Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

SIGN HERE

Signature of DFE

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2009

This Form is Open to Public Inspection

					Inspection		
Part I		tification Information					
For cale	ndar plan year 2009 or fiscal p	lan year beginning 01/01/2009		and ending 12/31/20	009		
A This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or			
	•	a single-employer plan;	a DFE (s	pecify)			
B This	return/report is:	the first return/report; an amended return/report;		eturn/report; an year return/report (less tha	on 42 months)		
C If the	plan is a collectively-bargaine	d plan, check here	ш .				
		Form 5558;	_	extension;	the DFVC program;		
D Chec	k box if filing under:			, exterision,	Ine Dr ve program,		
		special extension (enter des	•				
Part	II Basic Plan Inform	nation—enter all requested informa	ation				
	ne of plan ORP BENEFIT PLAN				1b Three-digit plan number (PN) ▶ 501		
					1c Effective date of plan 01/01/2009		
	ress should include room or s	e (employer, if for a single-employer puite no.)	olan)		2b Employer Identification Number (EIN) 61-1138864		
0500 DI	ANTSIDE DRIVE	0770 PLA	AUTOIDE DOUVE		2c Sponsor's telephone number 502-499-9991		
	ILLE, KY 40299		NTSIDE DRIVE LE, KY 40299		2d Business code (see instructions) 722110		
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.							
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.							
SIGN HERE	Filed with authorized/valid electronic signature.		09/27/2010	DENISE ROSS			
TILIXE	Signature of plan administ	rator	Date	Enter name of individual sig	ning as plan administrator		
SIGN	Filed with authorized/valid ele	ectronic signature.	09/22/2010	MICHAEL GREGORY			
HERE	Signature of employer/pla	n sponsor	Date	Enter name of individual sig	ning as employer or plan sponsor		

Date

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2009) v.092307.1

Enter name of individual signing as DFE

Form 5500 (2009)	Page 2	
3a Plan administrator's name and address (if same as plan sponsor	, enter "Same")	3b
RMD CORP		0-

	Plan administrator's name and address (if same as plan sponsor, enter "Sam D CORP	ne")		Iministrator's EIN
250	9 PLANTSIDE DRIVE JISVILLE, KY 40299		3c Ad	lministrator's telephone imber
			502	2-499-9991
4	If the name and/or EIN of the plan sponsor has changed since the last return the plan number from the last return/report:	n/report filed for this plan, enter the name, EIN	l and	4b EIN
а	Sponsor's name			4c PN
5	Total number of participants at the beginning of the plan year		5	190
6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6a, 6b, 6c, and 6d).		
_				470
а	Active participants		. 6a	176
b	Retired or separated participants receiving benefits		. 6b	
_	Other setinal as a second and initial and a setial of the feet was benefits		. 6c	
С	Other retired or separated participants entitled to future benefits		. 00	
d	Subtotal. Add lines 6a, 6b, and 6c		. 6d	176
е	Deceased participants whose beneficiaries are receiving or are entitled to re-	ceive benefits	. 6e	
f	Total. Add lines 6d and 6e		. 6f	176
g	Number of participants with account balances as of the end of the plan year		C ==	
	complete this item)		. 6g	
h	Number of participants that terminated employment during the plan year with		01	
7	less than 100% vested		. 6h	
8a	If the plan provides pension benefits, enter the applicable pension feature co		· 7	instructions:
u	in the plan provides pension benefits, enter the applicable pension reature co	des nom the list of Fian Characteristic Code	3 111 1110 1	iristructions.
b 1	the plan provides welfare benefits, enter the applicable welfare feature code	s from the List of Plan Characteristic Codes in	n the inst	tructions:
	4A 4B 4D 4H 4F			
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all the	at apply)	
	(1) Insurance	(1) X Insurance	11 37	
	Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurand	ce contracts
	(3) Trust	(3) Trust		
	(4) Seneral assets of the sponsor	(4) X General assets of the s		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the num	ber attac	ched. (See instructions)
а	Pension_Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) H (Financial Inform	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform		Small Plan)
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 3 A (Insurance Info	,	
		(4) C (Service Provide		,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participat	_	
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction S	Schedules)

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2009

		pursuant to El	RISA section 103(a)(2).	Tills Fo	Inspection		
For calendar plan year 20	09 or fiscal plan	year beginning 01/01/2009	and e	nding 12/31/2009			
A Name of plan RMD CORP BENEFIT PL	_AN			ee-digit number (PN)	501		
C Plan sponsor's name a RMD CORP	s shown on line	2a of Form 5500.	D Emplo	oyer Identification Numbe 38864	r (EIN)		
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca		ANCE COMPANY					
	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
35-0472300	70254	000010109977	176	01/01/2009	12/31/2009		
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and other persons in descending order of the amount paid.						
(a) Total amount of commissions paid (b) Total amount of fees paid							
	5494						
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all persons).				
		nd address of the agent, broker, o		sions or fees were paid			
BB&T INSURANCE SVC	S INC		OX 436869 VILLE, KY 40253-6869				
(b) Amount of sales ar	nd base	Fees	and other commissions paid				
commissions pa	id	(c) Amount	(d) Purpos	(e) Organization code			
	2560	0			3		
	(a) Name a	nd address of the agent, broker, o	or other person to whom commiss	sions or fees were paid			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid BB&T INSURANCE SERVICES INC. 2600 EASTPOINT PARKWAY LOUISVILLE, KY 40223							
(b) Amount of sales ar	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	e	(e) Organization code		
	2934	0			3		
For Donomicorly Dodicatio	n Act Notice	nd OMB Control Numbers and	the instructions for Form FEOD	•	hadula A (Form FEOO) 2000		

Schedule A (Form 5500)	2009	Page 2- 1			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Schedule A (Form 5500) 2009	Page 4	
information may be combined for reporting purpose	employees of the same employer(s) or members of the same employee organization(s), t s if such contracts are experience-rated as a unit. Where contracts cover individual employer carrier may be treated as a unit for purposes of this report.	

Schedule A (Form 5500	2009
--------------	-----------	------

8 Benefit and contract type (check all applicable boxes)

Part III

	а	Health (other than dental or vision)	b [Dental	С	Vision	c	Life insurance
	e 🏻	Temporary disability (accident and sickness)	f X	Long-term disability	g	Supplemental unemp	oloyment h	Prescription drug
	iΓ	Stop loss (large deductible)	iΠ	HMO contract	k	PPO contract		I Indemnity contract
	m D		SMEN	BERMENT		ı		
	···· [_ Guior (opesity) /						
9 [Ехре	erience-rated contracts:						
	a i	Premiums: (1) Amount received			9a(1)			
		(2) Increase (decrease) in amount due but unpaid	i		9a(2)			
		(3) Increase (decrease) in unearned premium res	erve		9a(3)			
		(4) Earned ((1) + (2) - (3))					9a(4)	
	b	Benefit charges (1) Claims paid			9b(1)			
		(2) Increase (decrease) in claim reserves			9b(2)			
		(3) Incurred claims (add (1) and (2))					9b(3)	
		(4) Claims charged					9b(4)	
	С	Remainder of premium: (1) Retention charges (o	n an a	ccrual basis)				
		(A) Commissions			9c(1)(A)			
		(B) Administrative service or other fees		<u> </u>	9c(1)(B)			
		(C) Other specific acquisition costs			9c(1)(C)			
		(D) Other expenses			9c(1)(D)			
		(E) Taxes		<u> </u>	9c(1)(E)			
		(F) Charges for risks or other contingencies.			9c(1)(F)			
		(G) Other retention charges			9c(1)(G)		1	
		(H) Total retention					9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	amou	nts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amo	unt held to provide b	enefits after	retirement	9d(1)	<u> </u>
		(2) Claim reserves					9d(2)	
		(3) Other reserves					9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no	ot inclu	ude amount entered	in c(2) .)		. 9e	
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	arrier				. 10a	49165
	b	If the carrier, service, or other organization incurr		•		•	401-	
	_	retention of the contract or policy, other than repo	orted i	n Part I, item 2 above	e, report am	ount	. 10b	
	Sp	ecify nature of costs						
Pa	rt I\	Provision of Information						
11	Dic	the insurance company fail to provide any inform	ation	necessary to comple	te Schedule	A?	Yes X	No
12	If th	he answer to line 11 is "Yes," specify the informati	on no	provided.				

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

Pension Benefit Guaranty Con	rporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 200	9 or fiscal plan	year beginning 01/01/2009		and en	ding 12	/31/2009	
A Name of plan RMD CORP BENEFIT PL			B Three plan	-digit number (PI	N) •	501	
C Plan sponsor's name at RMD CORP	s shown on line	e 2a of Form 5500.		D Employ 61-1138		ation Number	EIN)
		ing Insurance Contract (Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance car DELTA DENTAL OF KEN		(d) Contract or	(e) Approximate nur			Policy or co	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f)	From	(g) To
61-0659432	54674	000681740		340 01/01/2		09	12/31/2009
2 Insurance fee and comr descending order of the		ation. Enter the total fees and total	al commissions paid. Lis	st in item 3	the agents,	, brokers, and o	other persons in
(a) Total a	mount of comr			(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all p	ersons).			0
<u> </u>		nd address of the agent, broker,			ons or fees	were paid	
BB&T INSURANCE SER\		414 G	ALLIMORE ROAD STE NSBORO, NC 27404				
(b) Amount of sales an	d base	Fee	s and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpose	!		(e) Organization code
2770 0							
	(a) Name a	nd address of the agent, broker,	or other person to whom	commissi	ons or fees	were paid	
	(a) Name a	na address of the agent, broker,	or other person to whom	Commission	0113 01 1003	were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount	(0	d) Purpose		-	(e) Organization code

Schedule A (Form 5500)	2009	Page 2- 1			
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
		Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
	I				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai			
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual report.	be treated	d as a unit for purposes of		
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page	4		

X No

Yes

Schedule A	(Form	5500	2000
Scriedule A	(FOIIII	5500	<i> </i> 2008

b Benefit charges (1) Claims paid		art II		tion						
a			information may be combined for reporting p	urposes if such contracts	are experi	ence	e-rated as a unit. Wh	ere contrac		
e Temporary disability (accident and sickness)	8	Bene	efit and contract type (check all applicable boxes)	1						
i Stop loss (large deductible) j HMO contract k PPO contract l I Indemnity contract m Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount received		а	Health (other than dental or vision)	b X Dental	C	; □	Vision		d Life insuranc	е
i Stop loss (large deductible) j HMO contract k PPO contract l I Indemnity contract m Other (specify) 9 Experience-rated contracts: a Premiums: (1) Amount received		е	Temporary disability (accident and sickness)	f Long-term disability	ty C	ıΠ	Supplemental unemp	olovment	h Prescription	drug
## Dither (specify) ## Dither (specify) ## Disperience-rated contracts: ## Premiums: (1) Amount received. ## Premiums: (1) Received. ## Premiums: (1) Claims paid. ## Pa(1)		ιĖ				´ 🗀		,	H	•
### September-ated contracts: ### Premiums: (1) Amount received		m	_ · · · · · · · · · · · · · · · · · · ·		•	`⊔	11 o contract			illact
a Premiums: (1) Amount received			Other (specify)							
a Premiums: (1) Amount received	9	Fyne	prience-rated contracts:							
(2) Increase (decrease) in amount due but unpaid (3) Increase (decrease) in unearned premium reserve. (4) Earned ((1) + (2) - (3)). (5) Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves. (9b(1) 50657 (2) Increase (decrease) in claim reserves. (9b(2) 0 (3) Incurred claims (add (1) and (2)). (4) Claims charged. (5) Remainder of premium: (1) Retention charges (on an accrual basis). (6) C Remainder of premium: (1) Retention charges (on an accrual basis). (7) (8) Administrative service or other fees. (8) Q(1)(B) 8757 (9) Other expenses. (10) Other expenses. (10) Other expenses. (10) Other expenses. (10) Other retention charges. (11) F) Charges for risks or other contingencies. (11) G) Other retention charges. (12) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (12) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (2) Claim reserves. (3) Other reserves at end of year: (1) Amount held to provide benefits after retirement. (2) Claim reserves. (3) Other reserves. (3) Other reserves. (4) Claim reserves. (5) G(2) G(3) G(3) G(4) G(4) G(4) G(5) G(5) G(5) G(6) G(6) G(6) G(6) G(6) G(6) G(6) G(6					9a(1)			59410)	
(3) Increase (decrease) in unearned premium reserve			` '					()	
May			. , , , , , , , , , , , , , , , , , , ,					()	
b Benefit charges (1) Claims paid 9b(1) 50657 (2) Increase (decrease) in claim reserves. 9b(2) 0 (3) Incurred claims (add (1) and (2)) 9b(3) 50 (4) Claims charged. 9b(4) 50 C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions. 9c(1)(A) 2770 (B) Administrative service or other fees 9c(1)(B) 8757 (C) Other specific acquisition costs 9c(1)(D) (E) 7axes. 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(E) (G) Other retention charges 9c(1)(E) (H) 7 total retention 9c(1)(E) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or packed by the service of the reserves 9d(2) (2) Claim reserves. 9d(3) (3) Other reserves 9d(3) (4) Polividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier. 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount. 10b			. , , , , , , , , , , , , , , , , , , ,					9a(4)		59410
(2) Incurred claims (add (1) and (2)). (3) Incurred claims (add (1) and (2)). (4) Claims charged. (A) Commissions. (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges. (H) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (2) Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).). (B) Status of policyholder reserves. (C) Other sevenses. (D) Other expenses. (E) Taxes. (F) Charges for risks or other contingencies. (G) Other retention charges. (H) Total retention. (D) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.). (D) Credited.) (D) Other sevenses. (D) Other seven		_							7	
(3) Incurred claims (add (1) and (2)) 9b(3) 50 (4) Claims charged 9b(4) 50 C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions 9c(1)(A) 2770 (B) Administrative service or other fees 9c(1)(B) 8757 (C) Other specific acquisition costs 9c(1)(C) 9c(1)(D) (D) Other expenses 9c(1)(E) (F) Taxes 9c(1)(E) (F) Charges for risks or other contingencies 9c(1)(F) (G) Other retention charges 9c(1)(G) (H) Total retention 9c(1)(H) 17 (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) (C) Claim reserves 9d(2) (C) Claim reserves 9d(3) (C) Claim reserves 9d(3) (C) Claim reserves 9d(3) (C) Charges retroactive rate refunds due. (Do not include amount entered in c(2).) 9c (C)			• , ,		(-)			()	
(4) Claims charged								9b(3)		50657
C Remainder of premium: (1) Retention charges (on an accrual basis) (A) Commissions										50657
(B) Administrative service or other fees			. ,							
(B) Administrative service or other fees			(A) Commissions	·······	9c(1)(A	.)		2770)	
(D) Other expenses			(B) Administrative service or other fees					8757	7	
(E) Taxes			(C) Other specific acquisition costs		9c(1)(C)				
(F) Charges for risks or other contingencies			(D) Other expenses		9c(1)(D)				
(G) Other retention charges			(E) Taxes		9c(1)(E)				
(H) Total retention			(F) Charges for risks or other contingencies.							
(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9c(2) d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement 9d(1) (2) Claim reserves 9d(2) (3) Other reserves 9d(3) e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 9e 10 Nonexperience-rated contracts: 10a b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount. 10b			(G) Other retention charges		9c(1)(G	i)				
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			(H) Total retention					9c(1)(H)	1	11527
(2) Claim reserves			(2) Dividends or retroactive rate refunds. (These	e amounts were paid in	cash, or	С	redited.)	9c(2)		
(3) Other reserves		d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits a	fter	retirement	9d(1)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).) 10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier			(2) Claim reserves					9d(2)		
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier			(3) Other reserves					9d(3)		
a Total premiums or subscription charges paid to carrier		е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	d in c(2) .) .			9e		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	10	No	nexperience-rated contracts:							
retention of the contract or policy, other than reported in Part I, item 2 above, report amount		а	Total premiums or subscription charges paid to o	carrier				10a		
1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		b					•	4.01		
Specify nature of costs ▶				orted in Part I, item 2 abor	ve, report	amo	ount	. 10b		
		Sp	ecify nature of costs							
		Sp	ecify nature of costs							

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Provision of Information

Part IV

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

OMB No. 1210-0110

2009

	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). This Form					
an year beginning 01/01/2009	and e	nding 12/3	1/2009			
		ŭ	•	501		
ne 2a of Form 5500.	·	•	tion Number ((EIN)		
			Policy or co	ontract year		
(d) Contract or identification number	persons covered at end of	(f) F		(g) To		
00180684	297	01/01/2009	9	12/31/2009		
	commissions paid. List in item 3	the agents, b	orokers, and o	other persons in		
nmissions paid	(b) To	otal amount of	fees paid			
	s needed to report all persons).			0		
		ions or fees w	ere paid			
2600 E	ASTPOINT PARKWAY					
Fees	and other commissions paid					
(c) Amount	(d) Purpos	e		(e) Organization code		
0				3		
and address of the agent broker of	ur other person to whom commiss	ione or fees w	vere paid			
and address of the agent, broker, o	a outer berson to mnorn commiss	IOIIS OI IEES W	rore palu			
Fees	and other commissions paid					
(c) Amount	(d) Purpos	e		(e) Organization code		
	ne 2a of Form 5500. Thing Insurance Contract Contract Contract Contracts grouped as a second contract of identification number contract of id	ne 2a of Form 5500. D Emplo 61-113 Individual contracts grouped as a unit in Parts II and III can be reported. Individual contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (e) Approximate number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (b) Total Contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (b) Total Contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (b) Total Contract or identification number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (c) Approximate number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (c) Approximate number of persons covered at end of policy or contract year 00180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (d) Approximate number of persons covered at end of policy or contract year 0180684 297 Individual contracts grouped as a unit in Parts II and III can be reported. (e) Approximate number of persons covered at end of policy or contract year 0180684 Individual contracts grouped as a unit in Parts II and III can be reported. (e)	D Employer Identificated 61-1138864 Ining Insurance Contract Coverage, Fees, and Commissions Fill and III can be reported on a sinual contracts grouped as a unit in Parts II and III can be reported on a sinual contract or identification number (e) Approximate number of persons covered at end of policy or contract year (f) Fill and III can be reported on a sinual contract or identification number (f) Fill and III can be reported on a sinual contract or identification number (f) Fill and III can be reported on a sinual contract or identification number (f) Fill and III can be reported on a sinual contract or identification number of persons covered at end of policy or contract year (f) Fill and III can be reported on a sinual contract or identification number of persons covered at end of	ne 2a of Form 5500. D Employer Identification Number of 61-1138864 Ining Insurance Contract Coverage, Fees, and Commissions Provide inform. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule ICKY DBA ANTHEM BLUE CROSS AND BLUE SHIELD (d) Contract or identification number of persons covered at end of policy or contract year 00180684 297 01/01/2009 Ination. Enter the total fees and total commissions paid. List in item 3 the agents, brokers, and on the commissions paid (b) Total amount of fees paid 27923 fees. (Complete as many entries as needed to report all persons). and address of the agent, broker, or other person to whom commissions or fees were paid 2600 EASTPOINT PARKWAY LOUISVILLE, KY 40223 Fees and other commissions paid (c) Amount (d) Purpose Fees and other commissions or fees were paid Fees and other commissions paid		

Schedule A (Form 5500) 2009 Page 2-				
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d	
		Fees and other commissions paid		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d	
	I			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were pai		
(4)	and address of the agont, or	oner, et euret person le miem commissione et lece were per	-	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ame and address of the agent, bro	oker, or other person to whom commissions or fees were paid	d	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

Part II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivitins report.			idual contra	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year en			5	
_		racts With Allocated Funds:				
	а	State the basis of premium rates •				
	b	Premiums paid to carrier			6b	
	С	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection witl	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan c	heck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		ion guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year	. 7c(3)			
		(4) Transferred from separate account	. 7c(4)			
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6))			7d	
		Deductions:				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	• •			
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract e(5) from d)			7f	

Page	4

X No

Yes

	rt II	If more than one contract covers the same gree information may be combined for reporting puthe entire group of such individual contracts we	oup	of employees of the ses if such contracts	are expe	rienc	e-rated as a unit. Wh	ere contrac		
8	Bene	efit and contract type (check all applicable boxes)		_			<u>.</u>		_	
	a	Health (other than dental or vision)	b	Dental		С	Vision		d Life i	nsurance
	е	Temporary disability (accident and sickness)	f	Long-term disabili	ty	g	Supplemental unem	ployment	h Preso	cription drug
	i [Stop loss (large deductible)	i	HMO contract		k	PPO contract		I Inder	nnity contract
	m	Other (specify)	•			<u> </u>	I		Ш	,
	∟	Guidi (Specify)								
9	Expe	rience-rated contracts:								
		Premiums: (1) Amount received			9a(1))		72496	3	
		(2) Increase (decrease) in amount due but unpaid	١							
		(3) Increase (decrease) in unearned premium res								
		(4) Earned ((1) + (2) - (3))						9a(4)		724963
	b	Benefit charges (1) Claims paid			9b(1))		56282	1	
		(2) Increase (decrease) in claim reserves			9b(2))				
		(3) Incurred claims (add (1) and (2))						9b(3)		562821
		(4) Claims charged						9b(4)		
	С	Remainder of premium: (1) Retention charges (or	n a	n accrual basis)						
		(A) Commissions			9c(1)(A)		2793	2	
		(B) Administrative service or other fees			9c(1)(l			98580)	
		(C) Other specific acquisition costs			9c(1)(_				
		(D) Other expenses			9c(1)(l					
		(E) Taxes			9c(1)(l	_			_	
		(F) Charges for risks or other contingencies			9c(1)(I			99562	2	
		(G) Other retention charges								000074
		(H) Total retention		_		_		9c(1)(H)	226074
		$\begin{tabular}{ll} \end{tabular} \begin{tabular}{ll} \end{tabular} \beg$	am	ounts were paid ir	n cash, or	(credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)) Ar	nount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves						9d(2)		
		(3) Other reserves						9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot ir	clude amount entered	d in c(2) .)			. 9e		
10		nexperience-rated contracts:								
		Total premiums or subscription charges paid to ca						10a		
		If the carrier, service, or other organization incurre retention of the contract or policy, other than report						10b		
	Sp	ecify nature of costs •								
Pa	rt I\	/ Provision of Information								

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation Service Provider Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2009

This Form is Open to Public Inspection.

For calendar plan year 2009 or fiscal plan year beginning 01/01/2009	and ending 12/31/2009
A Name of plan RMD CORP BENEFIT PLAN	B Three-digit
RIND CORF BENEFIT FEAN	plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
RMD CORP	61-1138864
Part I Service Provider Information (see instructions)	
You must complete this Part, in accordance with the instructions, to report the information re or more in total compensation (i.e., money or anything else of monetary value) in connection plan during the plan year. If a person received only eligible indirect compensation for which answer line 1 but are not required to include that person when completing the remainder of	n with services rendered to the plan or the person's position with the n the plan received the required disclosures, you are required to
1 Information on Persons Receiving Only Eligible Indirect Compensat	ion
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of the indirect compensation for which the plan received the required disclosures (see instructions).	, , , , , , , , , , , , , , , , , , ,
b If you answered line 1a "Yes," enter the name and EIN or address of each person providing received only eligible indirect compensation. Complete as many entries as needed (see ins	
(b) Enter name and EIN or address of person who provided you dis	sclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	sclosure on eligible indirect compensation
(S) Enter name and Enver address of person time provided you as	2010 Carlo C
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you dis	closures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

answered	l "yes" to line 1a above	e, complete as many e	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in to	otal compensation
		(a) Enter name and EIN or	address (see instructions)		
ANTHEM H	HEALTH PLANS OF K	ENTUCKY		RITON PARK BLVD LLE, KY 40223		
61-1237516	6					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 62	THIRD-PARTY ADMINISTRATOR		Yes X No [Yes 🛛 No 🗌	16216	Yes No 🛚
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page 4- 1	Page	4-	1
------------------	------	----	---

(a) Enter name and EIN or address (see instructions)						
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a
	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element	estimated amount?
					(f). If none, enter -0	
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a
		by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest	Citici o .	sponsor)	disclosures?	compensation for which you answered "Yes" to element	
					(f). If none, enter -0	
			Yes No	Yes No		Yes No
		(a) Enter name and EIN or	address (see instructions)		
(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you a
()		by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest	0.1.01	sponsor)	disclosures?	compensation for which you answered "Yes" to element	
					(f). If none, enter -0	
			Yes No	Yes No		Yes No

0 - 1 1 - 1 - 0	/F	FF00\	0000
Schedule C	(Form	5500)	2009

Page 5-	1
----------------	---

Part I Service Provider Information (continued)

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
ANTHEM HEALTH PLANS OF KENTUCKY	12 13 15 62	16216
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine for or the amount of	compensation, including any e the service provider's eligibility the indirect compensation.
NEXT RX SERVICES, INC.	PRESCRIPTION DRUG REI ADMINISTRATIVE FEES.	BATES AND RELATED
16-1279199		
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.

Page 6-	1
----------------	---

Part II Service Providers Who Fail or Refuse to Provide Information				
4 Provide, to the extent possible, the following information for earthis Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide		

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)			
а	Name:	b EIN:	
С	Position:		
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN:	
C	Position:		
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN:	
C	Position:	D LIIV.	
d	Address:	e Telephone:	
Ex	xplanation:		
а	Name:	b EIN;	
C	Position:	₩ ±111,	
d	Address:	e Telephone:	
-			
Ex	xplanation:		
а	Name:	b EIN;	
C	Position:		
d	Address:	e Telephone:	
Ex	xplanation:		