNEY]

Printed Name: Earl Rogers, III
Title: Attorney
Date: 10/1/19

JNM

Jones, Nale & Mattingly PLC

August 23, 2022

Board of Directors
Fleming-Mason Energy Cooperative, Inc. and Subsidiary
1449 Elizaville Road
Flemingsburg, Kentucky 41041

Attention: Lauren C. Fritz

We are pleased to confirm our understanding of the services we are to provide for Fleming-Mason Energy Cooperative, Inc. and Subsidiary (the Cooperative) for the year ending December 31, 2022.

We will audit the consolidated financial statements of the Cooperative, which comprise the balance sheet as of December 31, 2022, and the related statements of revenue and comprehensive income, changes in members' equities and cash flows for the year then ending, and the related notes to the consolidated 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 Objectives

The objective of our audit is the expression of an opinion about whether your consolidated financial statements are fairly presented in all material respects, in conformity 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 consolidated 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 consolidated 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 consolidated financial statements and compliance with the provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a material effect on the consolidated 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 consolidated 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 consolidated financial statements. We will plan and perform the audit to obtain reasonable rather than absolute assurance about whether the consolidated 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 consolidated 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 1773.20(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 consolidated 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 consolidated 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 consolidated 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 consolidated 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 consolidated financial statements are free of material misstatement, we will perform tests of 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 information and property tax returns for the year ending December 31, 2021 based on information provided by you. We will also assist in preparing the consolidated 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 and audit in accordance with 7 CFR Chapter XVII, Part 1773.

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. You are also responsible for the selection and application of accounting principles for the preparation and fair presentation of the consolidated 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 consolidated 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 consolidated 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 consolidated 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 consolidated 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, consolidated 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 consolidated 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 consolidated financial statements, and related notes prior to their issuance and have accepted responsibility for them. You agree to oversee the nonaudit services by designating an individual, preferably from senior management, with suitable skill, knowledge, or experience; to evaluate the adequacy and results of the services and accept responsibility for them.

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 consolidated 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. RUS will consider the Cooperative to be in violation of its RUS Security Agreement and this part if the Cooperative fails to have an audit performed and documented in compliance with GAGAS and this part. We will make all audit-related documents available to the RUS. We are also required under RUS Part 1773.7, to contact RUS if we are unable to resolve any scope limitations with your audit, or if such limitations in scope violate this part.

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. We are also a member of the PCAOB Section of the American Institute of Certified Public Accountants which requires CPA firms to participate in a peer review program and meet the requirements under RUS Part 1773.5

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(ies) contesting the audit finding for guidance prior to destroying the audit documentation.

I am the engagement partner and am responsible for supervising the engagement and signing the reports or authorizing another individual to sign them.

Fees for the consolidated financial statement will be $14,300 for Fleming-Mason Energy Cooperative, Inc. and $2,150 for FM Utility Resources, LLC. 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.

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

Travis C. Frick, CPA, CGMA

Accepted:

By: _____

Date: 10/6/22

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 47
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 47. Provide Fleming-Mason Energy'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, indicate the effective date and the reason for the changes.

Response 47. Please see attached Board Policy 105.

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POLICY NO. 105

DIRECTOR & ATTORNEY COMPENSATION POLICY

I. OBJECTIVE

This policy addresses compensation to be paid to directors and retained attorney of the Cooperative in the performance of their duties for the Cooperative.

II. CONTENT

A. Director Compensation

1. All directors will be paid a fixed monthly sum of $600 under provisions of Section 5, Article IV, of the By-Laws of the Corporation.

2. All directors will be paid:

   a. $500 for each regular or special board meeting attended, either in person, telephonically, or electronically.

   b. $500 per day for each additional cooperative related meeting or training, in person, telephonically or electronically, including, but not limited to, NRECA, EKPC, CFC, CoBank, annual and regional meetings. If a director is appointed by the board to attend related board meetings and is compensated by that related board an amount less than $500 per day, Fleming-Mason will pay the difference between the amount received and the $500 maximum per day. A director attending online training that occurs over multiple days may be compensated for each day only if the training lasted longer than 4 hours per day. In such instance where the training was four hours or less per day, every two days of training shall equal one day for compensation purposes.

   c. A director may be compensated for no more than one meeting (board meeting, training or a committee meeting) per day.

   d. The cooperative will not pay any portion of the healthcare coverage for directors currently serving on the board, or hereafter elected or appointed to the board, effective January 1, 2014. Directors with healthcare policies currently provided by the cooperative may be continued and the cost of the coverage will be reimbursed by those directors as applicable. The cooperative shall not enroll any directors in healthcare coverage not currently covered by the cooperative group plan effective January 1, 2014.

   e. This policy has no effect on the healthcare coverage of previously retired directors or current directors covered by previous policy in regard to healthcare coverage upon retirement.

3. Each director will be reimbursed actual expenses of travel related to attendance of meetings on behalf of Fleming-Mason Energy. Reimbursement for the use of a personal vehicle will be reimbursed based on the IRS approved standard mileage rate up to a limit of the average cost of an airline ticket.

B. Attorney Compensation:

1. The Cooperative attorney will be hired on an annual basis and the Cooperative shall pay the attorney a monthly retainer to be agreed on between the parties which will commence at the beginning of the month in which hired.

2. After the initial hire, the attorney will have the retainer amount reviewed each year when salaries of the employees are reviewed.

3. The attorney may bill the Cooperative an additional amount for additional services rendered outside normal retainer business.

4. The Cooperative will not pay any portion of the healthcare coverage for an attorney after January 1, 2015.

5. An attorney with healthcare coverage currently provided by the Cooperative (October 2, 2014) may be continued and the cost of the coverage will be reimbursed by the attorney as applicable.

6. The Cooperative will not enroll any attorney in healthcare coverage not currently covered by the Cooperative group plan after January 1, 2015.

III. RESPONSIBILITY

The Chairman of the Board is responsible for the administration of and compliance with this policy.

Approved by Board of Directors: 02/03/2022

Replaces Policy No. 59 dated 10/2/2014

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 48
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 48. 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 48.

2023 The 85th Annual Meeting was held on June 28, 2023. Registration was between 7:30 am and 6:00 pm with a total of 1,104 registered members. The business meeting was held at 11:00 am with 351 registered members at that time. There was no official election since District 1 (Tom Saunders) and District 4 (Dina Gooding) were uncontested, and both seats were retained by acclamation. The total cost was $40,007.33.

2022 The 84th Annual Meeting was held on June 29, 2022. Registration was between 7:30 am and 6:00 pm with a total of 1,036 registered members. The business meeting was held at 11:00 am with 319 registered members at that time. There was no official election since District 3 (John Roe) and District 6 (Shane Smoot) were uncontested, and both seats were retained by acclamation. The total cost was $48,202.14.

2021 The 83rd Annual Meeting was held on June 24, 2021. Registration was between 7:30 am and 6:00 pm with a total of 1,086 registered members. The business meeting was held at 11:00 am with 391 registered members at that time. There was no official election since District 2 (Rick Hord), District 5 (Regina Rose), and District 7 (Timothy Eldridge) were uncontested, and the seats were retained by acclamation. The total cost was $45,769.88.

2020 The 82nd Annual Meeting was held on July 9, 2020. Registration was between 7:30 am and 6:00 pm with a total of 1,234 registered members. The business meeting was held at 10:00 am via radio frequency to allow for social distancing, with verification of quorum given by the cooperative attorney. There was no official election since District 1 (Tom Saunders) and District 4 (Dina Gooding) were uncontested, and both seats were retained by acclamation. The total cost was $40,347.22.

2019 The 81st Annual Meeting was held on June 20, 2019. Registration was between 7:30 am and 6:00 pm with a total of 1,024 registered members. The business meeting was held at 2:00 pm with a verification of quorum given by the cooperative attorney. There was no official election since District 3 (John Roe) and District 6 (Lonnie Vice) were uncontested, and both seats were retained by acclamation. The total cost was $46,062.43.

2018 The 80th Annual Meeting was held on June 21, 2018. Registration was between 7:30 am and 6:00 pm with a total of 810 registered members. The business meeting was held at 2:00 pm with a verification of quorum given by the cooperative attorney. There was no official election since District 2 (Rick Hord), District 5 (J.E. Smith, Jr.), and District 7 (Timothy Eldridge) were uncontested, and the seats were retained by acclamation. The total cost was $43,171.66.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 49
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 49. Provide any information, when known, that would have a material effect on net operating income, rate base, or cost of capital that have occurred after the test year but were not incorporated in the filed testimony and exhibits.

Response 49. Fleming-Mason Energy 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.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 50
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 50. 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 50. Please see attached schedules.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 51
RESPONSIBLE PERSON: John Wolfram
COMPANY: Catalyst Consulting LLC

Request 51. 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 Fleming-Mason Energy's rate application in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 51. The Excel spreadsheets responsive to this request were uploaded to the Commission website on August 4, 2023, concurrent with the filing of the Application in this docket.

FLEMING-MASON ENERGY COOPERATIVE, INC.
PSC CASE NO. 2023-00223
FIRST REQUEST FOR INFORMATION RESPONSE

COMMISSION STAFF'S FIRST REQUEST FOR INFORMATION DATED 8/15/2023
REQUEST 52
RESPONSIBLE PERSON: Lauren C. Fritz
COMPANY: Fleming-Mason Energy Cooperative, Inc.

Request 52. To the extent not already provided, provide all workpapers, calculations, and assumptions Fleming-Mason Energy used to develop its test year financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 52. All applicable workpapers should be included with the specific request.