COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

THE ELECTRONIC APPLICATION OF BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION FOR A GENERAL ADJUSTMENT OF RATES	))))	CASE NO. 2024-00287

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION'S
VERIFIED RESPONSE TO
COMMISSION STAFF'S FIRST REQUESTS FOR INFORMATION
ENTERED SEPTEMBER 25, 2024

Comes now Big Sandy Rural Electric Cooperative Corporation (Big Sandy), by counsel, and does hereby tender its Verified Response to Commission Staff's First Request for Information entered September 25, 2024.

Filed October 16, 2024

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

Electronic Application of Big Sandy Rural Electric Cooperative Corporation for a General Adjustment of Rates and Other General Relief	))))	Case No. 2024-00287

VERIFICATION OF JEFF PRATER

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JOHNSON)

Jeff Prater, President and General Manager of Big Sandy Rural Electric Cooperative Corporation, being duly sworn, states that he has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above-referenced case 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.

Jeff Prater

Jeff Prater

The foregoing Verification was signed, acknowledged and sworn to before me this 16th day of October, 2024, by Jeff Prater.

Judy L. McClure

Commission expiration: 6-19-2026

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

Electronic Application of Big Sandy Rural Electric Cooperative Corporation for a General Adjustment of Rates and Other General Relief	)))	Case No. 2024-00287

VERIFICATION OF ROBIN SLONE

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JOHNSON)

Robin Slone, Accounting Manager for Big Sandy Rural Electric Cooperative Corporation, being duly sworn, states that she has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above-referenced case 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.

Robin Slone

Robin Slone

The foregoing Verification was signed, acknowledged and sworn to before me this 16th day of October, 2024, by Robin Slone.

Judy L. McClure

Commission expiration: 6-19-2026

COMMONWEALTH OF KENTUCKY

BEFORE THE PUBLIC SERVICE COMMISSION

In the Matter of:

Electronic Application of Big Sandy Rural Electric Cooperative Corporation for a General Adjustment of Rates and Other General Relief	)))	Case No. 2024-00287

VERIFICATION OF JONI HAZELRIGG

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF JOHNSON)

Joni Hazelrigg, Consultant for Big Sandy Rural Electric Cooperative Corporation, being duly sworn, states that she has supervised the preparation of certain responses to Commission Staff's First Request for Information in the above-referenced case 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.

Joni Hazelrigg
Joni Hazelrigg

The foregoing Verification was signed, acknowledged and sworn to before me this 16th day of October, 2024, by Joni Hazelrigg.

Judy L. McClure
Commission expiration: 6-19-2026

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 1: Provide the following expense account data:

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

b. A listing, with descriptions, of all activities, initiatives, or programs undertaken by Big Sandy Energy 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 1(a): Please see the Excel file uploaded separately.

Response 1(b): Big Sandy provides the following activities, initiatives and programs that were impactful since our last general rate case in reducing costs or improving the efficiency of operations and maintenance. These following activities are not all inclusive of our activities, as Big Sandy continuously looks for cost saving measures. It is not possible to quantify the exact dollar amount of these actions.

Big Sandy applied for a SBA/PPP loan in 2020 in the amount of $538,970. The loan was forgiven that enabled it to recover up to eight weeks of payroll costs including benefits.

Overall, Big Sandy operates with a lean workforce for both inside and outside employees. Upgraded Automated Metering Reading infrastructure (AMR) from 2019-2023. This has added a significant number of Remote-enabled Disconnect meters and reduced operational expenses. It has also improved voltage monitoring, outage detection, the speed of communication.

Big Sandy has closely evaluated our Vegetation Management Program since the last rate increase, after experiencing loss of available contract workforce due to Covid 19, Big Sandy created a subsidiary "Big Sandy Forestry" to provide one crew that currently cuts all capital projects and mid cycle trees.

In April, 2020, Big Sandy drew down final loan funds in the amount of $7,000,000 at a fixed rate of 1.118 percent from FFB. Four million of that was invested in CFC Certificates with an annual return of 5 percent. The interest that is being earned on the certificate is more than enough to cover the debt service plus some.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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 the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 3: Provide the following:

a. A list of all outstanding issues of long-term debt as of the end of the latest calendar year together with the related information as shown in Schedule B1.

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

Response 3a: Please see the Excel file uploaded separately.

Response 3b: Not Applicable. Big Sandy did not have any outstanding short-term loans as of end of test year 2023.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 4: Provide Big Sandy RECC's internal accounting manuals, directives, and policies and procedures.

Response 4: Please see attached RUS Form 1717-b2 "Guide for Preparing Financial and Statistical Reports for Electric Distribution Borrowers". Also reference the Audited Financial Statements provided in Exhibit 17 of the Application for a summary of significant accounting policies.

UNITED STATES DEPARTMENT OF AGRICULTURE
Rural Utilities Service

BULLETIN 1717B-2

RD-GD-2002-45

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

TO: All Electric Distribution Borrowers

EFFECTIVE DATE: Date of approval.

OFFICE OF PRIMARY INTEREST: Assistant Administrator, Electric Program.

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

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

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

Blaine D. Stockton
Assistant Administrator
Electric Program

2/14/02
Date

INSTRUCTIONS FOR THE PREPARATION OF THE FINANCIAL AND STATISTICAL REPORT

TABLE OF CONTENTS

ACRONYMS

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

ACRONYMS
(continued)

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

1. REQUIREMENTS

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

2. REPORTS

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

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

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

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

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

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

3. GENERAL

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

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

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

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

4. SPECIFIC INSTRUCTIONS

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

Form 7

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

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

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

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

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

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

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

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

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

PART A, STATEMENT OF OPERATIONS

Column

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

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

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

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

Item No.

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

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

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

4 **Transmission Expense**
Accounts 560 through 573

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

Item No. (continued)

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

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

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

9 **Sales Expense**
Accounts 911 through 916

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

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

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

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

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

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

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

17 **Interest Expense - Other**
Account 431

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

Item No. (continued)

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

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

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

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

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

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

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

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

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

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

PART B, DATA ON TRANSMISSION AND DISTRIBUTION PLANT

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

Item No.

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

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

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

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

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

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

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

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

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

Att to Response 4
Page 12 of 48
Witness: Jeff Prater

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

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 5: Provide Big Sandy RECC's long-term construction planning program.

Response 5: Please see the attached Construction Work Plan.

2021-2024
CONSTRUCTION WORK PLAN

BIG SANDY RECC

KENTUCKY 58 FLOYD

Final Report

September 2020

POWER CENTRIC SOLUTIONS®

POWER CENTRIC SOLUTIONS

September 18, 2020

Jeff Prater
Vice President Operations
Big Sandy RECC
504 11th Street
Paintsville, KY 41240

Subject: **2021-2024 Construction Work Plan**

Dear Mr. Prater,

Power Centric Solutions (PCS) is pleased to submit the final 2021-2024 Construction Work Plan (CWP) to Big Sandy RECC. We thank you for the opportunity to support you on this project and wish to acknowledge the cooperation and assistance received from the management and staff of Big Sandy RECC in the preparation of the CWP report.

The Executive Summary in Section summarizes the findings and recommendations to serve the anticipated needs of your members based on the evaluation of the distribution system. The system information and results of the analysis are described in detail in subsequent sections of the CWP report, supporting the conclusions and recommendations. I hereby certify that this 2021-2024 Construction Work Plan was prepared by me or under my direct supervision and that I am a duly registered professional engineer under the laws of the State of Kentucky.

POWER CENTRIC SOLUTIONS, LLC

Paul Keith Mullen, Jr., P.E.
Principal & Vice President

Date: September 18, 2020

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APPENDICIES

Section 1: Executive Summary

Purpose of Report

This report identifies the 2021-2024 Construction Work Plan (CWP) system improvements recommended for Big Sandy Rural Electric Cooperative Corporation (Big Sandy RECC) to provide reasonable and reliable service to its members at the anticipated design load. Power Centric Solutions (PCS) has prepared this document in accordance with the Rural Utilities Services (RUS) Bulletin 1724D-101B to receive approval of proposed construction items and potential loan funding, and to support the preparation of the financial forecast.

System Statistics

Big Sandy RECC provides service to approximately 12,729 members located in Breathitt, Floyd, Johnson, Knott, Lawrence, Magoffin, Martin, and Morgan counties in Kentucky. Big Sandy RECC distributes power to its members through thirty-six 13.2 kV circuits served by nine substations. Big Sandy RECC purchases power under an all-requirements contract from East Kentucky Power Cooperative (EKPC) at nine 13.2 kV delivery points with a total winter capacity of 179.9 MVA. EKPX constructs, owns, and operates the transmission lines and substations. **Table 1.1** presents a two-year history of the system operating statistics.

Table 1.1: Historical System Statistics

Description	2018	2019
Members Served	12,822	12,729
Overhead Line Miles	1,010	1,011
Underground Line Miles	25	25
Members per Mile	12.4	12.3
Energy Purchases	238,929 MWh	227,583 MWh
Energy Sales	225,779 MWh	215,043 MWh
System Losses	5.5%	5.5%
Annual Peak	74,438 kW	67,439 kW
System Load Factor	36.6%	38.5%

1) Based on Form 7 data provided
2) Energy losses expressed as a percentage of the total energy purchases

Recommendations

The system expansion to service 12,893 new members and the recommended projects identified in **Section 3** of this report were designed to serve a projected system peak

demand of 78 MW. Table 1.2 lists the estimated cost for the 2021-2024 Construction Work Plan per RUS funding code, which includes 3% inflation on equipment.

Table 1.2: CWP Program Cost Summary

RUS Code	Description	Estimated Loan Funds
100	New Lines	$1,468,875
200	Tie Lines	$0
300	Conversions/Line Changes	$372,774
400	New Substations	$0
500	Substation Changes	$0
600	Miscellaneous Distribution Equipment	$6,909,937
700	Other Distribution Items	$1,481,468
	TOTAL	**$10,233,054**

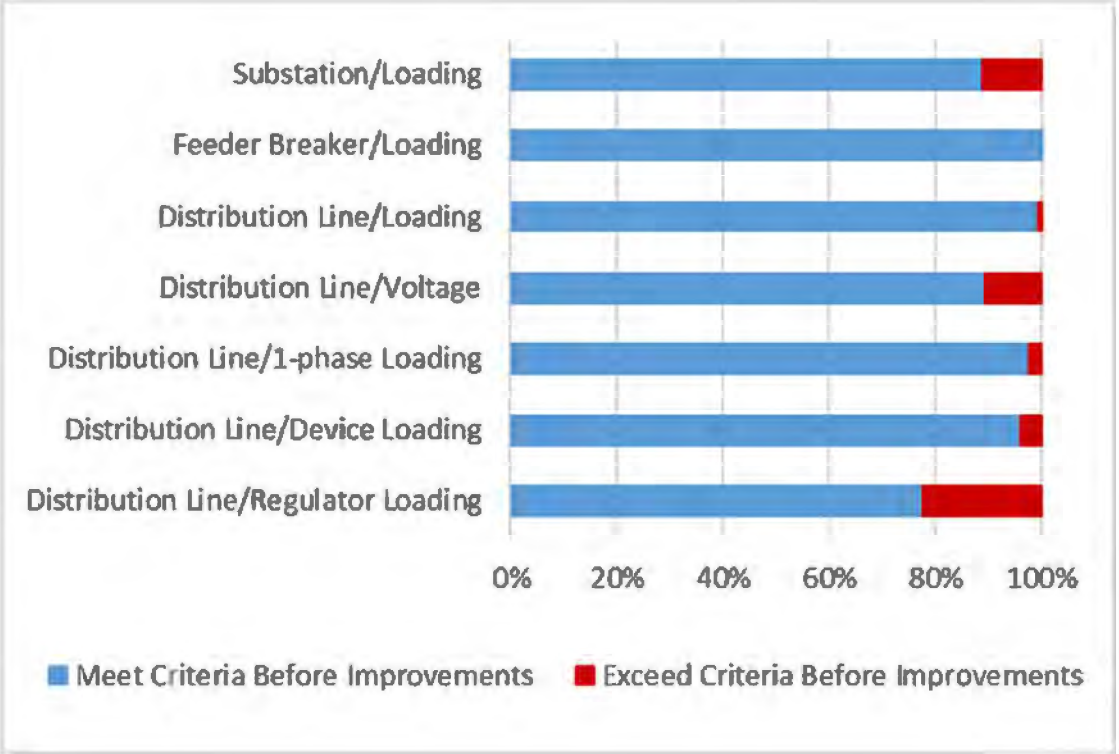
Summary of System Impacts

System deficiencies at the existing and projected peak loads were identified for the following categories based on the Big Sandy RECC's planning and operating criteria, the available system information, and engineering analysis performed in the distribution system model.

- Substation & Feeder Capacity
- Distribution Circuit Performance

The system deficiencies at the projected CWP design load as a percent of each facility asset are summarized in Figure 1.1. With the construction of the recommended improvements, all system deficiencies were corrected to meet the planning and operating criteria.

Figure 1.1: Projected Load Impact Summary



General Basis of Study

PCS has prepared this plan based on available information related to the performance and condition of the existing electric system, and assumptions of future loads and their impacts. PCS believes the recommendations contained herein are reasonable, considering the information provided by others and the analysis performed. However, future performance and the actual field condition of electric facilities may differ from those assumed, resulting in a variance in the projected outcomes and design/construction costs.

Section 2: Basis of Proposed Construction

Introduction

This section contains the basis for evaluating the Big Sandy RECC's electric system performance at existing and projected peak loading conditions to determine where upgrades are required to maintain reasonable and reliable service to its members. The criteria and assumptions listed are based on RUS approved planning and operating standards. The supporting system information, engineering models, and condition of assets were provided by the Big Sandy RECC.

Planning & Operating Criteria

The following criteria were used to assess the electric system's performance for the CWP planning period:

1. The minimum voltage on primary distribution lines is 118 volts (120 Volt base) after regulation with 124 Volt setpoint and 2 Volt bandwidth.
2. Primary conductors are not to be loaded over 75% of their thermal rating. Major tie lines will be limited to 75% of their thermal ratings.
3. The following equipment will not be thermally loaded by more than the percentage shown of its nameplate rating at a 55-degree rise with 90% power factor:
    a. 100% - Power Transformers (OA/FA)
    b. 80% - Voltage Regulators
    c. 70% - Reclosers
    d. 70% - Line Fuses
4. Loading on single phase lines will be flagged at 40 amperes. If a single-phase line exceeds this amount, it will be considered for multi-phasing.
5. Poles and/or crossarms are to be replaced if found to be physically deteriorated by visual inspection and/or tests.
6. Aged conductors are considered for replacement as needed.
7. New primary conductor sizes are to be determined on a case by case basis using the Economic Conductor Analysis method.

Distribution Line & Equipment Costs

The planning-level costs estimates presented in **Table 2.1** were used to determine the cost of proposed construction in 2020 dollars. The estimates are based on the inflated 2017 estimates from the 2014-2017 CWP.

Table 2.1: Unit Construction Costs

Category	Unit Cost
New Distribution Line	
3-ph 336 ACSR	$144,980/mi.
3-ph 3/0 ACSR	$134,980/mi.
1-ph 1/0 ACSR	$76,490/mi.
1-ph 2 ACSR	$65,240/mi.
Distribution Line Reconductor	
3-ph 336 ACSR	$163,110/mi.
3-ph 3/0 ACSR	$151,860/mi.
3-ph 1/0 ACSR	$112,500/mi.
3-ph 2 ACSR	$100,000/mi.
1-ph 1/0 ACSR	$98,990/mi.
1-ph 2 ACSR	$87,740/mi.
Distribution Line Regulators	
3-ph Regulator – 150 amp	$45,000/ea.
3-ph Regulator – 219 amp	$60,800/ea.
Distribution Protective Devices	
3-phase Recloser	$25,000/ea.
1-phase Recloser	$7,000/ea.

Status of Previous CWP Items

The construction items proposed in the 2014-2017 CWP were reviewed to determine if the projects were **completed**, postponed or were still **in-progress** during the preparation of this report. The projects that have been postponed were evaluated as part of the development of recommendations for this study to determine if the projects should be **cancelled** or included as a **carry-over**. Big Sandy RECC has completed all of the Code 300 projects from the 2014-2017 CWP, resulting in no carry-over projects for this report.

Historical & Projected System

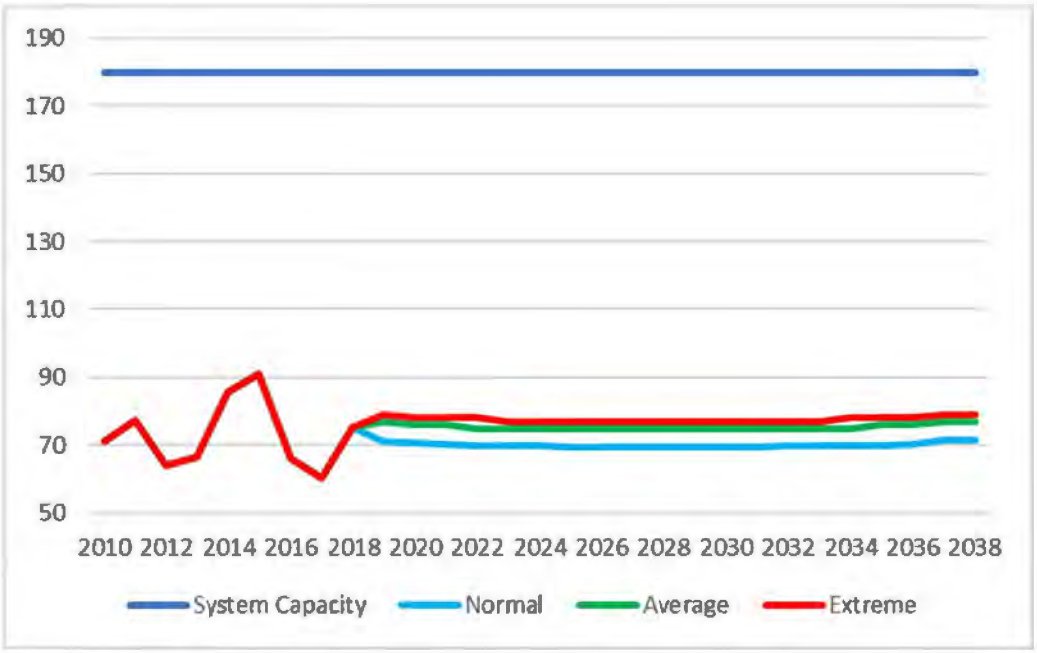
The performance of the existing electric system was evaluated at the historical and projected conditions based on the configuration and capacity of the installed assets and the planning and operating criteria outlined at the beginning of this section. This section presents the system load scenarios assessed and the resulting impacts that will form the

basis of the recommendations in **Section 3** for the proposed construction items.

Load Forecast

The 2018 Load Forecast (LF) report was prepared by EKPC to determine the projections for the number of members, energy purchases and sales, and peak demands on the system through 2038 based on various economic and weather conditions. The historical and projected system non-coincident peak demands from the LF are compared to the existing system capacity in **Figure 2.1**. Based on Big Sandy RECC's present knowledge of potential developments and anticipated growth in the service territory, the extreme projection in the LF was selected to represent the system peak loading during the CWP planning period. As a result, a CWP design load of 78 MW was assumed for the system analysis, which represents 46% of the EKPC calculated winter substation transformer capacity of 179.9 MVA.

Figure 2.1: Historical & Projected System NCP



Growth for each substation and feeder were identified by Big Sandy RECC as equal across the system. No additional spot loads are anticipated during the planning period outside of the basis for the LF. The resulting substation and feeder forecast is presented in **Appendix A**. The load milestones represented in each year of the substation and feeder forecast are referred to as a Load Level (LL) to identify in-service targets of each recommended facility upgrade or improvement instead of specific years.

Annual Energy, Load & Member Data

Based on the information presented the 2018 LF report prepared by EKPC, the

anticipated growth for energy sales and new members is -0.7% and -0.1%, respectively. The historical and projected growth was used as a basis for the forecast of new member connections during the CWP planning period.

Substation Loading

The Big Sandy RECC substation facilities and ratings are shown in **Table 2.2** with the existing and projected CWP loading. The projected loading presented is based on the highest projection in the planning period, which is LL1 of the 4-year CWP. Based on the existing configuration and ratings of the substation facilities, the projected load will not exceed the EKPC calculated winter substation transformer capacity. EKPC substation equipment ratings are presented in **Appendix B** of this report.

Table 2.2: Substation Loading

Substation ID	Total Capacity (MVA)	Planning Capacity (MVA)	Existing Peak (MVA)	Projected Peak (MVA)	Percent of Planning Load
Bill Wells	20.0	24.8	10.6	10.6	42.7%
Bonanza	20.0	24.8	6.8	6.8	27.4%
Jenny Wiley	14.0	18.1	7.6	7.6	42.1%
Martin County	14.0	18.1	12.0	11.9	66.1%
Middle Creek	20.0	24.8	8.5	8.5	34.4%
Redbush	6.4	8.3	4.3	4.3	52.2%
Salt Lick	14.0	18.1	5.5	5.5	30.2%
Thelma	14.0	18.1	9.9	9.9	54.7%
Volga	20.0	24.8	17.3	17.3	69.8%
TOTALS	**142.4**	**134.1**	**82.5**	**82.6**	**45.8%**

1) Above Planning Capacity in RED

Circuit Loading & Voltage

Load flows of the Big Sandy RECC distribution facilities were evaluated at the existing and projected LL1 CWP design loads against the loading and voltage planning criteria identified at the beginning of this section. A summary the feeders with one or more violations is given in **Table 2.3**, with the maximum calculated values at the projected CWP design load for each feeder. The summary also identifies if the condition was present at the existing peak. Based on the existing configuration and installed distribution facilities, the projected load for 14 feeders will exceed the planning criteria, excluding the violations for device loading.

Table 2.3: Distribution Facilities Violation Summary

Basis of Proposed Construction

Feeder ID	Existing Issue	Feeder Trip Setting Loading	Distr. Line Loading	Feeder Min. Voltage	1-ph Amps	Device Loading	Reg. Loading
Arkansas - CKT 655-144	YES	55%	***81%***	***117.2***	26.4	***96%***	***97%***
Cow Creek - Ckt 992-124	YES	45%	***109%***	119.2	24.4	***172%***	***135%***
Abbott Feeder Top 346-124	YES	35%	41%	121.9	17.5	***119%***	***86%***
Denver-Feed Bottom 708-134	YES	31%	37%	118.7	38.4	***77%***	0%
Mt Parkway - Ckt 608-114	YES	21%	21%	119.9	18.3	***77%***	0%
Cir# 211 - Middle Creek-134	YES	42%	49%	120.3	19.2	***161%***	0%
Cir# 417 Hospital-124	YES	15%	18%	123.3	29.5	***109%***	0%
Cir# 416- Beech Fork-144	YES	35%	40%	***41.2***	39.6	***167%***	24%
White House - Ckt 550-124	YES	32%	71%	***114.6***	25.3	***112%***	76%
Calloway - Ckt 756-114	YES	42%	***76%***	118.1	38.6	***117%***	73%
Milo - Ckt 551-134	YES	22%	***104%***	118.0	***49.1***	***196%***	0%
Tiger Mart - Ckt 287-144	YES	16%	21%	122.8	30.7	***113%***	0%
Spurlock - Ckt 311-114	YES	22%	27%	121.6	24.4	***87%***	0%
Volga - Ckt 225-114	YES	15%	18%	119.5	29.1	***129%***	0%
Hargus Circuit - 256-124 (2)	YES	40%	***97%***	118.0	***153.9***	***440%***	0%
Oil Field - Ckt 34-134	YES	7%	15%	121.4	23.5	***104%***	0%
NC90-Middle Creek-104	YES	31%	37%	119.4	30.9	***114%***	35%
NC679-Rock Fork-114	YES	27%	17%	121.6	24.4	***90%***	0%
Decoy Ckt #1173 Sub Switch	YES	27%	29%	***117.2***	***81.0***	***81%***	44%
River - Ckt 62-124	YES	43%	***172%***	118.2	39.2	***111%***	***138%***
Boones Camp - Ckt 63-114	YES	21%	73%	122.9	34.5	***95%***	0%
Volga - Ckt 95-134	YES	40%	***133%***	118.8	39.9	***149%***	0%
Thelma Ckt #392-114	YES	72%	***78%***	***113.1***	***54.0***	***198%***	0%
Flat Gap Ckt #661-124	YES	49%	73%	***115.3***	***49.4***	***111%***	0%
Denver Ckt #466-144	YES	59%	***181%***	***117.0***	32.0	56%	34%
St Hwy Ckt #497-134	YES	14%	25%	121.7	***40.5***	***107%***	0%

1) Above Planning Capacity in RED
2) The distribution model reflects the transfer from Hargus Circuit - 256-124 out of Redbush to Volga's Denver Ckt #466-144 feeder, which resulted in a mis-allocation of the peak loads. The deficiencies identified for both feeders above are not as severe once the allocation was corrected in the model.

System Outages & Reliability

RUS guidelines for a "Satisfactory" service reliability rating requires the borrower to limit the annual average outage per member to 200 minutes or less. Borrowers are required to maintain service interruption statistics for the categories listed in RUS Bulletin_1730A-119, which includes areas that are controllable by the individual borrower and those that are not. A summary of the average outage minutes per member for the last five years is shown in **Table 2.4**, as listed in the Big Sandy RECC 2019 RUS Form 300. RUS recommends that the averages for each category be considered when determining or modifying operating and design practices and criteria. The power supplier should be consulted if power supply interruptions are excessive.

Based on the 5-year average, the average outage minutes per member has exceeded 200 minutes for Big Sandy RECC for the past 5 years. The outages from major events and other events were the leading causes of the high numbers. Based on outage management data provided, overgrown vegetation is a large factor of the outages. Big Sandy RECC has identified worst performing feeders to develop recommended system improvements to address this issue.

Table 2.4: Average Service Interruption Minutes / Member

Year	Power Supplier	Major Event	Planned	All Other	Totals
2015	0.0	1,258.0	0.0	284.0	1,542.0
2016	0.0	104.0	45.0	278.0	427.0
2017	0.0	156.9	38.4	335.4	530.7
2018	20.2	331.3	28.9	399.6	780.0
2019	13.2	109.9	41.7	397.3	562.1
5-Year Averages	**6.7**	**392.0**	**30.8**	**338.9**	**768.4**

1) Annual minutes recorded per member as listed in 2019 RUS Form 300 for 2015-2018, and from BSRECC Form 7 for 2019.
2) BSRECC has identified worst performing feeders to develop recommended system improvements to improve reliability.

Analysis of Other System Studies

The evaluation of additional studies relevant to the preparation of this CWP is summarized below. The inclusion of these studies provides a comprehensive assessment of the system performance and needs, as well as promoting alignment with Big Sandy RECC's present goals and objectives.

Long-Range Plan

The current Long-Range Plan (LRP) was prepared in 1995 to serve a 20-year design load

of 100 MW. The CWP design load is within the LRP design load. At the maximum LRP design load, there are eight new substations planned. With the current and projected design load in this CWP considerably less than the LRP 20-year design load, additional planned substations are not required at this time.

O&M Survey

A periodic evaluation of a borrower's operation and maintenance (O&M) practices of is recommended by RUS. This review is documented in RUS Form 300 and is generally prepared every three years by the borrower and the assigned RUS field representative. The borrower receives ratings for the construction and condition of system facilities, O&M procedures and system performance, as well as engineering and O&M funding. For any items rated unsatisfactory a corrective action plan (CAP) is required to outline the steps the borrower will take to improve to an acceptable rating. The ratings are based on the following:

- 3 = Satisfactory - No additional action required at this time
- 2 = Acceptable, but should be improved
- 1 = Corrective action needed
- NA = Not Applicable

The most recent Form 300 was prepared in 2019, and NONE of the ratings were below 2, which is "Acceptable".

Sectionalizing Studies

A sectionalizing study defines protective device schemes and standardization, coordination objectives, and sectionalizing goals. Periodic reviews are recommended as reliability objectives change, new equipment and standards are introduced, or to respond to changes implemented by the power supplier or on Big Sandy RECC's distribution system. To maintain alignment with the existing sectionalizing goals, Big Sandy RECC routinely cycles through the entire system by evaluating the existing distribution protection on each substation. In addition, each CWP project includes sectionalizing recommendations to keep, replace or remove existing protective devices, or add new devices if required.

Section 3: Required Construction Items

Introduction

Impacts on system performance at the existing and projected loads were evaluated based on the selected planning criteria, and recommended solutions were developed to address requirements for the planning period. The purpose of this section is to detail the improvements recommended to expand and upgrade the system to adequately serve the members and align with the approved Preferred Expansion Plan from the approved Long-Range Plan. Recommended projects should be reviewed prior to construction to determine the overall feasibility of each project.

The cost of each project presented in this section is based on estimated 2020 costs and 3% annual inflation of material and labor at the proposed year of construction. Recommended timing of construction was based on projected criteria violations. and does not specifically consider resource or budget limitations. It is likely that such limitations will result in modifications to the scope and schedule of recommended projects.

Code 100: Service to New Members

The overhead and underground line construction required to serve new members was estimated based on the requirements of the previous two years as shown in **Appendix C**, and no member growth. Estimated new service construction includes poles, primary, secondary, and service conductor. Transformers and meters required for the new services are listed under **RUS Code 601**. A summary of the anticipated requirements for service to new members is provided in **Table 3.1**.

Table 3.1: Service to New Members

RUS Code	Description	New Members	Miles of Line	Estimated Loan Funds
101	Underground Members	92	9.7	$211,025
102	Overhead Members	440	43.0	$1,257,850
100	**Service to New Members**	**532**	**52.7**	**$1,468,875**

Code 300: Line Changes

The following projects represent the recommended upgrades of existing overhead and underground distribution lines, including replacing conductors, multi-phasing, line relocations, and voltage conversion. Poles involved in the project construction are included. Each project includes a detailed description of the proposed improvements, estimated cost, justification, and year of construction. Available options considered in the development of the proposed projects are also presented, should an alternative be required.

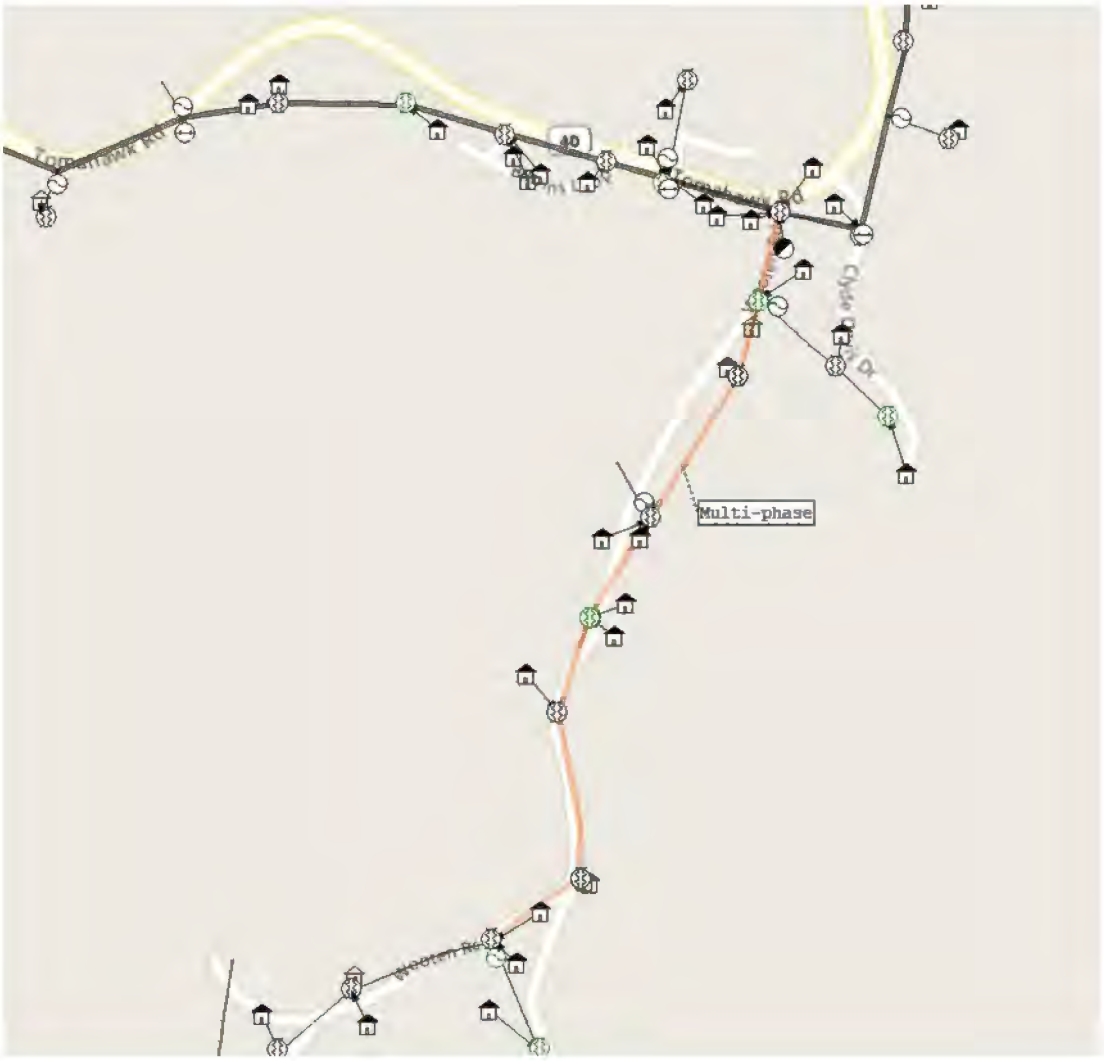
RUS Code: 301	Year: 2021
Project Name:	Kizer Road Reconductor
Substation/Feeder:	Bill Wells-Arkansas 655
Estimated Cost:	$84,002
Description:	Reconductor 0.50 miles of three-phase 1/0 ACSR to 336 ACSR from model line section OH12181 to OH12190. The overhead line exceeds conductor loading criteria at the existing peak, and voltage drops below criteria near the end of the feeder.
Justification:	Line Capacity and Voltage
Options:	No load transfer options available

Figure 3.1: Project 301

Required Construction Items

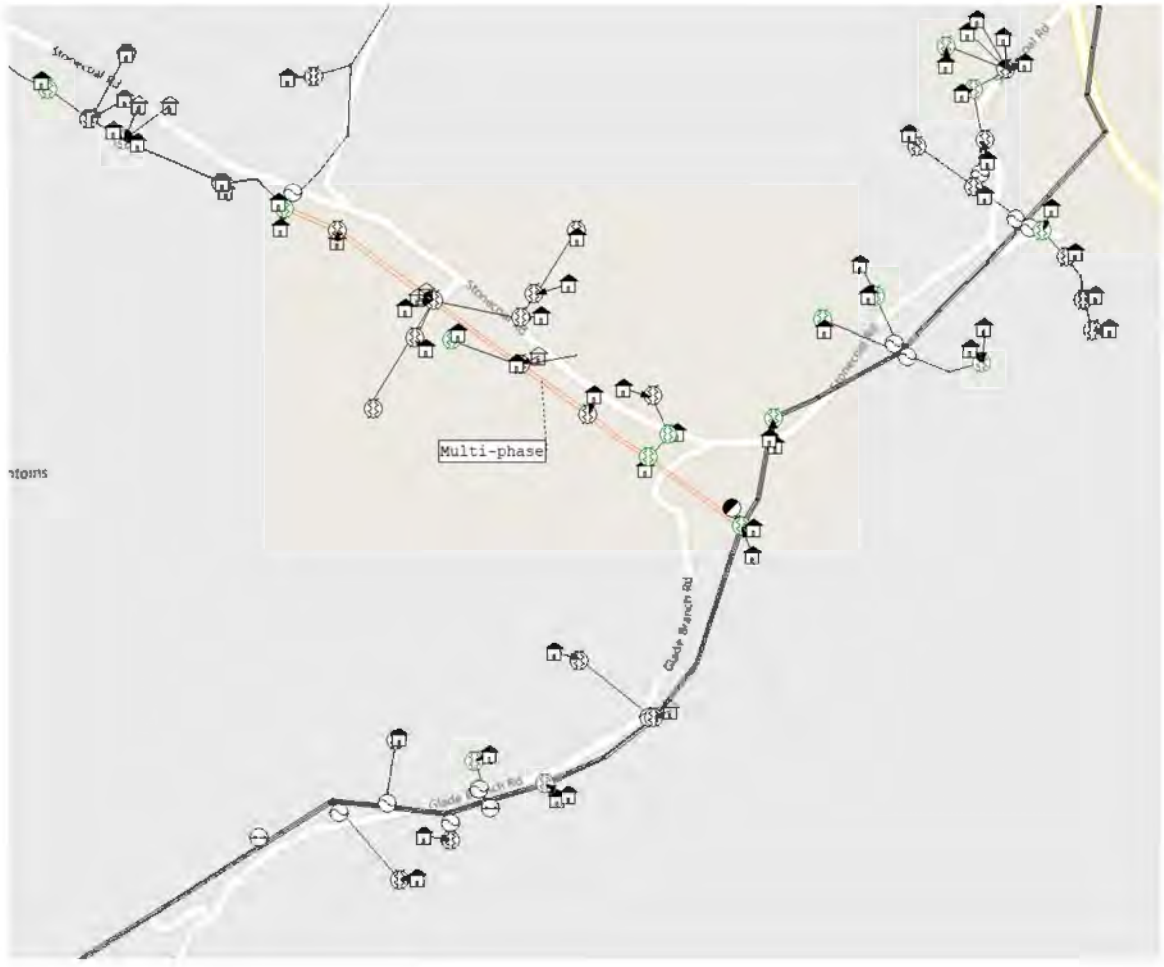
RUS Code: 302	Year: 2024
Project Name:	Wooten Road Multi-phase
Substation/Feeder:	Martin County-Milo 551
Estimated Cost:	$81,599
Description:	Multi-phase 0.52 miles from single-phase 1/0 ACSR to three-phase 1/0 ACSR from model line section OH14342 to OH14350 due to single-phase loading greater than criteria. Project also requires the addition of two 25L reclosers at the beginning of the tap at R_27896.
Justification:	Single-phase loading
Options:	No load transfer options available

Figure 3.2: Project 302



RUS Code: 303	Year: 2022
Project Name:	Stonecoal Road Multi-phase
Substation/Feeder:	Volga-Denver 466
Estimated Cost:	$69,489
Description:	Reconductor and multi-phase 0.49 miles of 6 CU to two-phase 1/0 ACSR from model line section OH1542 to OH1549 due to single-phase loading greater than criteria. Also requires the addition of a 100L recloser at the beginning of the tap at R_06420.
Justification:	Single-phase loading
Options:	No load transfer options available

Figure 3.3: Project 303



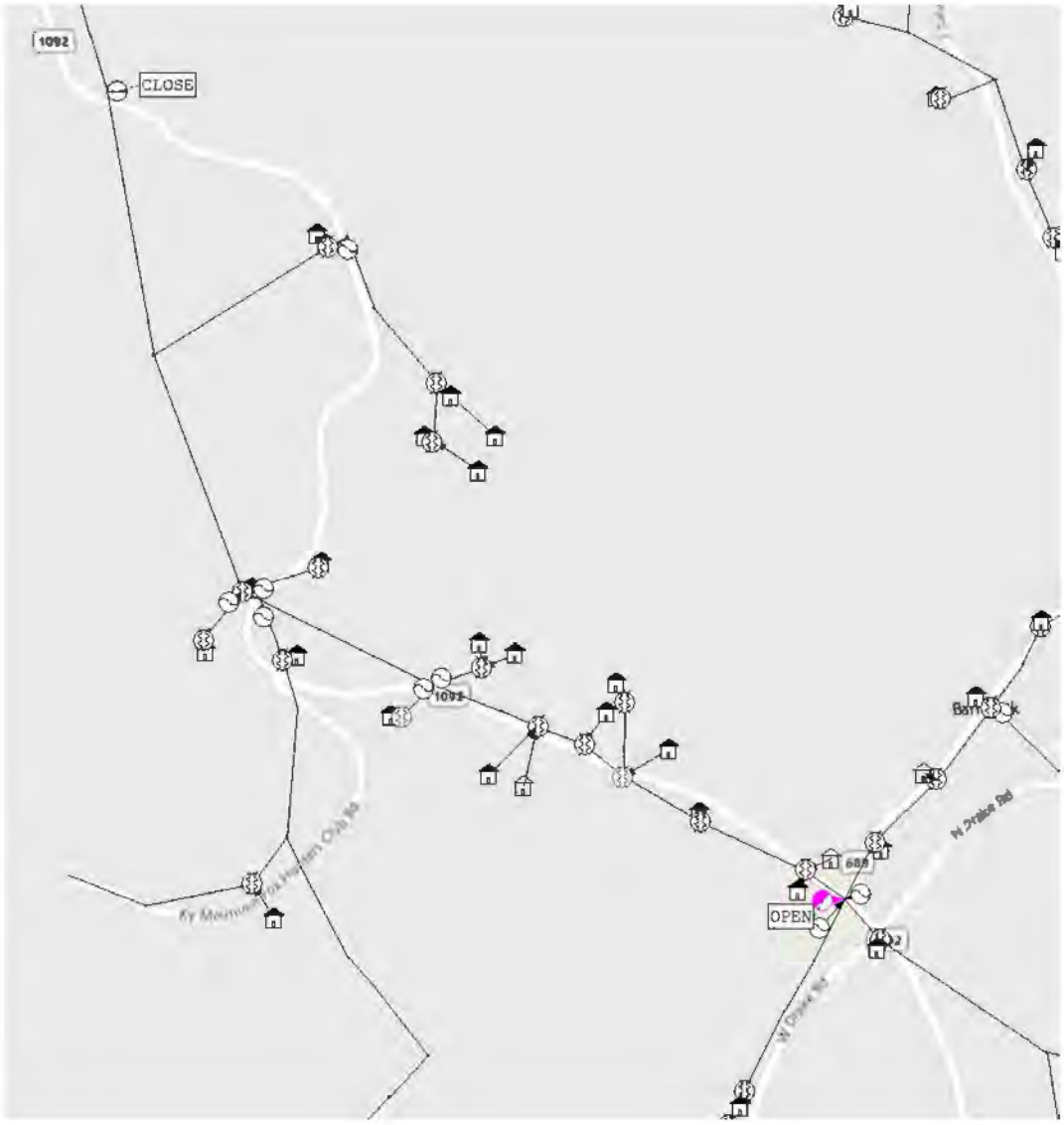
Required Construction Items

RUS Code: 304	Year: 2023
Project Name:	Big Branch Abbott Reliability
Substation/Feeder:	Middle Creek-Tiger Mart 287
Estimated Cost:	$137,684
Description:	Multi-phase 1.19 miles from model line section OH9492 to OH9520 and section OH9506 from two-phase 2 ACSR to three-phase 2ACSR. Church served by this line with an existing open wye/delta transformer bank is expanding and increasing load. Tap also currently serves a lift station and more than 80 customers. Project also requires the addition of a 50L reclosers at the beginning of the tap at R_09203, and is recommended to serve additional load and improve reliability.
Justification:	Load Expansion and Reliability
Options:	No options available

Figure 3.4: Project 304

RUS Code: N/A	Year: 2021
Project Name:	Route 689 Load Transfer
Substation/Feeder:	Volga-Flat Gap 661
Estimated Cost:	$0
Description:	Transfer load from Volga-Flat Gap 661 to Redbush-Oil Field 34 by opening at recloser R_07780 and closing at switch SB_11257 due to single-phase loading greater than criteria.
Justification:	Single-phase loading
Options:	Multi-phasing the tap was not selected to minimize cost.

Figure 3.5: Route 689 Load Transfer



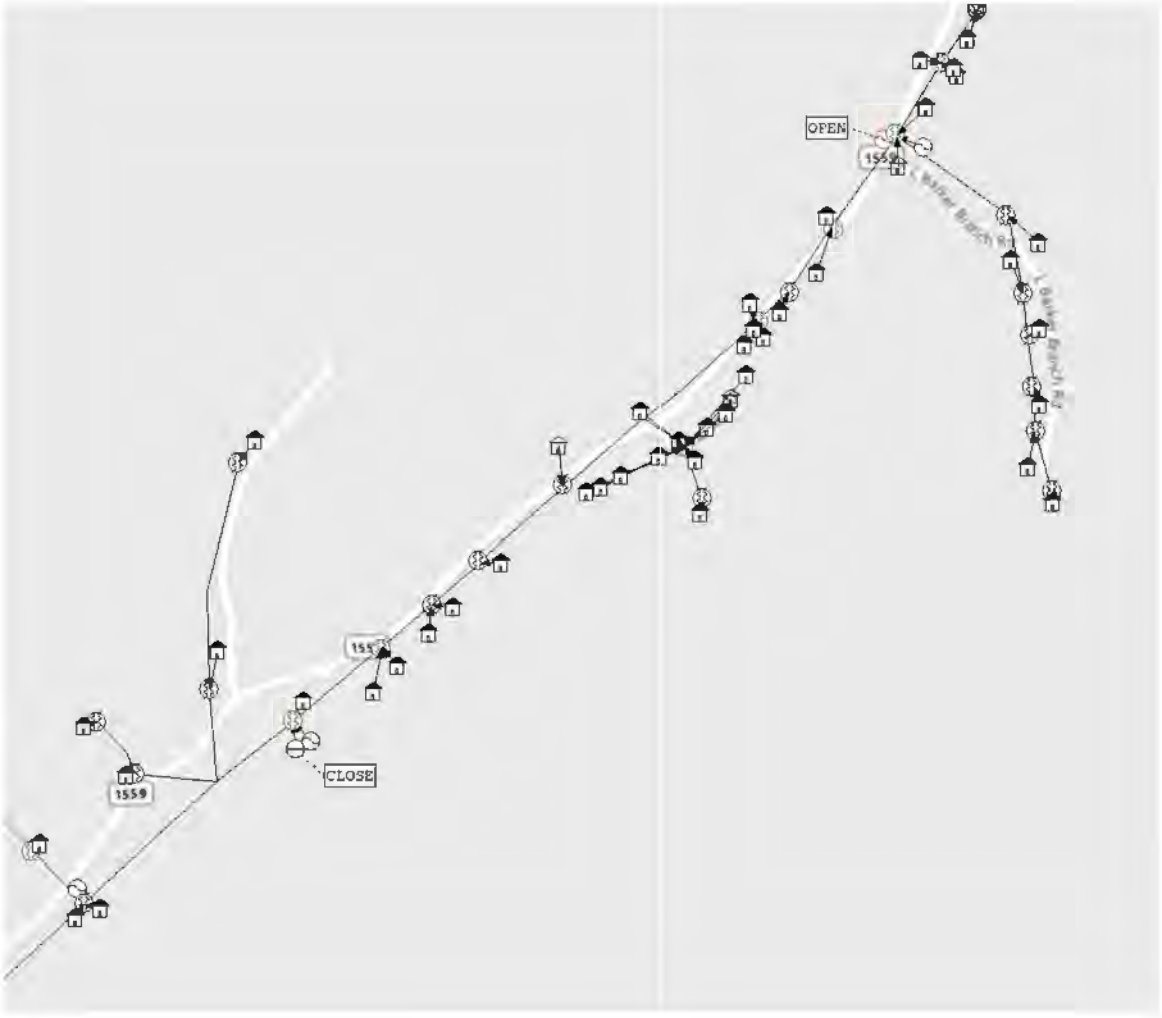
Required Construction Items

RUS Code: N/A	Year: 2021
Project Name:	Route 1559 Load Transfer
Substation/Feeder:	Volga-Thelma 392
Estimated Cost:	$0
Description:	Transfer load from Volga – Thelma 392 to Thelma-Volga 95 by opening switch SB_01327 and closing switch SB_03045. Capacity of the backbone of this feeder conductor loading criteria and voltage is below criteria on the feeder. Cost of the new regulator bank is included in Code 604.
Justification:	Line Capacity and Voltage
Options:	A new feeder out of Volga Substation was considered, but was not selected to minimize cost.

Figure 3.6: Route 1559 Load Transfer

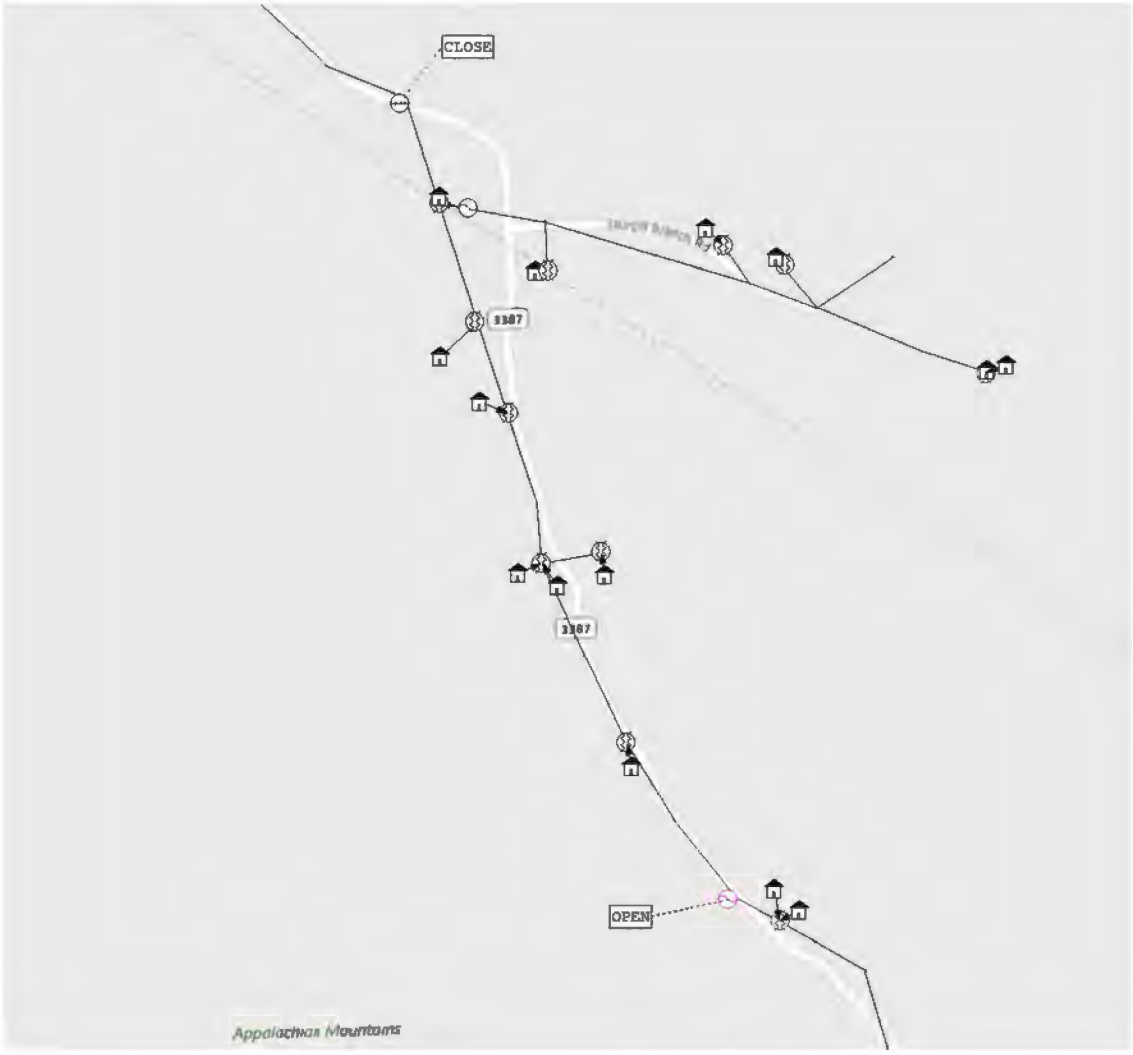
RUS Code: N/A	Year: 2021
Project Name:	Sitko Road Load Transfer
Substation/Feeder:	Volga-Thelma 392
Estimated Cost:	$0
Description:	Transfer load from Volga – Thelma 392 to Volga – St Hwy 497 to address single-phase loading greater than criteria. Transfer requires moving the open point by installing a new normally-open solid blade at model line section OH671 and closing at SB_06831.
Justification:	Single-phase loading
Options:	Multi-phasing the tap was not selected to minimize cost.

Figure 3.7: Sitko Road Load Transfer



RUS Code: N/A	Year: 2021
Project Name:	Route 3387 Load Transfer
Substation/Feeder:	Volga-Thelma 392
Estimated Cost:	$0
Description:	Transfer load from Volga – Thelma 392 to Volga – Thelma 392 by moving the open point with a new, open solid blade at model line section OH2432 and closing at SB_05081. This tap has single-phase loading greater than criteria.
Justification:	Single-phase loading
Options:	Multi-phasing the tap was not selected to minimize cost.

Figure 3.8: Route 3387 Load Transfer



Code 600: Miscellaneous Distribution Equipment

The miscellaneous distribution equipment needed for the CWP period was estimated based on the system analysis detailed herein and the requirements of the previous two years as shown in **Appendix C**. Miscellaneous distribution equipment includes service transformers and meters, sectionalizing equipment, capacitors and regulators, as well as the pole and conductor replacements required due to age or condition. The estimates detailed below include no equipment growth.

Transformers & Meters

Transformers and meters required during the CWP period for new members or for existing member upgrades (increased capacity) are presented in **Table 3.2** and **Table 3.3**, respectively. Estimates were based on the requirements of the previous two years. New, retrofit or replacement AMI meters are also included in **Table 3.3**. Other associated costs for AMI systems are listed under **RUS Code 705**.

Table 3.2: Service Transformers

RUS Code	Description	Quantities	Estimated Loan Funds
601	New Services		
	Pad-Mounted	24	$35,796
	Pole-Mounted	204	$225,369
	SUBTOTALS	***228***	***$261,165***
601	Service Upgrades		
	Pad-Mounted	0	$0
	Pole-Mounted	24	$39,816
	SUBTOTALS	***24***	***$39,816***
601	**Service Transformers**	**252**	**$300,981**

Table 3.3: New Meters

RUS Code	Description	Quantities	Estimated Loan Funds
601	New Services		
	Underground	24	$35,796
	Overhead	204	$225,369
	SUBTOTALS	***228***	***$261,165***
601	Service Upgrades		
	Underground	0	$0
	Overhead	24	$39,816
	SUBTOTALS	***24***	***$39,816***
601	AMI		
	AMR/Collar Combo	3,160	$609,620
	3-Wire TWACS	2,655	$385,580
	SUBTOTALS	***5,815***	***$995,200***
601	**New Meters**	**6,067**	**$1,296,181**

Service changes to existing members

The service changes needed for existing members during the CWP period are presented in **Table 3.4**, and were estimated based on the requirements of the previous two years. Service changes include poles, primary, secondary, and service conductor for upgrades to increase capacity or replacements due to age or condition.

Table 3.4: Service Changes

RUS Code	Description	Quantities	Estimated Loan Funds
602	Underground	0	$0
602	Overhead	44	$226,336
602	**Service Changes**	**44**	**$226,336**

Sectionalizing equipment

The distribution line breakers, reclosers, cutouts, fuses, and associated equipment needed during the CWP period are presented in **Table 3.5**, and are estimated based on the requirements of the previous two years. Sectionalizing equipment additions, upgrades or

relocations proposed with recommended tie lines and line changes are included in **RUS Code 200** and **RUS Code 300** projects presented herein.

Table 3.5: Sectionalizing Equipment

RUS Code	Description	Quantities	Estimated Loan Funds
	Salt Lick-Decoy Sub Switch Single-phase feeder recloser serving approximately 20 miles of overhead line has no load or outage monitoring capabilities. A new recloser is recommended to add this functionality to improve load planning and reliability. (Decoy Sub Switch Recloser)	1	$25,750
	General Add or upgrade protective devices	16	$344,732
603	**Sectionalizing Equipment**	**17**	**$370,482**

Line regulators

The distribution line regulators (or auto-boosters) and associated equipment needed during the CWP period are presented in **Table 3.6**. The regulators are recommended to maintain feeder voltage within the planning criteria based on the system analysis detailed herein.

Table 3.6: Line Regulators

RUS Code	Description	Load Level	Estimated Loan Funds
	Martin County-White House 550 Install a bank of 219 A regulators at OH10625 to correct low voltage less than 118 V.	1	$62,624
	Volga-Flat Gap 661 Install a bank of 219 A regulators at OH6251 to correct low voltage less than 118 V.	1	$62,624
	Volga-Thelma 392 Install a bank of 219 A regulators at OH7756 to correct low voltage less than 118 V. See Route 1559 Load Transfer.	1	$62,624
604	**Line Regulators**		**$187,872**

Pole replacement

Pole replacement needed during the CWP period due to condition, added height or strength are presented in **Table 3.7**. Estimates are based on the requirements of the previous two years. Poles required for new member services, service upgrades, and recommended tie lines and line changes are included in **RUS Code 100**, **RUS Code 602**, **RUS Code 200** and **RUS Code 300** projects presented herein.

Table 3.7: Pole Replacement

RUS Code	Description	Quantities	Estimated Loan Funds
606	**Pole Replacement**	**736**	**$2,906,648**

Conductor Replacement

Overhead or underground conductor replacement needed during the CWP period due to age or condition are presented in **Table 3.8**. Estimates include associated poles and hardware, and are based on the requirements of the previous two years.

Table 3.8: Conductor Replacements

RUS Code	Description	Line Miles	Estimated Loan Funds
608	**Conductor Replacement**	**16.4**	**$1,621,437**

Code 700 – Other Distribution Items

Additional distribution equipment includes Outdoor Lighting, Load Management / SCADA, AMI Equipment and GIS. Estimates for the CWP period are based on requirements of the previous two years as shown in **Appendix C**, and budgeting provided by Big Sandy RECC. The estimates detailed below include no equipment growth.

Outdoor Lights

New outdoor lights needed during the CWP period, as well as upgrades or replacements are presented in **Table 3.9**. Big Sandy RECC is replacing all mercury vapor and metal halide lights with LED as the fixtures or bulbs fails. The projections for this CWP are expected to complete the replacement program. Estimates include associated poles and hardware, and are based on the requirements of the previous two years.

Table 3.9: Outdoor Lights

RUS Code	Description	Quantities	Estimated Loan Funds
701	**Outdoor Lights**	**3,088**	**$1,481,468**

Appendix A: Substation & Feeder Forecast

						Projected Peaks (MW)																			
		Extreme	Winter	2018		2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	
Sub/Xfmr Name	Feeder Name	Area Growth Factor	Rated Capacity (MVA)	Base Year Pf (%)	Base Year Peak (MW)	LL 1	LL 2	LL 3	LL 4	LL 5	LL 6	LL 7	LL 8	LL 9	LL 10	LL 11	LL 12	LL 13	LL 14	LL 15	LL 16	LL 17	LL 18	LL 19	LL 20	Compound Annual Rate
System Non-Coincident Peak w/ Power Supplier			179.9	99.6%	74.3	78.0	78.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	78.0	78.0	78.0	79.0	79.0	79.0	79.0	0.07%
Total Substation Non-Coincident Peak			----	----	82.1	82.1	82.1	81.1	81.1	81.1	81.1	81.1	81.1	81.1	81.1	81.1	81.1	81.1	82.1	82.1	82.1	83.2	83.2	83.2	83.2	----
Coincident Factor			----	----	90.5%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	----
Bill Wells		1.0	24.8	99.8%	10.6	10.6	10.6	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.6	10.6	10.6	10.7	10.7	10.7	10.7	0.07%
	Town Branch - Ckt 656-134	1.0	7.8	99.8%	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.07%
	Katy Friend- Ckt 658-114	1.0	7.8	99.8%	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.07%
	Arkansas - CKT 655-144	1.0	7.8	99.8%	4.3	4.3	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.3	4.3	4.3	4.3	4.3	4.3	4.3	0.07%
	Cow Creek - Ckt 992-124	1.0	11.9	99.8%	5.4	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.4	0.07%
Total Feeder Non-Coincident Peak			----	----	10.7	10.6	10.6	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.6	10.6	10.6	10.7	10.7	10.7	10.7	----
Bill Wells	Coincident Factor		----	----	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Bonanza		1.0	24.8	99.8%	6.8	6.8	6.8	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.8	6.8	6.8	6.9	6.9	6.9	6.9	0.07%
	Mt Parkway - Ckt 608-114	1.0	7.8	99.8%	1.7	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	0.07%
	Denver-Feed Bottom 708-134	1.0	7.8	99.8%	2.5	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.5	2.5	2.5	2.5	0.07%
	Abbott Feeder Top 346-124	1.0	7.8	99.8%	2.8	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	2.7	0.07%
Total Feeder Non-Coincident Peak			----	----	7.0	6.8	6.8	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.8	6.8	6.8	6.9	6.9	6.9	6.9	----
Bonanza	Coincident Factor		----	----	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Jenny Wiley		1.0	18.1	99.4%	7.6	7.6	7.6	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.6	7.6	7.6	7.7	7.7	7.7	7.7	0.07%
	Cir# 417 hospital-124	1.0	7.8	99.4%	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	0.07%
	Cir# 211 - Middle Creek-134	1.0	7.8	99.4%	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.3	3.3	3.3	3.3	0.07%
	Cir# 416- Beech Fork-144	1.0	9.1	99.4%	3.2	3.2	3.2	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.2	3.2	3.2	3.2	3.2	3.2	3.2	0.07%
Total Feeder Non-Coincident Peak			----	----	7.6	7.6	7.6	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.6	7.6	7.6	7.7	7.7	7.7	7.7	----
Jenny Wiley	Coincident Factor		----	----	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Martin County		1.0	18.1	99.7%	11.9	11.9	11.9	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.9	11.9	11.9	12.1	12.1	12.1	12.1	0.07%
	Boones Camp - Ckt 552-144	1.0	11.0	99.7%	2.0	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	0.07%
	Milo - Ckt 551-134	1.0	11.0	99.7%	2.2	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	0.07%
	White House - Ckt 550-124	1.0	11.0	99.7%	3.2	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.6	3.6	3.6	3.6	0.07%
	Calloway - Ckt 756-114	1.0	9.1	99.7%	3.5	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.9	3.9	3.9	3.9	0.07%
Total Feeder Non-Coincident Peak			----	----	10.9	11.9	11.9	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.8	11.9	11.9	11.9	12.1	12.1	12.1	12.1	----
Martin County	Coincident Factor		----	----	109.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Middle Creek		1.0	24.8	99.8%	8.5	8.5	8.5	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.5	8.5	8.5	8.6	8.6	8.6	8.6	0.07%
	Walmart - Ckt 591-124	1.0	7.8	99.8%	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.07%
	GlynView - Ckt 234-104	1.0	5.5	99.8%	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.07%
	Spurlock - Ckt 311-114	1.0	7.8	99.8%	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.8	1.8	1.8	1.8	0.07%
	Salt Lick CKT 308-134	1.0	12.8	99.8%	4.5	4.3	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.3	4.3	4.3	4.3	4.3	4.3	4.3	0.07%
	Tiger Mart - Ckt 287-144	1.0	9.1	99.8%	1.5	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	1.4	0.07%
Total Feeder Non-Coincident Peak			----	----	9.0	8.5	8.5	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.5	8.5	8.5	8.6	8.6	8.6	8.6	----
Middle Creek	Coincident Factor		----	----	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Redbush		1.0	8.3	99.0%	4.3	4.3	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.3	4.3	4.3	4.3	4.3	4.3	4.3	0.07%
	Keaton - Ckt 720-144	1.0	5.5	99.0%	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.07%
	Volga - Ckt 225-114	1.0	7.8	99.0%	1.3	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	0.07%
	Hargus Circuit - 256-124	1.0	5.5	99.0%	2.4	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	0.07%
	Oil Field - Ckt 34-134	1.0	5.5	99.0%	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.07%
Total Feeder Non-Coincident Peak			----	----	4.8	4.3	4.3	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.3	4.3	4.3	4.3	4.3	4.3	4.3	----
Redbush	Coincident Factor		----	----	89.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Salt Lick		1.0	18.1	98.6%	5.4	5.4	5.4	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.4	5.4	5.4	5.4	0.07%
	NC90-Middle Creek-104	1.0	7.8	98.6%	2.5	2.4	2.4	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.4	2.4	2.4	2.4	2.4	2.4	2.4	0.08%
	NC679-Rock Fork-114	1.0	6.4	98.6%	1.8	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	0.08%
	NC169-RT 7 Mine-124	1.0	9.1	98.6%	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.08%
	SportsPlex 678-134	1.0	11.0	98.6%	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.08%
	Decoy Ckt #1173 Sub Switch	1.0	2.3	98.6%	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.08%
Total Feeder Non-Coincident Peak			----	----	5.6	5.4	5.4	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.4	5.4	5.4	5.5	5.4	5.4	5.4	----
Salt Lick	Coincident Factor		----	----	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Thelma		1.0	18.1	99.5%	9.9	9.9	9.9	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.9	9.9	9.9	10.0	10.0	10.0	10.0	0.07%
	Volga - Ckt 95-134	1.0	7.8	98.6%	2.8	3.1	3.1	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1	3.1	3.1	0.07%
	River - Ckt 62-124	1.0	9.1	99.5%	3.5	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9	4.0	4.0	4.0	4.0	0.07%
	Boones Camp - Ckt 63-114	1.0	7.8	99.5%	1.5	1.7	1.7	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.7	1.7	1.7	1.7	1.7	1.7	1.7	0.07%
	Rehab - Ckt 107-104	1.0	7.8	99.5%	1.1	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	0.07%
Total Feeder Non-Coincident Peak			----	----	9.0	9.9	9.9	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.9	9.9	9.9	10.0	10.0	10.0	10.0	----
Thelma	Coincident Factor		----	----	110.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----
Volga		1.0	24.8	99.5%	17.2	17.2	17.2	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.2	17.2	17.2	17.4	17.4	17.4	17.4	0.07%
	St Hwy Ckt #497-134	1.0	7.8	99.5%	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	0.07%
	Denver Ckt #466-144	1.0	7.8	99.5%	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.6	4.6	4.6	4.6	0.07%
	Thelma Ckt #392-114	1.0	11.0	99.5%	7.8	7.8	7.8	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.7	7.8	7.8	7.8	7.9	7.9	7.9	7.9	0.07%
	Flat Gap Ckt #661-124	1.0	7.8	99.5%	3.7	3.8	3.8	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.7	3.8	3.8	3.8	3.8	3.8	3.8	3.8	0.07%
Total Feeder Non-Coincident Peak			----	----	17.0	17.2	17.2	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.0	17.2	17.2	17.2	17.4	17.4	17.4	17.4	----
Volga	Coincident Factor		----	----	101.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	----

Appendix B: EKPC Substation Equipment Ratings

Substation	Station ID	Substation Voltage		Transformer							Regulator					Regulator Tap Changer			High-Side Fuse					Limits			
		Primary	Secondar	Nameplate	Highest Nameplate	Cooling	Winter	Summer	Highest Winter	Highest Summer	Rated Voltage	Nameplate (kVA)	Cooling	Winter	Summer	Amps	Winter	Summer	Amps	Type	TCC	Winter	Summer	Summer		Winter	
BILL WELLS	58E070	69.0	13.2	20	20	OA/FA/FA-65C	24.8	19.2	24.8	19.2	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	122.00	SMD1A	153-1	16.7	16.7	13.9	TC	13.9	TC
BONANZA	58E117	69.0	13.2	20	20	OA/FA/FA-65C	24.8	19.2	24.8	19.2	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	125.00	SMD1A	119-1	17.1	17.1	13.9	TC	13.9	TC
JENNY WILEY	58E057	69.0	13.2	14	14	OA/FA-65C	18.1	13.62	18.1	13.6	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	126.00	SMD1A	119-1	17.3	17.3	13.6	T	13.9	TC
MARTIN COUNTY	58E069	69.0	13.2	14	14	OA/FA-65C	18.1	13.62	18.1	13.6	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	126.00	SMD1A	153-1	17.3	17.3	13.6	T	13.9	TC
MIDDLE CREEK	58E081	69.0	13.2	12	20	OA-65C	16.8	11.86	24.8	19.2	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	125.00	SMD2B	153-1	17.1	17.1	11.9	T	13.9	TC
REDBUSH	58E030	69.0	12.47	5.601	6.44	OA-65C	7.9	5.53	8.3	6.3	13.2	167	OA-55C	7.5	4.9	219.00	5.00	5.00	120.00	SMD1A	119-1	16.4	16.4	4.9	R	5	TC
SALT LICK	58E082	43.8	13.2	11.2	14	OA-65C	15.7	11.07	18.1	13.6	13.2	333	OA-55C	15.1	9.8	438.00	10.00	10.00	125.00	SMD2B	119-1	10.9	10.9	9.8	R	10	TC
THELMA	58E038	69.0	13.2	11.2	14	OA-65C	15.7	11.07	18.1	13.6	13.2	333	OA-55C	15.1	9.8	438.00	10.00	10.00	125.00	SMD1A	119-1	17.1	17.1	9.8	R	10	TC
VOLGA	58E060	69.0	13.2	20	20	OA/FA/FA-65C	24.8	19.2	24.8	19.2	13.2	466	OA-65C	23.4	17.9	612.00	13.90	13.90	125.00	SMD1A	153-1	17.1	17.1	13.9	TC	13.9	TC

Appendix C: Historical Data

Client Name: **Big Sandy RECC**
RUS Designation: **Kentucky 58 Floyd**

From hand-written edits to PDF of PCS template
From BSRECC annual/quartly reports
Assumed
From BSRECC meter program estimates

		Historical Years			Projected Years				
Historical Services & Equipment	**RUS Code**	**2018**	**2019**	**Averages**	**1**	**2**	**3**	**4**	**Totals**
New Underground Services									
Number of Services	101	20	26	23	23	23	23	23	92
Primary (Linear Feet)		4,330	7,447	5,888	5,888	5,888	5,888	5,888	23,552
Secondary (Linear Feet)		0	0	0	0	0	0	0	0
Service Drop (Linear Feet)		5,972	7,764	6,868	6,868	6,868	6,868	6,868	27,472
Cost of New Line	101	$53,888	$40,665	$47,276	$50,439	$51,957	$53,521	$55,108	$211,025
Number of Transformers	601	5	6	5.5	6	6	6	6	24
Cost of New Transformers	601	$10,596	$3,899	$7,247	$8,556	$8,814	$9,078	$9,348	$35,796
Number of Meters	601	20	26	23	23	23	23	23	92
Cost of New Meters	601	$10,876	$2,318	$6,597	$3,243	$3,335	$3,450	$3,542	$13,570
Avg. Service Length/Member	101	515	585	550	555	555	555	555	555
Avg. Service Cost/Member	101	$2,694	$1,564	$2,129	$2,193	$2,259	$2,327	$2,396	$2,294
Avg. Cost/Transformer	601	$2,119	$650	$1,385	$1,426	$1,469	$1,513	$1,558	$1,492
Avg. Cost/Meter	601	$544	$89	$137	$141	$145	$150	$154	$148
Avg. Cost/Member		$3,768	$1,803	$2,786	$2,706	$2,787	$2,872	$2,956	$2,830
TOTAL New UG Services		$75,360	$46,882	$61,121	$62,238	$64,106	$66,049	$67,998	$260,391
New Overhead Services									
Number of Services	102	98	122	110	110	110	110	110	440
Primary (Linear Feet)		40,656	29,791	35,224	35,224	35,224	35,224	35,224	140,896
Secondary (Linear Feet)		0	0	0	0	0	0	0	0
Service Drop (Linear Feet)		22,107	21,016	21,562	21,562	21,562	21,562	21,562	86,248
Cost of New Line	102	$281,348	$297,256	$289,302	$300,630	$309,650	$319,000	$328,570	$1,257,850
Number of Transformers	601	53	49	51	51	51	51	51	204
Cost of New Transformers	601	$49,799	$54,474	$52,136	$53,856	$55,488	$57,171	$58,854	$225,369
Number of Meters	601	98	122	110	110	110	110	110	440
Cost of New Meters	601	$53,295	$10,876	$32,085	$15,510	$15,950	$16,500	$16,940	$64,900
Avg. Service Length/Member	101	640	416	528	516	516	516	516	516
Avg. Service Cost/Member	101	$2,871	$2,437	$2,654	$2,733	$2,815	$2,900	$2,987	$2,859
Avg. Cost/Transformer	601	$940	$1,112	$1,026	$1,056	$1,088	$1,121	$1,154	$1,105
Avg. Cost/Meter	601	$544	$89	$137	$141	$145	$150	$154	$148
Avg. Cost/Member		$3,923	$2,972	$3,448	$3,364	$3,464	$3,570	$3,676	$3,518
TOTAL New OH Services		$384,442	$362,605	$373,524	$369,996	$381,088	$392,671	$404,364	$1,548,119

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From BSRECC meter program estimates

		Historical Years			Projected Years				
Historical Services & Equipment	**RUS Code**	**2018**	**2019**	**Averages**	**1**	**2**	**3**	**4**	**Totals**
Underground Service Upgrades									
Number of Services		0	0	0	0	0	0	0	0
Cost of Service Upgrades	602	$0	$0	$0	$0	$0	$0	$0	$0
Number of Transformer Replacements		0	0	0	0	0	0	0	0
Cost of Transformer Replacements	601	$0	$0	$0	$0	$0	$0	$0	$0
Number of Meter Upgrades		0	0	0	0	0	0	0	0
Cost of Meter Upgrades	601	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Service Upgrade Cost/Member	602	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Cost/Transformer Upgrade	601	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Cost/Meter Upgrade	601	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Cost/Member Upgrade		$0	$0	$0	$0	$0	$0	$0	$0
TOTAL UG Service Upgrades		$0	$0	$0	$0	$0	$0	$0	$0
Overhead Service Upgrades									
Number of Services		12	9	11	11	11	11	11	44
Cost of Service Upgrades	602	$79,183	$26,561	$52,872	$54,098	$55,726	$57,398	$59,114	$226,336
Number of Transformer Replacements		10	2	6	6	6	6	6	24
Cost of Transformer Replacements	601	$16,124	$2,935	$9,529	$9,516	$9,804	$10,098	$10,398	$39,816
Number of Meter Upgrades		0	0	0	0	0	0	0	0
Cost of Meter Upgrades	601	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Service Upgrade Cost/Member	602	$6,599	$2,951	$4,775	$4,918	$5,066	$5,218	$5,374	$5,144
Avg. Cost/Transformer Upgrade	601	$1,612	$1,467	$1,540	$1,586	$1,634	$1,683	$1,733	$1,659
Avg. Cost/Meter Upgrade	601	$0	$0	$0	$0	$0	$0	$0	$0
Avg. Cost/Member Upgrade		$7,942	$3,277	$5,610	$5,783	$5,957	$6,136	$6,319	$6,049
TOTAL OH Service Upgrades		$95,307	$29,496	$62,402	$63,614	$65,530	$67,496	$69,512	$266,152
AMI Meter Implementation (AMR/Collar Combo)									
Number of Meters	601	360	1,000	680	900	900	960	400	3,160
Avg. Cost/AMI Meter	601	$324	$130	$180	$186	$191	$197	$203	$193
TOTAL AMI Meters	601	$116,719	$130,395	$123,557	$167,400	$171,900	$189,120	$81,200	$609,620
AMI Meter Replacements (3-Wire TWACS)									
Number of Meters	601	8	600	304	905	905	845	0	2,655
Avg. Cost/AMI Meter	601	$544	$89	$137	$141	$145	$150	$154	$145
TOTAL AMI Meters	601	$4,351	$53,488	$28,919	$127,605	$131,225	$126,750	$0	$385,580
Sectionalizing Equipment									
Number of Devices	603	6	1	4	4	4	4	4	16
Avg. Cost/Device	603	$4,862	$5,761	$20,000	$20,600	$21,218	$21,855	$22,510	$21,546
TOTAL Sectionalizing Equipment	603	$29,173	$5,761	$17,467	$82,400	$84,872	$87,420	$90,040	$344,732

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		Historical Years			Projected Years				
Historical Services & Equipment	**RUS Code**	**2018**	**2019**	**Averages**	**1**	**2**	**3**	**4**	**Totals**
Capacitors									
Number of Capacitors	605	0	0	0	0	0	0	0	0
Avg. Cost/Capacitor	605	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL Capacitors	605	$0	$0	$0	$0	$0	$0	$0	$0
Pole Replacements									
Number of Poles	606	147	221	184	184	184	184	184	736
Avg. Cost/Pole Replacement	606	$3,609	$3,722	$3,666	$3,776	$3,889	$4,006	$4,126	$3,949
TOTAL Pole Replacements	606	$530,569	$822,669	$676,619	$694,784	$715,576	$737,104	$759,184	$2,906,648
Conductor Replacement									
Miles of Line	608	2.2	0.0	1.1	1.25	1.25	1.25	1.25	5.0
Avg. Cost/Mile	608	$33,312	$0	$87,700	$90,331	$93,041	$95,832	$98,707	$94,478
TOTAL Conductor Replacement	608	$72,287	$0	$36,144	$112,914	$116,301	$119,790	$123,384	$472,389
Outdoor Lights									
Number of Outdoor Lights	701	739	805	772	772	772	772	772	3,088
Avg. Cost/Outdoor Light	701	$459	$431	$445	$459	$472	$487	$501	$480
TOTAL Outdoor Lights	701	$339,408	$347,233	$343,321	$354,348	$364,384	$375,964	$386,772	$1,481,468

Appendix D: Environmental Report

KY 58 - Big Sandy RECC
Environmental Report
September 2020

Code 200

The proposed construction includes **N\A** miles of overhead tie-lines that will be sited in existing utility right-of-way (ROW) and/or parallel public road ROW. The cooperative understands that new lines sited outside of utility or road ROW require a site-specific environmental report (ER).

Code 300

The proposed construction will consist of approximately **2.73 miles** of overhead line conversions. Line conversions include line re-conductors and phase changes. All line conversions will be performed within existing utility ROW (which is 40 feet in width). Access would be from public and private roads and through utility ROW. No additional easements or tree clearing is needed to perform this work. The attached 740c environmental worksheet provides more site-specific information about each project.

Environmental Commitments

If streams and/or wetlands are located in the right-of-way of new lines, relocations, or line conversions, appropriate best management practices (such as establishing a 25-foot buffer around these water features) will be implemented. Unless authorized by state and/or federal permits or licenses, vehicles will not traverse these water features. If it is determined that poles need to be sited in protected streams or wetlands or that culverts need to be built over these features, the cooperative will acquire the appropriate permits from the U.S. Army Corps of Engineers and/or the applicable state agency.

The cooperative has reviewed the most recent species list from the U.S. Fish and Wildlife Service, covering Breathitt, Floyd, Johnson, Knott, Lawrence, Magoffin, Martin, and Morgan counties. Species on this list include: Indiana bat, etc. The proposed project areas (i.e., utility and road ROW) are not suitable habitat for the other listed species; therefore, no effects to listed species are expected.

KY-58 2021-2024 CONSTRUCTION WORK PLAN
FORM 740C - ENVIRONMENTAL CHECKLIST

				Was project approved in a previous CWP or Amendment? If yes: provide status. If no: provide anticipated classification (per 7CFR1970)	Will work be entirely within existing ROW, generating station, industrial park, or substation fencing? If no: see next column. If yes: (1) is there new land disturbance? has SHPO provided feedback? (2) Are T&E species occurrences or habitat in/near project area? (3) Are federal/state lands (including wildife refuges), floodplains or wetlands crossed?	For substations: will new land disturbance be <1 acre, 1-5 acres, or >5 acres? For lines: provide the voltage, length, ROW width, & ROW type (road vs private; if road, distance from road).	Does this project require preparation of an Environmental Assessment or Environmental Impact Statement? If yes, the environmental work must be approved before the application submittal or removed from loan.
1. DISTRIBUTION							
100	a. New Line: (Excluding Tie-Lines)						
	Construction	Consumers	Miles				
	Underground	92	9.7	NA	NA	NA	NA
	Overhead	440	43.0	NA	NA	NA	NA
	Total Consumers	532	52.7	NA	NA	NA	NA
200	b. New Tie-Lines						
	Line Designation		Miles				
			0.00	N/A	NA	NA	NA
300	c. Conversion and Line Changes						
	Line Designation		Miles				
301	Kizer Rd - Reconductor three-phase 1/0 ACSR to 336 ACSR from model line section OH12181 to OH12190		0.50	No	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
302	Wooten Rd - Multi-Phase single-phase 1/0 ACSR to three-phase 1/0 ACSR from model line section OH14342 to OH14350		0.52	No	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
303	Stonecoal Rd - Multi-phase and multi-phase 6 CU to two-phase 1/0 ACSR from model line section OH1542 to OH1549		0.52	No	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
304	Big Branch Abbott - Multi-phase from model line section OH9492 to OH9520 and section OH9506 from two-phase 2 ACSR to three-phase 2ACSR		1.19	No	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
400	d. New Substations, Switching Stations, Metering Points, etc.						
	Station Designation	kVA	kV to kV				
				N/A	N/A	N/A	N/A
500	e. Substation, Switching Station, Metering Point Changes			NA	NA	NA	NA
	Station Designation	Description of Changes					
600	f. Miscellaneous Distribution Equipment			NA	NA	NA	NA
601	(1) Transformers						
	Transformers						
	UG	24		NA	NA	NA	NA
	OH	228		NA	NA	NA	NA
	(2) Meters	6,067					
	(3) Disconnect Collars	0					
		6,319		NA	NA	NA	NA
	Subtotal code 601 . . . (included in total of all 600 codes below)						
602	(2) Sets of Service Wires to increase Capacity	44		NA	NA	NA	NA
603	(3) Sectionalizing Equipment	17		NA	NA	NA	NA
604	(4) Regulators	3		NA	NA	NA	NA
605	(5) Capacitors	0		NA	NA	NA	NA
606	(6) Pole Replacement	736		NA	NA	NA	NA
607	(7) Miscellaneous Replacement	0		NA	NA	NA	NA

KY-58 2021-2024 CONSTRUCTION WORK PLAN
FORM 740C - ENVIRONMENTAL CHECKLIST

				Was project approved in a previous CWP or Amendment? If yes: provide status. If no: provide anticipated classification (per 7CFR1970)	Will work be entirely within existing ROW, generating station, industrial park, or substation fencing? If no: see next column. If yes: (1) is there new land disturbance? has SHPO provided feedback? (2) Are T&E species occurrences or habitat in/near project area? (3) Are federal/state lands (including wildife refuges), floodplains or wetlands crossed?	For substations: will new land disturbance be <1 acre, 1-5 acres, or >5 acres? For lines: provide the voltage, length, ROW width, & ROW type (road vs private; if road, distance from road).	Does this project require preparation of an Environmental Assessment or Environmental Impact Statement? If yes, the environmental work must be approved before the application submittal or removed from loan.
608	(8) Conductor Replacement	16.4 mi		No - 1970.53(d)(4)	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
610	(9) Line Relocation - Road Widening	N/A		NA	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
611	(10) Line Relocation - Safety and Access	N/A		NA	Existing ROW - Yes No Tree Clearing Required SHPO - NA T&E Species - NA Federal/State lands, floodplains, wetlands - NA	NA	NA
700	g. Other Distribution Items						
702	(1) Outdoor Lighting	3,088		NA	NA	NA	NA
704	(2) SCADA Equipment	N/A		NA	Yes - Inside Substation Fencing	NA	NA
705	(3) AMI Substation Equipment	N/A		NA	Yes - Inside Substation Fencing	NA	NA
2. TRANSMISSION							
800	a. New Line			NA	NA	NA	NA
	Line Designation						
900	b. New Substation, Switching Station, etc.			NA	NA	NA	NA
1000	c. Line and Station Changes			NA	NA	NA	NA
1100	d. Other Transmission Items			NA	NA	NA	NA
1200	e. GENERATION (including Step-up Station at Plant)			NA	NA	NA	NA
1300	f. HEADQUARTERS FACILITIES						
1301	New or additional Facilities	(Attach RUS Form 740g)		NA	NA	NA	NA
1302				NA	NA	NA	NA
1400	g. ACQUISITIONS						
1401	_____ Consumers	_____ Miles		NA	NA	NA	NA
1402				NA	NA	NA	NA
1500	h. ALL OTHER						
1501	GIS Hardware / Software Field Inventory			NA	NA	NA	NA
1502				NA	NA	NA	NA

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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

Request 6: Please see the Excel spreadsheet uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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

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

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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

Response 8: Please see Response 7. There were no active projects during the 12 months preceding the test year.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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: Big Sandy does not typically record capitalized interest as projects are typically short-term in nature.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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

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

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

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

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

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

f. Depreciation reserve (Account No. 108);

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

h. Computation and development of minimum cash requirements;

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

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

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

Response 10 : Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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 Big Sandy's last general rate case.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 12: Provide a copy of Big Sandy RECC's most recent depreciation study. If no such study exists, provide a copy of Big Sandy RECC's most recent depreciation schedule. The schedule should include a list of all facilities by account number, service life, and accrual rate for each plant item, the methodology that supports the schedule, and the date of schedule was last updated.

Response 12: Please see the Application, Exhibit 20. Big Sandy RECC is not proposing to adjust its depreciation rates in this proceeding. Big Sandy RECC's last depreciation study was completed December 31, 2007, which is attached at Application, Exhibit 20. Big Sandy's current depreciation rates were approved by the Commission in Case No. 2008-00401, *Application of Big Sandy Rural Electric Cooperative Corporation for an Adjustment in Rates for an Historical Test Period*.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 13: Provide Big Sandy RECC's cash account balances at the beginning of the test year and at the end of each month during the test year for total company and Kentucky jurisdictional operations.

Response 13: Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 14: Provide the average number of customers on Big Sandy RECC's system by rate schedule for the test year and two most recent calendar years.

Response 14: Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 15: 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 15: Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 16: Provide the comparative operating statistics as shown in Schedule G.

Response 16: Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 17: Provide the information requested in Schedule H1 for budgeted and actual numbers of full- and part-time employees by employee group, by month, and by year; and regular wages, overtime wages, and total wages by employee group, by month, for the test year and three most recent calendar years preceding the test year. Explain any variance exceeding 5 percent. Complete the information requested in Schedule H1.

Response 17: Please see the Excel file uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 18: State whether Big Sandy RECC, through an outside consultant or otherwise, performed a study or survey to compare its wages, salaries, benefits, and other compensation to those of other utilities in the region, or to other local or regional enterprises since Big Sandy's last base rate case.

a. If comparisons were performed, provide the results of the study or survey, including all workpapers and discuss the results of such comparisons. State whether any adjustments to wages, salaries, benefits, and other compensation in the rate application are consistent with the results of such comparisons.

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

Response 18(a): No outside consultant studies or surveys were conducted.

Response 18(b): Big Sandy has not performed an official wage and salary study, however, Big Sandy has informally collaborated with our sister cooperatives, and a comparison of wages based on job duties to ensure the compensation package is comparable to other cooperatives in the region. In addition to this, Big Sandy also monitors local businesses in the area to evaluate the pay scale in comparison to other local businesses.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 19: Provide the most recent wage, compensation, and employee benefits studies, analyses, or surveys conducted since Big Sandy RECC's last base rate case or that are currently utilized by Big Sandy RECC.

Response 19: Please see the response to Item 18(b).

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 20: 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 20: Big Sandy's Board of Directors voted to give raises to non-bargaining employees up to the amount of the percentage shown in the table below for the past three calendar years as well as a COLA in September of 2022. These percentages were the "up to" percentages that each employee could receive, based on the results of each employee's evaluation. Non-bargaining employees received a COLA increase in September of 2022. Bargaining employees received raises based on union contracts for the past three calendar years.

Employee Group	Amount of Increase	Effective Date
Bargaining Group	6.00% (of hourly wage or salary)	1/1/2021
Non-Bargaining Group	5.00% (of hourly wage or salary)	1/1/2021
Bargaining Group	3.00% (of hourly wage or salary)	1/1/2022
Non-Bargaining Group	3.00% (of hourly wage or salary)	1/1/2022
Non-Bargaining Group	3.00% (of hourly wage or salary)	9/14/2022
Bargaining Group	3.00% (of hourly wage or salary)	1/1/2023
Non-Bargaining Group	7.00% (of hourly wage or salary)	1/1/2023

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 21: Provide a schedule reflecting the salaries and other compensation of each executive officer for the test year and three most recent calendar years. Include the percentage annual increase and the effective date of each increase, the job title, duty and responsibility of each officer, the number of employees who report to each officer, and to whom each officer reports. For employees elected to executive office status since the test year in Big Sandy RECC's most recent rate case, provide the salaries for the persons they replaced.

Response 21: Please see the Excel file provided separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 22: 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 22:

Big Sandy offers health insurance through Anthem BCBS for all active employees, one retiree's spouse who is non-Medicare, and one retiree survivor who is non-Medicare.

Categories of health insurance include: Employee only, Employee/Spouse, Employee/Children, Family and Retiree Spouse, and Survivor non-Medicare.

Active Employees pay 10% of a base amount. The 2023 Deductible is $600 Single, $1800 Family.

Big Sandy offers, and pays, 100% of premium to Humana Medicare for its Retirees. The cost is $253.71 each, no deductible, no copays.

Big Sandy offers its active employees Dental and Vision insurance through Guardian, and the employee pays 100% of those premiums.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 23: Provide all current labor contracts and the most recent labor contracts previously in effect.

Response 23: Please see the attached contract.

Judy
Signed
ORIGINAL
Rec'd 11/12/20

AGREEMENT BETWEEN

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION

AND

LOCAL UNION NO. 317

OF THE INTERNATIONAL BROTHERHOOD

OF ELECTRICAL WORKERS

EFFECTIVE: JANUARY 1, 2021 THROUGH DECEMBER 31, 2025

TABLE OF CONTENTS

AGREEMENT

EFFECTIVE: JANUARY 1, 2021 Through December 31, 2025

THIS AGREEMENT, made and entered into this date 11/11/2020,

by and between the BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION of Paintsville, Kentucky, hereinafter referred to as the COOPERATIVE and LOCAL UNION NO. 317 of the INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, hereinafter referred to as the UNION, as the collective bargaining representatives for the employees of the COOPERATIVE in the classifications listed in Article V, Section 1, of this Agreement.

WITNESSETH

WHEREAS, the COOPERATIVE and the UNION have a common and sympathetic interest in the electrical industry, and together with the Public, will benefit from harmonious working arrangements for the adjustments of differences by rational and common sense methods, and therefore, for the purpose of facilitating the peaceful adjustments of differences that may arise from time to time, and to promote harmony and efficiency to the end that the COOPERATIVE, the UNION and the GENERAL PUBLIC may be benefitted the parties hereto contract and agree with each other as follows:

TO WIT; ARTICLE I. Recognition

Section 1. The UNION is hereby recognized as the sole exclusive bargaining agent for the collective bargaining purposes covering wages, hours and conditions of employment for all employees within the bargaining unit in view of the UNION'S certification by the N.L.R.B on the second day of June, 1950, in Case No. 9-RC-822.

Section 2. The UNION shall have the right to refer to the grievance procedure therein any complaint that the hiring policies of the EMPLOYER are discriminatory or unfair.

Section 3. The operation, control and management of the Company's facilities and operations, and all business and activities of the Company in connection therewith which are covered or affected by this Agreement, including the supervision and direction of the working forces at such facilities, operations and business, the right from time to time to make and enforce such reasonable rules applicable to employees covered by this Agreement, including rules concerning alcohol and substance abuse, and to enforce, change, abolish or modify existing rules applicable to employees covered by this Agreement, as it may from time to time deem necessary or advisable, are and shall continue to be solely and exclusively the functions and prerogatives of the management of the Cooperative, including the right to discipline or discharge for just cause (including violation of rules issued by the COOPERATIVE.)

Section 3 (a). All new employees shall be hired on a temporary basis, not to exceed ninety (90) working days actually worked.

During such ninety (90) working days probationary period, the COOPERATIVE may discharge or otherwise discipline, lay-off, transfer or assign such employees with or without cause, and such actions shall not be subject to the Grievance Procedure.

Section 4. The parties recognize that Kentucky statute KRS 336.130 (3) (a) prohibits a union or agency shop agreement. Consequently, for as long as laws prohibiting a union or agency shop are in effect, the provisions of subsection 4 (a) below shall not be effective. However, if during the life of this Agreement, federal or state statutes are changed by act of a legislative body or by popular vote, such that union or agency shop provisions are no longer prohibited, or if laws prohibiting union or agency shop provisions are declared unlawful, then the provisions of subsection 4 (a) will become effective where so permitted.

Section 4(a). All employees who are members of the UNION on the effective date of this Agreement shall be required to remain members of the UNION in good standing as a condition of employment within ninety (90) working days following dates of their employment or effective date of the Agreement, whichever is later. Any such workmen shall receive at least the minimum wages and work under the terms and conditions of this Agreement, with the exception of being covered under the fringe benefits of the Agreement.

Section 5. New employee shall be eligible for the following fringe benefits at these specific times:

Health Insurance and Hospitalization coverage and Dental coverage – ninety (90) days from date of hire; Sick leave, vacation, holidays and funeral leave – six (6) months from date of hire; Retirement – one (1) year from date of hire and minimum age of twenty-one (21) years old.

Seniority shall begin or commence at the date of hiring. The COOPERATIVE shall be required to make all payments required by law.

ARTICLE II. Grievance Procedure

Section 1. Any complaint, grievance or dispute that may arise with respect to the application or performance of this Agreement between the COOPERATIVE and the UNION or any *employee (s)* shall be taken up for settlement in the simplest and most direct manner. Except whereby mutual consent another procedure is agreed upon such matters shall be handled in accordance with the following:

1. Between the employee or employees concerned, together with the UNION'S steward if so desired, and the foreman or immediate supervisor of the aggrieved employee.

2. Should any matter not be adjusted in the 1st step above within forty-eight (48) hours, exclusive of Sundays and holidays, it shall be reduced to writing and referred to the Manager of the EMPLOYER and the Business Manager of the UNION.

3. All questions or disputes which are not adjusted as a result of the above procedure shall then be referred to a Joint Conference Committee of three (3) representatives of the UNION and three (3) representatives of the EMPLOYER. Each party shall have the privilege of changing representatives upon the proper notice to the other party. The Joint Conference Committee shall meet within forty-eight (48) hours after such notice is given either party. It shall select its own secretary and chairman.

4. If not satisfactorily adjusted after exhausting all of the above steps, the grievance or complaint shall be referred to arbitration provided such grievance involves an interpretation of the meaning or application of the terms of the Agreement, according to the following procedures; within five (5) days, the parties shall jointly request the Federal Mediation and Conciliation Service to appoint a third member, both parties to be bound by such appointment. Each party shall defray the expenses of its own member of the Board of Arbitration and the fee and expenses of the third member shall be born equally by the parties, together with any incidental or general expenses in connection with the arbitration mutually agreed upon in advance. The majority decision of the Board shall be final and binding on both parties.

Section 2. In any discharge or disciplinary suspension case where the Arbitrator decides that the aggrieved employee should be awarded any back pay, the COOPERATIVE shall be entitled to full credit on such awards for the employee's gross interim earnings, unemployment compensation benefits, workers' compensation benefits received or receivable and any other compensation he receives from any form of employment during the period he was not working for the COOPERATIVE. Subject to the foregoing qualifications and limitations, the Arbitrator's award shall be final and binding upon the COOPERATIVE, the UNION and the aggrieved employee or employees.

Section 3. The UNION and the employees agree that during the term of the Agreement neither the UNION, it's officers, agents or members shall authorize, instigate, aid, condone or engage in any work stoppage, strike of any kind or description, including so-called sympathy strikes, or otherwise interrupt, impede or restrict services of the COOPERATIVE or engage in any activity which would tend to cause an interruption or delay in the accomplishment of the work and business of the COOPERATIVE.

The UNION and the employees further agree that during the term of this Agreement, the UNION, it's officers, agents or members will not honor or recognize any picket lines, or picketing in any form, including picket lines or picketing out of so-called sympathy, except picketing at the COOPERATIVE'S Eleventh Street, Paintsville, Kentucky location which results from an lawful labor dispute between the COOPERATIVE and the UNION after this Agreement has expired. No employee will be required to cross a picket line which would put him in physical jeopardy or the property of the COOPERATIVE in jeopardy, such contention having to be proved by the employee.

Any employee who engages in any conduct prohibited by this Section, or who fails or refuses to comply with any provision of this Section, shall be subject to appropriate discipline, including discharge, without warning, by the COOPERATIVE.

The COOPERATIVE agrees not to lock-out employees during the term of this Agreement.

ARTICLE III. Vacation

Section 1. All employees within the bargaining unit shall be entitled to and shall receive vacations each year. The vacation for all those employees who have been regularly employed by the BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION for one year shall receive one (1) week or forty (40) hours vacation with pay and for those employees employed two (2) years to ten (10) years, three (3) weeks or one hundred twenty (120) hours. After ten (10) years employees shall receive an additional day of vacation for each year of employment with the COOPERATIVE, up to a maximum of four (4) weeks or one hundred and sixty (160) hours, except for employees hired before January 1, 1987, which may accumulate up to five (5) weeks or two hundred (200) hours.

Section 2. The vacation period of each employee shall be set by the EMPLOYER with due respect to the desire, seniority and preference of the employee consistent with the efficient operation of the BIG SANDY RURAL ELECTRIC COOPERATIVE. Employee will enter request to Management for vacation thirty (30) days prior to the date vacation is to start, when possible and practical. Employees will make every effort to provide Management thirty (30) days' notice for vacation that last for one (1) week or longer.

Section 3. If a vacation day falls on a holiday, another day shall be granted in lieu thereof. Employees who leave the service of the COOPERATIVE and have a vacation due them, shall be compensated in pay the amount that has accrued up to the date of severance.

Section 4. Crew Leaders, with eighteen (18) months seniority, as crew leaders, shall be paid his appropriate rate while on vacation or sick leave.

ARTICLE IV. Hours and Overtime

Section 1. No shift (whether an eight (8) hour shift or ten (10) hour shift), will start after 8:30 a.m. The COOPERATIVE will give one (1) week notice of any change in the shift hours and such changed schedule will run for at least one (1) work week. During such shifts, employees will be entitled to not more than thirty (30) minutes for a lunch period. Employees working ten (10) hour shifts will only receive over-time at time and one-half (1 ½) after ten (10) hours actually worked in a work day or after forty (40) hours actually worked in a workweek. Hours taken as holidays, vacation and funeral leave under this Agreement will count as hours worked for purposes of overtime.

When employee or employees are called out before or after the regularly scheduled working hours they shall receive not less than two (2) hours' time at the rate of time and one-half, except that if they worked longer than two (2) hours they shall receive time and one-half for the entire time worked until the regular scheduled work day begins, after which time the regular

rate of pay will become effective. Overtime to begin at the time the employee is called out and ends when he reports back. When called out on Sunday and legal holidays, they shall receive not less than two (2) hours' time at the rate of time and one-half except that if they work longer than two (2) hours, they shall receive time and one-half for the entire time worked. Overtime to begin at the time of calling the employees out and ends when he reports back. All employees used shall be reimbursed for room and board occurring on all emergency work. It shall be the responsibility of the Manager of the COOPERATIVE to keep an accurate, overtime list, and to distribute the overtime among the qualified employees in their classification as equal as possible, and to post said overtime list on the bulletin board before the tenth of each month, for the previous month.

Section 2. For all employees covered by this Agreement, kept as later provider, the regular work week shall be Monday through Friday. The regular work week shall not exceed forty (40) hours, and the regular work day shall not exceed ten (10) hours. All work in the excess of regularly scheduled hours in any one day or in any one week shall be paid at the rate of time and one-half (1 ½). The COOPERATIVE shall give the employee three days prior notice for Saturday work except for breakdowns.

Section 3. The following days shall be recognized as paid holidays at the employee's straight time rate of pay, provided the holiday falls on a regular work day, or the holiday is recognized to fall on a regularly scheduled work day: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve and Christmas Day. Holidays falling on Saturday or Sunday will be observed as the Nation observes them. Time and one-half to be paid in addition for all work performed on such holidays.

Section 4. Employees shall not be required to work outside during inclement weather except to restore service because of emergency conditions. Employees shall be assigned to work inside or under shelter during such weather. Such assignments shall not be for more than the regular work day or work week. Thus, the employee is assured of a full week's pay.

ARTICLE V. Wages

Effective January 1, 2021, all employees covered by this agreement will receive the following pay increases: $ 2.00 per hour, effective January 1, 2021; $ 1.00 per hour, effective January 1, 2022; $ 1.00 per hour, effective January 1, 2023; $ 1.00 per hour, effective January 1, 2024 and then $ 1.00 per hour, effective January 1, 2025.

Employees will be paid biweekly, which is every two weeks (i.e. every other Friday). If the payday falls on a holiday, the employee will be paid on the day before the holiday.

CLASSIFICATION

EFFECTIVE: 1/1/2021 thru 12/31/2025

Jan. 1, 2021	Jan. 1, 2022	Jan. 1, 2023	Jan. 1, 2024	Jan. 1, 2025
$ 2.00 per hr.	**$ 1.00 per hr.**	**$ 1.00 per hr.**	**$ 1.00 per hr.**	**$ 1.00 per hr.**
Lineman, 1st Class				
(w/less than 1 yr. experience w/ the company)				
$ 35.21	$ 36.21	$ 37.21	$ 38.21	$ 39.21
Serviceman, Journeyman/Lineman				
$ 36.25	$ 37.25	$ 38.25	$ 39.25	$ 40.25
Lineman, 1st Class (w/1 yr. or longer experience w/ the company)				
$ 36.00	$ 37.00	$ 38.00	$ 39.00	$ 40.00
Transformer, Meterman Serviceman Journeyman w/license				
$ 37.35	$ 38.35	$ 39.35	$ 40.35	$ 41.35
Assistant Transformer Meterman Serviceman				
$ 36.41	$ 37.41	$ 38.41	$ 39.41	$ 40.41
Asst. Staking Engineer				
$ 36.41	$ 37.41	$ 38.41	$ 39.41	$ 40.41
Asst. Staking Eng. Helper				
$ 35.50	$ 36.50	$ 37.50	$ 38.50	$ 39.50
Warehouseman				
$ 35.45	$ 36.45	$ 37.45	$ 38.45	$ 39.45
Crew Leader				
$ 38.48	$ 39.48	$ 40.48	$ 41.48	$ 42.48
Mechanic				
$ 34.71	$ 35.71	$ 36.71	$ 37.71	$ 38.71

APPRENTICES

(Lineman, Serviceman and Meterman)

1st 6 months				
$ 30.65	$ 31.65	$ 32.65	$ 33.65	$ 34.65
2nd 6 months				
$ 31.50	$ 32.50	$ 33.50	$ 34.50	$ 35.50
2nd year				
$ 32.51	$ 33.51	$ 34.51	$ 35.51	$ 36.51
3rd year				
$ 33.18	$ 34.18	$ 35.18	$ 36.18	$ 37.18
4th year				
$ 34.42	$ 35.42	$ 36.42	$ 37.42	$ 38.42
Therefore				
$ 36.00	$ 37.00	$ 38.00	$ 39.00	$ 40.00

GROUNDSMAN

1st 6 months				
$ 24.61	$ 25.61	$ 26.61	$ 27.61	$ 28.61
2nd 3 months				
$ 25.16	$ 26.16	$ 27.16	$ 28.16	$ 29.16
2nd 6 months				
$ 26.10	$ 27.10	$ 28.10	$ 29.10	$ 30.10
2nd year				
$ 27.09	$ 28.09	$ 29.09	$ 30.09	$ 31.09
3rd year				
$ 27.53	$ 28.53	$ 29.53	$ 30.53	$ 31.53
4th year				
$ 28.32	$ 29.32	$ 30.32	$ 31.32	$ 32.32
Therefore				
$ 28.71	$ 29.71	$ 30.71	$ 31.71	$ 32.71

A mechanic may be hired at a rate established by the COOPERATIVE, under the following conditions: The employer may set the starting and quitting time. The regular work week shall not exceed forty (40) hours, and the regular work day shall not exceed ten (10) hours. All work in the excess of regularly scheduled hours in any one day or in any one week shall be paid at the rate of time and one-half (1 ½). All other overtime and fringe benefit payments afforded other employees under the terms of this Agreement will apply to the mechanic. It is the understanding between both parties Local 317 and BIG SANDY RECC, that a mechanic is not to infringe on any other classifications work.

It is understood by Local 317 that BIG SANDY RECC will retain the right to employ temporary right of way employees.

Apprentices shall mean either Apprentice Lineman or Apprentice Meterman. Apprentice Lineman shall be advanced ~~only~~ on a basis of the time served, ability and completion of studies in a Lineman Educational Curriculum. Recommendations for advancement shall be initialed by the UNION Labor Committee and submitted to Committee representing the EMPLOYER for approval. It is understood that if a Groundsman is advanced to an apprentice, that the time served as Groundsman up to and including two (2) years shall apply to his apprenticeship rating.

It is mutually understood between both parties that the EMPLOYER will contribute an amount equal to ten percent (10%) of the employees monthly base salary, toward purchasing a retirement plan for the employee with a reputable insurance company. This ten (10%) contribution will continue throughout this Union Contract dated January 1, 2021 to December 31, 2025.

ARTICLE VI. Apprentices

Section 1. An apprentice lineman is one who is learning line work and must serve as such for four (4) years before becoming a journeyman lineman. An apprentice working voltage in excess of 600 volts must be under the direct supervision of a journeyman.

Section 1. (a) An apprentice promoted from a lower rating to a higher rating, prior to promotion shall be required to take the I.B.E.W. test before promotion is put in effect and the COOPERATIVE Manager shall be advised by the UNION of such test.

Section 2. The ratio of apprentices to journeyman shall not be more than two (2) apprentices to one (1) journeyman or fraction thereof. Foreman is to be counted as journeyman. No journeyman shall be displaced by an apprentice.

ARTICLE VII. Seniority

Section 1. Seniority of an employee coming within this Agreement shall accumulate from the first day of employment with the COOPERATIVE. Illness, injury or military service in time of national emergency shall not be considered as a break in seniority.

Section 2. Promotions to positions in the bargaining unit, demotion, lay-offs, however, that employees have sufficient ability and qualifications to perform the work required. Employees who have been laid off shall be called back to work and placed on jobs which they can perform in accordance with their previous seniority. Employees so recalled must report to work within five (5) working days after being notified of such recall and advise the COOPERATIVE immediately of their intentions to report. In case of lay-offs, seniority need not be carried over twelve (12) months. This paragraph shall cover employees working with the COOPERATIVE at the time this Agreement goes into effect and all employees that become regular employees.

Section 3. In the event it becomes necessary to lay off one (1) employee and there are two (2) employees having relatively equal ability and seniority, one of whom must be laid off, the decision as to which of the two (2) employees shall be affected, the lay-off shall be made by the Job Steward and the Manager. COOPERATIVE shall give employee to be laid off a minimum of one-week notification prior to lay off.

A seniority list shall be made up by the COOPERATIVE within sixty (60) days after the date of this Agreement. A copy shall be furnished to the Secretary of the UNION and a copy posted on the bulletin board. This list shall be open for correction for a period of thirty (30) days thereafter, and if any employee does not make a protest in writing to the COOPERATIVE, with a copy to the UNION, within such thirty (30) day period after posting of such list, his seniority shall be as shown on list. The seniority list shall be brought up to date once each six (6) months thereafter.

Section 4. Through the representation of the UNION, employees shall have the right to hearing on any differences of opinion as to the competency of any employee to fill a new position of vacancy, or promotion or demotion, of discipline administered or lay-offs, or discharge or of discrimination. Such hearing shall follow the established grievance procedure. This paragraph is not to be interpreted as meaning the Local UNION has the right to a hearing on the competency of new employees hired by the COOPERATIVE. New employees shall mean those employees who have worked for less than ninety (90) days.

ARTICLE VIII. Sick Leave

Section 1. Employees compelled to be absent from regular duties because of illness or accident shall be compensated at the regular straight time rate of pay as follows:

On January 1st of each year, each employee then having completed one (1) years prior

service, with the COOPERATIVE, shall be compensated for the first twelve (12) days of such illness occurring during the prospective year. On January 1st of each year, each employee then having completed one (1) years prior service with the COOPERATIVE, shall be compensated for the first twelve (12) days of such illness and can accumulate up to sixty (60) days sick leave with applicable rate of pay.

Should the employee become ill in the first months after this agreement is executed, the employee shall receive the maximum credit of twelve (12) days – should he have been employed for at least one year. During the prospective year, employees with less than one (1) year of service on January 1st of each year shall be compensated based on the number of months prior service with the COOPERATIVE at the rate of one (1) day each month's prior service. If an employee is off work due to illness, he shall contact the COOPERATIVE, if possible, and if the ~~Board of Directors~~ Supervisor required a doctor's certificate, it shall be at the expense of the COOPERATIVE.

Any I.B.E.W. employee, employed by BIG SANDY RECC for 10 years or longer is to be paid at his regular hourly rate of pay for all sick leave due him up to thirty (30) days if he is laid off because of lack of work; or, under the same conditions, will be paid at his regular hourly rate of pay for sick leave due him, up to a maximum of forty-five (45) days, only if he retires at age 62 or above.

Personal Days – Full days only, for personal use.

Year	# of Personal Days
2021	3 days
2022	3 days
2023	3 days
2024	3 days
2025	3 days

The number of personal days each employee has accumulated as of January 1, 2008, will be the maximum that will be accumulated. Such days and all days earned subsequent to January 1, 2008, must be used before an employee retires or leaves the employee of the COOPERATIVE.

Section 2. The COOPERATIVE agrees to continue in effect for the term of this Agreement its present group insurance programs so as to make available to all regular full-time employees who have completed their probationary period, the COOPERATIVE's basic group insurance plans, as modified below:

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

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

The COOPERATIVE agrees to pay the cost of hospitalization insurance now in existence for its employees and family; (as modified below regarding the rising health care cost and regarding spouses.)

REGARDING cost of hospitalization insurance; the COOPERATIVE will pay all costs for hospitalization insurance with the exception as follows:

THE EMPLOYEE will pay:

2021 – 12% of Monthly Base Cost for Hospitalization Insurance.

2022 – 12% of Monthly Base Cost for Hospitalization Insurance.

2023 – 12% of Monthly Base Cost for Hospitalization Insurance.

2024 – 12% of Monthly Base Cost for Hospitalization Insurance.

2025 – 12% of Monthly Base Cost for Hospitalization Insurance.

In each year of this Contract, The Employee will pay 12% of monthly base cost of hospitalization insurance. Notwithstanding the above, any annual premium increase shall be capped at 5% based upon previous year's cost to employee.

For example, if Employee's monthly cost is $100 in 2021, Employee's monthly cost could not exceed $105 in 2022.

(This cost will be payroll deducted (biweekly) as with any other benefit costing the employee)

The COOPERATIVE and the UNION believe rising health care costs must be addressed in the interest of the COOPERATIVE members. Effective upon ratification of this Agreement,

COOPERATIVE bargaining unit employees are required to notify the COOPERATIVE about health care coverage available to their spouse through their employer. If an employee's spouse has a health care plan available through their employer, they will be required to obtain such insurance provided if such coverage is reasonably comparable.

The COOPERATIVE will augment additional cost of this provision up to $200.00 per month per employee for employee-only coverage upon proof of such additional cost. This provision will terminate upon the date the employee of the coop retires. But, a dependent of the employee will continue to be covered by the COOPERATIVE's healthcare plan.

Additionally, the COOPERATIVE will be provided an incentive program that may be adjusted from time to time as determined by the COOPERATIVE with the understanding the employees may opt back in to the COOPERATIVE plan when they desire **subject** to the enrollment procedures of the existing health care plan.

Nothing herein will require employees to provide health care coverage to dependents in conflict with court ordered requirements.

A spouse who loses insurance from their employer will be added to the COOPERATIVE's health insurance program within thirty (30) days of notice of termination of such coverage. An employee who has a spouse covered by the COOPERATIVE's health insurance program shall certify in writing yearly, during the month of January, that the spouse continues to be unemployed or is not eligible for health insurance from their employer.

Employees hired on and after January 1, 2008 will, at the time of retirement receive employee-only health insurance from the COOPERATIVE until they become eligible for Medicare or the Medicare-type program in effect at that time.

Section 3. Any employee will be granted a leave of absence with pay at his base hourly rate for up to three (3) consecutive scheduled workdays upon presentation of evidence satisfactory to the COOPERATIVE for attending the funeral of a member of his immediate family. Immediate family shall mean spouse, children, mother, father, sister, brother, mother-in-law or father-in-law, grandparents and grandchildren.

Section 4. An employee will be granted a leave of absence with pay at his base hourly rate for any three (3) consecutive scheduled workdays upon presentation of evidence satisfactory to the COOPERATIVE for admittance of a member of his immediate household to the hospital, or one day leave of absence for emergency room treatment or outpatient surgery at the hospital. Household shall mean: spouse, children, parents and grandparents.

ARTICLE IX. General Provisions

Section 1. This Agreement sets out the entire understanding between the COOPERATIVE and the UNION with respect to the unit of employees described in this Agreement. Neither party intends to be bound or obligated except to the extent that it has expressly so agreed herein and this Agreement shall be strictly construed. Neither the UNION

nor the COOPERATIVE shall use or attempt to sue in any arbitration or in any legal proceeding of any kind under this Agreement or which involves this Agreement any concession or change in language or position which the COOPERATIVE made or agreed to in the course of the negotiations for this Agreement, and evidence of any such concession or change in language opposition on the COOPERATIVE's part shall be inadmissible. This Agreement applies only to the collective bargaining unit defined in this Agreement. None of the benefits, rights or privileges accorded by this Agreement to the UNION or to any employee covered by this Agreement shall survive the expiration or termination of this Agreement.

It is distinctly understood and agreed to by the UNION that the COOPERATIVE shall not be obligated, contractually or otherwise, to continue in effect any custom, practice or benefit unless it has contractually obligated itself to do.

Section 2. The EMPLOYER shall furnish adequate safety appliances and Personal Protective Equipment (which includes belts, climbers and body tools) in accordance with OSHA 29 CFR 1910.132 (H). Employer is not obligated to replace such P. P. E. if employee loses or negligently abuses such P.P.E. Members of the UNION shall cooperate in every way to minimize accidents and shall at all times use every effort for the preservation of the safety appliances and tools and shall use them when needed.

Section 3. No less than five (5) men will be used when erecting poles of greater length than twenty-five (25) feet by hand. This does not include poles erected by mechanized equipment.

Section 4. When higher than 600 volts are to be worked the journeyman assigned to the job shall exercise his judgment in determining the need of journeyman helpers. When an employee is assigned to a service truck and is called out before or after the employee's regular work time, on call out work, the employee assigned to the service truck and the

employer, shall exercise their judgment in determining assistance, the employee might need.

Section 5. It is agreed that should any job classification be omitted from Article V, Section 1, or created after the signing of this Agreement the parties hereto shall meet and amend this Agreement to include such classification.

Section 6. The COOPERATIVE acknowledges receipt of a copy of the Constitution of the International Brotherhood of Electrical Workers.

Section 7. Promotions to positions within the bargaining unit, demotions, lay-offs, or transfers shall be based on seniority and classification provided, however, that employees must have sufficient ability to perform the work required within the classifications.

Section 8. No employee within the bargaining unit will be requested to take time off in lieu of overtime pay. The COOPERATIVE shall be the sole judge as to the necessity of overtime work, and the employee shall be obligated to work overtime when requested to do so. When possible, this request shall be made two (2) days prior to scheduled overtime. Scheduled overtime shall be divided equally among the employees in the district who perform the classification of the work required to be done on overtime.

Section 9. The COOPERATIVE shall provide exclusive bulletin space for the UNION and shall be located in the storeroom where employees will see same when entering or leaving storeroom.

Section 10. When an employee (Journeyman) is designated by the COOPERATIVE Superintendent, Manager or General Foreman to fill the vacancy of foreman and/or crew leader for eight (8) consecutive hours (full day) such acting foreman and/or crew leader shall be paid at the higher rate of the one whose place he fills.

Section 11. The COOPERATIVE agrees that if and when it contracts with private contractors to do any of its work, that said private contractor will be informed that there is an existing contract between the COOPERATIVE and the INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS (Local UNION No. 317) and it is the understanding that no contracts will be let to private contractors while Local 317 employees are laid off, if so, the employees laid off will be re-called and placed to work in the classification they were last employed. This contract applies to maintenance employees. Any new construction of ten (10) miles or more shall be called construction and a new contract shall be agreed to for these construction works.

Section 12. The COOPERATIVE agrees to purchase five (5) work uniforms, and one work jacket, or seven (7) pants and seven (7) shirts, no jacket, per year for its employees. However, employee may elect to receive boots or a combination of uniforms and boots. The amount of money allocated to each employee, will be the average cost of uniforms per employee, computed each year.

Section 13. Negotiations shall be held during the regular working day between the hours of 7:30 A.M. and 4:00 P. M. at no lost time to the Local UNION's negotiating committee. The COOPERATIVE and the UNION will alternate paying for such lost time by the local UNION negotiating committee, with the COOPERATIVE paying for such lost time in the first negotiating session, the UNION paying for such lost time in the second negotiating session, and alternatively, the COOPERATIVE and the UNION thereafter.

Section 14. The Employer agrees that it will make deductions from the pay of each member within the bargaining unit on the basis of individually signed payroll deduction authorization forms and will pay over the aggregate of such deductions to the Financial Secretary of the Local UNION designated against his receipt therefore in the name of the Local UNION.

The Employer agrees to make this deduction monthly, as designated in the individually signed payroll deduction authorization, and to send a check for the total amount, together with a list of the individual's names from whom the deductions were made designating the amount deducted on each form, plus a list of names of the employees removed from or added to the payroll during the current month to the Financial Secretary designated by the UNION on or before the last day of each month in which deductions are made.

The UNION agrees to save the EMPLOYER harmless from any action growing out of these deductions and commenced by any employee against the EMPLOYER and assumes full responsibility for the disposition of the funds so deducted once they have been turned over to the Financial Secretary of the UNION.

ARTICLE X. Termination

Section 1. The COOPERATIVE and the UNION each acknowledge that this Agreement has been reached as a result of collective bargaining in good faith by both parties hereto, and that both parties hereto have had the unlimited opportunity during negotiations to submit and discuss proposals on all subjects which are bargainable matters. While it is the intent and purpose of the parties hereto that each of them shall fully perform all obligations by them to be performed in accordance with the terms of this Agreement, the UNION and the COOPERATIVE agree that the COOPERATIVE shall not be obligated to bargain collectively with the UNION during the term of this Agreement on any matter pertaining to rates of pay, wages, hours of employment, or other conditions of employment, and the UNION and the COOPERATIVE hereby specifically waive any right which it might otherwise have to request or demand such bargaining and acknowledges that the COOPERATIVE's obligations during the term of this Agreement shall be limited to the performance and discharge of its obligations under this Agreement.

IN WITNESS WHEREOF, the parties have hereunto set their hands on quintuplicate copies this date: September 24, 2020.

I.B.E.W. Business Manager

President & General Manager of Coop

Chairman of the Board

Vice Chairman of the Board

Board Secretary

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 24: Provide each medical insurance policy that Big Sandy RECC currently maintains.

Response 24: Please see attached.

Kentucky Rural Electric Cooperative
Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
Summary Plan Description
Amendment No. 1

For the Summary Plan Description, which is effective January 1, 2023, Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description hereby amends such document as of July 1, 2023 as follows:

Under SECTION V—SCHEDULE OF BENEFITS, K. Schedule of Medical Benefits - PPO Option, DELETE:

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*.

Under SECTION VI—MEDICAL BENEFITS, A. Covered Medical Charges, DELETE:

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.

Under SECTION VI—MEDICAL BENEFITS, A. Covered Medical Charges, DELETE:

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.

And REPLACE with:

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.

Under SECTION VI—MEDICAL BENEFITS, B. Medical Plan Exclusions, ADD:

16. **Diabetic Supplies.** Diabetic supplies are covered through the Prescription Drug Benefits program. Please refer to the section entitled **Prescription Drug Benefits**.

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.

Under SECTION IX—PRESCRIPTION DRUG BENEFITS, K. Covered Prescription Drug Charges, DELETE:

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.

And REPLACE with:

3. **Diabetic.** Insulin and other injectable diabetic medications, lancets and lancet devices, blood glucose meters, calibration liquid, insulin needles, syringes and pen needles, pump cartridge, continuous blood glucose monitor, blood glucose and ketone test strips, 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.

Under SECTION IX—PRESCRIPTION DRUG BENEFITS, K. Covered Prescription Drug Charges, ADD:

9. **Weight Loss Drugs. *Pre-certification* is required.**

All other terms and conditions of this Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description which are not affected by this amendment remain unchanged.

Kentucky Rural Electric Cooperative hereby adopts the provisions of this amendment of the Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description, and its duly authorized officer has executed this amendment.

By: DocuSigned by: Judy McClure D95F3154FF674E7... Date: 4/15/2024

Title: Executive Assistant & HR Director

Kentucky Rural Electric Cooperative
Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
Summary Plan Description
Amendment No. 2

For the Summary Plan Description, which is effective January 1, 2023, Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description hereby amends such document as of January 1, 2023 as follows:

1. The Plan will provide treatment for the condition related to the current public health emergency at the applicable benefit level.
2. The Plan will provide telemedicine and virtual visit services *related to the public health emergency* at the applicable benefit level.
3. The *Plan* will cover treatments for COVID-19 as approved by the U.S. Food and Drug Administration (FDA) under Emergency Use Authorizations (EUA). Coverage includes the administration and services necessary to receive the treatment. While both this amendment and the EUA for the specific treatment are in effect, the services will not be considered *experimental/investigational* under the *Plan*.

   Limited to the services outlined herein, this provision shall override any potentially conflicting, specific exclusions, defined terms, or other plan provisions for these services.
4. The *Plan* will cover the cost of at-home COVID-19 tests through the Prescription Drug Benefits only. At-home COVID-19 tests are excluded under the medical plan.
5. Administrative/return to work testing is not covered.
6. The *Plan* will cover the approved and CDC recommended COVID-19 vaccine(s), following the CDC's specifications. Coverage includes the vaccine's administration and services necessary to receive the vaccine.

   COVID-19 Vaccination Benefit level:

Network Providers	Non-Network Providers
100%, *deductible* waived	

7. In accordance with the federal guidance for the extension of certain timeframes during the COVID-19 National Emergency, the Plan will disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency, or such other date announced by the agencies in a future notification for all *plan participants*, beneficiaries, qualified beneficiaries, or *claimants* wherever located in determining the following periods and dates:
   a. the time period to request special enrollment under ERISA
   b. the election period for COBRA continuation coverage under ERISA
   c. the date for making COBRA premium payments pursuant to ERISA
   d. the date for individuals to notify the *Plan* of a qualifying event or determination of disability under ERISA
   e. the date within which *plan participants* may file a benefit *claim* under the *Plan's claims* procedure
   f. the date within which *claimants* may file an *appeal* of an *adverse benefit determination* under the *Plan's claims* procedure
   g. the date within which *claimants* may file a request for an *external review* after receipt of an *adverse benefit determination* or a *final internal adverse benefit determination*
   h. the date within which a *claimant* may file information to perfect a request for *external review* upon a finding that the request was not complete

Limited to the services outlined herein, this provision shall override any potentially conflicting, specific exclusions for these services.

This shall remain in effect until the public health emergency, as declared by the Secretary of Health and Human Services (HHS), has ended.

All other terms and conditions of this Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description which are not affected by this amendment remain unchanged.

Kentucky Rural Electric Cooperative hereby adopts the provisions of this amendment of the Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description, and its duly authorized officer has executed this amendment.

By: Judy McClure Date: 3-20-2024

Title: Executive Assistant & H.R. Director

Kentucky Rural Electric Cooperative
Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
Summary Plan Description
Amendment No. 3

For the Summary Plan Description, which is effective January 1, 2023, Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description hereby amends such document as of May 12, 2023 as follows:

Under SECTION VI—MEDICAL BENEFITS, A. Covered Medical Charges, ADD, alphabetically:

COVID-19 Services. The *Plan* provides coverage for diagnostic testing (except over-the-counter), treatment, and *experimental/investigational* treatment.

Under SECTION VI—MEDICAL BENEFITS, B. Medical Plan Exclusions, ADD, alphabetically:

COVID-19 Services. Dental personal protection equipment (PPE). At-home (over-the-counter) COVID-19 tests are excluded under the medical plan. Refer to the **Prescription Drug Benefits** section of this plan document for coverage information.

Examinations. Administrative/return-to-work testing related to COVID-19, except as required under applicable federal law.

Under SECTION IX—PRESCRIPTION DRUG BENEFITS, K. Covered Prescription Drug Charges, ADD, alphabetically:

COVID-19 Home Tests. The *Plan* will cover the cost of at-home COVID-19 tests through the Prescription Drug Benefits only.

All other terms and conditions of this Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description which are not affected by this amendment remain unchanged.

Kentucky Rural Electric Cooperative hereby adopts the provisions of this amendment of the Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description, and its duly authorized officer has executed this amendment.

By: DocuSigned by: Judy McClure EF3823445C28428... Date: 5/15/2024

Title: Executive Assistant & HR Director

Kentucky Rural Electric Cooperative
Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
Summary Plan Description
Amendment No. 4

For the Summary Plan Description, which is effective January 1, 2023, Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description hereby amends such document as of January 1, 2024 as follows:

Under SECTION III—CONSOLIDATED APPROPRIATIONS ACT OF 2021 AND TRANSPARENCY IN COVERAGE REGULATIONS, DELETE entire section and REPLACE with:

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* in an emergency department of a hospital or independent freestanding emergency department provided by *non-network* providers or facility
2. 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* and are dependent on covered benefits.

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 in an emergency department of a hospital or independent freestanding emergency department 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 no 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 in an emergency department of a hospital or independent freestanding emergency department 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 lesser of billed charges or the median plan *network* contract rate (called the Qualifying Paying Amount or QPA) 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 these *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*. Cost-sharing for air ambulance services is based on the lesser of billed charges or the QPA.

D. Appeals

If you receive *emergency services* in an emergency department of a hospital or independent freestanding emergency department from a *non-network* provider, covered services from a *non-network* provider at a *network* facility, or *non-network* air ambulance services, and believe those services are covered by your *Plan's* benefits and 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 by 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/or 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 *non-network* provider's services based on what you may pay *non-network* providers 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.

Under SECTION V—SCHEDULE OF BENEFITS, B. Schedule of Benefits, Pre-Certification, DELETE:

7. *durable medical equipment (DME)* in excess of $500 (purchase/rental price)

And REPLACE with:

7. *durable medical equipment (DME)* in excess of $3,000 (purchase/rental price)

Under SECTION V—SCHEDULE OF BENEFITS, B. Schedule of Benefits, Pre-Certification, DELETE:

14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of ten (10) visits per *calendar year* per therapy type

And REPLACE with:

14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of eighteen (18) visits per *calendar year* per therapy type

Under SECTION VI—MEDICAL BENEFITS, A. Covered Medical Benefits, DELETE:

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.

And REPLACE with:

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 and hearing aids purchased over the counter 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.

Under SECTION VI—MEDICAL BENEFITS, B. Medical Plan Exclusions, DELETE:

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.

And REPLACE with:

12. **Court-Ordered Treatment.** Any treatment of a *plan participant* in a public or private *institution* as the result of a court order or due to a criminal offense.

Under SECTION VI—MEDICAL BENEFITS, B. Medical Plan Exclusions, DELETE:

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.

And REPLACE with:

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. This exclusion does not apply to hair loss services attributed to a covered medical condition.

Under SECTION VI—MEDICAL BENEFITS, B. Medical Plan Exclusions, ADD alphabetically:

60. **Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a *hospital, hospice unit, skilled nursing facility, inpatient rehabilitation hospital*, or *residential treotment facility* licensed and regulated by a state or federal agency and is acting within the scope of their license.

Under SECTION VII—HEALTH CARE MANAGEMENT PROGRAM, B. Utilization Review, What Services Must Be Pre-Certified (Approved Before they are Provided), DELETE:

7. *durable medical equipment (DME)* in excess of $500 (purchase/rental price)

And REPLACE with:

7. *durable medical equipment (DME)* in excess of $3,000 (purchase/rental price)

Under SECTION VII—HEALTH CARE MANAGEMENT PROGRAM, B. Utilization Review, What Services Must Be Pre-Certified (Approved Before they are Provided), DELETE:

14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of ten (10) visits per *calendar year* per therapy type

And REPLACE with:

14. *outpatient* rehabilitation/*habilitation services* (physical therapy, occupational therapy, and speech therapy) in excess of eighteen (18) visits per *calendar year* per therapy type

All other terms and conditions of this Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description which are not affected by this amendment remain unchanged.

Kentucky Rural Electric Cooperative hereby adopts the provisions of this amendment of the Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description, and its duly authorized officer has executed this amendment.

By: Judy McClure Date: 3-20-24

Title: Executive Assistant & H.R. Director

Kentucky Rural Electric Cooperative
Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
Summary Plan Description
Amendment No. 5

For the Summary Plan Description, which is effective January 1, 2023, Kentucky Rural Electric Cooperative Employers Benefit Plan ~~East~~ Big Sandy Rural Electric Cooperative Corporation Summary Plan Description hereby amends such document as of January 1, 2024 as follows:

Under SECTION V—SCHEDULE OF BENEFITS, K. Schedule of Medical Benefits - PPO Option, DELETE:

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.

And REPLACE with:

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.
Colonoscopies, Mammograms, & Prostate Exams	No charge	Up to $500 per year: 100%, *deductible* waived Charges in excess of $500: 70%, *deductible* waived	Calendar Year Maximum: One (1) exam per benefit, regardless of any other factors.

All other terms and conditions of this Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description which are not affected by this amendment remain unchanged.

Kentucky Rural Electric Cooperative hereby adopts the provisions of this amendment of the Kentucky Rural Electric Cooperative Employers Benefit Plan Big Sandy Rural Electric Cooperative Corporation Summary Plan Description, and its duly authorized officer has executed this amendment.

3-20-24

Judy McClure
Executive Assistant & H.R. Director

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Big Sandy Rural Electric Cooperative: PPO Plan Option

Coverage Period: 01/01/2023 - 12/31/2023
Coverage for: Individual and Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-209-0071. 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. **Yes, for specialty drugs:** Lumicera. To contact, call 1-855-847-3553.	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 after deductible	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 after deductible	
	Preventive care/screening/ immunization	No Charge	**Up to $500 per Year:** No charge **Charges in Excess of $500:** 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**	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)	
		Services: 10% co-insurance after deductible **Lab and X-Ray Outpatient Professional Services:** 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.**

* 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-insurance **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-four (34) 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 (34-Day**	Not Covered	**Pre-certification may be required.**

* 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)	
		Supply): 20% co-insurance up to 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.**
	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.
	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.**
	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.
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	**Pre-certification is required.**
	Rehabilitation services	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required** for physical therapy and occupational therapy in excess of ten (10) visits per calendar year per therapy type.
	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.**
	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.

* 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)	
	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:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-844-209-0071

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

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.

Kentucky Rural Electric Cooperative

Kentucky Rural Electric Cooperative Employers Benefit Plan
Big Sandy Rural Electric Cooperative Corporation
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.

This plan document does not determine rights under the *Plan*; the collective bargaining agreement always will remain the final authority. In the case of a dispute, the information in the union plan documents or collective bargaining agreement will control to the extent permitted by law. If you are a union *employee* covered under a collective bargaining agreement that provides benefits with the *employer*, you should contact your local Human Resources Representative to obtain a copy of the summary plan description that applies to you.

Review your *Explanation of Benefits* (*EOB*) forms, other *claim* related information, and available *claims* history. *Notify* the *Third Party Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The *Plan* will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminates. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this *Plan* until the *appeal* rights provided have been exercised and the *Plan* benefits requested in such *appeals* have been denied in whole or in part.

If the *Plan* is terminated or amended, or if benefits are eliminated, the rights of *plan participants* are limited to *covered charges incurred* before termination, amendment, or elimination.

A *plan participant* should contact the *Plan Administrator* to obtain additional information, free of charge, about *Plan* coverage of a specific benefit, particular drug, treatment, test, or any other aspect of *Plan* benefits or requirements. Refer to the Quick Reference Information Chart for contact information.

A. Quick Reference Information Chart

When you need information, please check this document first. If you need further help, call the appropriate phone number listed in the following Quick Reference Information Chart:

QUICK REFERENCE INFORMATION	
Information Needed	**Whom to Contact**
Plan Administrator • Second-Level *Appeals* of *Pre-Service* and *Post-Service Claims*	Kentucky Rural Electric Cooperative 4775 Lexington Road Winchester, KY 40391 1-859-745-9672
Medical Claims Administrator/Third Party Administrator (Medical and Dialysis) • *Claim* Forms (Medical) • Medical *Claims* • First-Level *Appeals* of *Post-Service Claims* • Eligibility for Coverage • Plan Benefit Information	AmeriBen P.O. Box 7186 Boise, ID 83707 1-844-209-0071 www.MyAmeriBen.com
Medical Management Administrator • *Pre-Certification*, Concurrent Review, and Case Management • First-Level *Appeals* of *Pre-Service Claims*	AmeriBen Medical Management PO Box 7186 Boise, ID 83707 1-844-209-0071
PPO Provider Network Names of *Physicians* & *Hospitals* • Network Provider Directory - see website	Anthem 1-833-835-2714 www.anthem.com
Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Specialty Pharmacy Program	**Retail** Navitus Health Solutions, LLC PO Box 999 Appleton, WI 54912 1-866-378-4755 www.navitus.com Fax: 1-920-735-5315 **Mail Order** Birdi P.O. Box 8004 Novi, MI 48376-8004

B. Plan is Not an Employment Contract

The *Plan* is not to be construed as a contract for or of employment.

C. Plan Administrator

The *employer* is the *Plan Administrator*. The name, address, and telephone number of the *Plan Administrator* are:

Kentucky Rural Electric Cooperative
4775 Lexington Road
Winchester, KY 40391
1-859-745-9672

The *Plan* is administered by the *Plan Administrator* within the purview of Employee Retirement Income Security Act of 1974 (ERISA), and in accordance with these provisions. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* shall administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care, and treatments are *experimental/investigational*), to decide disputes which may arise relative to a *plan participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any *claim* for benefits and the meaning and intent of any provision of the *Plan*, or its application to any *claim*, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrotor* 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
3. completes the employment *waiting period* of ninety (90) consecutive days as an active *employee*

   A *waiting period* is the time between the first day of *active employment* and the first day of coverage under the *Plan*.

Effective Date of Employee Coverage

An *employee* will be covered under this *Plan* 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-one (31) 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 (and mother/covered parent) is not enrolled in this *Plan* on a timely basis, there will be no payment from the *Plan* beyond the initial thirty-one (31) 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 two (2) weeks after the person initially becomes eligible for coverage, or as shown in the Qualifying Events Chart subsection for each type of special enrollment period.

Late Enrollment

An enrollment is late if it is not made on a timely basis or during a special enrollment period. *Late enrollees* and their *dependents* who are not eligible to join the *Plan* during the special enrollment period may join only during the *open enrollment period.*

The time between the date a *late enrollee* first becomes eligible for enrollment under the *Plan* and the first day of coverage is not treated as a *waiting period.* Coverage begins January 1.

D. Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If an *employee* is declining enrollment for themselves or their *dependents* (including a spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this *Plan* if there is a loss of eligibility for that other coverage (or if the *employer* stops contributing towards the other coverage). However, a request for enrollment must be made as shown in the Qualifying Events Chart subsection after the coverage ends (or after the *employer* stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, or placement for adoption 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-one (31) days of marriage	Enroll yourself, if applicable Enroll your new spouse and other eligible *dependents*
Divorce or annulment	Date of event	thirty-one (31) 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-one (31) 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-one (31) days of adoption	Enroll yourself Enroll the newly adopted child and all other eligible dependents

Your *dependent* child reaches maximum age for coverage	Date of event	thirty-one (31) 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-one (31) days of spouse's or *dependent's* death	Coverage will terminate for the *dependent* from your health coverage
Significant change in or cost of your, or your spouse's, health coverage due to spouse's employment, including open enrollment	Date of event	thirty-one (31) days of effective date of change in coverage	Enroll yourself and other eligible *dependents*
A change in the place of residence of the employee, spouse, or dependent	Date of event	thirty-one (31) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Special requirements relating to the Family and Medical Leave Act	Date of event	thirty-one (31) days of effective date of change in coverage	Enroll or drop coverage for yourself, your spouse, or covered *dependent* children
Spouse or covered *dependent* obtains coverage in another group health plan	Date of event	thirty-one (31) days of gain of coverage	Drop coverage for yourself, your spouse, or covered *dependent* children
Loss of other coverage, including COBRA coverage	Date of event	thirty-one (31) days of the date of loss of coverage	Enroll yourself, your spouse and eligible *dependent* children
Spouse's loss of coverage, including COBRA coverage	Date of event	thirty-one (31) 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-one (31) 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-one (31) days of order	Enroll yourself, if applicable Enroll the eligible child named on *QMCSO*

G. Termination of Coverage

Rescission of Coverage

The *employer* or *Plan* has the right to rescind any coverage of the *employee* and/or *dependents* for cause, making a fraudulent *claim*, or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the *Plan*. The *employer* or *Plan* may either void coverage for the *employee* and/or covered *dependents* for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the *Plan's* discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the *Plan* will provide at least thirty (30) days' advance written *notice* of such action.

When Employee Coverage Terminates

Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for COBRA continuation coverage):

1. the date the *Plan* is terminated
2. the last day of the calendar month in which the covered *employee* ceases to be in one (1) of the eligible classes

   This includes termination of *active employment* of the covered *employee*, an *employee* on disability, *leave of absence*, or other *leave of absence*, unless the *Plan* specifically provides for continuation during these periods.
3. the date of the covered *employee's* death
4. the end of the period for which the required contribution has been paid if the charge for the next period is not paid when due

For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled **Continuation Coverage Rights Under COBRA**.

When Dependent Coverage Terminates

A *dependent's* coverage will terminate on the earliest of these dates (except in certain circumstances, a covered *dependent* may be eligible for COBRA continuation coverage):

1. the date the *Plan* or *dependent* coverage under the *Plan* is terminated
2. the date that the *employee's* coverage under the *Plan* terminates for any reason, including death
3. the date a covered spouse loses coverage due to loss of dependency
4. the first date that a person ceases to be a *dependent* as defined by the *Plan*
5. the date 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.

Every year during the annual *open enrollment period*, *employees* and their *dependents* who are *late enrollees* will be able to enroll in the *Plan*.

Benefit choices made during the *open enrollment period* will become effective January 1 and remain in effect until the next January 1 unless there is a special enrollment event or change in family status during the year (birth, death, marriage, divorce, adoption, 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 allawed 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 *cavered 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, *ca-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 *nan-network out-af-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 aut-af-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**.

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. wellness program
5. 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*.

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 *natification* 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 Administratar* 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 cloims 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 determinotion*. 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 *oppeal* 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 *natify* the *Plan* within thirty (30) days of the date when any *natice* 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 Administratar,* 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, *natices,* 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. Benefits Administrator

   b. Accounting

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 core 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*.

Late Enrollee

A *plan participant* who enrolls under the *Plan* other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the *Plan* or during a special enrollment period.

Leave of Absence

A period of time during which the *employee* does not work, but which is of a stated duration, after which time the *employee* is expected to return to active work.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life-Threatening Disease or Condition

Any *disease* or condition from which the likelihood of death is probable unless the course of the *disease* is interrupted.

Long Term Acute Care Hospitals

Facilities that specialize in the treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures.

Long Term Care

Generally refers to non-medical care for patients who need assistance with basic daily activities such as dressing, bathing, and using the bathroom. Long-term care may be provided at home or in facilities that include nursing homes and assisted livings.

Maintenance Care

Therapy or treatment intended primarily to maintain general physical condition, including, but not limited to routine, long-term, or maintenance care which is provided after the resolution of an acute medical problem. This includes services performed solely to preserve the present level of function or prevent regression for an *illness, injury,* or condition that is resolved or stable.

Mastectomy

The surgical removal of all or part of a breast.

Maximum Amount or Maximum Allowable Charge

The benefit payable for a specific coverage item or benefit under the *Plan*. Maximum allowable charge(s) will be based on one (1) of the following options, depending on the circumstances of the *claim* and at the discretion of the *Plan Administrator*:

1. *network* allowed amount
2. *network non-participating provider* rate
3. the negotiated rate established in a contractual arrangement with a provider
4. the *usual and customary* and/or *reasonable* amount
5. the actual billed charges for the covered services

The maximum allowed amount for emergency care from a *non-network* provider will be determined using the median *Plan network* contract rate paid to *network* providers for the geographic area where the service is provided.

The *Plan* has the discretionary authority to decide if a *charge* is *usual and customary* and/or *reasonable* for a *medically necessary* service. The maximum allowable charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Maximum Benefit

Any one (1) of the following, or any combination of the following:

1. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* during the entire time they are covered by this *Plan*
2. the *maximum amount* paid by this *Plan* for any one (1) *plan participant* for a particular *covered charge*

   The *maximum amount* can be for either of the following:

   a. the entire time the *plan participant* is covered under this *Plan*
   b. a specified period of time, such as a *calendar year*
3. the maximum number as outlined in the *Plan* as a *covered charge*

   The maximum number relates to the number of:

   a. treatments during a specified period of time
   b. days of confinement
   c. visits by a *home health care agency*

Medical Care Facility

A *hospital*, a facility that treats one (1) or more specific ailments, or any type of *skilled nursing facility*.

Medical Child Support Order

Any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that mandates one (1) of the following:

1. provides for child support with respect to a *plan participant's* child or directs the *plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law)
2. enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan

Medical Management Administrator

A team of medical care professionals selected to conduct *pre-certification* review, *emergency* admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the **Health Care Management Program** section of this document.

Medical Non-Emergency Care

Care which can safely and adequately be provided other than in a *hospital*.

Medically Necessary/Medical Necessity

Care and treatment which is recommended or approved by a *physician*; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a *physician* recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder and Nervous Disorders/Substance Use Disorder

Any *disease* or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and *mental health* or *substance use disorder* benefits, such plan or coverage shall ensure all of the following:

1. The financial requirements applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such *mental health* or *substance use disorder* benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the *Plan* (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to *mental health* or *substance use disorder* benefits (if these benefits are covered by the group health *Plan* or health insurance coverage offered in connection with such a plan).

Morbid Obesity

Severity of obesity judged appropriate for procedure, as indicated by one (1) or more of the following:

1. adult patient has BMI of forty (40) or greater
2. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of forty (40) (or 140% of the 95th percentile in age and sex matched growth chart) or greater
3. adult patient has BMI of thirty-five (35) or greater and a clinically serious condition related to obesity (e.g. type 2 diabetes, obesity hypoventilation, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, severe osteoarthritis, difficult to control hypertension)
4. adolescent patient [thirteen (13) to seventeen (17) years of age] has BMI of thirty-five (35) (or 120% of the 95th percentile in an age and sex matched growth chart) or greater and a clinically serious condition related to obesity [e.g. type 2 diabetes, obstructive sleep apnea, nonalcoholic steatohepatitis, pseudotumor cerebri, Blount disease (tibia vara), slipped capital femoral epiphysis]
5. adult patient has BMI of thirty (30) or greater with type 2 diabetes mellitus with inadequately controlled hyperglycemia despite optimal medical treatment (e.g. oral medication, insulin)

Network

An arrangement under which services are provided to *plan participants* through a select group of providers.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile *accidents*.

Non-Network

Services rendered by a *non-participating provider* within the designated *network* area.

Non-Participating Provider

A health care practitioner or health care facility that has not contracted directly with the *Plan*, *network*, or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Notice/Notify/Notification

The delivery or furnishing of information to a *claimant* as required by federal law.

Open Enrollment Period

The annual period during which you and your *dependents* are eligible to enroll for coverage or change benefit plan options.

Other Plan

Shall include but is not limited to:

1. any primary payer besides the *Plan*
2. any other group health plan
3. any other coverage or policy covering the *plan participant*
4. any first-party insurance through medical payment coverage, personal injury protection, *no-fault auto insurance* coverage, uninsured, or underinsured motorist coverage
5. any policy of insurance from any insurance company or guarantor of a responsible party
6. any policy of insurance from any insurance company or guarantor of a third party
7. workers' compensation or other liability insurance company
8. any other source, including, but not limited to, crime victim restitution funds, medical, disability, school insurance coverage, or other benefit payment

Out-of-Network

See *Non-Network*.

Out-of-Pocket Limit

A *Plan's* limit on the amount a *plan participant* must pay out of their own pocket for medical expenses *incurred* during a *calendar year*. Out-of-pocket limits accumulate on an individual, family, or combined basis. After a *plan participant* reaches the out-of-pocket limit, the *Plan* pays benefits at a higher rate.

Outpatient

Treatment including services, supplies, and medicines provided and used at a *hospital* under the direction of a *physician* to a person not admitted as a registered bed patient; or services rendered in a *physician's* office, laboratory, or x-ray facility, an *ambulatory surgical center*, or the patient's home.

Participating Provider

A health care provider or health care facility that has contracted directly with the *Plan* or an entity contracting on behalf of the *Plan* to provide health care services to *plan participants*.

Patient Protection and Affordable Care Act of 2010 (PPACA)

The Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered *prescription drugs* are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

Plan

Kentucky Rural Electric Cooperative Employers Benefit Plan, which is a benefits plan for certain *employees* of Kentucky Rural Electric Cooperative and is described in this document. Kentucky Rural Electric Cooperative Employers Benefit Plan is a distinct entity, separate from the legal entity that is your *employer*.

Plan Administrator

Kentucky Rural Electric Cooperative, which is the named *fiduciary* of the *Plan*, and exercises all discretionary authority and control over the administration of the *Plan* and the management and disposition of *Plan* assets.

Plan Participant/Participant

Any *employee* or *dependent* who is covered under this *Plan*.

Plan Sponsor

Kentucky Rural Electric Cooperative

Post-Service Claim

Any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Tests/Testing

Those *diagnostic services* done prior to scheduled *surgery*, provided that all of the following conditions are met:

1. The tests are approved by both the *hospital* and the *physician*.
2. The tests are performed on an *outpatient* basis prior to *hospital* admission.

3. The tests are performed at the *hospital* into which confinement is scheduled, or at a qualified facility designated by the *physician* who will perform the *surgery*.

Pre-Certification/Pre-Certified

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the *medical necessity* and *reasonableness* of a *plan participant's* course of treatment.

Pregnancy

Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be *medically necessary* in the treatment of an *illness* or *injury*.

Pre-Service Claim

Any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan* (e.g. a request for *pre-certification* under the **Health Care Management Program**).

Preventive Care

Certain preventive services mandated under the *Patient Protection and Affordable Care Act of 2010 (PPACA)* which are available without cost sharing when received from a *network* provider. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**. For more information, you may contact the *Plan Administrator/employer* as outlined in the Quick Reference Information Chart.

Primary Care Physician (PCP)

Family practitioners, general practitioners, pediatricians, internists, OBGYNs, gynecologists, certified nurse midwife, chiropractor, nurse practitioner, physician assistant, and clinical/multi-specialty group.

Prior Plan

The coverage provided on a group or group-type basis by the group insurance policy, benefit plan, or service plan that was terminated on the day before the effective date of the *Plan* and replaced by the *Plan*.

Prior to Effective Date or After Termination Date

Dates occurring before a *plan participant* gains eligibility from the *Plan*, or dates occurring after a *plan participant* loses eligibility from the *Plan*, as well as charges *incurred* prior to the effective date of coverage under the *Plan* or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Psychiatric Hospital

An *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally *ill* persons either by, or under the supervision of, a *physician*.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a psychiatric hospital.
4. It requires that every patient be under the care of a *physician*.
5. It provides twenty-four (24) hour per day nursing service.

The term psychiatric hospital does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care*, or educational care.

Qualified Individual

An individual who is a covered *participant* or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an *approved clinical trial* according to the trial protocol with respect to the treatment of cancer or other *life-threatening disease or condition*; and
2. either:
    a. The referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.
    b. The *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

Qualified Medical Child Support Order (QMCSO)

A *medical child support order* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *plan participant* or eligible *dependent* is entitled under this *Plan*.

Reasonable

In the *Plan Administrator's* discretion, services, supplies, or fees for services or supplies which are necessary for the care and treatment of *illness* or *injury* not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards, and practices as they relate to similar scenarios; and the cause of *injury* or *illness* necessitating the services and/or charges.

This determination will consider, but will not be limited to, the findings and assessments of the following entities:

1. The National Medical Associations, societies, and organizations
2. The Food and Drug Administration

To be reasonable, services and/or fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The *Plan Administrator* retains discretionary authority to determine whether services and/or fees are reasonable based upon information presented to the *Plan Administrator*. A finding of provider negligence and/or malpractice is not required for services and/or fees to be considered not reasonable.

Charges and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the *maximum allowable charge*), when they result from provider error(s) and/or facility-acquired conditions deemed reasonably preventable through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The *Plan* reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the *Plan* and to identify charges and/or services that are not reasonable, and therefore not eligible for payment by the *Plan*.

Rehabilitation Hospital

An *institution* which mainly provides therapeutic and restorative services to *ill* or *injured* people. It is recognized as such if it meets the following criteria:

1. It carries out its stated purpose under all relevant federal, state, and local laws.
2. It is accredited for its stated purpose by either The Joint Commission or the Commission on Accreditation for Rehabilitation Facilities.

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

1. *room, board,* and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured facility-based setting
4. the resources and programming to adequately diagnose, care, and treat a psychiatric and/or substance use disorder
5. facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care

Room and Board

A *hospital's* charge for:

1. room and linen service
2. dietary service, including meals, special diets, and nourishment
3. general nursing service
4. other conditions of occupancy which are *medically necessary*

Security Standards

The final rule implementing HIPAA's security standards for the Protection of Electronic PHI, as amended.

Sickness

See *Disease*.

Skilled Nursing Facility

A facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an *inpatient* basis to persons recovering from an *injury* or *illness*. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a *physician*.
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, *custodial care*, or educational care.

This term also applies to charges *incurred* in a facility referring to itself as an extended acute rehabilitation facility, *long-term acute care facility*, or any other similar nomenclature.

Sound Natural Tooth

A tooth that is stable, functional, free from decay and advanced periodontal *disease*, and in good repair at the time of the *accident*.

Spinal Manipulation/Chiropractic Care

Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder/Mental Health Treatment Center

An *institution* which provides a program for the treatment of *substance use disorder* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be at least one (1) of the following:

1. affiliated with a *hospital* under a contractual agreement with an established system for patient referral
2. accredited as such a facility by The Joint Commission or CARF
3. licensed, certified, or approved as an alcohol or *substance use disorder* treatment program center, *psychiatric hospital*, or *facility* for *mental health* by a state agency having legal authority to do so
4. is a facility operating primarily for the treatment of *substance use disorder* and meets these tests:
    a. maintains permanent and full-time facilities for bed care and full-time confinement of at least twenty-four (24) hour-per-day nursing service by a registered nurse (R.N.)
    b. has a full-time psychiatrist or psychologist on the staff
    c. is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of *substance use disorder*

Substance Use Disorder

The DSM-5 definition is applied as follows: Substance use disorder describes a problematic pattern of using alcohol or another substance (whether obtained legally or illegally) that results in impairment in daily life or noticeable distress. An individual must display two (2) of the following eleven (11) symptoms within twelve (12) months:

1. consuming more alcohol or other substance than originally planned
2. worrying about stopping or consistently failed efforts to control one's use
3. spending a large amount of time using drugs/alcohol, or doing whatever is needed to obtain them
4. use of the substance results in failure to fulfill major role obligations such as at home, work, or school
5. craving the substance (alcohol or drug)
6. continuing the use of a substance despite health problems caused or worsened by it

This can be in the domain of *mental health* (psychological problems may include depressed mood, sleep disturbance, anxiety, or blackouts) or physical health.

7. continuing the use of a substance despite its having negative effects in relationships with others (for example, using even though it leads to fights or despite people's objecting to it)
8. repeated use of the substance in a dangerous situation (for example, when having to operate heavy machinery, when driving a car)
9. giving up or reducing activities in a person's life because of the drug/alcohol use
10. building up a tolerance to the alcohol or drug

    Tolerance is defined by the DSM-5 as either needing to use noticeably larger amounts over time to get the desired effect or noticing less of an effect over time after repeated use of the same amount.
11. experiencing withdrawal symptoms after stopping use

    Withdrawal symptoms typically include, according to the DSM-5: anxiety, irritability, fatigue, nausea/vomiting, hand tremor, or seizure in the case of alcohol.

Surgery/Surgical Procedure

Any of the following:

1. the incision, excision, debridement, or cauterization of any organ or part of the body and the suturing of a wound
2. the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction
3. the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body
4. the induction of artificial pneumothorax and the injection of sclerosing solutions
5. arthrodesis, paracentesis, arthrocentesis, and all injections into the joints or bursa
6. obstetrical delivery and dilatation and curettage
7. biopsy
8. surgical injection

Temporomandibular Joint (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the *Plan*. The Third Party Administrator is not an insurer of health benefits under this *Plan*, is not a *fiduciary* of the *Plan*, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for *Plan* financing and does not guarantee the availability of benefits under this *Plan*.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**. Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability/Totally Disabled

In the case of a *dependent* child, the complete inability, as a result of *injury* or *illness*, to perform the normal activities of a person of like age and sex and in good health.

Uniformed Services

The Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health

Service; and any other category of persons designated by the President of the United States in time of war or *emergency*.

Urgent Care Claim

Any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for *Plan* determination, could seriously jeopardize the *claimant's* life, health, or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *claim*. Whether a *claim* is an urgent care claim will be determined by an individual acting on behalf of the *Plan* applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any *claim* that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the *Plan*. Urgent care claims are a subset of *pre-service claims*.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a *physician* is in attendance at all times that the facility is open, that is engaged primarily in providing minor *emergency* and episodic medical care to a *plan participant*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fees which the provider most frequently charges (or accepts) for the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) 'same geographic locale' and/or 'area' shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term 'usual' refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term 'customary' refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one (1) individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age, and who has received such services or supplies within the same geographic locale.

The term 'usual and customary' does not necessarily mean the actual charge made (or accepted), nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period

An interval of time during which the *employee* is in the continuous, *active employment* of their participating *employer*.

SECTION XXI--PLAN ADOPTION

A. Severability

In the event that any provision of this document is held by a court of competent jurisdiction to be excessive in scope or otherwise invalid or unenforceable, such provision shall be adjusted rather than voided, if possible, so that it is enforceable to the maximum extent possible, and the validity and enforceability of the remaining provisions of this document will not in any way be affected or impaired thereby.

B. Adoption

Kentucky Rural Electric Cooperative, hereby adopts the provisions of this Kentucky Rural Electric Cooperative Employers Benefit Plan, and its duly authorized officer has executed this summary plan description effective the first day of January 2023.

By: Judy McClure Date: _____

Title: Executive Asst. & HR. Director

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

#24

2023

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Group Medicare
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Humana Medicare Employer Plan – Premium Information

BIG SANDY RURAL ELECTRIC - PPO

Date:	8/23/2022
	Humana Medicare Employer Plan
Plan Names:	PASSIVE PPO 079 463 with Standard Rx335
Rx Formulary:	Group Plus Formulary - TBD
Additional Medication Buy-Ups:	$0 Generic Statins
Additional Services Included:	Hearing

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2023 - 12/31/2023	$253.71

PASSIVE PPO 079 463 Medical and Rx Benefit Overview

	(In-Network Benefits match Out-of-Network Benefits)
Deductible	None
Inpatient Acute Hospital	$0 Copayment per Admission
Skilled Nursing Facility	$0 Copayment (Days 1-100)
Physician Office Visits	$0 Copayment
Specialist Office Visits	$0 Copayment
Outpatient Surgical	$0 Copayment
Ambulance	$0 Copayment
Emergency Room	$0 Copayment
Medical Maximum Out of Pocket	$1,000 Combined (Medicare Covered Services)
Prescription Drugs (Retail 30 day supply)	Rx335 $10/$25/$45/20% (Max $100) from $0 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

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Humana Medicare Employer Plan – Rating Assumptions and Stipulations

BIG SANDY RURAL ELECTRIC

Proposal Terms

The benefits presented on the previous page are a high-level summary. Please consult the Plan Design Exhibit for a more detailed outline of the benefits proposed. Final benefits may differ due to annual changes in CMS benefit requirements.

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana will hold the proposed rate(s) unless there are material changes to existing or implementation of new federal regulations or requirements, and/or any unforeseen/unusual circumstances (i.e. pandemic) that would impact Group Medicare.

Humana will hold the proposed rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

All members are retired and enrolled in Medicare Part A and/or Part B.

A minimum average employer contribution level of 76% of the proposed premium for the plan.

A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.

Enrolled membership should not change from current, or differ from the information provided, by more than 10% per year. This proposal assumes 32 currently enrolled members.

Humana's Medicare Advantage plan is the only plan offered and there is no additional secondary plan wrapping around or offered in conjunction with this plan for all current and future Medicare eligible retirees.

Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.

Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy TrOOP accumulators will be reset on January 1 each year.

We are pleased to present this Humana Group Medicare Advantage proposal to you and assume all information provided is accurate with the understanding if there is a material change from the current offering environment, Humana has the right to revise or rescind the quote.

Humana
Group Medicare
Advantage

HUMANA MEDICARE EMPLOYER LPPO PLAN

2023 LPPO for Standard Plan 079 Option 463 - Passive

		2022		2023	
Annual Maximum Out-of-Pocket		• In-Network: $1,000 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Chiropractic Services (Routine), Hearing Services (Routine), Private Duty Nursing, Wigs (medically necessary), Extra Services and the Plan Premium). • Combined In and Out-of-Network: $1,000 per individual per plan year (excludes Part D Pharmacy, COVID-19 Testing, COVID-19 Treatment, Chiropractic Services (Routine), Hearing Services (Routine), Private Duty Nursing, Wigs (medically necessary), Extra Services, Worldwide Coverage and the Plan Premium).		• In-Network: $0 per individual per plan year (excludes Part D Pharmacy, Chiropractic Services (Routine), Hearing Services (Routine), Private Duty Nursing, Wigs (medically necessary), Extra Services and the Plan Premium). • Combined In and Out-of-Network: $0 per individual per plan year (excludes Part D Pharmacy, Chiropractic Services (Routine), Hearing Services (Routine), Private Duty Nursing, Wigs (medically necessary), Extra Services, Worldwide Coverage and the Plan Premium).
Annual Deductible		• Combined In and Out-of-Network: NONE • Combined In-Network Exclusions: N/A • Combined Out-of-Network Exclusions: N/A		• Combined In and Out-of-Network: NONE • Combined In-Network Exclusions: N/A • Combined Out-of-Network Exclusions: N/A	
Place of Treatment	Benefit	Network Coverage Plan Pays (1):	Non-Network Coverage Plan Pays (1):	Network Coverage Plan Pays (1):	Non-Network Coverage Plan Pays (1):
Primary Care Physician	• Office Visit	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Surgical Procedures	100%	100%	100%	100%
	• Allergy Shots and Injections	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%	100%	100%
Specialist	• Office Visit	100%	100%	100%	100%
	• Advanced Imaging Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Surgical Procedures	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
	• Podiatry Services (Medicare-covered)	100%	100%	100%	100%
	• Chiropractic Services (Medicare-covered)	100%	100%	100%	100%
	• Cardiac Therapy	100%	100%	100%	100%
	• Supervised Exercise Therapy (SET) Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%	100%	100%
	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
	• Allergy Shots and Injections	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
	• Administration of Drugs in a Physician's Office	100%	100%	100%	100%
	• Chemotherapy Drugs	100%	100%	100%	100%
	• Dental Services (Medicare-covered)	100%	100%	100%	100%
	• Hearing Services (Medicare-covered)	100%	100%	100%	100%
	• Vision Services (Medicare-covered)	100%	100%	100%	100%
	• Eyewear for Post-Cataract Surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery	100% •for eyeglasses and contacts following cataract surgery
	• Diabetic Eye Exam	100%	100%	100%	100%
	• Acupuncture (Medicare-covered) • Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. • Limited to 20 combined visit(s) per year	100%	100%	100%	100%

Humana. Group Medicare Advantage

Preventive Services	• Abdominal Aortic Aneurysm Screening • Alcohol Misuse Screening and Counseling • Annual Wellness Visit • Bone Mass Measurement • Breast Cancer Screening • Cardiovascular Disease Behavioral Therapy • Cardiovascular Disease Screening • Cervical and Vaginal Cancer Screening • Colorectal Cancer Screening • Depression Screening • Diabetes Screening • Diabetes Self-Management Training • Glaucoma Screening • Hepatitis C Screening • HIV Screening • Kidney Disease Education Services • Immunizations • Lung Cancer Screening • Medicare Diabetes Prevention Program • Medical Nutrition Therapy • Obesity Screening and Therapy • Physical Exams (Routine) • Prostate Cancer Screening Exam • Smoking and Tobacco Use Cessation • STI Screening and Counseling • "Welcome to Medicare" Preventive Visit	100%	100%	100%	100%
Inpatient Hospital Services	• Inpatient Care (All Authorized Admissions)	100% per admission	100% per admission	100% per admission	100% per admission
	• Inpatient Physician Services	100%	100%	100%	100%
	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission	100% per admission	100% per admission	100% per admission
Inpatient Psychiatric Facility	• Inpatient Mental Health Care/Substance Abuse Services (All Authorized Admissions)	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility	100% per admission •190 day lifetime limit in a psychiatric facility
	• Inpatient Mental Health/Substance Abuse Physician Services	100%	100%	100%	100%
Partial Hospitalization	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
Outpatient Hospital	• Surgical Services	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
	• Advanced Imaging Services	100%	100%	100%	100%
	• Nuclear Medicine Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
	• Cardiac Therapy	100%	100%	100%	100%
	• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services	100%	100%	100%	100%
	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
	• Chemotherapy Drugs	100%	100%	100%	100%
	• Renal Dialysis Services	100%	100%	100%	100%
	• Mental Health/Substance Abuse Services	100%	100%	100%	100%
	• Opioid Treatment Services	100%	100%	100%	100%
	• Outpatient Physician Services	100%	100%	100%	100%
Skilled Nursing Facility (SNF)	• SNF Care (no 3 day hospital stay is required)	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days	100% per day (days 1-100) •Plan pays $0 after 100 days
	• SNF Physician Services	100%	100%	100%	100%
Urgent Care Center	• Urgently Needed Care	100%	100%	100%	100%
	• Lab Services	100%	100%	100%	100%
Emergency Room	• Emergency Services (2)	100%	100%	100%	100%
	• Emergency Room Physician Services	100%	100%	100%	100%
Ambulance	• Ambulance Services	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation	100% per date of service •Limited to Medicare-covered transportation

Humana Group Medicare Advantage

Travel Benefit	• US Travel Benefit	Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	N/A	Member receives in-network benefit when services are received from a participating PPO provider in another Humana PPO service area.	N/A
Worldwide Coverage	• Emergency Services and Urgently Needed Care Only	N/A	80% coinsurance limited to emergency Medicare-covered services. $100 deductible per year, $25,000 Maximum Benefit per year or 60 consecutive days, whichever is reached first.	N/A	80% coinsurance limited to emergency Medicare-covered services. $100 deductible per year, $25,000 Maximum Benefit per year or 60 consecutive days, whichever is reached first.
Comprehensive Outpatient Rehabilitation Facility	• Pulmonary Therapy	100%	100%	100%	100%
	• Therapies (Occupational, Physical, Audiology, and Speech)	100%	100%	100%	100%
Freestanding Radiological Facility	• Advanced Imaging Services	100%	100%	100%	100%
	• Nuclear Medicine Services	100%	100%	100%	100%
	• Diagnostic Procedures and Tests	100%	100%	100%	100%
	• Radiation Therapy	100%	100%	100%	100%
Ambulatory Surgical Center	• Surgical Procedures	100%	100%	100%	100%
	• Diagnostic Colonoscopy	100%	100%	100%	100%
Freestanding Laboratory	• Lab Services	100%	100%	100%	100%
Dialysis Center	• Renal Dialysis Services	100%	100%	100%	100%
Home Health	• Home Health Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care	100% •excludes Personal Home Care
DME Provider	• Durable Medical Equipment	100%	100%	100%	100%
	• Diabetic Monitoring Supplies	100%	100%	100%	100%
Medical Supply Provider	• Medical Supplies	100%	100%	100%	100%
Prosthetics Provider	• Prosthetics	100%	100%	100%	100%
Pharmacy (Part B Only)	• Durable Medical Equipment	100%	100%	100%	100%
	• Medical Supplies	100%	100%	100%	100%
	• Diabetic Monitoring Supplies	100%	100%	100%	100%
	• Medicare-covered Part B Drugs	100%	100%	100%	100%
Additional Telehealth Services	• Primary Care Physician - Virtual Visit	100%	N/A	100%	N/A
	• Specialist - Virtual Visit	100%	N/A	100%	N/A
	• Behavioral Health and Substance Abuse - Virtual Visit	100%	N/A	100%	N/A
	• Urgently Needed Care - Virtual Visit	100%	N/A	100%	N/A
Other Benefits	• COVID-19 Testing and Treatment - Based on Place of Treatment (POT)	•100%	•100%	•Available	•Available
	• Chiropractic Services (Routine)	•100%	•100%	•100%	•100%
	• Hearing Services (Routine)	•$2,000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. - HER872	•$2,000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. - HER872	•$2,000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. - HER872	•$2,000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. •Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. - HER872
	• Private Duty Nursing (Member's Home)	•90%	•90%	•90%	•90%
	• Private Duty Nursing (Inpatient)	•90%	•90%	•90%	•90%
	• Wigs (Medically Necessary) (Prosthetics Provider) • $300 combined In & Out-of-Network maximum benefit coverage amount per year	•100%	•100%	•100%	•100%
	• Wigs (Medically Necessary) (Durable Medical Equipment) • $300 combined In & Out-of-Network maximum benefit coverage amount per year	•100%	•100%	•100%	•100%

Humana. Group Medicare Advantage.

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor.			
Extra Benefits (MSB)	• SilverSneakers®	Available	Available
	• Personal Health Coaching	Available	Available
	• Smoking Cessation (Additional)	Available	Available
	• Meal Program	Available	Available
	• Post-Discharge Transportation Services	Available	Available
	• Post-Discharge Personal Home Care	Available	Available
Care Management	• **Clinical Programs/Disease Management (3)** *- Case Management* *- Humana at Home®* *- Chronic Condition Management* *- Transplant Management* *- Behavioral Health Care Coordination*	Available	Available

(1) All coinsurance percentages are based on the Medicare fee schedule and not billed charges. All copayments are on a 'per visit' basis, unless otherwise noted.
(2) Emergency room copayment waived if admitted or if hospital is outside the U.S.
(3) We have provided examples of various Health Education and clinical programs. Actual programs may vary by market.
2023 COVID-19 Testing and Treatment Update: Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.

Humana Group Medicare Advantage

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Extra Services (VAIS)	• Complementary and Alternative Medicine and Weight Management - Not available in Puerto Rico	Available	Available
	• Dental Discount (Florida GoldPlus) - Available in Florida only	Available	Available
	• Dental Discount (HumanaDental) - Not available in Florida or Puerto Rico	Available	Available
	• Healthy Hearing Discount (HearUSA) - Available in Florida only	Available	Available
	• Hearing Discount (TruHearing) - Not available in Florida or Puerto Rico	Available	Available
	• Lifeline® Medical Alert Systems	Available	Available
	• Meal Delivery Discount (Freshly) - Not available in Alaska, Hawaii or Puerto Rico	Not Available	Available
	• Meal Delivery Discount (Mom's Meals)	Available	Available
	• Bill Management Service (Silver Bills)	Not Available	Available
	• Vision Discount (EyeMed)	Available	Available

Go365® by Humana is included in this plan:

Go365 is a wellness program that rewards Medicare beneficiaries for completing eligible healthy activities that help them establish and maintain a healthy lifestyle. As they achieve manageable health goals, Go365 keeps members engaged and motivated by acknowledging their efforts. By completing healthy activities like walking, getting and Annual Wellness Exam, or volunteering, members earn rewards they can redeem for gift cards in the Go365 Mall.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. Certain services under the plan require authorization by network providers. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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Group Medicare
Advantage

HUMANA MEDICARE EMPLOYER Rx PLAN

2023 Rx for Standard Plan Rx 335
Group Plus Formulary - PDG 2

30 day Supplies

Plan/ Option	30 day Standard Retail from $0 to Catastrophic (1)				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$25	$45	20% ($100 maximum out-of-pocket per prescription)	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($100 maximum out-of-pocket per prescription)	$7,400

Plan/ Option	30 day Standard Mail Order from $0 to Catastrophic (1)				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$10	$25	$45	20% ($100 maximum out-of-pocket per prescription)	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($100 maximum out-of-pocket per prescription)	$7,400

**** Generic Statins are covered at 100% ****
*Tier 1: Generic or Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

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90 day Supplies

Plan/ Option	90 day Standard Retail (2) from $0 to Catastrophic (1)				90 day Standard Retail (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$20	$50	$90	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($90 maximum out-of-pocket per prescription)	$7,400

Plan/ Option	90 day Standard Mail Order (2) from $0 to Catastrophic (1)				90 day Standard Mail Order (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
000/000	$20	$50	$90	N/A	Member pays the greater of $4.15 for generic/preferred multi-source drugs/biosimilars and $10.35 for all other drugs; OR 5% coinsurance ($90 maximum out-of-pocket per prescription)	$7,400

**** Generic Statins are covered at 100% ****

Footnotes

1 Catastrophic: When a member's True Out Of Pocket (TrOOP) cost reaches $7,400.

2 Retail and Mail Order: Retail and Mail Order benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:

a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,

b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price, not to include maximums.

Humana Group Medicare Advantage

Extra Services

The benefit and discount information presented here are current as of the date of this document. If a change should occur prior to implementation, Humana will clarify any change and notify the group sponsor. The products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services should be addressed with Customer Care by calling the number on the back of your Humana membership card.
CMS does not permit discussing the below services with potential enrollees prior to enrollment.

Prescription Medication Discount	Members show their Humana member ID card at participating pharmacies when they buy non-covered prescription medicines to receive any available discounts. Depending on the medicine purchased, quantity limits may apply.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premiums and/or member cost-share may change each year. The formulary and pharmacy network may change at any time. You will receive notice when necessary. Please refer to the Evidence of Coverage for additional information regarding covered services and limitations or any other contractual conditions. For a complete description of benefits, exclusions and limitations please refer to the actual Evidence of Coverage. If a discrepancy arises between this information and the actual Evidence of Coverage, the Evidence of Coverage will prevail in all instances.

Humana is a Medicare Employer Prescription Drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

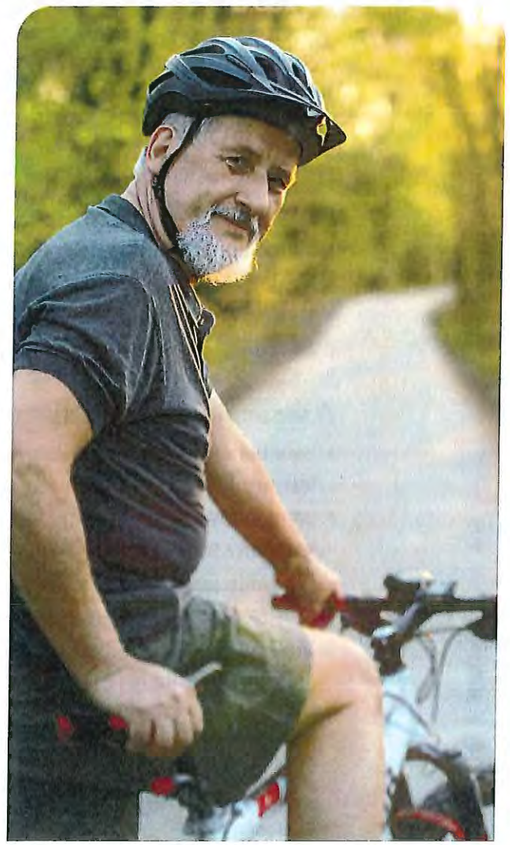
Group Medicare Advantage plan guide

Understonding your Medicare plan and how it works is important. Your healthcare plan should help you on your journey to better health, which may help you achieve the retirement you want—so you can spend more time doing what you love most.

Inside this guide you'll find:

Plan specific information

- Medical Summary of Benefits
- Hearing Benefits
- Rx Summary of Benefits
- Enrollment Form



Humana.

Get the hassle-free care you deserve

Humana Medicare Advantage PPO with prescription drug plan offers you:

- All the benefits of Original Medicare, plus extra benefits
- Maximum out-of-pocket protections
- Worldwide emergency coverage
- Programs to help improve health and well-being

A dedicated team and more...

- Your benefit levels are the same for in-network and out-of-network providers
- Large network of providers, specialists and hospitals to pick from
- You don't need a referral to see any healthcare provider
- Coverage for office visits, including routine physical exams
- Almost no claim forms to fill out or mail—we take care of that for you
- Dedicated Customer Care specialists who serve only our Group Medicare members

Welcome to a more human way to healthcare

Take action to enroll

Dear Group Medicare Beneficiary,

We're excited to let you know that **Big Sandy RECC** has asked Humana to offer you a Medicare Advantage and Prescription Drug Plan that gives you more benefits than Original Medicare.

Your health is more important than ever. That's why Humana has a variety of tools, programs and resources to help you stay on track. At Humana, helping you achieve lifelong well-being is our mission. During our over 30 years of experience with Medicare, we've learned how to be a better partner in health.

Get to know your plan
Review the enclosed materials. This packet includes information on your Group Medicare healthcare option along with extra services Humana provides.

- If you have questions about your premium or need help, please call our dedicated Group Medicare Customer Core representatives at **866-396-8810 (TTY: 711),** Monday - Friday, 8 a.m. – 9 p.m., Eastern time.
- Go to **Humana.com**, "Member Resources" and select "Humana Drug List" then scroll to "Required Fields" to find a list of drugs covered by your Humana Group Medicare plan. For **Rx 335** choose **GRP 2**.
- Use Humana's Find a doctor tool at **Humana.com/FindaDoctor** for a list of network providers.

Enrollment Information
- To begin your Humana coverage, please enroll before your effective date by filling out the enrollment form in the back of this book and mailing it to:
  Big Sandy Rural Electric Cooperative
  Attn: Judy McClure
  504 11TH St
  Paintsville, KY 41240-1422
- You must complete a separate application for each family member eligible for your plan.
- Please keep a copy of your application for your records.

What to expect after you enroll

- **Enrollment confirmation**
  You'll receive a letter from Humana once the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment.
- **Humana member ID card**
  Your Humana member ID card will arrive in the mail shortly after you enroll.

- continued on next page

- **Evidence of Coverage (EOC)**
  You will receive information on how to view or request a copy of an Evidence of Coverage document (also known as a member contract or subscriber agreement). Please read the document to learn about the plan's coverage and services. This will also include your privacy notice.
- **Take your Medicare Health Assessment**
  CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment.

  It's nine simple questions about your health. Your answers will help us guide you to tools and resources available to help you reach your health goals. The information you provide will not affect your plan premiums or benefits or what you pay for them.

  Once you have received your Humana member ID card or after your plan is effective, you can call our automated voice service anytime to take this survey at **888-445-3389 (TTY: 711)**. When you call, you'll be asked to provide your eight-digit member ID number located on the front of your Humana member ID card, so have your ID card handy.

  You may also take the survey online at **MyHumana.com** after activating your online account.
- **In-home Health and Well-being Assessment (IHWA)**
  This is a yearly detailed health review conducted in the comfort of your home, providing an extra set of eyes and ears for your doctor so you can feel more in control of your health and well-being.

  You may receive a call from one of our IHWA vendors, Signify Health or Matrix Medical Network, to schedule your assessment. If you have questions, you may ask when they call, or contact Humana at the phone number listed on the back of your member ID card.

We look forward to serving you now and for many years to come.

Sincerely,
Group Medicare Operations

Your health at your fingertips with MyHumana

Get your personalized health information on MyHumana

A valuable part of your Humana plan is a secure online accaunt called MyHumana where you can keep track of your claims and benefits, find providers, view important plan documents and more.

Get the most out of MyHumana by keeping your account profile up to date. Whether you prefer using a desktop, laptop, or smartphone, you can access your account anytime.*

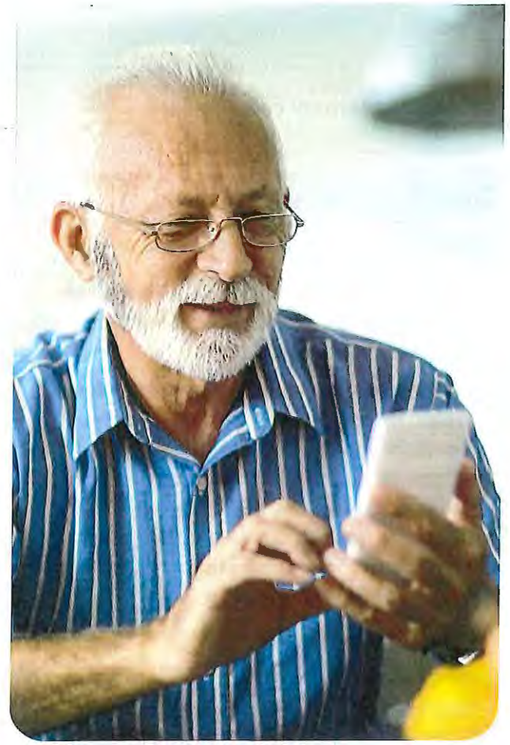
Getting started is easy—just have your Humana member ID card ready and follow these three steps:

1. **Create your account.**
   Visit **Humana.com/registration** and select the "Start activation now" button.

2. **Choose your preferences.**
   The first time you sign into your MyHumana account, be sure to choose how you want to receive information from us—online or mailed to your home. You can update your communication preferences at any time.

3. **View your plan benefits.**
   After you set up your account, be sure to view your plan documents so you understand your benefits and costs. You can also update your member profile if your contact information has changed.

*Standard data rates may apply.



The MyHumana mobile app

If you have an iPhone or Android, download the MyHumana mobile app. You'll have your plan details with you at all times.*

Visit **Humana.com/mobile-apps** to learn about our many mobile opps, the app features and how to use them.

With MyHumana and the MyHumana mobile app, you can:

- Review your plan benefits and claims
- Find pharmacies in your network
- Find providers in your network
- Lookup and compare medication prices
- View or update your medication list
- View or print your Humana member ID card

Have questions?

If you need help using MyHumana, try our Chat feature or call Customer Care at the number listed on the back of your Humana member ID card.

Building healthy provider relationships

Having a relationship with your primary care provider (PCP) is an important step in protecting and managing your health.

With the Humana Group Medicare PPO plan, you can use any provider who is part of our network, or you can use any provider who accepts Medicare and agrees to bill Humana. Your benefit plan coverage remains the same, even if you receive care from an out-of-network provider. For more information, refer to your Summary of Benefits located in this packet.

Why choose a Humana network provider?

- Your PCP will get to know your overall health history and can guide you toward preventive care to help you be healthy and active.
- Your plan doesn't require referrals to see other providers, but your PCP can help guide you when you need specialized care.
- Humana Medicare PPO network providers must take payment from Humana for treating plan members.
- Network providers coordinate with Humana, which makes it easier to share information. Patients may have a better experience when providers share information this way.
- Humana supplies in-network providers with information about services and programs available to patients with chronic conditions.

Is your healthcare provider in Humana's provider network?

If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory at **Humana.com/Findadoctor**. You can also find a complete list of network providers and pharmacies at MyHumana, your personal, secure online account at **MyHumana.com** or on the MyHumana mobile app (standard data rates may apply).

Medical preauthorization

For certain services and procedures, your provider or hospital may need to get advance approval from Humana before your plan will cover any costs. This is called prior authorization or preauthorization. Providers or hospitals will submit the preauthorization request to Humana. If your provider hasn't done this, please call our Customer Care team, as Humana may not be able to pay for these services.

Use Humana's Find a Doctor tool to search for a provider near you

Choosing a doctor or healthcare facility is an important decision. You can use Humana's Find a Doctor tool to search for an in-network provider near you.

1. Go to **Humana.com/FindaDoctor**.

2. **Find a doctor or pharmacy**
   Use the tabs to help you search for a doctor or pharmacy.

3. **Location**
   Enter a ZIP code and the distance radius you want to search.

4. **Options**
   Select a lookup method from 3 options:
   1) Coverage type—choose Medicare or Medicare-Medicaid then select the network that represents your plan,
   2) Member ID, or
   3) Sign in to MyHumana for more accurate results in finding your network.

5. **Select the "Search" button for your results**
   Have you found the doctor or facility that you're looking for? If you need to revise your search, you can search again without leaving the results page.

Find a doctor on the MyHumana mobile app

Once you are enrolled with Humana, you can use the MyHumana mobile app to find a provider near you. On the app dashboard, locate the "Find Care" section.

Call our Customer Care team at **866-396-8810 (TTY: 711)**, Monday – Friday, 8 a.m. – 9 p.m., Eastern time.

Telehealth visits are available through your Humana plan

The doctor is in, even if you can't or don't want to go into an office. Telehealth visits allow you to get nonemergency medical care or behavioral healthcare through your phone,* tablet or computer.†

Virtual care where you're most comfortable

Telehealth could be used for chronic condition management, follow-up care after an in-office visit, medication reviews and refills, and much more—just like an in-office visit.

When should I use it? For a nonemergency issue, instead of going to the emergency room (ER) or an urgent care center.

Ask your trusted provider if they offer telehealth visits and if so, what you need to do to get started. If you don't have a primary care provider or if your PCP doesn't offer virtual visits, you can use the "Find a doctor" tool on **Humana.com** or call the number on the back of your member ID card to get connected with a provider that offers this service.

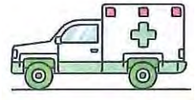
Connect with someone who cares

Use telehealth services to connect with a licensed behavioral health specialist. These providers are available when you may need them to caach you through many of life's challenges. These providers can:

- Discuss healthy ways you can deal with stress, anxiety or sadness
- Listen without judgment as you talk about your life, relationships and feelings
- Help you set and meet behavioral and emotional goals
- Assist you in developing strategies for living a fuller, healthier life

Ask your trusted provider about any virtual behavioral health options they may offer. One option is Array, a national in-network virtual behavioral health provider. Visit **Arraybc.com/patients/Humana** or call **888-410-0405 (TTY: 711)** to learn more.

Delivering the care you need securely, conveniently and on your terms—that's human care.



Remember, when you have a life-threatening injury or major trauma, call 911.

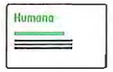
*Depending on the initial consultation, video may be required for telehealth visits.
†Standard data rates may apply.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any description of when to use telehealth services is for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

Having a provider you're happy with can play an important role in your health and meeting your needs

If your healthcare provider says they do not accept Humana insurance, give them this flyer.

Once you are a member of the Humana Group Medicare Preferred Provider Organization (PPO) plan, sharing this information can help your provider understand how this plan works.



Don't forget to take your Humana member ID card to your first appointment.

A message for your provider

Humana will provide coverage for this retiree under a Group Medicare PPO plan. The in-network and out-of-network benefits are structured the same for any member of this plan. This means you can provide services to this retiree or any member of this plan if you are a provider who is eligible to participate in Medicare.

Contracted healthcare providers

If you're a Humana Medicare Employer PPO-contracted healthcare provider, you'll receive your contracted rate.

Out-of-network healthcare providers

Humana is dedicated to an easy transition. If you're a provider who is eligible to participate in Medicare, you can treat and receive payment for your Humana-covered patients who have this plan. Humana pays providers according to the Original Medicare fee schedule less any member plan responsibility.

Claims process

If you need more information about our claims processes or about becoming a Humana Medicare Employer PPO-contracted provider, call Provider Relations at **800-626-2741**, Monday – Friday, 9 a.m. – 6 p.m., Eastern time. **This number is not for patient use.**

Patients, please call the Group Medicare Customer Care number on the back of your Humana member ID card.

Humana.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **866-396-8810 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (聽障專線：711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

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Medicare Part D prescription medication tiers

Tier 1 – Generic or preferred generic

Essentially the same medications, usually priced differently

Have the same active ingredients as brand-name medications and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic medications to have the same quality, strength, purity and stability as brand-name medications. Your cost for generic medications is usually lower than your cost for brand-name medications.

Tier 2 – Preferred brand

A medication available to you for less than a nonpreferred

Generic or brand-name medications that Humana offers at a lower cost to you than nonpreferred medications.

Tier 3 – Nonpreferred medication

A more expensive medication than a preferred

More expensive generic or brand-name prescription medications that Humana offers at a higher cost to you than preferred medications.

Tier 4 – Specialty

Medications for specific uses

Some injectable and other high-cost medications to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

Important information about your prescription medication coverage

Some medications covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits or step therapy. You can visit **Humana.com** to register or sign in and select Pharmacy or call Humana's Group Medicare Customer Care team to check coverage on the medications you take.

Prior authorization

The Humana Group Medicare Plan requires you or your provider to get prior authorization for certain medications. This means that you will need to get approval from the Humana Group Medicare Plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your provider when a prior authorization is required. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

Quantity limits

For some medications, the Humana Group Medicare Plan limits the quantity of the medication that is covered. The Humana Group Medicare Plan might limit how many refills you can get or quantity of a medication you can get each time you fill your prescription. Specialty medications are limited to a 30-day supply regardless of tier placement.

One-time transition fill

For certain medications typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered medication during the first 90 days of your enrollment. Once you have received the transition fill* for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medications should be tried if the medication requires step therapy.

*Some medications do not qualify for a transitional fill, such as medications that require a Part B vs D determination, CMS Excluded medications, or those that require a diagnosis review to determine coverage.

Step therapy

In some cases, the Humana Group Medicare Plan requires that you first try certain medications to treat your medical condition before coverage is available for a more expensive medication prescribed to treat your medical condition.

Next steps for you

1. Visit **Humana.com/Pharmacy** to view your prescription drug guide. The prescription drug guide will provide information on quantity limits, step therapy or if a prior authorization is required. If you have additional questions, please call our Customer Care number on the back of your Humana member ID card.
2. Talk to your provider about your medications if they require prior authorization, have quantity limits or if step therapy is needed.

Next steps for your provider

1. Go online to **Humana.com/Provider** and visit our provider prior authorization page. This page has a printable form that can be mailed or faxed to Humana.
2. Call **800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

How to find the list of medications covered by your Humana Group Medicare plan

View the most complete and current Drug Guide information online.

Humana's Drug List, also called "formulary," lists the most widely prescribed medications covered by Humana and is updated regularly by doctors and pharmacists in our medical committee. Updates to this year's formulary are posted monthly. New medications are added as needed, and medications that are deemed unsafe by the Food and Drug Administration (FDA) or a drug's manufacturer are immediately removed. We will communicate changes to the Drug List to members based on the Drug List notification requirements established by each state.

If a specific medication you need is not on the list, please call the Customer Care number on the back of your Humana member ID card.

To find a list of drugs, use the GRP# provided within the Welcome Letter.

- Go to **Humana.com**
- Hover over the tab, **"Member Resources"** and then select **"Humana Drug List"**
- Scroll to **"Required Fields"**, from the **"Select plan type"** choose **Group Medicare** in the drop-down menu, select **"plan year"** and then select the **"Find Drug Guide"** button
- Scroll and locate your GRP # within the drug list

You can print out the full list of drugs covered under your Humana plan, called the Prescription Drug Guide. (You must have Adobe Reader to view and print these documents.)

CenterWell Pharmacy

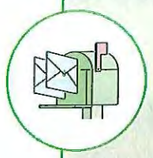
You have the choice of pharmacies for prescription retail and mail order services, CenterWell Pharmacy™ is one option.*

Online

After you become a Humana member, you can sign in to **CenterWellPharmacy.com** with your MyHumana identification number and start a new prescription, order refills or check on an order.

Provider

Your provider can send prescriptions electranically through e-prescribe or by downloading the fax form from **CenterWellPharmacy.com/forms** and faxing the prescriptian to CenterWell Pharmacy at **800-379-7617** or CenterWell Specialty Pharmacy™ at **877-405-7940**.



Mail

Download the "Registration & Prescription Order Form" from **CenterWellPharmacy.com/forms** and mail your paper prescriptions to: CenterWell Pharmacy, P.O. Box 745099, Cincinnati, OH 45274-5099

Phone

For maintenance medication(s), call CenterWell Pharmacy at **800-379-0092 (TTY: 711)**, Mon. – Fri., 8 a.m. – 11 p.m., and Sat., 8 a.m. – 6:30 p.m., Eastern time.

For specialty medication(s), call CenterWell Specialty Pharmacy at **800-486-2668 (TTY: 711)**, Mon. – Fri., 8 a.m. – 11 p.m., and Sat., 8 a.m. – 6:30 p.m., Eastern time.

*Other pharmacies are available in the network.

Where you get your vaccines may determine how it is covered

Medicare Part B vaccines

The Medicare Part B portion of your plan covers vaccines administered at your provider's office if the vaccine is directly related to the treatment of an injury or direct exposure to a disease or condition, such as hepatitis B, rabies, and tetanus.

The following Medicare Part B vaccines may be obtained at your provider's office or are readily available at a network pharmacy: influenza (flu), pneumococcal, and COVID-19 vaccine and boosters.

Medicare Part D vaccines

The Medicare Part D portion of your plan covers vaccines that are considered necessary to help prevent illness. Some common vaccines that you should get at your pharmacy, not from your provider, include shingles, Tdap and hepatitis A.

Diabetes coverage

Medicare Part B

Part B covers certain preventive services for people at risk for diabetes. You must have Part B to get the services and supplies it covers, like:

- diabetic testing supplies
- insulin pumps*
- continuous glucose monitors (CGM)*
- insulin administered (or used) in insulin pumps

Medicare Part D

Part D typically covers diabetes supplies used to administer insulin. You must be enrolled in a Medicare drug plan to get the supplies Part D covers, like:

- diabetes medications
- insulin administered (or used) with syringes or pens
- syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g., Omnipod or VGO)

Diabetic testing supplies

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucase testing supplies. The following meters along with their test strips and lancets are covered at $0 through CenterWell Pharmacy™.

- CenterWell TRUE METRIX® AIR by Trividia
- Accu-Chek Guide Me® by Roche
- Accu-Chek Guide® by Roche

To order a meter and supplies from CenterWell Pharmacy, call **888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Sat., 8 a.m. – 6:30 p.m., Eastern time.

Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can also request a no-cost meter from the manufacturer by calling Roche at **877-264-7263 (TTY: 711)**, or Trividia Health at **866-788-9618 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Enhanced vaccine and insulin coverage

Part B

Part B medications: Some Medicare members may see lower out-of-pocket costs for certain Part B medications as determined by CMS.

$35 insulin copay: Members who administer insulin via an insulin pump will pay **no more than $35** for every one-month (up to a 30-day) supply. If your plan has a deductible, the deductible does not apply to Part B insulin.

Part D

$0 vaccines: Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list† will be **$0**.

$35 insulin copay: Member cost share of this plan's covered Part D insulin products will be **no more than $35** for every one-month (up to a 30-day) supply.

Giving you **support** with **less stress** matters to us, because when your plan gives you **peace of mind**, you're free to **put yourself, and your health, first.**

*CGMs are available through participating retail pharmacies. In addition, CGMs and Insulin pumps are available through our preferred durable medical equipment vendors, CCS Medical, 877-531-7959 or Edwards Healthcare, 888-344-3434.

†For more information regarding the Centers for Disease Control and Prevention's ACIP vaccine recommendations, please go to www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html.

Your personalized benefits statement

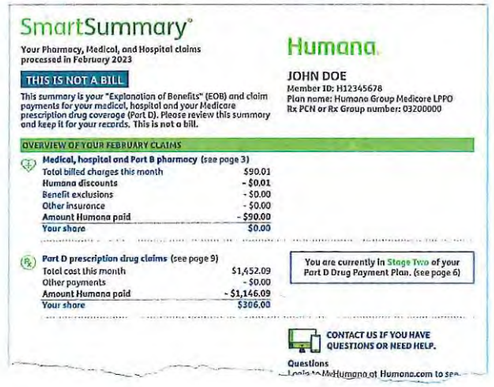
Humana's SmartSummary provides a comprehensive overview of your health benefits and healthcare spending. **You'll receive this statement after each month you've had a claim processed.** You can also sign in to your MyHumana account and see your past SmartSummary statements anytime.

SmartSummary helps you:

- Understand your total healthcare picture
- Manage your monthly and yearly healthcare costs
- Engage with your providers by having a list of the healthcare services you receive
- Learn about preventive care, health conditions, treatment options and ways to help reduce health expenses

SmartSummary includes:

- **Numbers to watch.** SmartSummary shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- **Personalized messages.** SmartSummary gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- **Your prescription details.** A personalized prescription section tells you more about your prescription medications, including information about dosage and the pharmacy provider. This page can be useful to take to your provider appointments or to your pharmacist.
- **Information relevant for you.** SmartSummary personalizes an informational section with tips on topics that may be helpful for your health.


SmartSummary®

Your Pharmacy, Medical, and Hospital claims processed in February 2023

Humana.

THIS IS NOT A BILL

This summary is your "Explanation of Benefits" (EOB) and claim payments for your medical, hospital and your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. This is not a bill.

JOHN DOE
Member ID: H12345678
Plan name: Humana Group Medicare LPPO
Rx PCN or Rx Group number: 03200000

OVERVIEW OF YOUR FEBRUARY CLAIMS

Medical, hospital and Part B pharmacy (see page 3)

Total billed charges this month	$90.01
Humana discounts	- $0.01
Benefit exclusions	- $0.00
Other insurance	- $0.00
Amount Humana paid	- $90.00
Your share	$0.00

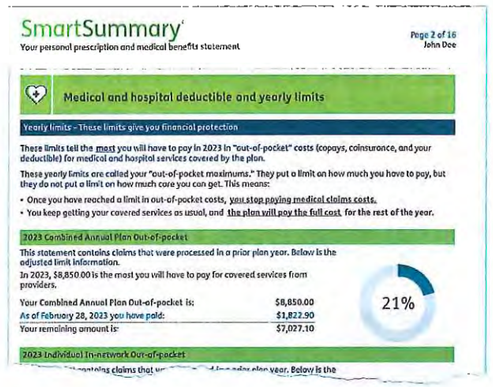
Part D prescription drug claims (see page 9)

Total cost this month	$1,452.09
Other payments	- $0.00
Amount Humana paid	- $1,146.09
Your share	$306.00

You are currently in Stage Two of your Part D Drug Payment Plan. (see page 6)

CONTACT US IF YOU HAVE QUESTIONS OR NEED HELP.

Questions


SmartSummary®

Your personal prescription and medical benefits statement

Page 2 of 16
John Doe

Medical and hospital deductible and yearly limits

Yearly limits – These limits give you financial protection

These limits tell the most you will have to pay in 2023 in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan.

These yearly limits are called your "out-of-pocket maximums." They put a limit on how much you have to pay, but they do not put a limit on how much care you can get. This means:

- Once you have reached a limit in out-of-pocket costs, you stop paying medical claims costs.
- You keep getting your covered services as usual, and the plan will pay the full cost for the rest of the year.

2023 Combined Annual Plan Out-of-pocket

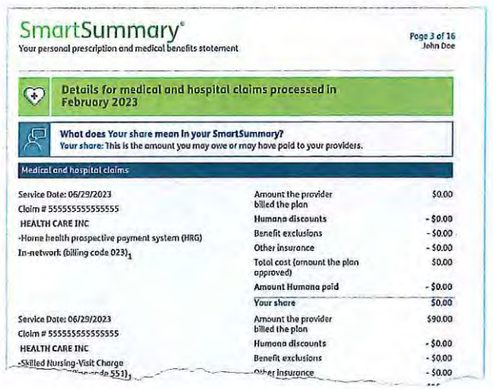
This statement contains claims that were processed in a prior plan year. Below is the adjusted limit information.

In 2023, $8,850.00 is the most you will have to pay for covered services from providers.

Your Combined Annual Plan Out-of-pocket is:	$8,850.00
As of February 28, 2023 you have paid:	$1,822.90
Your remaining amount is:	$7,027.10

21%

2023 Individual In-network Out-of-pocket


SmartSummary®

Your personal prescription and medical benefits statement

Page 3 of 16
John Doe

Details for medical and hospital claims processed in February 2023

What does Your share mean in your SmartSummary?
Your share: This is the amount you may owe or may have paid to your providers.

Medical and hospital claims

Service Date: 06/29/2023	Amount the provider billed the plan	$0.00
Claim # 555555555555555	Humana discounts	- $0.00
HEALTH CARE INC	Benefit exclusions	- $0.00
-Home health prospective payment system (HRG)	Other insurance	- $0.00
In-network (billing code 023)1	Total cost (amount the plan approved)	$0.00
	Amount Humana paid	- $0.00
	Your share	$0.00
Service Date: 06/29/2023	Amount the provider billed the plan	$90.00
Claim # 555555555555555	Humana discounts	- $0.00
HEALTH CARE INC	Benefit exclusions	- $0.00
-Skilled Nursing-Visit Charge	Other insurance	- $0.00

Extras that may help you improve your overall well-being, at no additional cost

SilverSneakers

SilverSneakers® is a health and fitness program designed for senior adults that offers fun and engaging classes and activities. The program concentrates on improving strength and flexibility so daily living activities become easier. Available at no additional cost through your Humana Medicare Advantage plan, SilverSneakers has online and in-person sessions at any pace—sit, stand, walk or run. Visit **SilverSneakers.com/StartHere** to get your SilverSneakers ID number and find a location near you, or call SilverSneakers at **888-423-4632 (TTY: 711)**.

Go365

Go365 by Humana® is a wellness program that rewards you for completing eligible healthy activities like working out or getting your Annual Wellness Visit. You can earn rewards to redeem for gift cards in the Go365 Mall.

If you have a MyHumana account, you can use the same information to log in to **Go365.com**. If not, activate your profile at **MyHumana.com**. Once you log into Go365, you'll see eligible activities you can complete to earn rewards and details on how to track your actions.

Humana Care Management

Humana care management programs support qualifying members to help them remain independent at home, by providing education about chronic conditions and medication adherence, help with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost. For more information, please contact the number on the back of your Humana member ID card or visit **Humana.com/home-care**.

Humana Well Dine® meal program

After your overnight inpatient stay in a hospital or nursing facility, you're eligible to receive up to 28 nutritious meals (2 meals per day for 14 days). The meals will be delivered to your door at no additional cost to you. For more information, please contact the number on the back of your Humana member ID card or visit **Humana.com/home-care/well-dine**.

Advance care planning with MyDirectives

MyDirectives®, an online advance care plan platform, helps you ensure your wishes are met in case unexpected medical emergencies happen or as illnesses progress. With MyDirectives, you can make your exact wishes known and identify the people you trust to speak for you as well. Sign in to **MyHumana.com**, go to MyHealth tab, in the drop down select MyHealth Overview and then select MyDirectives under Resources.

Humana Health Coaching

Available to all Humana Group Medicare members, our health coaching program provides guidance to help you develop a plan of action that supports your health and well-being goals. A health coach works with you to create a personal vision for your health and well-being, brings clarity to your goals and priorities and provides accountability and support. Get started by calling **877-567-6450 (TTY: 711)**.

Humana Neighborhood Center

Humana Neighborhood Centers offer a variety of classes in-person and online. Watch daily online classes like cooking demos, crafts, and meditation. To see a full list of virtual activities and to RSVP for classes and other events, visit **HumanaNeighborhoodCenter.com.** To find a Humana Neighborhood Center near you, visit **Humana.com/Humana-neighborhood-centers.**

Frequently asked questions

Do I need to show my red, white and blue Medicare card when I visit the doctor?
No. You'll get a Humana member ID card that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

What should I do if I move or have a temporary address change?
If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details and call to notify Humana of the move.

What should I do if I have to file a claim?
Call Humana Group Medicare Customer Care for more information and assistance. To request reimbursement for a charge you paid for a service, send the provider's itemized receipt and the Health Benefits Claim Form (also available at **Humana.com**) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number.

What if I have other health insurance coverage?
If you have other health insurance, show your Humana member ID card and your other insurance cards when you see o healthcare provider. The Humana Group Medicare plan may be eligible in combinatian with other types of health insurance coverage you may have. This is called coordination of benefits. Please notify Humana if you have any other medical coverage.

When does my coverage begin?
Your former employer or union decides how and when you enroll. Check with your benefits administrator for the praposed effective date of your enrollment. Be sure to keep your current healthcare coverage until your Humana Group Medicare PPO plan enrollment is confirmed.

What if my service needs a prior authorization?
If your medical service or medication requires a prior authorization, yaur provider can contact Humana to request it. You can call Customer Care if you have questions regarding what medical services and medications require prior authorization.

What if my provider says they will not accept my plan?
If your provider says they will not accept your PPO plan, you can give your provider the "Group Medicare Provider Information" flyer on page 11. It explains how your PPO plan works. You can also call Customer Care and have a Humana representative contact your provider and explain how your PPO plan works.

What should I do if I need prescriptions filled before I receive my Humana member ID card?
If you need to fill a prescription after your coverage begins but before you receive your Humana member ID card, take a copy of your temporary proof of membership to any in-network pharmacy.

How can I get help with my drug plan costs?
People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **800-MEDICARE (800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **877-486-2048**. You can also call the Social Security Administration at **800-772-1213**. If you use a TTY, call **800-325-0778.** Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.socialsecurity.gov**.

Medical insurance terms

Coinsurance
Your share of the cost after deductible
A percentage of your medical and drug costs that you may pay out of your pocket for covered services after you pay any plan deductible.

Copayment
What you pay at the provider's office for medical services
The set dollar amount you pay when you receive medical services or have a prescription filled.

Deductible
What you pay up front
The amount you pay for healthcare before your plan begins to pay for your benefits.

Exclusions and limitations
Anything not covered or covered under limited situations or conditions
Specific conditions or circumstances that aren't covered under a plan.

Maximum out-of-pocket
The most you'll spend before your plan pays 100% of the cost
The most you would have to pay for services covered by a health plan, including deductibles, copays and coinsurance. If and when you reach your annual out-of-pocket limit, the Humana Group Medicare plan pays 100% of the Medicare-approved amount for most covered medical charges.

Network
Your plan's contracted medical providers
A group of healthcare providers contracted to provide medical services at discounted rates. The providers include doctors, hospitals and other healthcare professionals and facilities.

Plan discount
A way Humana helps you save money
Amount you are not responsible for due to Humana's negotiated rate with provider.

Premium
The regular monthly payment for your plan
The amount you and/or your employer regularly pay for Medicare or Medicare Advantage coverage.

Pharmacy terms

Catastrophic coverage
What you pay for covered drugs after reaching $8,000
Once your out-of-pocket costs reach the $8,000 maximum, you pay $0 until the end of the plan year.

Coinsurance
Your share of your prescription's cost
This is a percentage of the total cost af a medication you pay each time you fill a prescription.

Copayment
What you pay at the pharmacy for your prescription
The set dollar amount you pay when you fill a prescription.

Deductible
Your cost for Part D prescription medications before the plan pays
The amount you pay for Part D prescription medications before the plan begins to pay its share.

Exclusions and limitations
Anything not covered
Specific conditions or circumstances that aren't covered under a plan.

Formulary
Medications covered under your plan
A list of medications approved for coverage under the plan. Also called a Drug List.

Out-of-pocket
Portion of costs you pay
Amount you moy have to pay for most plans, including deductibles, copays and coinsurance.

Know your numbers

Find important numbers anytime you need them*

Humana Group Medicare Customer Care
866-396-8810 (TTY: 711),
Monday – Friday, 8 a.m. – 9 p.m., Eastern time

Medicare Health Assessment
888-445-3389 (TTY: 711), daily

MyHumana
Sign in to or register for MyHumana to access your personal and secure plan information at **Humana.com**

MyHumana mobile app
Humana.com/mobile-apps

Doctors in your network
Humana.com/FindaDoctor

Telehealth
Please contact your local provider to ask about virtual visit opportunities, or access nationwide Humana in-network telehealth options by using the "Find a doctor" tool on **Humana.com** or call the number on the back of your member ID card to get connected with a provider that offers this service.

Array behavioral health
888-410-0405 (TTY: 711)
Arraybc.com/patients/Humana

CenterWell Pharmacy™
800-379-0092 (TTY: 711),
Mon. – Fri., 8 a.m. – 11 p.m., and
Sat., 8 a.m. – 6:30 p.m., Eastern time
CenterWellPharmacy.com

CenterWell Specialty Pharmacy™
800-486-2668 (TTY: 711),
Mon. – Fri., 8 a.m. – 11 p.m., and
Sat., 8 a.m. – 6:30 p.m., Eastern time
CenterWellSpecialtyPharmacy.com

Humana Clinical Pharmacy Review Team
800-555-2546 (TTY: 711),
Monday – Friday, 8 a.m. – 8 p.m., Eastern time

SilverSneakers®
888-423-4632 (TTY: 711),
Monday – Friday, 8 a.m. – 8 p.m., Eastern time
SilverSneakers.com

Go365 by Humana™
Go365.com

Humana Care Management
866-396-8810 (TTY: 711),
Monday – Friday, 8 a.m. – 9 p.m., Eastern time
Humana.com/home-care

Humana Well Dine®
866-396-8810 (TTY: 711),
Monday – Friday, 8 a.m. – 9 p.m., Eastern time
Humana.com/home-care/well-dine

Humana Health Coaching
877-567-6450 (TTY: 711)

Humana Neighborhood Centers
Humana.com/Humana-neighborhood-centers

State health insurance program offices
800-633-4227 (TTY: 711), daily
www.cms.gov/apps/contacts/#

*You must be a Humana member to use these services.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **866-396-8810 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 **(Chinese):** 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (** 聽障專線：**711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

GHHLE7BEN 0822

Humana. A more human way to healthcare™

2024

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/463

Humana®

Y0040_GHHKNCTEN24_M

SB079463EN24

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

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** **$0** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Wigs (medically necessary) 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** **$0** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Wigs (medically necessary) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Chiropractic Services (Routine); Hearing Services (Routine); Private Duty Nursing; Wigs (medically necessary); 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.	**$0** per admit	**$0** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** copay	**$0** copay
Ambulatory surgical center	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** capay	**$0** 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 yeor will be covered.	**Covered at no cost**	**Covered at no cost**
EMERGENCY CARE		
Emergency room	**$0** copay for Medicare-covered emergency room visit(s)	**$0** 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 conditian that requires immediate medical attention.	**$0** copay	**$0** copoy
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** copay	**$0** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** copay	**$0** copay
Outpatient X-rays	**$0** copay	**$0** copay
Radiation therapy	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing	**$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
Routine hearing	**$2,000** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	**$2,000** combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$0** 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)	**$0** 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	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$0** 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
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.	**$0** per admit	**$0** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$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
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 1-100	**$0** copay per day for days 1-100
PHYSICAL THERAPY		
	$0 copay	**$0** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	**$0** copay
PART B PRESCRIPTION DRUGS		
	$0 copay or **0%** of the cost	**$0** copay or **0%** of the cost
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Originol Medicare provider requirements.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** copay
Routine chiropractic visit(s)	**$0** copay for routine chiropractic visits up to unlimited visit(s) per year.	**$0** copay for routine chiropractic visits up to unlimited visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DIABETES MANAGEMENT TRAINING		
	$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
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	**0%** of the cost
Medical supplies	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)	**0%** of the cost	**0%** of the cost
Wigs (medically necessary) **$300** combined In & Out-of-Network maximum benefit coverage amount per year	**$0** copay	**$0** copay
Diabetes monitoring supplies	**$0** copay	**$0** copay
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$0** copoy **Partial Hospitalization:** **$0** copoy
PRIVATE DUTY NURSING		
	10% of the cost	**10%** of the cost
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	**$0** copay
Cardiac rehabilitation	**$0** copay	**$0** copay
Pulmonary rehabilitation	**$0** copay	**$0** copay
RENAL DIALYSIS		
Renal dialysis	**$0** copay	**$0** 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	**$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
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

Note: *A cost share ronge 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.*

Notes

Notes

Important

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- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235（聽障專線：711）。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Find out **more**

You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsaring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users shauld call 1-877-486-2048.

Humana®

Humana.com

SB079463EN24

Routine Hearing

$2,000 allowance

Routine Hearing Benefit Summary		
Hearing services	**In-network**	**Out-of-network***
Routine hearing exam • N/A	N/A	N/A
Fitting/evaluation • N/A	N/A	N/A
Hearing aids		
• Combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) every 3 years	$2,000 combined in and out of network maximum benefit coverage amount	$2,000 combined in and out of network maximum benefit coverage amount
• ($2,000 total combined in and out of network maximum annual benefit)		

*Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions.

Humana is a Medicare Advantage organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Humana.

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Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nikáadoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

2024

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 335

Humana®

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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 **$5,030**. 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)	**$25** copay	**$25** copay
3 (Non-Preferred Drug)	**$45** copay	**$45** copay
4 (Specialty Tier)	**20%** of the cost (**$100** copay maximum per prescription)	**20%** of the cost (**$100** copay maximum per prescription)
90-day supply		
1 (Generic or Preferred Generic)	**$20** copay	**$20** copay
2 (Preferred Brand)	**$50** copay	**$50** copay
3 (Non-Preferred Drug)	**$90** copay	**$90** copay
4 (Specialty Tier)	N/A	N/A

Some Generic Statins are covered at **100% for all members.

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.

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 **$5,030**.
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 **$8,000**, you have a **$0** copayment.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 25: Provide detailed descriptions of all early retirement plans or other staff reduction programs Big Sandy RECC has offered or intends to offer its employees during the test year. Include all cost-benefit analyses associated with these programs.

Response 25: Big Sandy did not offer any early retirement plans during the test year.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 26: Provide a complete description of Big Sandy RECC's other post-employment benefit package(s) provided to its employees.

Response 26: Please see the attached policy 100-0055.

#26 pg7

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION

POLICY STATEMENT NO. 100-055

SUBJECT: **Insurance and Benefits**

PURPOSE: **It shall be the policy of the Cooperative to maintain group insurance coverage for its employees as detailed under the provisions of this policy.**

This policy information is not an attempt to summarize all benefits or rules of each benefit plan. A Summary Plan Description is available for this purpose. This policy does not represent a promise or agreement to provide benefits and does not create any independent right to employee benefits. Instead, the rules regarding benefits, eligibility, and all other matters relating to the plan identified herein are governed exclusively by the terms of the formal plan document. Any inconsistency between the language in this policy and the formal plan document will be resolved based solely on the terms of the plan document. Please refer to the Plan Description and/or plan document if you need additional information regarding any plan or insurance below.

RESPONSIBILITY: President/ General Manager

POLICY:

The following coverage's and provisions shall apply to this policy:

A. Workmen's Compensation:

This insurance protection will provide benefits for the employee who is injured while on duty and is provided subject to the provisions and requirements of the Cooperative's Workers Compensation Plan and Kentucky laws. This premium will be paid by the Cooperative. In the event that worker's compensation proceeds are not received by a normal payday, the cooperative may advance to the employee the estimated amount due from the insurance company through accounts payable. The employee will then reimburse the Cooperative immediately upon receipt of the benefit. Total compensation will not exceed 100% of the employee's base salary or wages.

B. Short Term and Long-Term Disability:

Short Term and Long-Term disability insurance are provided as specified in the plan summary. Employees become eligible after completing six months of employment. This insurance protection will assure the full-time employee at least partial income during any short term or long-term disability (accident, illness, etc.) and will serve to reduce the amount of sick leave paid during the absence. Total compensation will not exceed 100% of the employee's base salary or wages. This premium will be paid by the Cooperative.

In the event that disability compensation is not received by a normal payday, the cooperative may advance to the employee the estimated amount due from the insurance company

through accounts payable. The employee will then reimburse the Cooperative immediately upon receipt of the benefit.

C. Business Travel Accident Insurance:

The Cooperative shall maintain Business Travel accident insurance as specified in the summary plan description and is designed to protect its employees while traveling on Cooperative business should an accident causing injury occur. This premium will be paid by the Cooperative.

D. Major Medical Group Insurance:

1. The Cooperative strives to provide a medical insurance plan that will provide insurance protection and will provide for the payment of a major portion of hospital and doctor expenses for all eligible full-time employees (after completion of 90 days employment), retired employees, and their dependents. The Cooperative and the employee will split the cost as determined by management, the IBEW contract and approved by the Board of Directors.

Coverage Waiver: If an employee waives insurance coverage because they already have coverage, their pay rate will be adjusted by $1.50 during the period insurance is waived. The employee will sign a Health Insurance Waiver Verification Election form.

2. Termination of employment, by death, voluntary or involuntary (except for gross misconduct), or reduction in hours from the Cooperative that would result in the loss of insurance, they and/or their family may continue to be covered by this policy, provided all premium costs are assumed by the individual, depending if these individuals fall under the Consolidated Omnibus Budget Reconciliation Act paying 102% of the cost of the plan.

3. Spouse's comparable coverage: Employees shall notify the Cooperative about health insurance coverage available to their spouse through their employer and they will be required to obtain such insurance provided such coverage is reasonably comparable. Management will make that determination after comparing each plan specifications, including but not limited to plan premium, deductibles, coverage and network. The employee will update this information at least annually. The employee will be reimbursed up to $200 per month toward any additional premium cost of this provision, upon submitting proof of cost.

4. Death of employee hired on or before February 27, 2008 only. If a regular full-time employee should die after reaching normal retirement, and before actual retirement, either 30 years or age 62, as per retirement plan, group medical and hospitalization insurance will be continued for the surviving spouse and eligible dependents. The Cooperative will pay 100% of the premium cost. The continued coverage will terminate when and of the following events occur: a) Spouse remarries or becomes eligible for benefits under any other plan, such as Medicare; b) a child ceases to be a dependent.

5. Retired Employees

a. Regular Retired Employee: If hired prior to February 27, 2008, at the time of retirement after 30 years employment or reaching the age of 62, the Cooperative will pay 100% of the premium cost of the group major medical insurance for retired employee and their spouse and/or dependent children covered on the retired employee's last day of active service. If hired on and after February 27, 2008, at the time of retirement receive employee-only health insurance from the Cooperative until they become eligible for Medicare or the Medicare-type Program in effect at that time.

b. Disability Retirement: If hired prior to February 27, 2008, the Cooperative will pay 100% of the premium cost of the group medical and hospitalization insurance for the employee, spouses and dependent children, when an employee with 20 years of service at the cooperative becomes disabled and under the care of a physician. If hired on or after February 27, 2008, the Cooperative will pay for the employee only medical and hospitalization insurance.

c. Death of Retiree: In the event of covered retiree's death who was hired prior to February 27, 2008, the group medical and hospitalization insurance will be continued for the surviving spouse and eligible dependents. The cooperative will pay 100% of the premium cost. The continued coverage will terminate if the spouse remarries or becomes eligible for benefits under any other plan or a child ceases to be a dependent. Employees hired on or after February 27, 2008 will not be eligible for this benefit.

E. Dental Insurance:

This insurance protection will provide for the payment of dental expenses for all eligible full-time employees, retired employees until the age of 65, and their dependents. The employee is responsible for payment of the entire premium of this policy, if they opt to purchase it.

In the event of an employee's death or retirement from the Cooperative, (s)he and/or their family may continue to be covered by this policy, provided all premium costs are assumed by the individual, depending if these individuals fall under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

F. Life Insurance

Basic life insurance will be provided to eligible full-time employees at two times their annual salary. This premium will be paid by the Cooperative. The employee can purchase additional coverage on family members. Any premium over and above this basic coverage on the employee shall be paid by the employee.

G. Flex Spend Account

Employees have the option to participate in a Health Savings Pre-Tax Account. Participation will be payroll deducted.

H. Retirement and Security Program

1. These programs are designed to provide retirement income for eligible full-time employees and their families in addition to the benefits provided by Social Security. The Cooperative has multiple retirement programs due to the length of time the cooperative has been in business. Plan participation is dependent upon date of hire and job title, union or non-union.

2. Eligibility. Employees become eligible to participate in a retirement plan the 1st of the month following completion of one (1) year of employment. The specific plan of eligibility is determined by their job title, union or nonunion designation.

3. The eligible employee may voluntarily contribute to the appropriate 401(k) plan.

4. The Cooperative will contribute an amount as set forth in the IBEW contract for union employees and they will contribute an amount determined by management and the Board of Directors for non-union employees.

5. Non-union employees hired prior to January 1, 2011 will continue participation in a non-contributory retirement plan where only the Cooperative contributes the amount directed by the National Rural Electric Cooperative Association (NRECA). Additionally, the eligible employee may choose to contribute to a 401(k) through the NRECA.

6. Additional plan details for all plans are specifically defined by the adoption agreements as entered into by and between the Board of Directors and NRECA and any independent 401(k) or retirement plans.

I. Credit Union

Employees are eligible to join the Rural Cooperative Credit Union for a basic initial fee of $5.00. Credit Union services vary and are set by the Credit Union.

J. Supplemental Insurance

The Cooperative allows supplemental policies to be offered to employees through various companies. The Cooperative does not pay for or contribute to the purchase of any supplemental policies. Supplemental plans can be payroll deducted.

This policy supersedes any existing policy which may be in conflict with the provisions of this policy.

APPROVED BY THE BOARD OF DIRECTORS

SOURCE:	**Adopted**	**09/07/84**
	Amended	**01/15/88, 06/17/94, 01/20/95, 05/16/97** **10/16/98, 07/16/04, 02/27/08, 07/22/09** **12/17/2010, 12/19/2014, 06/23/2016, 11/25/2019**
	Amended	**02/27/2020** **04/23/2020**

Secretary _____

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 27: Provide a complete description of the financial reporting and ratemaking treatment of Big Sandy RECC's pension costs.

Response 27: Utility pension costs incurred are spread to the general ledger accounts charged with labor. These expense accounts would directly impact the ratemaking revenue requirement.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 28: Regarding Big Sandy's employee compensation policy:

a. Provide Big Sandy RECC's written compensation policy as approved by the board of directors.

b. Provide a narrative description of the compensation policy, including the reasons for establishing the policy and Big Sandy RECC's objectives for the policy.

c. Explain whether the compensation policy was developed with the assistance of an outside consultant. If the compensation policy was developed or reviewed by a consultant, provide any study or report provided by the consultant.

d. Explain when Big Sandy RECC's compensation policy was last reviewed or given consideration by the board of directors.

Response 28(a): Compensation is managed by the President/General Manager, consultation with the Board of Directors, and informal information from neighboring cooperatives. Please see attached Big Sandy RECC policy #300-190; Wage and Salary Plan Policy. This is the only written compensation policy approved by the Board. This policy was reviewed and considered by the Board on 03/24/2016.

Response 28 (b): Please see response to part (a) above. Big Sandy is committed to competitive compensation. Big Sandy's compensation policy is driven by the need to retain qualified personnel and fair and equitable compensation for all employees.

Response 28(c): Big Sandy has not used an outside consultant for our compensation policy.

Response 28(d): Big Sandy's Board of Directors are involved in compensation of employees.

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION

POLICY STATEMENT NO. 300-190

WAGE AND SALARY PLAN POLICY

SUBJECT: WAGE AND SALARY PLAN POLICY

PURPOSE OR OBJECTIVE: TO ESTABLISH A GUIDE FOR ALL COMPENSATION DECISIONS AND JOB LEVELS.

POLICY: This Policy was established as a guide for all wage and salary decisions. Each employee will be classified into their specific job title to be evaluated and reviewed for any promotions, wage increase or compensation decisions. Job Titles and Grade Levels are as follows:

JOB TITLE	GRADE
Customer Service Rep. I	11
Customer Service Rep. II	11
Communications/Member Service Asst.	11
Customer Service Specialists	12
Consumer Accounting Clerk	12
Plant Accountant	13
Payroll/Accounting Clerk	13
Dispatch/Operations Assistant	14
	15
GIS/Dispatcher/Operations	16
Executive Secretary/H.R. Admin.	16
ROW Supervisor/Arborist	16
Accounting & Finance Manager	17
	18
Member Service/P.R. Mgr.	17
IT Manager	17

VP of Customer Services	**19**
VP of Financial Services	**20**
Line Superintendent	**21**
VP of Operations	**22**

RESPONSIBILITY: President & General Manager

SOURCE: Adopted: December 27, 2012

Revised: MARCH 24, 2016

In conjunction with revised policy #300-130 in 2/2016

Kelly Shepherd

Kelly Shepherd, Secretary

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 29: State whether Big Sandy RECC's expenses for wages, salaries, benefits, and other compensation included in the test year, and any adjustments to the test year, are compliant with the board of director's compensation policy.

Response 29: Big Sandy's Board of Directors are involved in compensation of employees.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

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

a. Regular salary or wages.

b. Overtime pay.

c. Excess vacation payout.

d. Standby/Dispatch pay.

e. Bonus and incentive pay.

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

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

h. Healthcare benefit cost.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee

i. Dental benefits cost.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee.

j. Vision benefit cost.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee.

k. Life insurance cost.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee.

l. Accidental death and disability benefits.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee.

m. Defined Benefit Retirement.

(1) Amount paid by Big Sandy Energy.

(2) Amount paid by employee.

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

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

Response 30a. through 30o: Please see the Excel spreadsheet Schedule I filed separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 31: For each item of benefits listed in Item 30 above for which an employee is required to pay part of the cost, provide a detailed explanation as to how the employee contribution rate was determined.

Response 31: Big Sandy employees are eligible for health insurance after 90 days employment. The cooperative pays 90% of the premiums and the employee pays 10% of the full premiums for each coverage level for all employees. The percentage that is paid by employees was determined through the bargaining agreement with the union and was carried through to the non-bargaining employees to be reasonable throughout.

Healthcare/Medical Benefits: The employee is required to pay 10% of the cost of the premium. This contribution rate was determined while looking at the local, state, and national benchmarks with the KREC plan.

Dental Benefits: All Big Sandy employees, except Staff, pay 100% of the premiums. The coop pays for an Employee only dental plan for the Staff. Every year Big Sandy researches and compares pricing and the value of this benefit.

Vision Insurance: All employees pay 100% of their vision insurance premiums. This was determined reasonable due to the lower cost of premiums. Every year we research and compare pricing and the value of this benefit.

Long-term and Short-term Disability Insurance: Big Sandy pays 100% of the LTD and STD and

this benefit is effective after six months of employment.

In 2022, Big Sandy switched from the NRECA to The Hartford which provided a substantial amount of money to the coop.

Basic Life & AD&D coverage: Big Sandy pays 100% of a Life Insurance and Accidental Death & Dismemberment plan for all employees and the Board of Directors. NRECA offers this coverage to coops at a reasonable low rate.

Defined Benefit Retirement: After one-year of employment, Big Sandy pays 100% of the NRECA rate for this non-union, defined benefit retirement plan, for employees who were hired prior to January 1, 2011. Under ten employees of Big Sandy have this retirement plan. These employees have a 401k, but Big Sandy does not contribute to this 401k.

Defined Contribution: Big Sandy chose to transition to a 401k Retirement plan for the non-union employees hired on or after January 1, 2011. After one-year of employment, Big Sandy contributes 10% of the employee's base wages to this 401k plan. The employees are eligible to contribute any amount up to the legal limits.

Big Sandy also provides a 401k to the Union employees and contributes 10% of their base wages to that 401k. Employees are allowed to contribute any amount up to the legal limits.

Big Sandy compared and evaluated contribution options with local employers and comparable jobs and decided to offer the 10% to a 401k to obtain more, quality employees.

In order to save on healthcare, in 2021, Big Sandy chose to move its retirees (who were eligible for Medicare) from the KREC Health Insurance Plan and enroll them in a Humana Medicare Plan. This change saved Big Sandy approximately $100k in premiums plus it saved on our self-

funded KREC insurance the claims cost, which in turn saved thousands of dollars for any surcharge assessments from the plan. This benefitted Big Sandy and our retirees. As retirees obtain Medicare, we transition them to the Humana plan.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 32: 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, etc.). Include the associated employee contribution rates and employer contribution rates of the total premium cost for each category, and each plan's deductible(s) amounts.

Response 32: Big Sandy offers health insurance through Anthem BCBS for all active employees, one Retiree's Spouse who is non-Medicare and one Retiree survivor who is non-Medicare.

Categories include: Employee only, Employee/Spouse, Employee/Children, Family and Retiree Spouse & Survivor non-Medicare.

Active Employees pay 10% of a base amount, Big Sandy pays 90% of the premium. The 2023 Deductible is $600 Single, $1800 Family.

Big Sandy offers and pays 100% of premium to Humana Medicare for its Retirees. The cost is $253.71 each, no Deductible, no copays.

Big Sandy offers its active employees Dental and Vision through Guardian, and the employee pays 100% of those premiums. Coverage is eligible to the following categories:

Dental: Employee Only and Employee/Family

Vision: Employee only, Employee/ Spouse, Employee/Children and Employee & Family.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 33: 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 33: Board of Directors have life insurance thru NRECA, a $50,000 Accidental Death Policy, and the Business Travel and Accident Policy that all employees and board are eligible for. The coop pays 100% of the premiums for these policies.

Big Sandy pays 100% of the premium for all active employees with a 2X their salary life insurance plan through NRECA.

NRECA offers employees many options of supplemental life insurance plans of which the employee would pay the premiums.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 34: 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 34: Big Sandy does not offer Board members a retirement plan.

Big Sandy RECC active employees are eligible for the following retirement plans:

1. Big Sandy RS Plan (only non-union employees hired prior to 1/1/2011); Coop pays premium; NRECA rate of 38.96%.
2. Big Sandy 401k (sub 001) (only non-union employees hired prior to 1/1/2011); Coop does not contribute; employees can contribute any amount, up to legal limits.
3. Big Sandy 401k (sub 003) (only non-union employees hired after 1/1/2011); Coop contributes 10% of the base wages; employees can contribute any amount, up to legal limits
4. Big Sandy 401k (sub 002) (only union employees); Coop contributes 10% of the base wages; employees can contribute any amount, up to the legal limit.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 35: Provide an analysis of Big Sandy's expenses for research and development activities for the test year and the three preceding calendar years. For the test year, include the following:

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

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

c. Details of services and other benefits provided to Big Sandy by each organization during the test year and the preceding calendar year;

d. Total expenditures of each organization including the basic nature of costs incurred by the organization; and

e. Details of the expected benefits to Big Sandy.

Response 35(a) through 35(e): Big Sandy has no research and development activities.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 36: Provide a running total for the following information concerning the cost of preparing the case:

a. A detailed schedule of expenses incurred to date for the following categories: For each category, the schedule should include the date of each transaction, check number or other document reference, the vendor, the hours worked, the rates per hour, amount, a description of the services performed, and the account number in which the expenditure was recorded. Provide copies of any invoices, contracts, or other documentation that support charges incurred in the preparation of this rate case. Indicate any costs incurred for this case that occurred during the test year.

(1) Accounting;

(2) Engineering;

(3) Legal;

(4) Consultants; and

(5) Other Expenses (Identify separately).

b. An itemized estimate of the total cost to be incurred for this case. Expenses should be broken down into the same categories as identified in 37 a. above, with an estimate of the hours to be worked and the rates per hour. Include a detailed explanation of how the estimate was determined, along with all supporting work papers and calculations.

c. Provide monthly updates of the actual costs incurred in conjunction with this rate case, reported in the manner requested in 37.a. above. Updates will be due when Big Sandy RECC files its monthly financial statements with the Commission, through the month of the public hearing.

Response 36(a) and 36(b): Please see the Excel spreasheet uploaded separately.

Response 36(c): Big Sandy will provide the requested monthly updates of the actual costs incurred in conjunction with the rate case.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 37: Provide the following information for the most recent calendar year concerning Big Sandy RECC and any affiliated service corporation or corporate service division/unit:

a. A schedule detailing the costs charged, either directly or allocated, by the service company to Big Sandy RECC. Indicate Big Sandy RECC's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

b. A schedule detailing the costs charged, either directly or allocated, by the service company to Big Sandy RECC. Indicate Big Sandy RECC's accounts where these costs were recorded. For costs that are allocated, include a description of the allocation factors utilized.

Response 37(a) and 37(b): Big Sandy Forestry LLC is a subsidiary of Big Sandy RECC and provides vegetation management services. Please see the Excel files uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 38: Provide the following information for the most recent calendar year concerning all affiliate-related activities not identified in response to Item 37:

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

b. Provide the names of affiliates to whom Big Sandy provided some form of service and the type of service Big Sandy 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 38(a) through 38(c): Big Sandy has no affiliate-related activities other than listed in Response 37.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 39: Describe Big Sandy RECC's lobbying activities and provide a schedule showing the name, salary, and job title of each individual whose job function involves lobbying on the local, state, or national level.

Response 39: Big Sandy does not engage in lobbying activities.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 40: Regarding demand-side management, conservation, and energy-efficiency programs, provide the following:

a. A list of all programs currently offered by Big Sandy.

b. The total cost incurred for these programs by Big Sandy in each of the three most recent calendar years.

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

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

Response 40 (a): In coordination with East Kentucky Power Cooperative, Inc. ("EKPC"), Big Sandy RECC offered the following DSM programs:

(1) **Button Up Weatherization Program -**This program offers incentives to the residential members who add insulation in the attic and use weatherization techniques to reduce heat loss in the home.
(2) **Virtual Energy Assessment** – An online tool that members can use to
(3) **Heat Pump Retrofit Program** – The program provides an incentive to residential members to convert the home from less efficient resistance heat sources to more efficient air-to-air heat pumps, geothermal heat pumps, or mini-split heat pumps.
(4) **Touchstone Energy Home Program** – This program provides a rebate for members meeting a set of energy-efficiency standards when building a new home.
(5) **Direct Load Control (Air Conditioning and Water Heaters)**- allows for the installation of utility provided switches on air conditioners and water heaters that can be managed by EKPC during peak usage to reduce load.
(6) **Bring Your Own Thermostat (BYOT)**- The program provides an incentive for members to purchase programmable smart thermostats that can be managed by EKPC during peak usage to reduce load.
(7) **How SmartKY** – This program provides on-bill financing for members who make energy efficiency upgrades to their homes.

(8) **Community Assistance Resources for Energy Savings Program (CARES)** – This program provides an incentive to enhance the weatherization and energy efficiency services provided to the end-use members by the Kentucky Community Action Agencies (CAA) network.

Response 40b

In the three most recent years, Big Sandy RECC paid out $21,261.08 in DSM expenses but was

fully reimbursed by East Kentucky Power Cooperative.

Response 40c – 40d Please see attached.

Response 40c.

January 01, 2021 to December 31, 2021

Measure	# Customers	#Measures	Rus Amount (Incentives + Admin)	Lost Revenue Amount	MMBTU	kWh	Summer kW	Winter kW
⊟ Big Sandy RECC	3	0	$3,600.00	$0.00	327.729	96,048.000	9.605	16.008
⊟ Residential	3	0	$3,600.00	$0.00	327.729	96,048.000	9.605	16.008
LED Promo- Online App	2	0	0.0000	0.0000	0.163782816000000	48.000000	0.004800	0.008000
LED-Promotional		0	$0.00	$0.00	0.164	48.000	0.005	0.008
RESIDENTIAL LIGHTING	1	0	3600.0000	0.0000	327.565632000000000	96000.000000	9.600000	16.000000
LED		0	$3,600.00	$0.00	327.566	96,000.000	9.600	16.000
Total	3	0	$3,600.00	$0.00	327.729	96,048.000	9.605	16.008

January 01, 2022 to December 31, 2022

Measure	# Customers	#Measures	Rus Amount (Incentives + Admin)	Lost Revenue Amount	MMBTU	kWh	Summer kW	Winter kW
⊟ Big Sandy RECC	4	0	$8,165.00	$2,305.00	426.501	124,995.000	12.560	20.880
⊟ Residential	4	0	$8,165.00	$2,305.00	426.501	124,995.000	12.560	20.880
COMMUNITY ASSISTANCE RESOURCES FOR ENERGY SAVINGS	2	0	4200.0000	1200.0000	32.285687604000000	9462.000000	1.440000	2.880000
CARES HEAT PUMP ELIGIBLE		0	$4,200.00	$1,200.00	32.286	9,462.000	1.440	2.880
HEAT PUMP RETROFIT	1	0	590.0000	1105.0000	25.703665686000000	7533.000000	0.320000	0.000000
Heat Pump Retrofit		0	$590.00	$1,105.00	25.704	7,533.000	0.320	0.000
RESIDENTIAL LIGHTING	1	0	3375.0000	0.0000	368.511336000000000	108000.000000	10.800000	18.000000
LED		0	$3,375.00	$0.00	368.511	108,000.000	10.800	18.000
Total	4	0	$8,165.00	$2,305.00	426.501	124,995.000	12.560	20.880

January 01, 2023 to December 31, 2023

Measure	# Customers	#Measures	Rus Amount (Incentives + Admin)	Lost Revenue Amount	MMBTU	kWh	Summer kW	Winter kW
Big Sandy RECC	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250
Residential	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250
COMMUNITY ASSISTANCE RESOURCES FOR ENERGY SAVINGS	3	0	5456.0800	1800.0000	48.428531406000000	14193.000000	2.160000	4.320000
CARES HEAT PUMP ELIGIBLE		0	$5,456.08	$1,800.00	48.429	14,193.000	2.160	4.320
ENERGY STAR MANUFACTURED HOME	1	0	1240.0000	900.0000	13.853296520000000	4060.000000	0.470000	0.930000
ENERGY STAR MANUFACTURED HOME		0	$1,240.00	$900.00	13.853	4,060.000	0.470	0.930
RESIDENTIAL LIGHTING	1	0	2800.0000	0.0000	0.000000000000000	0.000000	0.000000	0.000000
LED		0	$2,800.00	$0.00	0.000	0.000	0.000	0.000
Total	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250

Response 40d.

January 01, 2023 to December 31, 2023

Measure	# Customers	#Measures	Rus Amount (Incentives + Admin)	Lost Revenue Amount	MMBTU	kWh	Summer kW	Winter kW
Big Sandy RECC	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250
Residential	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250
COMMUNITY ASSISTANCE RESOURCES FOR ENERGY SAVINGS	3	0	5456.0800	1800.0000	48.428531406000000	14193.000000	2.160000	4.320000
CARES HEAT PUMP ELIGIBLE		0	$5,456.08	$1,800.00	48.429	14,193.000	2.160	4.320
ENERGY STAR MANUFACTURED HOME	1	0	1240.0000	900.0000	13.853296520000000	4060.000000	0.470000	0.930000
ENERGY STAR MANUFACTURED HOME		0	$1,240.00	$900.00	13.853	4,060.000	0.470	0.930
RESIDENTIAL LIGHTING	1	0	2800.0000	0.0000	0.000000000000000	0.000000	0.000000	0.000000
LED		0	$2,800.00	$0.00	0.000	0.000	0.000	0.000
Total	5	0	$9,496.08	$2,700.00	62.282	18,253.000	2.630	5.250

The total cost paid out by Big Sandy RECC for demand-side management, conservation, and energy efficiency in test year 2023 was $9,496.08 but all expenses were reimbursed by EKPC.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 41: 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 41(a) through 41(f): Please see the Excel spreadsheet provided separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 42: Provide an analysis of Other Operating Taxes as shown in Schedule J for the most recent calendar year.

Response 42: Please see the Excel file provided separately.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 43: 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 Big Sandy RECC according to each invoice, and a description of the services performed.

Response 43: Please see the Excel spreadsheet provided separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 44: Provide the following information for Big Sandy. If any amounts were allocated, show a calculation of the factor used to allocate each amount.

a. A detailed analysis of all charges booked during the text year for advertising expenditures. Include a complete breakdown of Account No. 913 – Advertising Expenses, and any other advertising expenditures included in any other expense accounts, as shown in Schedule L1. The analysis should specify the purpose of the expenditure and the expected benefit to be derived.

b. An analysis of Account No. 930 – Miscellaneous General expenses for the test year. Include a complete breakdown of this account as shown in Schedule L2 and provide detailed workpapers supporting this analysis. At a minimum, the workpapers should show the date, vendor, reference (i.e., voucher no., etc.), dollar amount, and brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule L2.

c. An analysis of Account No. 426 – Other Income Deductions for the test year. Include a complete breakdown of this account as shown in Schedule L3 and provide detailed workpapers supporting this analysis. At a minimum, the workpapers should show the date, vendor, reference (i.e., voucher no. etc.), dollar amount, and brief description of each expenditure of $500 or more, provided that lesser items are grouped by classes as shown in Schedule L3.

Response 44(a) - (c): Please see the Excel spreadsheet uploaded separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 45: Provide the name and personal mailing address of each member of Big Sandy's board of directors. 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 45: BIG SANDY RECC BOARD OF DIRECTORS, PRESIDENT & HR Dir.

DANNY WALLEN, CHAIRMAN **1** **EKPC Representative**
2964 KY RT 2040
OFFUTT KY 41240-8947
606-872-1329
Email: dlwallen@icloud.com
Board email: dawallen@bigsandyrecc.com

JIM MCKENZIE **2**
295 HONEY LANE
STAMBAUGH, KY 41257
606-265-3461 or Cell 606-792-7540
Email: jimmckenzie54@icloud.com
Board email: jmckenzie@bigsandyrecc.com

VELMA MAY **3**
5650 MIDDLE FORK RD.
LEANDER, KY 41222-8869
606-297-6797 or cell effective 5/31/24: 606-367-7708
Email: velma.may49@yahoo.com
Board email: vmay@bigsandyrecc.com
JAMES VANHOOSE, SECRETARY **4**
500 NELSON BRANCH RD.
LOWMANSVILLE, KY 41232

606-793-0963 Works @ Peoples Ins. Agency 606-298-0863, ext 5930
Email: kandjv@foothills.net
Board email: jvanhoose@bigsandyrecc.com

GARY FRANCIS 5
60 LAUREL RIDGE
PRESTONSBURG, KY 41653
606-226-3217
Email: gfrancis@bigsandyrecc.com
Board email: gfrancis@bigsandyrecc.com

GREG DAVIS, VICE CHAIRMAN 6 KAEC Representative
1041 ST RT 850
DAVID KY 41616
(606)886-1641 or Cell 606-791-5956 * Pager 606-924-2627
Email: gbdavis@mikrotec.com
Board email: gdavis@bigsandyrecc.com

JASON HOLBROOK 7
8922 ST. RD. FK. (Bylaws revised & redistricted to add #7 again) seated 6/25/2020
PRESTONSBURG, KY 41653
606-331-8283
Board email: jholbrook@bigsandyrecc.com

PRESIDENT & GENERAL MANAGER, JEFF PRATER Interim 2/12/2024
1365 SALYERS BR. Hired 6/1/2024 Pres. & GM
HUEYSVILLE, KY 41640
CELL # 606-791-4095
Work Direct Line 606-229-7855
jprater@bigsandyrecc.com

ATTORNEY MICHAEL SCHMITT Hired Jan. 1, 2023
4186 TRADITION WAY
LEXINGTON, KY 40509
Cell# 606-434-4168
mschmitt@bigsandyrecc.com

JUDY MCCLURE
Executive Assistant & HR Director Hired by Board 3/25/24

332 East Dorton Blvd.
Staffordsville, KY 41256
Direct Line # 606-229-7870
Home 606-297-2188 or Cell # 606-367-1581
jmcclure@bigsandyrecc.com

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 46: 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. If any of the listed expenses in this analysis include the costs for directors' spouses, list expenses for the directors' spouses separately.

Response 46: Please see the Excel spreadsheet uploaded separately.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 47: Provide Big Sandy RECC's written policies on the compensation of its attorneys, auditors, and all other professional service providers. Include a schedule of fees, per diems, and other compensation in effect during the test year. Include all agreements, contracts, memoranda of understanding, and any other documentation that explains the nature and type of reimbursement paid for professional services. If any changes occurred during the test year, indicate the effective date of these changes and the reason for these changes.

Response 47: Please see attached policies: 1) #400-005; Functions and Compensation of Cooperative Attorneys; and 2) #400-010; Board of Directors Compensation. These compensation amounts are paid per month. The mileage paid to the Board is set by the IRS yearly mileage rate, measuring the director's mileage to and from their home to the coop address.

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION
POLICY STATEMENT NO. 400-010
SECTION D

SUBJECT: **BOARD OF DIRECTORS - COMPENSATION**

OBJECTIVE: To provide fair and equitable compensation for members of the Board of Directors.

POLICY:

A. Per Diem of $900.00 plus mileage from the Director's home shall be paid to each Director for attending a regular or special Board Meeting.

B. Directors authorized to attend any meeting, workshop, seminars, etc. shall be paid $300.00 per day and shall be reimbursed for all legitimate expenses for attendance at such meetings. A detailed expense account, with receipts attached as appropriate shall be submitted to the Board for approval. No expenses will be paid for spouses of Directors accompanying them to meetings. Travel shall be reimbursed on the following basis.

1. If commercial air travel is available, then without regard to the mode actually used, reimbursement shall be for the expenses actually incurred in an amount not to exceed round trip air coach fare, if the same is available; otherwise, first class fare, plus cost of transportation to and from airport and other expenses attendant to air travel.

2. Mileage reimbursement, plus toll costs, for use of personal automobile shall be at the rate set forth in Policy No. 100-015, Section A.

3. Expenses incurred for travel earlier than sufficient time to attend a meeting shall not be reimbursed.

C. The following benefits will be paid 100% of the premium cost:

1. Business travel accident insurance.

2. 24-Hour accident insurance.

D. Travel and Per Diem

1. $300 Per Diem will be paid for one (1) day before meeting; if overnight stay is required.

2. If meeting ends late and overnight stay is required, $300 Per Diem would be paid for the following day.

3. Directors are allowed to attend, if so desired, two (2) of the following meetings yearly:

   NRECA Director's Conference
   NRECA Annual Meeting (*Allowed every other year.)
   Legislative Conference (*Every other year)

   a. *** It is encouraged to split up attendance of above meetings so that a representative is in attendance at all three meetings every year.**

4. KAEC & EKPC Annual Meetings – Available to all every year.

5. Any other meeting desiring to attend, must be presented prior to the board for approval.

6. Director must be willing and able to travel alone – if necessary. (No Staff or CEO)

RESPONSIBILITY: It shall be the responsibility of the Chairman of the Board to see that the provisions of the policy are carried out.

SOURCE:

ADOPTED:	January 18, 1991
AMENDED:	December 16, 1993
	June 17, 1994
	April 19, 1996
	February 18, 2000
	January 19, 2001
	February 16, 2001
	November 24, 2010
	January 24, 2013
	February 28, 2013
REVISED:	JUNE 23, 2016
	DECEMBER 8, 2022

Secretary James Vanhoose

Policy #400-010

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION
POLICY STATEMENT NO. 400-005
SECTION D

SUBJECT: **FUNCTIONS AND COMPENSATION OF COOPERATIVE ATTORNEYS**

PURPOSE:

A. To recognize the need for continuing legal guidance and counsel in the regular and special activities of the Cooperative, to insure maximum protection of the legal rights of the Cooperative, and to maintain operational conformity to the limitations prescribed by law.

B. To provide for the functions of the legal consultant employed as the regular Cooperative Attorney(s) or a monthly retainer fee basis and for additional counsel as required from time to time.

POLICY:

It shall be the policy of Big Sandy RECC to maintain a continuing relationship with the Attorney or firm of attorneys for the purpose of procuring the necessary legal assistance and advice to protect the corporate interests of the Cooperative.

The Board of Directors shall designate the Cooperative Attorney(s) upon the recommendation of the President/General Manager.

FUNCTIONS:

The services required of the Attorney(s) will vary in nature and extent according to the conditions and problems that arise. These services can be divided into routine and special services.

A. Routine services shall be rendered on an annual retainer fee basis and shall include the following:

1. Attendance at regular and special Board Meetings, or meetings of committees of the Board, when requested by the Board or President/General Manager.

2. Review of minutes of all Board Meetings, regular or special, to check conformity with the bylaws and applicable state and federal law and regulations.

3. Review of minutes, resolutions, bylaw amendments, notice of meetings, and review of the proceedings of the Annual Meeting of Members, or of Special Meeting of Members, and attending such meetings to be available for consultation and participation if events warrant.

4. Normal assistance and advice on tax matters, including reports and claims for exemption.

5. Review and legal approval of contracts and other documents as to form, substance and execution.

6. Miscellaneous letters and legal matters of a Minor nature not requiring an unusual amount of time, study and attention.

7. Advice and consultation concerning Miscellaneous matters of cooperative business, including policy and personnel actions, as requested by the Board or President/General Manager.

8. Attendance at association meetings pertaining to The activities of the Cooperative where special services are not required, and the choice of attending is left to the discretion of the attorney(s).

9. Handling of loan documents and mortgages.

B. 1. Attorney(s) may be requested by the Board of Directors to attend legal seminars, NRECA Annual Meetings and Regional Meetings. Such Meetings shall be compensated for at the rate of $250.00 per day plus expenses. Expenses shall be reimbursed as described in Policy No. 400-010. This amount shall become effective January 1, 2011.

2. Routine services shall be compensated for and included in the retainer fee of **$900.00** per month. This amount shall become effective January 1, 2021.

3. The following benefits will be paid 100% of the Premium cost.

(1) Business travel accident insurance.

RESPONSIBILITY: The Board of Directors.

SOURCE:

REVISED	January 15, 1988
REVISED	June 17, 1994
REVISED	October 16, 1996
REVISED	January 19, 2001
REVISED	February 16, 2001
REVISED	November 16, 2004
REVISED	November 24, 2010
REVISED	JULY 23, 2015
REVISED	June 23, 2016
REVISED	November 19, 2020

James Vanhoose
Secretary

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION
POLICY STATEMENT NO. 400-010
SECTION D

SUBJECT: **BOARD OF DIRECTORS - COMPENSATION**

OBJECTIVE: To provide fair and equitable compensation for members of the Board of Directors.

POLICY:

A. Per Diem of $900.00 plus mileage from the Director's home shall be paid to each Director for attending a regular or special Board Meeting.

B. Directors authorized to attend any meeting, workshop, seminars, etc. shall be paid $300.00 per day and shall be reimbursed for all legitimate expenses for attendance at such meetings. A detailed expense account, with receipts attached as appropriate shall be submitted to the Board for approval. No expenses will be paid for spouses of Directors accompanying them to meetings. Travel shall be reimbursed on the following basis.

1. If commercial air travel is available, then without regard to the mode actually used, reimbursement shall be for the expenses actually incurred in an amount not to exceed round trip air coach fare, if the same is available; otherwise, first class fare, plus cost of transportation to and from airport and other expenses attendant to air travel.

2. Mileage reimbursement, plus toll costs, for use of personal automobile shall be at the rate set forth in Policy No. 100-015, Section A.

3. Expenses incurred for travel earlier than sufficient time to attend a meeting shall not be reimbursed.

C. The following benefits will be paid 100% of the premium cost:

1. Business travel accident insurance.

2. 24-Hour accident insurance.

D. Travel and Per Diem

1. $300 Per Diem will be paid for one (1) day before meeting; if overnight stay is required.

2. If meeting ends late and overnight stay is required, $300 Per Diem would be paid for the following day.

3. Directors are allowed to attend, if so desired, two (2) of the following meetings yearly:

   NRECA Director's Conference
   NRECA Annual Meeting (*Allowed every other year.)
   Legislative Conference (*Every other year)

   a. *** It is encouraged to split up attendance of above meetings so that a representative is in attendance at all three meetings every year.**

4. KAEC & EKPC Annual Meetings – Available to all every year.

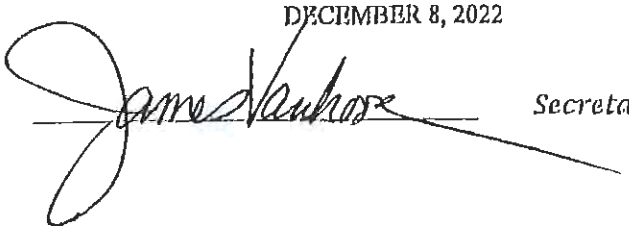
5. Any other meeting desiring to attend, must be presented prior to the board for approval.

6. Director must be willing and able to travel alone – if necessary. (No Staff or CEO)

RESPONSIBILITY: It shall be the responsibility of the Chairman of the Board to see that the provisions of the policy are carried out.

SOURCE:

ADOPTED:	January 18, 1991
AMENDED:	December 16, 1993
	June 17, 1994
	April 19, 1996
	February 18, 2000
	January 19, 2001
	February 16, 2001
	November 24, 2010
	January 24, 2013
	February 28, 2013
REVISED:	JUNE 23, 2016
	DECEMBER 8, 2022



Secretary James Vanhoose

Policy #400-010

BIG SANDY RURAL ELECTRIC COOPERATIVE CORPORATION
POLICY STATEMENT NO. 400-005
SECTION D

SUBJECT: **FUNCTIONS AND COMPENSATION OF COOPERATIVE ATTORNEYS**

PURPOSE:

A. To recognize the need for continuing legal guidance and counsel in the regular and special activities of the Cooperative, to insure maximum protection of the legal rights of the Cooperative, and to maintain operational conformity to the limitations prescribed by law.

B. To provide for the functions of the legal consultant employed as the regular Cooperative Attorney(s) or a monthly retainer fee basis and for additional counsel as required from time to time.

POLICY:

It shall be the policy of Big Sandy RECC to maintain a continuing relationship with the Attorney or firm of attorneys for the purpose of procuring the necessary legal assistance and advice to protect the corporate interests of the Cooperative.

The Board of Directors shall designate the Cooperative Attorney(s) upon the recommendation of the President/General Manager.

FUNCTIONS:

The services required of the Attorney(s) will vary in nature and extent according to the conditions and problems that arise. These services can be divided into routine and special services.

A. Routine services shall be rendered on an annual retainer fee basis and shall include the following:

1. Attendance at regular and special Board Meetings, or meetings of committees of the Board, when requested by the Board or President/General Manager.

2. Review of minutes of all Board Meetings, regular or special, to check conformity with the bylaws and applicable state and federal law and regulations.

3. Review of minutes, resolutions, bylaw amendments, notice of meetings, and review of the proceedings of the Annual Meeting of Members, or of Special Meeting of Members, and attending such meetings to be available for consultation and participation if events warrant.

4. Normal assistance and advice on tax matters, including reports and claims for exemption.

5. Review and legal approval of contracts and other documents as to form, substance and execution.

6. Miscellaneous letters and legal matters of a Minor nature not requiring an unusual amount of time, study and attention.

7. Advice and consultation concerning Miscellaneous matters of cooperative business, including policy and personnel actions, as requested by the Board or President/General Manager.

8. Attendance at association meetings pertaining to The activities of the Cooperative where special services are not required, and the choice of attending is left to the discretion of the attorney(s).

9. Handling of loan documents and mortgages.

B. 1. Attorney(s) may be requested by the Board of Directors to attend legal seminars, NRECA Annual Meetings and Regional Meetings. Such Meetings shall be compensated for at the rate of $250.00 per day plus expenses. Expenses shall be reimbursed as described in Policy No. 400-010. This amount shall become effective January 1, 2011.

2. Routine services shall be compensated for and included in the retainer fee of **$900.00** per month. This amount shall become effective January 1, 2021.

3. The following benefits will be paid 100% of the Premium cost.

(1) Business travel accident insurance.

RESPONSIBILITY: The Board of Directors.

SOURCE:

REVISED	January 15, 1988
REVISED	June 17, 1994
REVISED	October 16, 1996
REVISED	January 19, 2001
REVISED	February 16, 2001
REVISED	November 16, 2004
REVISED	November 24, 2010
REVISED	JULY 23, 2015
REVISED	June 23, 2016
REVISED	November 19, 2020

James Vanhoose
Secretary

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 48: Provide Big Sandy RECC's policies, specifying the compensation of directors and a schedule of standard directors' fees, per diems, and other compensation in effect during the test year. If changes occurred during the test year, indicate the effective date and the reason for the changes.

Response 48: Please refer to the attached policies in Response 47.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 49: 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 49: 2024 - The Annual Meeting was held on May 16, 2024, at 10:00 a.m. with a total of 422 registered members. There was no official election since District 1 (Danny Wallen) and District 2 (Jim McKenzie) were uncontested, and both seats were retained by acclamation. The total cost was $10,019.

2023 - The Annual Meeting was held on May 18, 2023, at 10:00 a.m. with a total of 438 registered members. There was no official election since District 5 (Gary Francis) and District 6 (Greg Davis) were uncontested, and both seats were retained by acclamation. The total cost was $15,612.

2022 - The Annual Meeting was held on May 19, 2022, at 10:00 a.m. with a total of 206 registered members. There was no election this year. The total cost was $12,206.

2021 - The Annual Meeting was held on June 10, 2021, at 10:00 a.m. with a total of 302 registered members. District 3 (George Spriggs) was replaced by Velma May with a total of 1,823 members voting. District 4 (James Vanhoose) was uncontested. The total cost was $18,709.

2020 - The Annual Meeting was held on May, 2020, at 10:00 a.m. with a total of 359 registered members. BSRECC members voted to reseat both District 1 (Danny Wallen) and, District 2 (Jim McKenzie), the total number of member votes was 2072. The total cost was $15,779.

2019 - The Annual Meeting was held on May 30, 2019, at 10:00 a.m. with a total of 330 registered members. There was no official election since District 5 (Robert Moore) and District 6 (Greg Davis) were uncontested, and both seats were retained by acclamation. The total cost was $11,200.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 50: Provide any information, when known, that would have a material effect on net operating income, rate base, or cost of capital that have incurred after the test year but were not incorporated in the filed testimony and exhibits.

Response 50: Big Sandy borrowed an additional $3,000,000 in long term debt in April, 2024.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 51: 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 51: Please see the Excel spreadsheets provided separately.

ATTACHMENTS ARE EXCEL SPREADSHEETS AND UPLOADED SEPARATELY

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 52: 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 Big Sandy RECC's rate application in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 52: The Excel spreadsheet files responsive to this request were uploaded to the Commission website on October 1, 2024, concurrent with the filing of the Application in this docket.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 53: To the extent not already provided, provide all workpapers, calculations, and assumptions Big Sandy RECC used to develop its test year financial information in Excel spreadsheet format with all formulas, columns, and rows unprotected and fully accessible.

Response 53: The Excel spreadsheet files responsive to this request were uploaded to the Commission website on October 1, 2024, concurrent with the filing of the Application in this docket.

Big Sandy Rural Electric Cooperative Corporation
Case No. 2024-00287
Commission Staff's First Request for Information

Request 54: State the credit metrics that are used in Big Sandy RECC's debt covenants.

Response 54: Along with reporting and other requirements, the general financial covenants that Big Sandy is required to meet are as follows:

- RUS/FFB: The average Coverage Ratios in the 2 best years out of the 3 most recent calendar years must not be less than any of the following:

  TIER = 1.25
  DSC = 1.25
  OTIER = 1.1
  ODSC = 1.1

- CFC: Average MDSC ratio of 1.35 (based on the best 2 out of the last 3 calendar years