IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF KANSAS

MARTIN J. WALSH, SECRETARY OF LABOR, U.S. DEPARTMENT OF LABOR,	)	
Plaintiff,	)	
v.	)	
DANIELL. WHITNEY; MICHELLE WILLSON; MEDOVA HEALTHCARE FINANCIAL GROUP, LLC; MIDLANDS CASUALTY INSURANCE COMPANY, INC.; JUST DIABETIC SUPPLIES, LLC; ADVENT HEALTH SERVICES, LLC d/b/a DIRECTHEALTH; BENISON CAPITAL ADVISORS, INC.; PATRICK ENTERPRISES, INC.; LIFESTYLE HEALTH PLANS GROUP BENEFIT PROGRAM; LIFESTYLE HEALTH PLANS - LEVEL FUNDED GROUP BENEFITS; LEVEL FUNDED LIFESTYLE SELF-INSURED HEALTH PLAN; LIFESTYLE HEALTH PLANS,	)	**CIVIL ACTION** **Case No. 2:20-cv-02624-TC-ADM**
Defendants.	)	

FIRST REPORT OF INDEPENDENT FIDUCIARY

Receivership Management, Inc. ("RMI"), in its capacity as court-appointed Independent Fiduciary, by counsel and pursuant to ¶ 8(d) of the Consent Order entered in this matter (Dkt. 32) ("Consent Order"), submits to the Court this First Report.

I. Introduction

On March 18, 2021, the Consent Order was entered appointing RMI as Independent Fiduciary on an interim basis "for all the employee welfare benefit plans, as defined in Section

(3)(1) of [ERISA] (the "Plans")… for which Defendant Medova [Healthcare Financial Group, LLC ("Medova")] serves as the claims administrator." Consent Order, ¶ 1. The Consent Order confers various responsibilities and powers upon the Independent Fiduciary relating to the Plans. *Id.*, *passim*. The Consent Order requires RMI to "report all actions taken and all assets expended in its administration of the Plans" by June 9, 2021, and monthly thereafter. *Id.*, ¶ 8(d).

II. First Report of Independent Fiduciary

RMI is in the process of gathering information and taking control of assets as provided in the Consent Order. Because it is still in the process of taking control of the Plan assets over which it is given authority in the Consent Order, RMI has not yet directly expended any Plan assets in its administration of the Plans. To date, Medova, under the direction and with the approval of RMI, continues to collect premium-equivalent contributions from Plan participants ("Participants") and employer-sponsors ("Employers"), deduct its fees and the fees of certain other service providers, pay stop-loss premiums and collect stop-loss proceeds, and administer and pay medical claims. RMI continues to gather information about these and other issues relating to Medova's level-funded Lifestyle Health Programs through frequent, direct communications with Medova personnel and counsel.

A. Status of Change of Control of Bank Accounts.

Pursuant to ¶ 1 and Appendices A and B of the Consent Order, RMI has made substantial progress towards the transfer of control from Medova to RMI of approximately 2,450 Plan accounts, nine Medova accounts, and a lockbox account, all held at Simmons Bank. Upon being served with the Consent Order, Simmons Bank froze all Plan bank accounts and advised RMI that any refused payments would result in bank charges. Understanding that these accounts have thousands of disbursements per week, RMI ordered the accounts restored and implemented

procedures by which RMI may approve financial transactions to be executed by Medova necessary to the essential operations of the Plans. It is expected that the process of changing control of these accounts will be near completion by the time of this filing.

B. Information Gathering by RMI.

RMI submitted to Medova information requests seeking certain business and financial records of Medova relating to the Plans. Medova has been producing such records and RMI is in the process of reviewing and analyzing them. From March 24-26, 2021, RMI's President, Robert E. Moore, Jr., and two of its financial employees, Jacqueline Lawson and David Bennett, visited Medova's Wichita offices to gain insight into Medova's business and financial practices, including operation of the level-funded Lifestyle Health Programs at issue in this case, Medova's claims procedures (including its use of an outside vendor, Complete Health Systems ("CHS"), in connection with claims administration), the flow of funds collected as premium-equivalent contributions from Participants and Employers, expense payments, and stop-loss operations of the Plans. From April 6-9, 2021, Mr. Bennett, a CPA, returned to Medova's offices to learn more about its claims and stop-loss procedures. What follows is based on these meetings, as well as RMI's review of documents, and information exchanged through counsel.

1. The Plans and the Relevant Agreements

As of the date of this filing, there are approximately 2,450 active ERISA Plans for which Medova acts as TPA. Each Plan is a single-employer, self-funded employee welfare benefit plan subject to ERISA. Each Employer executes and adopts a Plan Document describing in detail the benefits to be provided to its employee-Participants and their dependents. *See* Ex. 1, Sample Plan Document. In all, there are tens of thousands of individual Participants in the Plans for which Medova provides services.

Each Employer enters into its own Administrative Services Agreement ("ASA") with Medova. Pursuant to the ASA, Medova is obligated to provide an extensive suite of TPA and related services critical to the proper functioning of the Plans. *See* Ex. 2, Sample ASA. Most importantly, Medova administers and pays medical claims and obtains and pays premiums for stop-loss insurance coverage.[1] In fact, there is little if anything the Employers do in connection with the Plans beyond the payment of monthly contributions.

Prominent in both the ASA and the Plan Document is the disclosure that each Plan is a single-employer, self-funded health benefit plan subject to ERISA, and that responsibility for the funding and payment of benefits rests with the Employer, which is to fund such payments from its general assets. For example, the Plan Document describes each Plan as "a self-funded group health plan sponsored and maintained by the Employer…. Funding for the benefits provided by the Plan is derived from the general assets of the Employer…." Ex. 1, p. 1. The ASA recognizes each Plan is a "self-funded welfare plan," and each Employer "agrees that Medova will administer the Plan as an employee welfare benefit plan subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA")…." Ex. 2, p. 1. The ASA also provides: "Employer acknowledges that Employer will be responsible for any claims shortfalls to the extent that Employer has not purchased specific or aggregate stop loss insurance coverage (or other similar coverage) covering such shortfall." ASA, p. 17, ¶ 5(A)(vii).

Under ERISA, this is not an unusual arrangement. Employers are responsible for the payment of benefits under health and welfare benefit plans they adopt and implement. To limit the financial risk of excessive claims, however, an Employer will (and should) obtain indemnification for such claims. Typically, employers secure what is referred to as "stop-loss"

[1] Pursuant to the Consent Order, these activities are now overseen by the Independent Fiduciary.

insurance. Generally, stop-loss insurance protects the Employer from the high costs of health care that may be incurred by a single covered Participant (specific stop loss) and across the entire Plan (aggregate stop loss). Medova arranges with stop-loss carriers to provide a separate policy for each Plan that includes both specific and aggregate stop-loss coverage. *See* Ex. 3 Sample Stop-Loss Policy. The purpose of these agreements is to limit the economic impact to the Employer of an ERISA self-funded health benefit plan. Otherwise, the Employer's assets would be subject to potentially catastrophic health costs without protection.

In general under an aggregate stop-loss policy, the Employer bears the cost of medical claims up to a specified annual amount known as the "attachment point."[2] For the aggregate cost of annual medical claims over the attachment point, the stop-loss carrier reimburses the Employer pursuant to the aggregate policy. For example, the stop-loss policy in Exhibit 3 has an attachment point of $93,350 for the Employer, whose Plan covers 26 Participants. *See* Ex. 3, Application p. 2.

Aggregate stop-loss policies typically reimburse the Employer at the end of the Plan year for the total amount of medical claims incurred and paid above the attachment point. *See, e.g.,* Ex. 3, Policy pp. 6-7, § III . The stop-loss policies here, however, include what is called an "accommodation" feature. The accommodation feature helps an Employer's cash flow by providing monthly accommodation for claims in excess of a pro-rated attachment point based on how many months have expired in the Plan year. *See, e.g.,* Ex. 3, Agg. Accom. End., § 1. Claims must be both incurred and paid by the Plan up to the relevant pro-rated attachment point before accommodation in the form of reimbursement will be provided. *Id.*, § 2(b). If the Plan is provided accommodation payments based on claims incurred and paid in excess of the pro-rated

[2] The amount up to the attachment point is also sometimes referred to as the Employer's deductible under the stop-loss policy.

attachment point, it may owe accommodation funds back later in the year if its total claim payments fall below a later, pro-rated attachment point, or the full attachment point at year-end. *Id.*, § 4.

2. Medova's "Level-Funded" Lifestyle Health Programs

Medova markets its Lifestyle Health Programs as "level funded," representing that the Employer need only contribute to its Plan a fixed amount of premium each month to fully cover all Participants. *See* Ex. 4, Medova website pages. At the March meetings in Wichita, Medova described to RMI how it calculates Employer contributions at the beginning of each Plan year.[3] RMI was told that Medova starts with the average medical claims expense for the prior two years,[4] then adds the "fixed costs" of its TPA fees, stop-loss premiums, network access fees, utilization review costs, and broker and stop-loss commissions. The total of these amounts is then divided by 12 to arrive at the monthly "level funded premium amount."

Medova issues invoices to the Employers at the beginning of each month. Upon receipt of the Employer's contribution, Medova immediately deducts all stop-loss premiums, commissions, and fees (including its own). After these deductions, Medova contends that 25 to 30 percent of the monthly amount contributed remains to pay medical claims, although the Independent Fiduciary has identified instances where the percentage is much lower. It appears Medova's intent is to price the Lifestyle Health Programs so that the annual total of Employer contributions net of fees and expenses will be sufficient to pay claims up to the aggregate stop-

[3] Not all Plans operate on a calendar year. Instead, each Plan year begins on the anniversary date of the month in which the Plan first obtained coverage.

[4] Medova later informed RMI that it calculates potential claims costs by using Milliman underwriting software, individual health applications, two years of claims data if available, and current and renewal rates from existing health carriers.

loss attachment point. The stop-loss carrier then reimburses the Employer for any medical costs above the attachment point. This is why Medova contends that Employers are not responsible to pay any amounts over and above the monthly level-funded premium amount, despite the self-funded nature of the Plans and their need to comply with ERISA. As discussed further ahead, it appears that Medova attempts to achieve this outcome by delaying the payment of certain approved claims for significant periods of time.

3. Medova's Stop-Loss Practices.

In the past, the aggregate stop-loss policies were issued by Midlands Casualty Insurance Company ("MCIC"), a captive insurance entity licensed in Hawaii and controlled by Medova.[5] As a captive insurer, MCIC is not rated. In 2018, it failed to meet minimum financial standards under Hawaii law and was able to comply in 2019 only after a $4,500,000 capital infusion. Medova ceased using MCIC to provide direct stop-loss coverage after the Department of Labor ("DOL") criticized the arrangement during its pre-filing investigation. Thereafter, until April 1, 2021, MCIC has had quota-share reinsurance treaties/agreements with several A-rated insurance carriers that "front" the aggregate risk on its behalf ("Fronting Carriers").[6] Under these agreements, the Fronting Carriers directly provide stop-loss coverage to the Employers, but then reinsure all of the risk to MCIC. MCIC pays the Fronting Carriers fees in the form of ceding

[5] "Captive Insurers" are insurance entities that provide coverage only for specific beneficiaries or risks, and are not available to the general public. In general, they are not as heavily regulated nor are they required to have the same level of surplus as traditional insurers.

[6] In a meeting with representatives of the Independent Fiduciary on Wednesday, March 24, 2021, Defendant Daniel Whitney, Medova's President, stated that the MCIC quota share arrangement would not be used for new or renewing Plans after April 1, 2021. He further stated that MCIC would therefore not be completely out of every Plan's stop-loss coverage until October 1, 2022 (accounting for a 6-month run out period after expiration of the Plan year for Plans that renewed under the quota share system as late as March 30, 2021).

commissions, and the Fronting Carriers ultimately retain no risk except to pay any covered losses MCIC is unable to pay.

In addition, several of the Fronting Carriers allow Medova to hold a majority (as much as 80 to 90 percent) of the stop-loss premiums paid by the Employers to fund the aggregate accommodation feature of the policies. These amounts, which constitute a substantial portion of the total monthly contributions to the Plans, are transferred into one of several accommodation accounts (depending on the Fronting Carrier), and are then administered by Medova. Thus, Medova (now with the Independent Fiduciary's oversight) determines when funds from these accommodation accounts should be paid to Plans, and when such payments should be returned by Plans.

Medova makes weekly transfers of funds to and from the accommodation and Plan accounts. While monthly aggregate analysis reports for each Plan are provided by CHS, based on statements by Medova personnel it does not rely on those reports to determine how much a Plan may be due in accommodation payments to cover claims, nor does Medova compute the Plan's actual attachment point (which varies throughout the year). Instead, it examines whether a Plan has enough assets after deduction of fees and expenses to pay medical claims, and if not, attempts to determine what funds are available from the accommodation fund and transfers any available amount into the Plan's account. If a Plan accumulates enough funds to repay some of those amounts, Medova directs those funds from the Plan's account back to the accommodation fund. Neither MCIC nor Medova appears to report to the stop-loss carrier medical claims that may need more funding than is available in the accommodation fund. Medova's staff reported to the Independent Fiduciary that there are no written procedures or guidelines that it follows for

the computation of amounts paid or retrieved from Plan accounts in connection with the accommodation feature.

On or about March 29, 2021, Medova submitted a request to RMI to "claw back" $635,999.10 to the accommodation funds from 212 Plans.[7] Medova indicated these Plans had "received too much money" and for the current period needed to refund the money. No documentation was supplied to indicate how these amounts were computed and on what basis this action was being taken. To gain a further understanding of Medova's request, on April 6, 2021, the Independent Fiduciary sent its CPA, David Bennett, to Medova to meet with Medova's claims manager, Michael Rohlmeier, and its director of finance, David Duncan. During these meetings, they confirmed there are no written procedures being followed for these actions and no standard method of calculation to determine how much a Plan should receive or how much should be clawed back. Based on Mr. Duncan's statements to Mr. Bennett, Mr. Duncan does not rely on monthly aggregate reports to determine the amounts to be clawed back. In reviewing a small sample, Mr. Bennett identified several of the 212 Plans for which money was being returned to the accommodation account despite having their own outstanding claims, some older than 60 days. This "claw back" of Plan assets to the accommodation fund was not approved.

4. Medova's Claims Practices.

Based on the structure of its Lifestyle Health Programs, it is necessary for Medova to delay the payment of certain approved medical claims. In a meeting on March 26, 2021, Mr. Whitney confirmed to the president of RMI, Robert E. Moore, Jr., that the level-funded feature of the Lifestyle Health Programs is dependent upon delaying the payment of approved

[7] Although this particular request related only to 212 Plans, it is clear that Medova follows these same practices for all of the Plans.

claims when Plan bank accounts balances and available accommodation funds are insufficient to pay them. When a Plan account has insufficient funds, Medova simply holds claims for an indefinite period of time until enough monthly contributions, accommodation payments, and stop-loss proceeds accumulate to pay them.

On March 26, 2021, Medova presented the Independent Fiduciary with a request to approve the payment of claims for 2,698 Plans.[8] Medova supported its request with a spreadsheet identifying outstanding "ready" (*i.e.*, approved) claims and each Plan's bank account balance. *See* Ex. 5. For many of these Plans, Medova showed a large amount of unpaid claims, but no recommended payment amount. Further analysis disclosed that for 643 Plans, there were $12,669,570.44 in adjudicated, processed claims ready for funding. These 643 Plans, however, were short on available funds to pay those claims in an amount totaling $9,906,314.01.[9] Medova stated it had not informed any of the 643 Employers regarding these shortfalls, and that its practice is not to provide any Explanation of Benefits in connection with such claims until funding is available.[10]

At Mr. Moore's request, Medova then provided an aging report on unpaid medical claims for all Plans. That report revealed that, as of March 26, 2021, there were $5,561,967.30 of unpaid claims with processing dates over 90 days old. When asked why these claims were unpaid, Medova representatives responded that the Employers had not contributed enough funds

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[8] This number appears to include non-ERISA plans (*i.e.,* church and government plans) administered by Medova over which the Independent Fiduciary has no authority under the Consent Order.

[9] The actual shortfall is likely to be higher because the unpaid claims were compared against each Plan's unreconciled bank balance on the report date, without taking into account any outstanding checks or ACH payments that may not have been reflected in those balances.

[10] Although this report indicates 643 Plans had insufficient funds to pay claims, such shortfalls could occur with any of the Plans depending on their level of claims and funding at any particular time.

to pay the submitted medical claims, and there were insufficient accommodation funds either due or available to pay such claims. Medova representatives, although admitting many of these claims are very old, stated they would not be paid until an Employer had completed funding its "medical expense" amount. RMI has requested similar updated weekly claims reports but to date Medova has not provided them.

The Independent Fiduciary has concluded that Medova's practice of delaying the payment of approved medical claims is contrary to ERISA regulations, the ASA, the Plan Document, and other agreements. These claims practices are not disclosed to Employers, Participants, or providers. The Independent Fiduciary has provided Medova legal and factual support for its conclusion that Medova's claims practices are improper. Medova has responded that it believes the stop-loss carriers may provide additional accommodation that would cure the asset deficiencies, and the Independent Fiduciary has allowed Medova time to attempt to reach such a resolution. To date, Medova has not indicated that any such resolution is possible.

The Independent Fiduciary has informed Medova that its business practice of delaying the payment of approved claims cannot continue and Medova must cure the asset deficiencies either with additional proceeds from the stop-loss policies or additional Employer contributions as required by the ASA and Plan Document. Thus far, Medova has refused to seek additional contributions from Employers. While the Independent Fiduciary has not imposed a specific deadline, the Independent Fiduciary has been clear that Medova must quickly reach an agreement with the stop-loss carriers or seek additional contributions from the Employers.

C. Additional Actions of the Independent Fiduciary.

RMI and Medova are negotiating the form of notices to be sent to Plan Participants and Employers concerning the Consent Order and appointment of the Independent Fiduciary, as well

as necessary amendments to the Plan Document and ASA. RMI is also in the process of preparing a Request For Proposals ("RFP") to be directed to independent actuarial firms that can assist RMI with its obligation "to perform an assessment of the actuarial soundness of the Plans and their financial viability" under Consent Order ¶ 7. RMI will solicit input from Medova and the Secretary concerning the content of the RFP.

Respectfully submitted,

RECEIVERSHIP MANAGEMENT, INC.,
IN ITS CAPACITY AS INDEPENDENT
FIDUCIARY

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Exhibit 1

EMPLOYEE BENEFIT BOOKLET

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INTRODUCTION

This Plan of comprehensive major medical benefits is established by and maintained through the provisions of this Plan Document, which also is intended to be a Summary Plan Description compliant with applicable law. The Plan is a self-funded group health plan sponsored and maintained by the Employer with the assistance of a third-party Claims Administrator. Funding for the benefits provided by the Plan is derived from the general assets of the Employer and contributions made by Covered Persons through a Section 125 Plan, as described below. The Plan is not intended to be insured, and is intended to come within the purview of the Employee Retirement Income Security Act of 1974 ("**ERISA**"). As such, to the extent permitted by law, ERISA preempts State law and jurisdiction with respect to the Plan.

This Plan is effective as stated in Attachment #1, as amended by this revised Employee Benefit Booklet effective as of the date set forth in the bottom right hand corner. The Attachment #1 and this Employee Benefit Booklet/Summary Plan Description constitute the complete Plan document (collectively the "**Plan Document**" or "**Plan**"). The Employer intends to continue this Plan without interruption thereafter, but reserves the right to terminate the Plan. This Plan may be reviewed and amended from time to time by the Employer. For purposes of the reporting requirements of the Employee Retirement Income Security Act (ERISA) of 1974, Plan Year shall end and the next Plan Year will begin as specified in Attachment #1.

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs which are not covered by the Plan and which would otherwise be covered by secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

SECTION 125 PLAN RULES

The Group Medical Plan is funded through a cafeteria plan ("**Section 125 Plan**") intended to comply with section 125 of the Internal Revenue Code of 1986, as amended ("**Internal Revenue Code**"), which permits Employees to reduce their compensation on a pre-tax basis and have that amount contributed to the Medical Plan on their behalf. Any Section 125 Plan is hereby amended and deemed to include contributions made on an after-tax basis to the extent required by law under "COBRA" (as defined below) and the Family Medical Leave Act, as amended ("**FMLA**").

Any Employee who is eligible to participate but elects not to participate or who fails to return a completed enrollment form within 31 days of first becoming eligible may not participate in the Medical Plan unless he meets the requirements under the section below titled "Late Requests."

An Eligible Employee who has previously completed an enrollment form but fails to return a new election form before the last day of the Annual Enrollment Period for a subsequent Plan Year will be deemed to have made the same election as in effect prior to the end of the preceding Plan Year, adjusted for any increases or decreases in premiums.

PERMITTED ELECTION CHANGES

Generally, once an election is made it cannot be revoked or changed during the Plan Year. However, the Employee may revoke an election and file a new election for the remainder of the Plan Year if the Employee has an election change that is permitted by Internal Revenue Service ("**IRS**") rules. The following are permitted election changes to the extent permitted by the Plan Administrator and communicated to the Claims Administrator:

Change in Status Events

If an election change is on account of and consistent with an IRS-defined change in status, an election change may be made if it is made within thirty-one (31) days of the change in status. For purposes of this rule, a change in status includes the following:

- marriage;
- birth, adoption, placement for adoption;
- legal separation, divorce;
- termination or commencement of spouse's employment;
- taking of an unpaid leave of absence by the Employee or spouse;
- switching from part-time to full-time or from full-time to part-time by Employee or spouse;
- Dependent satisfies or ceases to satisfy an eligibility requirement; and
- a change in the place of residence of the Employee, spouse, or Dependent.

Cost or Coverage Change Rules

An election change may be made if it is made within thirty-one (31) days of a cost or coverage change. For purposes of this rule, a cost or coverage change includes the following:

- significant changes in health coverage (as opposed to change in cost) of the Employee or spouse attributable to the spouse's employment;

- significant changes in the cost of health coverage;
- entitlement to Medicare or Medicaid;
- termination of Medicaid or State Children's Health Insurance Program (CHIP or SCHIP) due to loss of eligibility for such coverage, and the Participant requests coverage under the group health plan within sixty (60) days of the loss of coverage;
- Employee or Dependent becomes eligible for a premium assistance subsidy under CHIP and the Employee requests coverage under the group health plan within sixty (60) days after the date the Employee or Dependent becomes eligible for the premium assistance subsidy; and
- changes required by court orders, but only if the order requires other coverage and that coverage is provided.

Patient Protection & Affordable Care Act Changes

- An Employee may elect to drop minimum essential coverage under this Plan if the Employee is eligible to buy coverage in the Health Insurance Marketplace. The Employee (and any of the Employee's Dependents who were covered under the Plan prior to the revocation of the Employee's election) must intend to enroll in coverage under a Health Insurance Marketplace (also known as the Health Insurance Exchange) no later than the first day of the second month following the month that includes the Employee's revocation of coverage under the Plan.
- An Employee may elect to drop minimum essential coverage under this Plan if the Employee's employment status changes from a position in which the Employee was reasonably expected to average at least 30 hours of service per week to a position in which the Employee will reasonably be expected to average less than 30 hours of service per week. In order to drop coverage for this reason, the covered Employee and all covered Dependents must intend to enroll in minimum essential coverage (i.e., another major medical plan) no later than the first day of the second month following the month coverage under this Plan is dropped.

The Plan Administrator may permit any other election change that it determines is allowed by law.

PATIENT PROTECTION AND AFFORDABLE CARE NON-GRANDFATHERED GROUP

The following provisions shall apply for plan years beginning on or after September 23, 2010 to ensure compliance with Federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to the ("**Act**"):

1. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential benefits or preventive benefits as defined in the Act and as listed below. If the plan is still in force, but your coverage previously terminated as a result of exhausting the lifetime dollar maximum, you will be provided with a separate notice of a 30-day open enrollment opportunity to re-enroll under the plan.

   Essential health benefits include:
   - Ambulatory patient services;
   - Emergency services;
   - Hospitalization;
   - Maternity and newborn care;
   - Mental health and substance use disorder services, including behavioral health treatment;
   - Prescription drugs;
   - Rehabilitative and Habilitative services & devices;
   - Laboratory services;
   - Preventive & wellness services & chronic disease management;
   - Pediatric services, including oral and vision care.

   Preventive benefits" means: evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved; with respect to Covered Persons who are infants, children and adolescents, evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and with respect to Covered Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

   Preventive health benefits include:

   - Services recommended by the US Preventive Services Task Force;
   - Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC;
   - Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration;
   - Preventive care and screenings for women supported by HRSA.

2. If the plan contains an annual maximum dollar limit, such limit shall not apply to essential health benefits.

3. Coverage cannot be rescinded except for fraud or intentional misrepresentation of a material fact. If your coverage is rescinded, you will be provided with a 30-day advance written notice prior to the date of rescission.

4. If coverage includes Dependents, Dependent child coverage will continue until the end of the month the Dependent child turns age 26 (except as otherwise expressly provided in the Attachment #1) regardless of the Dependent child's marital status, whether the Dependent child is claimed for tax purposes; student status; employment status; or residence with you or financial support from you. Coverage does not include the spouse or child of such Dependent child unless that child meets other coverage criteria established under state law.

5. Any "per calendar year" or "per plan year" dollar limits are not applied to preventive benefits.
6. Coverage for preventive benefits, as defined in the Act, does not require payment of any deductible, copayment, or coinsurance if obtained from a participating provider.
7. All internal and external appeal rights will be administered in accordance with the Act or state law, whichever provides greater rights to the consumer. There will be no fee for filing for an external review.
8. Emergency services from non-participating providers will be covered at the same coinsurance percentage or copayment amount as services provided by participating providers, subject to "Exclusion" #72.
9. This amendment takes effect on the date specified in Attachment #1. This amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions otherwise provided in any section of the Plan.

LIFESTYLE WELLNESS PROGRAM

Your Employer together with the Claims Administrator has established a wellness program known as the "Lifestyle Wellness Program" ("**Wellness Program**") which is part of the Plan. In addition to the summary of the Wellness Program below, you should review the Claims Administrator's Lifestyle Wellness brochure and your Employer's enrollment materials, benefits guides, or annual wellness informational packet, as well as any successor brochures, enrollment materials, benefits guides, annual wellness informational packets, pamphlets or other documents ("**Pamphlets**") provided by the Claims Administrator or your Employer for information describing the Wellness Program.

All of these documents together constitute the entire Wellness Program and will be interpreted and administered together as a single program as determined by the Claims Administrator. The Pamphlets are incorporated into this Plan by reference and can be amended by the Claims Administrator or the Employer without formal need to amend this Plan. Notwithstanding anything in this Plan or the Pamphlets to the contrary, your Employer may discontinue or elect not to participate in the Wellness Program under this Plan at any time.

Your participation in the Wellness Program is voluntary, but to receive benefits under the program, Participants and their covered spouses must satisfy the requirements of the Wellness Program. These requirements are outlined in the Pamphlets, if any, provided to all eligible Participants and their covered spouses. The Pamphlets also outline ways to meet program requirements, specify program dates and deadlines, and include supplemental information regarding the Wellness Program. You may qualify for rewards under the Wellness Program regardless of your health status. The reward, as discussed in the Pamphlets, is your ability to qualify for a "Care Plan Deductible" and to earn enough points to receive additional deductible credits (or perhaps another reward, if any) for each Plan Year upon satisfying the Wellness Program's requirements. Participants and covered spouses may qualify for an incentive or reward under the Wellness Program at least one time per year.

The Wellness Program is reasonably designed to promote health and prevent disease, and includes the following elements:

- A lower "Care Plan Deductible" that is available for the current Plan Year for Participants and their covered spouses who (a) complete certain lab work and an annual wellness exam and (b) enroll in a qualifying "Care Management Plan" (as established by your Physician consistent with guidelines set forth by the Claims Administrator) all within the first calendar quarter of a Plan Year.
- A way to earn wellness points toward additional deductible credits for the following Plan Year by complying with the Participant's Care Management Plan during such Plan Year (and at least during the second, third, and fourth quarters of each such Plan Year), or by participating in certain other wellness-related activities described in the Pamphlets; and
- Such additional programs and benefits as are (or in the future may be) described in the Pamphlets and communicated to Employees for participating in, among other programs, certain healthy actions such as visiting a gym regularly or attending wellness coaching or tobacco cessation coaching.

Participants and their spouses who properly participate in the Plan may participate in the Wellness Program benefits, and each may earn a separate reward under the Wellness Program, depending on the activities completed by each, respectively. Employees must be employed (or be on COBRA) at the time any deductible credit adjustment is awarded by the Claims Administrator or the Employer, and you must also be employed (or be on COBRA) at the time any other award is paid under the Wellness Program. Participation in the Wellness Program does not impact "eligibility" for (or other terms of) the Plan. All Plan administrative, technical, and legal provisions apply to the Wellness Program. The Wellness Program is an unfunded Employer benefit in the same manner as all other Plan benefits.

Participation in the Wellness Program will terminate as described in the Pamphlets, or if not described in the Pamphlets, on the date you are no longer eligible under the Plan.

The Pamphlets may, in the future, be revised to include additional covered individuals; provided, however, that Eligible Employees will be notified in the preceding Plan Year in which any changes in eligibility or benefits under the Wellness Program occur.

PARTICIPATORY, OUTCOME-BASED & ACTIVITY-BASED ELEMENTS OF THE WELLNESS PROGRAM

The Wellness Program consists of participatory, outcome-based and activity-based elements. The requirements for each type of element are described in more detail below:

Participatory Elements of the Wellness Program

One or more elements of the Wellness Program are classified as "participatory." Participatory wellness programs must be made available to all similarly situated individuals, regardless of health status. Under a participatory wellness program, you are required to engage in an activity that is not related to a health factor (with no specific outcome required) to receive an incentive or a reward under the Wellness Program.

Outcome-Based Elements of the Wellness Program

One or more elements of the Wellness Program are (or may be) classified as outcome-based. An outcome-based wellness program requires you to attain or maintain a specific health outcome related to a health factor in order to obtain the offered reward or incentive. Outcome-based wellness programs must meet certain requirements in order to comply with HIPAA; the requirements can be found on the Department of Labor ("**DOL**") website.

If you are unable to meet the initial standard in an outcome-based program based on the measurement, test, or screening, a reasonable alternative standard for you to qualify for the incentive or reward must be made available to you, or the condition for obtaining the reward must be waived. Since the Care Management Plan is established by your Physician, please contact your physician to discuss any appropriate modifications consistent with the directly following paragraph.

Under an outcome-based wellness program, the plan or issuer may not seek verification, such as a statement from an individual's Physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy the standard, as a condition of providing a reasonable alternative standard. If your Physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for you, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of your Physician with regard to medical appropriateness or waive the condition for obtaining the reward. The Employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

Activity-Based Elements of the Wellness Program

One or more elements of the Wellness Program are (or may be) classified as "activity-only." An activity-only wellness program requires you to complete or to perform an activity related to a health factor in order to obtain the offered reward or incentive, but it does not require you to attain any specific health outcome to receive the reward. Activity-only wellness programs must meet certain requirements in order to comply with HIPAA; the requirements can be found on the DOL website. Again, since the Care Management Plan is established by your Physician, please contact your physician to discuss any appropriate modifications consistent with the directly following paragraph.

If you are unable to participate in an activity-only wellness program due to a health factor, your Employer will provide safeguards to ensure you are given a reasonable opportunity to qualify for the incentive or reward (i.e., a reasonable alternative standard) or the condition for obtaining the award will be waived. Under an activity-only wellness program, it is permissible for a plan or issuer to seek verification, such as a statement from your Physician, that a health factor makes it unreasonably difficult for you to satisfy, or

medically inadvisable for you to attempt to satisfy, the otherwise applicable standard in an activity-only wellness program, if reasonable under the circumstances. If your Physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for you, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of your Physician with regard to medical appropriateness or waive the condition for obtaining the reward. The Employer may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

Other Legal Requirements

In order to ensure compliance with PPACA and HIPAA, the maximum permissible reward (or penalty) under the Wellness Program components is capped. Specifically, the maximum rewards (or penalties) for the components of the Wellness Program that may be classified as (i) activity-only wellness programs that are offered in connection with the Plan, and/or (ii) outcome-based wellness programs that are offered in connection with the Plan may not total up to more than 30% of the total cost of coverage (including both Employer and Employee contributions). In addition, the maximum permissible reward (or penalty) is 50% of the total cost of coverage under the Plan for wellness program incentives designed to prevent or reduce tobacco use.

The Wellness Program is intended to be administered and operated in compliance with, among other applicable laws, the Americans with Disabilities Act, as amended ("**ADA**") and the Act, as amended, including any corresponding regulations issued by the Equal Employment Opportunity Commission ("**EEOC**"), pertaining to wellness programs which include a disability inquiry or medical exam (such as nicotine testing).

Weight Management

Participants and their covered spouses may also receive additional Weight Management Benefits if they participate in the Lifestyle Health Plans disease management program. See section titled "Weight Management Benefit."

DEFINITIONS

Actively at Work (Active Work): Performing compensated services for the Employer for 30 or more hours per week.

Allowable Charge: The maximum expense covered by this Plan for a service, supply, or treatment. The Allowable Charge for a given service, supply, or treatment will vary by the degree of complexity of the service, supply, or treatment provided, as well as the area of the country in which the service, supply, or treatment is provided, as determined by the Claims Administrator.

Annual Enrollment Period: The period designated each year by the Employer prior to the beginning of each Plan Year, during which Employees make coverage elections for the next Plan Year. These include Section 125 Plan elections. Changes to coverage may be made during this Annual Enrollment Period. Any election changes made outside this Annual Enrollment Period may only be made if they correspond with an IRS permitted election change event as explained in the "Permitted Election Changes" section.

Annual Maximum Amount: The maximum payable for each Covered Person for all Covered Expenses for the Calendar Year. The annual maximum amount shall not exceed the aggregate Annual Maximum for all covered services incurred in the Calendar Year.

Approved Transplant Services: Medically Necessary services and supplies which are related to a: heart, kidney, liver or bone marrow or other human tissue transplant procedure; are approved in writing under the Pre-Certification process; and include but are not limited to:

- pre-transplant patient evaluation for the Medical necessity of the transplant; and
- Hospital charges; and
- Physician charges; and
- tissue typing and ancillary services.

Calendar Year: The period from January 1 through December 31 of the same year.

Claims Administrator: Medova Healthcare Financial Group, LLC.

Covered Charges: That part of necessary expenses incurred which is (a) for care of a Covered condition; and (b) incurred while a person's coverage is in force; and (c) does not exceed the Allowable Charge for the service, supply, or treatment; and (d) is shown as a Covered Expense listed in the "Covered Expenses" section. Covered Charges are considered incurred on the date a service is rendered, a supply is furnished, or treatment is rendered.

Covered Condition: Any Non-Occupational Sickness or Injury for which a person is covered by this Benefit.

Covered Person: An Eligible Employee or Eligible Dependent whose coverage is effective under this Plan.

Creditable Coverage: Coverage under a group plan including a government or church plan, individual or group health insurance coverage, Medicare, Medicaid, state provided health care including risk pools, military sponsored health care, Peace Corps health benefit plans, a health program of the Indian Health Service or a tribal organization, and any other public health plan.

Custodial Care: Services and supplies provided to a Covered Person, whether or not the person is disabled, which cannot be expected to contribute substantially to the improvement of a medical condition according to generally accepted standards. Such care includes, but is not limited to: (1) assisting the person to walk; getting in and out of bed; bathing; dressing; preparing special diets; supervising medicine which can usually be self-administered and which does not require the attention of medical or paramedical personnel; and (2) assisting the person in other activities of daily life. Such care is custodial without regard to the provider by which it is prescribed, referred or performed.

Dependent: Includes (1) the Employee's Eligible Dependent who has coverage in force under the Plan:

(2) the Employee's child, stepchild or adopted child who has coverage in force under the Plan, who has reached the limiting age for Dependents but who cannot earn his own living due to mental or physical handicap. All other requirements for Dependents must be met. The Employee must furnish the Plan Administrator or Claims Administrator with proof of the child's incapacity and dependency within 31 days after the date the limiting age is reached. The Plan Administrator or Claims Administrator may also require proof of continuing incapacity and dependency. If proof is not given within 60 days of a request, coverage for the Dependent will end 60 days after the request is made.

Disability: You are Disabled if, due to Non-Occupational Sickness or Injury, you are unable to do the substantial and material duties of your regular job. A Dependent is Disabled if, due to Sickness or Injury, he is unable to do his normal activities.

Eligible Dependent: Includes (1) the Employee's legal spouse, whether same-sex or opposite-sex, in a marriage validly entered into under the laws of a United States or foreign jurisdiction having the authority to sanction marriages; (2) the Employee's natural child up to age 26, adopted child (see also adopted child provisions under the section titled "Dependent Eligibility"); or stepchild up to age 26; and (3) children who are named as "alternate recipients" in a Qualified Medical Child Support Order approved by this Plan. An otherwise Eligible Dependent child ceases coverage at the end of the month after attaining their 26th birthday, unless otherwise expressly provided in the Attachment #1.

Eligible Dependent will not include: (1) a foster child; (2) a child or spouse who lives outside of the USA or from whom the Employee is legally separated or divorced; (3) a child or spouse who is covered as an Employee; or (4) legal guardianship that does not contain a qualified medical recipient provision. The Claims Administrator or Plan Administrator reserves the right to require whatever documentation necessary to establish a Dependent's eligibility status.

Eligible Employee: (1) An Employee working for an Employer who has satisfied their Waiting Period, or (2) an Employee who was covered under the Plan on their last day of active work and on (a) approved FMLA leave or (b) any other approved leave of absence of no longer than 90 days (except as otherwise expressly provided in the Attachment #1) ("**Approved Leave Period**"), or, if earlier, until employment is terminated by the Employer. An Employee who has reached the end of approved FMLA leave or who is on any other approved leave of absence for longer than the Approved Leave Period is not an Eligible Employee.

Emergency: The sudden and unexpected onset of a medical condition, a severe Injury or the acute exacerbation of a chronic condition, which is threatening to life, limb or sight and which requires immediate medical or surgical treatment. The determination of Emergency will be made by the Utilization Review Organization contracting with the Claims Administrator at the time of occurrence.

Employee: An individual who qualifies (and is classified by the Employer) as a common-law employee on the payroll records of either the Employer or any other entity treated as a single employer with the Employer under Section 414(b) or (c) of the Internal Revenue Code. Notwithstanding any provision in the Plan to the contrary, unrelated entities cannot participate in the Plan.

Enrollment Date:

A. For someone who enrolls during their Waiting Period, Enrollment Date, usually their date of hire, is the start of their Waiting Period.

B. For someone who enrolls after their Waiting Period, Enrollment Date, usually due to a permitted election change event is the date the Employee actually enrolls himself and/or his Eligible Dependents in the Plan. See section titled "Late Requests".

Experimental: A service, drug or supply not accepted or approved by a relevant segment of the medical community or government oversight agencies as beneficial for the diagnosis or treatment of the Sickness or Injury at the time services were rendered. The Claims Administrator will make determination based on reliable evidence related to federal law, clinical trials, written protocols and reports published in authoritative medical and scientific literature.

Free-Standing Surgical Center: A facility licensed as a free-standing or ambulatory surgical center.

Hospital:

1. An institution which: (a) is operated lawfully; and (b) mainly and continuously provides medical, diagnostic, and surgical facilities; these facilities may be on the premises or available on a prearranged basis supervised by a staff of one or more licensed Physicians; and (c) provides inpatient care for which a charge is made; and (d) provides 24-hour nursing care by, or supervised by, a registered graduate nurse (R.N.); or
2. An institution which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organization; or
3. Any other institution required to be recognized as a Hospital for benefit payment purposes under the law of the state in which the Employee lives.

   A "private" room is a room with one bed. A "semi-private" room is a room with two beds. A "ward" is a room with more than two beds.

Injury: Accidental bodily injury or injuries which cause a covered loss. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or other cause.

Late Enrollee: An Employee or Dependent who enrolls for coverage more than 31 days after their initial eligibility period, except as indicated below:

- An Employee or Dependent who waived coverage because that person had other Creditable Coverage, who enrolls within 31 days after the other coverage terminates.
- An Employee or Dependent who enrolls for coverage within 31 days of marriage, birth, adoption or placement for adoption. If a spouse does not enroll at the time of marriage, the spouse will not be considered a Late Enrollee if application is made within 31 days of the birth or adoption of a child when the child is added as a Dependent.

Medically Necessary: Drugs, therapies, and other health care services that meet the requirements set forth in the "Medically Necessary Requirement" titled section of this Plan Document.

Medicare: Title XVIII of the Social Security Act of 1965, as amended. A person is eligible for Medicare on and after the date he is eligible for any Medicare coverage.

Non-occupational Sickness or Injury: Any Sickness or Injury other than an Occupational Sickness or Injury.

Occupational Sickness or Injury: Accidental bodily Injury or Sickness arising out of or in the course of any employment for wage or profit to the extent you are covered or are required to be covered by applicable Workers' Compensation or Occupational Disease Act or similar law.

Physician: A legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Dentist (D.D.S.), Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Advanced Registered Nurse Practitioner (A.R.N.P.), Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist, and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan Adjustment: The maximum amount of billed charges the Plan will consider when determining Covered Charges as determined by the Claims Administrator. Benefit payments of Covered Charges are based on what the Claims Administrator determines to be the Plan Adjustment amount. Amounts billed in excess of the Plan Adjustment amount are not payable under this Plan.

Plan Administrator: Employer as stated in Attachment #1.

Plan Sponsor: Employer as stated in Attachment #1, along with any successors or assigns.

Preferred Provider: Any Physician, laboratory, or other provider (other than a Hospital) contracting with the Preferred Provider Organization as of the day the Covered Charge is incurred. The term "Preferred Provider" will also include any mail-order pharmacy program designated as "preferred" on the applicable Schedule of Benefits, regardless of whether such mail-order pharmacy is part of a broader Preferred Provider Organization or other network.

Preferred Provider Hospital: Any Hospital contracting with the Preferred Provider Organization as of the day the Covered Charge is incurred.

Severe Mental Illness: A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Sickness: Illness, disease or pregnancy which cause a covered loss while a person's coverage is in force; and congenital defects, birth abnormalities and prematurity of a covered newborn child.

Waiting Period: The length of time a newly hired employee must wait before he is eligible to be covered under this plan.

Year: The period from January 1st through December 31st of the same Calendar Year (except as otherwise expressly provided in the Attachment #1).

COVERED EXPENSES
FOR EMPLOYEES AND DEPENDENTS

BENEFITS

Benefits will be paid for Covered Charges incurred for Covered Expenses for the medical care of Non-Occupational Sickness or Injury as shown in the Schedule of Benefits, subject to any limitations, conditions, and exclusions otherwise provided in any section of this Summary Plan Description.

"***Covered Expenses***" are the Medically Necessary services, supplies and/or treatments that are covered under this Plan. The "Covered Expense" is not necessarily the actual charge made nor the specific service, supply, or treatment furnished to a Covered Person by a provider. Charges for services or supplies to improve general health or to relieve physical or mental discomfort not related to a particular medical condition (including, but not limited, to gym memberships, weight loss programs and similar endeavors, as well as any Sickness which results because prescribed medications or treatments were deliberately not followed) or any other cost which arises solely due to a provider's medical error are not considered Covered Expenses. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) not to be considered an Allowable Charge for a Covered Expense. All Covered Expenses are subject to applicable coinsurance(s), copay(s), deductible(s), encounter fee(s), Plan Adjustments and other limitations or exclusions provided by the Plan.

Covered Expenses:

1. Inpatient Hospital Services: Inpatient Hospital Services are:
   a. Room, board and general nursing care for each day of confinement as an inpatient in a Hospital, including confinement solely for dental care or treatment.
   b. Miscellaneous services and supplies furnished by the Hospital and not included in the room charge. This benefit is paid only for expense Incurred during inpatient confinement in a Hospital. Supplies are limited as stated in the section titled "Exclusions."
2. Outpatient Hospital Services: Outpatient Hospital Services are services and supplies furnished by a Hospital or a Free-Standing Surgical Center on an outpatient basis. Supplies are limited as stated in the section titled "Exclusions."
3. Non-Hospital Services: Non-Hospital Services are services and supplies furnished by non-Hospital providers, including but not limited to, Ambulance, Birthing Centers, Dialysis Facilities, Free-Standing Surgical Centers, Home Health Care, Hospice Care, Urgent Care Centers, In-Store Health Clinic, treatment for Mental or Nervous Disorders, Alcohol Abuse or Chemical Abuse provided in a Treatment Center and Nursing Care Facilities. Supplies are limited as stated in the section titled "Exclusions."
4. Physician's Fees: Assistant surgeon expenses are limited to 20% of the Plan Adjustment amount for the surgical procedure for which services are rendered. Mid-level provider expenses are limited to 85% of the Plan Adjustment amount.
5. Treatment of Mental or Nervous Disorders up to the maximum(s) shown on the Schedule of Benefits for medical and surgical services that are otherwise covered under the Plan, including Physician's Office Visits. Mental or Nervous Disorders are treated the same as any other Sickness.
6. Treatment of Alcohol Abuse and Chemical Abuse up to the maximum(s) shown on the Schedule of Benefits for medical and surgical services that are otherwise covered under the Plan, including Physician's Office Visits. Alcohol Abuse and Chemical Abuse are treated the same as any other Sickness.
7. Treatment for Severe Mental Illness.
8. Chiropractic Services. Limited to the maximum(s) shown on the Schedule of Benefits.
9. Transportation by Ambulance, railroad or regularly scheduled airline to and from the nearest

Hospital with facilities for Medically Necessary treatment. Eligible air ambulance charges are exempt from PPO Network fee schedules and will be allowed based on Plan Adjustment Determination.

10. Skilled nursing care in a Nursing Care Facility provided that without such care the patient would require an inpatient Hospital stay, up to the maximum(s) shown on the Schedule of Benefits.
11. Home Health Care following confinement in a Hospital or Nursing Care Facility up to the maximum(s) shown on the Schedule of Benefits.
12. Hospice Care / Respite Benefits up to the maximum(s) shown on the Schedule of Benefits.
13. Charges made by a Birthing Center excluding charges made separately by any practitioner for services provided at the center.
14. Repair or replacement, if necessary, of natural teeth due to damage caused solely by Injury for which the initial contact with a Physician or dentist occurred within 72 hours of the Injury due to the severity of the Injury. This includes functional correction of natural teeth due to Injury.
15. Services and supplies required to correct damage to eyesight or hearing caused by Injury.
16. Charges made for treatment of loss or impairment of speech up to the maximum(s) shown on the Schedule of Benefits.
17. Cosmetic correction of damage caused solely by Injury or Sickness.
18. Cosmetic correction of congenital deformities of a newborn child.
19. Benefits for prosthetic devices are limited to the initial device, unless required due to progression of a Sickness or Injury or growth of a child.
20. Benefits for diabetic vision services, i.e. dilated eye screening, excludes refraction.
21. Reconstructive surgery following mastectomy as follows:
    a. reconstruction of the breast on which the mastectomy has been performed;
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.
22. Hospitalization for a woman and newborn following childbirth of 48 hours for a vaginal delivery and 96 hours for a cesarean delivery. The length of stay begins at the time of delivery if the delivery takes place in a Hospital. If the delivery does not take place in a Hospital, the length of stay begins once the woman and newborn are admitted to the Hospital as inpatients. The mother and newborn are not required to stay 48/96 hours if the attending provider determines that an earlier discharge of the mother and newborn is appropriate and meets the most current standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, and one home visit is provided within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care.

    In addition, coverage includes postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. Coverage includes coverage for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care.

    Coverage for inpatient treatment and for each outpatient and postpartum home care visit will include, at a minimum:
    a. physical assessment of the mother and the newborn infant,
    b. parent education, to include, but not be limited to:
        1) the recommended childhood immunization schedule,
        2) the importance of childhood immunizations,
        3) resources for obtaining childhood immunizations,
    c. training or assistance with breast or bottle feeding, and
    d. the performance of any Medically Necessary and appropriate clinical tests

    Maternity coverage under this provision is limited to an Employee or spouse. See exclusion for

coverage of Dependent children under the section titled "Exclusions."

23. Routine mammogram annually ages 40 and above; between ages 35-39, one baseline mammogram as shown on the Schedule of Benefits;

24. Routine annual mammogram at any age for insureds at high risk of breast cancer, i.e. family history;

25. Routine annual pap smear and gynecological exam as shown on the Schedule of Benefits;

26. Immunizations for children from birth through the date such child is 18 years of age against the following diseases: diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, Haemophilus, influenza type B, hepatitis A, and any other immunization subsequently required for children by the United States Department of Health and Human Services. This benefit is payable as shown on the Schedule of Benefits.

27. Standard Preventive and Wellness Benefit: The following services will accumulate toward the limits set forth in the Schedule of Benefits for the Standard Preventive and Wellness Benefit, unless noted otherwise:
    a. Routine prostate exam annually, and annual routine PSA Test at ages 40 and above;
    b. Well child care in accordance with American Academy of Pediatric Guidelines to age 21;
    c. Annual adult routine physical examination and routine blood and other routine laboratory tests;
    d. Annual Influenza Vaccine;
    e. Adult routine immunizations as recommended by the United States Department of Health and Human Services in its most recently published Adult Immunization Schedule;
    f. Routine colorectal cancer screening, as follows:
        1) Digital rectal exam annually at ages 40 and above;
        2) Flexible sigmoidoscopy, every 5 years at ages 40 and above;
        3) Barium enema every 5 years at ages 40 and above;
        4) Fecal occult blood test annually at ages 50 and above
        5) Colonoscopy every 10 years at ages 50 and above;
    g. Bone density testing for a female Qualified Covered Person who is 45 years of age or older for bone density testing for the diagnosis and treatment of osteoporosis, when such test is requested by a primary care or referral Physician. A "**Qualified Covered Person**" means an individual with an estrogen hormone deficiency, vertebral abnormalities, primary hyperthyroidism, a history of fragile bone fractures who is receiving long-term glucocorticoid or who is currently under treatment for osteoporosis.

28. Routine nursery care of a newborn child of the Employee or spouse while the mother is confined in a Hospital.

29. Mastectomy coverage for women with known genetic changes that predispose them toward developing cancer based on mutations in the BRCA1 and 2 genes. These expenses will be limited to an inclusive payable case rate of $30,000 for surgeon, facility and ancillary charges.

30. Inpatient care for a minimum of
    a. 48 hours following a mastectomy; and
    b. 24 hours following a lymph node dissection for the treatment of breast cancer.

31. Wigs or other scalp prostheses necessary for the comfort and dignity of the Covered Person who is undergoing chemotherapy or radiation therapy for the treatment of cancer and other conditions. This benefit is paid up to the maximum(s) shown on the Schedule of Benefits.

32. Coverage for audiological services and hearing aids for children up to eighteen (18) years of age will be provided. In addition, such coverage shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and the hearing aid benefit will be limited for each hearing-impaired ear to one aid every forty-eight (48) months. Coverage under this section will also include up to four additional ear molds per year for children up to two (2) years of age.

33. Transplants are limited to human to human organ transplants and bone marrow transplants, subject to any Benefit Maximums shown on the Schedule of Benefits and subject to any separate transplant contract that may be secured by or on behalf of the Employer ("**transplant contract**").

Benefits for Approved Transplant Services are payable for organ and bone marrow transplants subject to all terms, conditions, exclusions and benefit maximums of this Plan.

The Covered Person should contact the Claims Administrator when a transplant has been decided, but before the donor selection process begins, to establish available benefits. The Claims Administrator should be contacted to determine if coverage applies before charges are Incurred in connection with any contemplated transplant.

Prior Authorization from the Claims Administrator must be obtained before a Covered Person seeks treatment for a transplant. After obtaining Prior Authorization, the Covered Person must receive Pre-Certification from the Utilization Review Organization. If coverage is authorized, benefit payments will only be made if the person's coverage is in force at the time the charges are Incurred, and the transplant is Pre-Certified. A transplant contract, if any, will supersede the Preferred Provider contract, if any, with a Preferred Provider Organization.

Prior Authorization means a Covered Person must:

a. notify the Claims Administrator of the procedure to be performed;
b. have the Physician submit a complete medical history, including current diagnosis, transplant protocol and informed consent; and
c. have the Physician certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective.

Transplant Benefit Period

Expenses must be Incurred during the Transplant Benefit Period. The Transplant Benefit Period begins the date of the initial evaluation for the transplant, if the procedure receives Prior Authorization, and ends on the earliest of:

a. 1 year from the date the transplant procedure is performed;
b. The date coverage for the Covered Expense terminates; or
c. The date of the person's death.

If, during the same admission as the initial transplant, a retransplant occurs, the Transplant Benefit Period is 1 year from the date of the initial transplant. If a retransplant occurs during a subsequent admission, a new Transplant Benefit Period starts from the date of Prior Authorization.

Designated Facilities for Approved Transplant Services

A Covered Person who is authorized for a heart, heart/lung, intestinal, kidney, kidney/pancreas, pancreas, liver, lung or bone marrow transplant procedure will be encouraged to use a Designated Transplant Facility.

34. The following services or supplies when prescribed by a Physician and not included above:

a. anesthetics and their administration;
b. physical therapist's fees;
c. x-rays (but not dental x-rays) and laboratory tests done for diagnosis or treatment;
d. chemotherapy and radiation therapy;
e. blood and blood plasma;
f. dialysis in an approved clinic or treatment facility, but only if Pre-Certified by Utilization Review Organization in compliance with the Pre-Certification process. Coverage is limited to 200% of CMS allowances for Preferred Providers and limited to 100% of CMS allowances for Non-Network providers;
g. artificial limbs and eyes;
h. casts, splints, trusses, crutches, and braces (but not dental braces);
i. oxygen and rental equipment for its administration;

j. rental (up to the purchase price) or purchase of a wheelchair, hospital type bed, or other Durable Medical Equipment which meets all of the following criteria;
   1) can withstand repeated use; and
   2) is mainly used for a medical purpose; and
   3) is not useful except to treat Sickness or Injury; and
   4) is essential for a person's treatment plan that is medically reviewed on a regular basis.

   Such equipment will be paid for on a rental basis during the time benefits are payable. The Claims Administrator may, at their option, purchase such equipment; in this event, the Covered Charge is limited to the purchase price and the cost of installation reduced by any amount paid for rental.

k. voluntary sterilization up to the maximums shown on the Schedule of Benefits;

l. coverage for diabetes treatment, services and supplies also include:
   1) Podiatric health care provider services as are deemed Medically Necessary to prevent complications from diabetes;
   2) Diabetes self-management training, which includes: visits Medically Necessary upon the diagnosis of diabetes, a Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management, and visits when re-education or refresher training is Medically Necessary;

35. In addition to the above mentioned services, this plan will cover preventive services as set forth by the US Preventative Task Force ("**USPSTF**"), unless otherwise excluded in this Summary Plan Description as allowed by the Act.

36. Hyperbaric oxygen ("**HBO**") therapy is covered when Medicare coverage criteria are met. Coverage is limited to 200% of the Medicare allowable per unit of treatment. Treatment is only eligible if there are no measurable signs of healing for at least 30 days of prior treatment with standard wound therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30 day period of treatment.

37. Coverage for anti-venom administered in an office or facility setting. Limited to 200% of the Medicare allowance per unit.

38. Initial cycle of Granix or Zarxio in conjunction with oncology treatment only when National Comprehensive Cancer Network ("**NCCN**") guidelines are met.

39. Charges for Allograft or similar skin care graft. Limited to 200% of the CMS allowance.

40. Breast Recurrence Score test including Oncotype DX, MammaPrint and Prosigna Breast Cancer Prognostic Gene Signature Assay upon prior approval by the oncology management vendor.

41. Medically necessary expenses for epi-pen and insulin injectable medications unless otherwise excluded in this document.

42. Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome antiretroviral therapy as approved through the Drug Coverage Review process.

43. Medically necessary acupuncture and naturopathy.

44. Effective March 1, 2020, expenses associated with testing for COVID-19 will be provided until the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d, or until March 1, 2021, if later, and include the following:

- *Diagnostic Tests*. The following items are covered at 100% with no cost sharing (including deductibles, copayments and coinsurance), as provided in the Families First Coronavirus Response Act, as amended ("**FFCRA**") and Coronavirus Aid, Relief, and Economic Security Act, as amended ("**CARES Act**"), and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated

rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and Plan.

- In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy one of the following conditions:
  - that are approved, cleared, or authorized by the FDA;
  - for which the developer has requested or intends to request emergency use authorization to the extent permitted by FFCRA and/or the CARES Act under Sections 510(k), 513, 515 or Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
  - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
  - that are deemed appropriate by the Secretary of Health and Human Services.
- Items and services furnished during an office visit, urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

- *Qualifying Coronavirus Preventive Services*. The following items are covered at 100% with no cost sharing (including deductibles, copayments and coinsurance), and do not require Pre-Certification.
  - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

The above benefits are specific to Diagnosis of COVID-19. Covered Persons who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's terms and procedures implemented by the Claims Administrator.

PRE-CERTIFICATION

Services that require Pre-Certification by the Utilization Review Organization in order for the services to be covered under the Plan are indicated in this Plan document. All services requiring Pre-Certification, as noted in this Plan, are to be certified in advance by the Utilization Review Organization, except for emergencies. The Covered Person or their representative is required to call the phone number for pre-certification located on the back of their ID card for the services specified above at least forty-eight (48) business hours prior to services being rendered. The Covered Person or their representative must identify the services to be rendered and the associated diagnosis and procedure codes necessary for Pre-Certification determinations and service pre-pricing.

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatments are Medically Necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Covered Person and the Plan. Pre-Certification establishes whether certain

care and services covered under the Plan are Medically Necessary. It ensures that the Pre-Certified care and services will not be denied on the basis that they are not Medically Necessary (as defined by this Plan). The Pre-Certification process will also establish the reference prices for requested services. However, Pre-Certification does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as Plan limitations, exclusions, and eligibility at the time care and services are provided.

ANNUAL MAXIMUM AMOUNT

The Annual Maximum Amount payable under this Benefit is shown in the Schedule of Benefits. It is the maximum total benefits payable for each person, for all Covered Conditions not considered essential benefits under PPACA.

1. When the amount a person has been paid under this Benefit equals the Annual Maximum Amount, coverage for that person will be suspended for the remainder of the Year. Coverage will be reinstated for the following Year provided the member meets eligibility requirements.

2. If a person's coverage ends because his Maximum Amount has been paid, coverage on the remaining covered family members may be continued, subject to the following. Premium must be paid. The employee and his family members must otherwise be eligible for coverage.

IMPORTANT INFORMATION ABOUT PPO NETWORKS

The Plan has contracted with certain Preferred Provider Organizations ("**PPOs**"). If you have any questions about whether a provider participates in a PPO network under the Plan, please contact the Claims Administrator. Providers that participate in these PPO networks are known as "**Preferred Providers**." Covered Expenses obtained from Preferred Providers are considered to be in-network. Your costs will generally be lower when you obtain medical care from Preferred Providers as in-network cost sharing is lower. In addition, since the Plan has contracted with these PPO networks, you will not generally be responsible for additional charges from Preferred Providers known commonly as "Balance Billing." Please see the section titled "Plan Adjustment Determination" for any exceptions on Balance Billing. Please see below in the section titled "Important Information About Non-Network Providers" for more detail on what "Balance Billing" generally means. Please refer to your Attachment #1 for details on cost sharing requirements.

PREFERRED PROVIDER ORGANIZATION ACCESS

Regional Networks
Access to regional Preferred Provider Organization (PPO) networks will be utilized when available and cost effective for a majority of Covered Persons.

National Networks
Employers with Employees residing outside of a regional network access area or those with Employees in multiple geographic areas may elect coverage with a national network of providers.

Wrap Networks
Access to a wrap network may be elected by the Plan Sponsor to provide additional network benefits to Covered Persons that incur Medically Necessary expenses due to an Emergency situation when traveling or attending school outside of their regional network area. Wrap network coverage will not apply when traveling outside of the regional network area for the purposes of obtaining treatment.

IMPORTANT INFORMATION ABOUT NON-NETWORK PROVIDERS

If you receive benefits outside of the network of approved providers under the Plan ("**Non-Network**"), you will pay more and may be Balance Billed. The amounts allowed for Covered Services accessed under your Non-Network benefits will be subject to the Claims Administrator Non-Network Reimbursement Schedule maximum (which will almost always be the lowest of the potential amounts in the Plan Adjustment determination as set forth below). Notwithstanding any provision in the Plan to the contrary, except as expressly provided in the Attachment #1 or as expressly otherwise provided by the Plan, the amount allowed for Covered Services accessed under your Non-Network benefits cannot exceed 100% of the CMS (Medicare) allowable for the services incurred and may be less per the Plan Adjustment determination. You will be responsible for the applicable cost sharing related to such Covered Charges. You also may be responsible for the difference between the charges billed by the Non-Network provider and the Plan Adjustment Determination, which is "**Balance Billing**." Please refer to your Attachment #1 for details.

PLAN ADJUSTMENT DETERMINATION

A "Plan Adjustment" determination will be applied to all in-network claims incurred with gross charges of $10,000 or greater in billed charges. Except as otherwise expressly provided by the Plan (including Attachment #1), the Plan Adjustment for all in-network claims applied to the claim will be based on the lesser of the final claim allowable when adjustment methodologies described in section 1, 2, 3 or 4 are applied to each claim as follows:

1. The negotiated PPO network allowable;
2. The direct negotiated rate with the provider as outlined in a single case agreement for a specific claim or episode of care for a member;
3. An adjustment amount equal to 35% of billed charges for all claims incurred and billed by a provider; or
4. The amount equivalent to the lesser of a commercially available database or such other cost or quality based reimbursement methodologies as may be available and utilized by the Claims Administrator.

For all Non-Network claims, except as may be expressly provided in the Attachment #1 or as otherwise expressly provided by the Plan, the Plan Adjustment will be determined based on the lesser of 1, 2, or 3 below:

1. 100% of the CMS allowable for the services incurred;
2. Billed charges less an 80% of billed charges Plan Adjustment; or
3. The allowable listed in the Non-Network Reimbursement Schedule maintained by the Claims Administrator.

The Plan Adjustment methodologies listed above may be amended or replaced from time to time at the Claims Administrator's discretion, without notice.

IMPLANT COVERAGE PROCEDURE

Implant charges billed at $5,000.00 or less will be processed with the applicable network pricing or Plan allowance pricing at 35% of billed charges, and the manufacturer implant invoice is not required.

The Claims Administrator reserves the right to request an invoice for any Preferred Provider implant charges billed in excess of $5,000.00. Upon timely receipt of any invoice requested by the Claims Administrator, the charges will be allowed up to 300% of the invoice amount. In the event a requested invoice is not supplied within the allowed time frame outlined in this document, the charges will be limited to the lesser of the network discount amount or 35% of billed charges. For implant charges solely from Preferred Providers, the Claims Administrator reserves the right to review the charges and can instead apply the above limitation as set forth in this paragraph. See also section titled "Exclusions" for same information.

The manufacturer implant invoice will be required for all implant charges in excess of $5,000 for Non-Network providers. The charges billed by Non-Network providers will be allowed up to the lesser of 200% of the invoice amount or 35% of billed charges.

DIALYSIS COVERAGE PROCEDURE

Dialysis charges in an approved clinic or treatment facility, but only if Pre-Certified by the Utilization Review Organization vendor in compliance with the Pre-Certification process will be considered eligible.

The Claims Administrator reserves the right to review the charges from Preferred Providers and can limit the allowance to the lesser of the network discount amount or 200% of CMS allowances. The charges billed by Non-Network providers will be allowed up to 100% of CMS allowances. See also section titled "Covered Expenses" for same information.

EXCLUSIONS

Covered Charges will not include the following unless shown in Attachment #1 Additional Covered Expenses:

1. treatment, services or supplies which are:
   a) not Medically Necessary;
   b) Experimental/Investigational, educational, or primarily for the purpose of medical or other research;
   c) rendered in connection with Custodial Care or convalescent care;
   d) not required for the Sickness or Injury;
   e) related to hemophilia and other blood clotting or blood clotting factor conditions;
   f) related to treatment for renal dialysis, unless such treatment is provided in an approved clinic or treatment facility and authorized in advance by the Claims Administrator;
   g) required when person's intentional use of intoxicating or hallucinogenic drugs or medicine, unless taken on the advice of, and under the direction of a Physician is a contributing factor to the loss;
   h) in excess of the Plan Adjustment for the service, supply, or treatment; or
   i) not prescribed by a Physician as required to treat the Sickness or Injury;
   j) charges for autopsies;
   k) related to surgical implants charges billed in excess of $5,000 for which a manufacturer's invoice has been required by the Claims Administrator and that exceed 400% above the manufacturer's invoice provided for Preferred Providers and 200% above the manufacturer's invoice for Non-Network providers, however, (i) that in the event the invoice is not supplied, the Preferred Provider charges will be limited to the lesser of 50% of billed charges or the network allowed amount and Non-Network provider charges will be limited to 35% of billed charges as discussed in section titled "Implant Coverage Procedure;" and (ii) for implant charges solely from Preferred Providers, the Claims Administrator reserves the right to review the charges and can instead apply the limitation set

forth in this paragraph;

l) related to any condition that is not disclosed by the Employee during the enrollment and/or application process with the Claims Administrator, as required by the Employer or the Claims Administrator as part of the "Employee Health Application Form" or otherwise, unless (i) the Employer approves the payment of such claim despite such non-disclosure or (ii) the Employer determines that payment of such claim is required by applicable law;

2. services which are misrepresented;
3. services, supplies or drugs not approved for reimbursement by the Centers for Medicare and Medicaid Services (CMS) or any successor organization;
4. services related to and in advance of treatment for non-covered expenses;
5. caused by or related to complications Incurred in connection with treatment for non-covered expenses;
6. charges in excess of the Covered Charge;
7. routine services except as shown in Covered Charges;
8. any charge for any treatment performed outside of the United States, other than for Emergency Treatment;
9. dental care or treatment, except as shown in Covered Charges;
10. eye examinations, eyeglasses, hearing exams, and hearing aids and service or supplies related thereto, except as shown in Covered Charges;
11. orthoptic therapies;
12. cosmetic surgery, except as shown in Covered Charges;
13. loss which occurs during, or as a result of, the person's participation in the commission of, or attempt to, commit a felony;
14. services or supplies provided, or paid for by, any federal, state or local government (except under Medicaid) unless the person is legally required to pay;
15. charges the person is not legally required to pay;
16. charges the person is not required to pay in the absence of coverage;
17. services or supplies furnished by a person who usually resides in Your home or who is a member of Your family; a family member includes Your spouse and the children, brothers, sisters, and parents of You or Your spouse;
18. charges for missed or canceled appointments;
19. charges for copying medical records;
20. charges for completing claim forms;
21. charges for travel time, transportation costs, or professional advice given on the telephone;
22. stand-by charges or surcharges for after hours, weekend, or home visits;
23. loss due to suicide or attempted suicide if the suicide or attempted suicide is not the result of a medical condition;
24. self-inflicted Injury that is the result of intentionally self-inflicted injuries or illnesses. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).
25 loss due to Occupational Injury/Sickness, or any loss covered under Worker's Compensation;
26. immunizations, x-rays or tests not related to Sickness or Injury, except as shown in the Covered Charges;
27. Services related to any mass screening type of physical or health examination (such as mobile vans or school testing programs), except for pap smears and mammograms performed at a mobile facility certified by the Centers for Medicare and Medicaid Services;
28. drugs not approved by the Food and Drug Administration (FDA);
29. any food item including breast milk, formulas and other nutritional products;
30. implantable stimulators unless prior approval is given by the Claims Administrator;
31. sex transformation surgery and related services, or the reversal thereof except as related to gender dysphoria when the services have been approved through this Plan's medical management prior authorization;
32. surrogate parenting;
33. drugs, therapies and treatment for the restoration or enhancement of sexual activity;

34. well baby care except as shown in Covered Charges;
35. Wellness Benefits, except as shown in Covered Charges;
36. elective abortion;
37. medication prescribed as a smoking deterrent; and/or any treatment for tobacco use disorders except as required by federal law;
38. treatment of alopecia (loss of hair);
39. all weight loss surgical procedures including bariatric surgery/gastric bypass surgery, and any related services for medical and non-medical reasons;
40. treatment (including cutting or removal) of toe nails or superficial lesions of the feet including corns, calluses and hyperkeratosis, other than removal of nail matrix or root, except when required to treat diabetes;
41. hygienic and preventive maintenance foot care, treatment of flat feet, subluxation of the foot, or shoe orthotics, except when required to treat diabetes;
42. electroshock wave therapy for treatment of plantar fasciitis, except to treat diabetes;
43. removal of impacted wisdom teeth;
44. any procedure, service, supply, or treatment required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or their associated structures;
45. surgery of the jaw (orthognathic);
46. dietary or nutritional supplements, vitamins, and mega-vitamins except as subject to review for Medically Necessary treatment of a Sickness or illness;
47. weight loss programs including but not limited to: weight reduction or weight control procedures, devices, regimens, treatments, services or products; also including any drugs used for weight control; nutrition-based therapy, in the treatment of obesity or morbid obesity except as required by federal law or as provided in the Weight Management Benefit of this document;
48. expenses related to a Sickness or Injury for which a third party is or may be responsible, unless such expenses are advanced as provided in the provision titled Right of Reimbursement;
49. services and supplies related to alternative or complementary medicine, including but not limited to acupressure, aroma therapy, bioenergial synchronization technique (BEST), contact reflex analysis, holistic medicine herbal therapy, hypnotism, iridology (study of the iris), Reike therapy, Rolfing, thermography, or other forms of alternative treatment as defined by the Plan Sponsor;
50. services for massage therapy unless prescribed in writing by Your Physician;
51. items for comfort or convenience, including but not limited to television, telephone, beauty/barber service, guest service, and supplies, equipment or similar incidental services and supplies such as air conditioners, air purifiers and filters, batteries, battery chargers, dehumidifiers, humidifiers, or whirlpools;
52. expenses Incurred as part of a rest cure, or at a health spa or similar facility;
53. devices and computers to assist in communication and speech;
54. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
55. oral appliances for snoring disorders;
56. treatment of benign gynecomastia (abnormal breast enlargement in males);
57. radial keratotomy of keratomileusis for or excimer laser photo refractive keratectomy;
58. surgical treatment of excess sweating (hyperhidrosis);
59. cosmetic drugs, growth hormones, MS and Rheumatoid Arthritis injectables (unless otherwise covered elsewhere in this Summary Plan Description) and all self-injectables. Injectables not purchased and administered through the Physician's office.
60. Actiq, Fentanyl, Daptomycin, Duragesic, Fentora and Vancomycin in excess of $1,000 in allowed charges per prescription refill; provided, however, that if a prescription for any of these drugs exceeds $1,000 per prescription refill, any such prescription request will be sent to the Plan's Utilization Review Organization and any such drugs must receive prior authorization before being filled in order to be payable from the Plan;

61. Charges in connection with participation in an assault, felony, illegal act, strike, civil disorder, riot, or the intentional act of another during an altercation in which the Covered Person participated, other than as a spectator;
62. Charges in connection with war or act of war (declared or undeclared), insurrection, rebellion, armed invasion, aggression or service in the Armed Forces of any country;
63. Radiation therapy services for dermatitis or similar skin conditions;
64. Transplant donor expenses except when included as part of a transplant contract;
65. Hospital charges for dental services or treatment, unless a written statement is submitted by a Physician indicating the necessity and appropriateness of such Hospital charges;
66. Hospital admissions on Fridays or Saturdays due to a surgical procedure that will be performed on the following Monday or later, unless special need is shown;
67. Expenses incurred which are in excess of the Allowable Charges for the same services or supplies, and expenses incurred for services or supplies which are determined to be medically unnecessary, as determined by the Plan's Utilization Review Organization;
68. In Vivo or In Vitro fertilization or any other fertilization procedure, test, treatment or drug;
69. Expenses for vision therapy, unless special need is shown;
70. Expenses incurred for a Dependent child in connection with childbirth, pregnancy, complications of pregnancy or any related conditions, except this Plan will cover any such expenses required as preventive services as set forth by the USPSTF;
71. Benefits paid by any plan providing benefits for or by reason of Hospital care or treatment, medical, dental, or other health services which benefits are provided as a result of injuries from a motor vehicle accident to the extent that such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any automobile or motor vehicle insurance policy;
72. Expenses in excess of the Medicare allowance or the maximum allowance by Preferred Providers for the same service in the area where the service could be performed; this will not apply to Covered Persons residing or attending school more than 50 miles from a Preferred Provider; however, this exclusion will apply to persons who are admitted to a Hospital due to an Emergency if they do not transfer to an available Preferred Provider Hospital once they are medically stable, and this exclusion will also apply to persons residing or attending school more than 50 miles from a Preferred Provider if such person travels the same or further distance to a Non-preferred (Non-Network) Provider than to an available Preferred Provider. When expenses are incurred with a Non-preferred (Non-Network) Provider in an Emergency, this Plan will provide benefits in compliance with Treas. Reg. § 54.9815-2719A(b)(3)(i), any successor regulation thereto, or any otherwise applicable law. Specifically, the Plan will pay the greatest of the following three amounts: (i) the Allowable Charge amount calculated using the same method the Plan uses to determine payments for Non-Preferred (Non-Network) Provider services, (ii) the median amount agreed to by Preferred Providers for the same services, or (iii) the amount that would be paid under Medicare Parts A and B, without regard to copayments and coinsurance. See the Plan Adjustment Determination provisions for Non-preferred (Non-Network) Providers above. Importantly, and as described in the above-cited regulations and to the extent allowed by other applicable law, if the Plan is unable to determine the median amount agreed to by Preferred Providers for emergency services, either because no per-service amount has been negotiated or as a result of the Plan being unable to obtain the information from any Preferred Provider, the Plan will disregard subsection (i) above, and shall simply pay the greater of subsection (ii) or (iii).

    NOTE: The Plan's Utilization and Peer Review Committee determines Medical Necessity, if an Emergency exists, if a condition can be treated by a Preferred Provider, when a person is medically stable, the maximum allowance accepted by Preferred Providers, and whether or not a procedure is Experimental, unproven or obsolete. For purposes of this note and above exclusion, Preferred Provider also means Preferred Provider Hospital;
73. Expenses incurred for diagnosis and treatment associated with tissue or organ transplant, except

as specifically provided elsewhere in this Plan;

74. Expenses paid by any individual health insurance policy, except Hospital-Indemnity Only type policies;
75. Diagnosis and treatment of dislocations, strains, sprains or misplacements of vertebrae, except as stated in the Schedule of Benefits (to include all services) per person in any Calendar Year or when requiring the administration of general anesthesia, an open cutting operation of confinement in a Hospital;
76. Foot Orthotics, arch supports or other foot support devices, elastic stockings, garter belts or similar devices and orthopedic shoes including any casting or fitting charges except as stated in Covered Expenses;
77. Services or supplies related to sexual malfunctions or inadequacies, or the reversal of sterilization procedures;
78. Injury while driving or riding in any organized automobile or motorcycle race or speed contest;
79. Expenses incurred due to the negligence of a third party, or otherwise, if such expenses are or could be compensable by a liability or medical carrier, or would have been compensable if the Covered Person had not released said third party from liability for such expenses;
80. Any drug labeled "Caution – Limited by Federal Law for Investigational Use" or Experimental drugs.
81. Any drug that the FDA has determined to be contraindicated for the specific treatment;
82. Intravenous immunoglobulin (IVIG) infusion, IVIG therapy and all IVIG services;
83. Interferon therapy and services;
84. Remicade, Tecfidera, Tobramycin, Acthar, Rituxan/Rituximab and Imbruvica ibrotinib;
85. Expenses for brand name Proton Pump Inhibitors;
86. The following drugs and medications, including any generic forms, are not covered under this Plan. When a generic is listed the brand equivalent will also not be eligible. Extended release medications are not eligible when an alternative is available. Abacavir, Abciximab, Absorica, Actemra, Actimmune, Adempas, Afinitor, Aggrastat, Aldurazyme, Alecensa, Alimta, Alteplase, Ambrisentan (letairis), Amrix, Angiomax (bivalirudin), Aubagio, Avastin, Avonex, Benlysta, Betaseron, Bosulif, Cabometyx, Carbaglu, Cerdelga, Cerezyme, Cimzia, Cinryze, Cometriq, Copaxone, Cosentyx, Daklinza, Dalvance, Daratumumab, Daurismo, Doptelet, Duexis, Durvalumab, Elaprase, Enbrel, Entyvio, Epclusa, Erbitux, Erivedge, Erleada, Euflexxa, Evzio, Fabrazyme, Fidaxomicin, Firazyr, Flurbiprofen, Folfox regimen, Folotyn/Pralatrexate, Forteo, Fulphila, Gattex, Gazyva, Genvoya, Gilenya, Gilotrif, Glassia, Gleevec (Imatinib), Glybera, Harvoni, Hetlioz, Humira, Ibrance, Iclusig, Ilaris, Incivek, Inflectra, Ingrezza, Inlyta, Integrilin, Intelence, Iressa, Isentress, Isoproterenol, Jadenu, Jakafi, Jevanta, Juxtapid/Lomitapide, Jynarque, Kadcyla, Kalydeco, Keytruda, Kisqali, Krystexxa, Kuvan, Kymriah, Kynamro, Kyprolis (Carfizomib), Lanreotide, Latuda, Leuprolide, Lexiva, Lialda, Lotronex, Lumizyme, Lupron, Makena, Mavenclad, Mavyret, Mekinist, Migergot, Migranal, Mvasi, Myozyme, Myrbetriq, Naglazyme, Natalizumab, Neulasta, Neupogen, Ninlaro, Norditropin, Northera, NPlate, Nucala, Ocaliva, Ocrevus, Odomzo, Olysio, Opdivo, Opsumit, Oral Kinase Inhibitors, Orencia, Orkambi, Orthovisc, Otezla, Otrexup, Oxycontin, Paclitaxel Protein, Pegasys, Pennsaid, Pertuzumab, Plegridy, Pomalyst, Prezcobix, Proleukin, Prolia/Xgeva, Promacta, Provenge, Ravicti, Rebif, Remodulin (Treprostinil), Revlimid, Rinvoq, Romiplostim, Rybelsus, Sandostatin, Selzentry, Simponi, Skyrizi, Soliris, Sovaldi, Spinraza, Spravato, Sprycel (Dasatinib), Stelara, Stivarga, Stribild, Sublocade, Subsys, Sutent, Symdeko, Synvisc, Synvisc-One, Tafinlar, Tagrisso, Taltz (Ixekizumab), Tarceva, Tasigna, Tavalisse, Tecentriq, Temodar, Temozolomide, Tenecteplase, Thiola, Toujeo, Tracleer, Treanda (Bendamustine HCI), Tremfya, Treximet, Trientine, Trisenox, Trodelvy, Trokendi Truvada, Tysabri, Udenyca, Ultomiris, Uptravi, Valcyte, Vandetanib, Velcade, Verzenio, Viberzi, Victoza, Victrelis, Viekira, Vimovo, Vimpat, Vosevi, Votrient, Vpriv, Vraylar, Xalkori, Xeljanz, Xgeva, Xifaxan, Xofigo, Xolair, Xtandi (Enzalutamide), Xyrem, Yervoy, Zaltrap, Zavesca, Zelboraf, Zepatier, Zileuton ER, Zolgensma, Zyflo, Zytiga and Zyvox;

87. Gene Therapy or Genetic Testing, except as required by federal law or otherwise eligible in the Covered Expenses section;
88. Expenses incurred for breast surgery, removal or replacement of a prosthesis or augmentation or reduction mammoplasty, except as otherwise covered in the Covered Expenses section;
89. Expenses incurred as a result of radioactive contamination or the hazardous properties of chemical or nuclear material;
90. Expenses for blood storage;
91. Supplies utilized in a Physician setting; provided, however, that:
(i) other supplies that are Covered Charges utilized in a Hospital or other (non-Physician) setting are limited to an allowed amount which is the greater of $2,000 per day or one of the following amounts (but not both), depending upon the procedure:
(a) $5,000.00 per billing statement for supplies related to a medical or surgical setting; or
(b) $10,000.00 per billing statement for supplies related solely to brain, orthopedic, or cardiology services; and
(ii) such supplies utilized by a Preferred Provider that are Covered Charges utilized in a Hospital or other (non-Physician) setting will be processed with the applicable network pricing, but the Claims Administrator reserves the right to review the charges and can instead apply the above limitation in this paragraph;
92. Facility charges for preventive colonoscopy are limited to a maximum allowance of $10,000.00 per procedure; provided, however, that charges from Preferred Provider facilities for preventive colonoscopy will be processed with the applicable network pricing, but the Claims Administrator reserves the right to review the charges and can instead apply the above maximum allowance as provided in this paragraph;
93. Expenses billed by a non-preferred (Non-Network) anesthesia provider in excess of the Centers for Medicare and Medicaid Services or any successor organization allowance plus 30%;
94. Sleep Study in a Hospital setting unless special need is shown;
95. Charges, as determined by the Claims Administrator, which are the result of a Covered Person's voluntary non-compliance of Medically Necessary care when prescribed by a Physician, including but not limited to Hospital and Physician services if the Covered Person leaves a Hospital against the medical advice of the Physician;
96. Charges for Optune;
97. Charges for CAR-T cell therapy;
98. Autologous chondrocyte implantation;
99. Charges incurred for which the Plan has no legal obligation to pay;
100. Intraoperative Electromyography (EMG) Monitoring;
101. Expenses related to participation in high risk sports such as mixed martial arts, boxing or any other sport designed to inflict bodily harm;
102. Procrit, Retacrit, Epogen, Aransep and all generic/biosimilars except when administered as part of dialysis treatment plan; and
103. RNAi Therapeutic Drugs.

DRUG COVERAGE REVIEW

Medications, including those that have received FDA approval, are subject to coverage review. Drug coverage review is used to encourage appropriate and cost-effective use of prescription drugs by allowing coverage only when certain conditions are met. The review includes, but is not limited to, approval criteria based on FDA-approved labeling, national guidelines, best-practices and alternative therapies as well as compliance with dosing guidelines and avoidance of duplicate therapies. The Claims Administrator has the right to review to override any exclusion of a non-covered medication in a uniform and nondiscriminatory manner. In the event the member has exhausted all other medical treatment plan options, there is an appeals process under this Plan to allow for further consideration.

STEP THERAPY REQUIREMENTS

Step therapy is designed to help members save money by using the most cost-effective treatments. It requires that an appropriate first step medication, often a generic, is attempted to treat the medical condition. If necessary, a review by the prescribing physician and a clinical team would determine coverage for an alternative brand-name drug. However, if a brand-name drug is dispensed and there is a generic available, the patient will pay the cost difference between the generic and the brand-name drug.

MEDICALLY NECESSARY REQUIREMENT

Benefits will be paid only for `Medically Necessary' care and treatment of non-occupational Sickness or Injury.

The term `Medically Necessary' as used above means:

A. Drugs, therapies or other treatments that are required and appropriate for care of the Sickness or the Injury; that are given in accordance with generally accepted principles of medical practice in the U.S. at the time furnished; and that would be reimbursable and covered by the Centers for Medicare and Medicaid Services in the absence of any coverage under the Plan; and that are not Experimental, educational or investigational; and that are not furnished in connection with medical or other research; all as determined by the Claims Administrator; and

B. Health care services provided by a Physician, exercising prudent clinical judgment, to a patient for the purposes of preventing, evaluating, diagnosing or treating a Sickness, Injury, disease, or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, Injury, or disease; and (c) not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Sickness, Injury or disease.

SKILLED NURSING CARE BENEFIT

This Benefit is subject to all the terms and provisions of this Plan, except as herein stated.

A. DEFINITION

Nursing Care Facility: Means a lawfully operated facility which: (1) provides full time bed care for resident patients; and (2) provides 24 hour nursing service by, or supervised by, a registered graduate nurse (R.N.) or licensed practical nurse on duty at all times; and (3) regularly provides skilled nursing care supervised by a Physician; and (4) keeps a daily medical record of each patient. Nursing Care Facility does not include: a Hospital; or a rest home or home for the aged; or a facility mainly for drug addicts, alcoholics or the mentally ill; or a Custodial Care or educational care facility.

B. BENEFITS

Benefits will be paid for Nursing Care Facility Covered Charges incurred for skilled nursing care by the Employee or his Dependent while coverage is in force. Benefits will be paid for room, board and miscellaneous fees for service and supplies required due to Sickness or Injury.

C. EXCLUSIONS

No benefits will be paid: (1) unless the confinement is deemed Medically Necessary and cost effective and prior approval has been obtained from the Claims Administrator; or (2) for intermediate level nursing care or Custodial Care.

HOME HEALTH CARE BENEFIT

This Benefit is subject to all the terms and provisions of this Plan, except as herein stated.

A. DEFINITION

Home Care: Means the services listed below which: (1) are provided in the home (except for Physician's office visits) by a licensed or certified home health agency; (2) are provided following confinement in a Hospital or skilled nursing home and when continued confinement would otherwise be required; (3) are required for the care or treatment of Sickness or Injury; and (4) are given on the written request of a Physician.

Home Care services include: Physician's home and office visits; nursing services, home health aide services consisting mainly of care of the patient; services provided by licensed physical, occupational, speech, nutrition, inhalation or respiratory therapists; and medical equipment and supplies which would be covered if provided by a Hospital.

B. BENEFIT

Benefits will be paid for Covered Charges for Home Care incurred by the Employee or his Dependent while coverage is in force.

C. EXCLUSIONS

No benefits will be paid unless the Home Care is deemed Medically Necessary and cost effective and prior approval has been obtained from the Claims Administrator. No benefits will be paid for Custodial Care.

HOSPICE CARE BENEFIT

This Benefit is subject to all the terms and provisions of this Plan, except as herein stated.

A. DEFINITION

Hospice Care: Means the services listed below which are provided: (1) by a licensed or certified Hospice or by any other medically appropriate facility; (2) to terminally ill persons who have, as certified by a Physician, a life expectancy of not more than 6 months; (3) for the purpose of palliative control of pain and not for cure; and (4) are given on the written request of a Physician.

Hospice Care includes: fees of Physicians, nurses, paramedicals and home health aides acting within the scope of their practice and providing services directly to the patient; room and board charges; and other medical services and supplies required under the Hospice Care plan.

B. BENEFIT

Benefits will be paid for Covered Charges for Hospice Care incurred by the Employee or his Dependent while coverage is in force.

C. EXCLUSIONS

No benefits will be paid: (1) unless the Hospice Care is deemed Medically Necessary and cost effective and prior approval has been obtained from the Claims Administrator; (2) for Custodial Care; (3) for care for which no charge would be made in the absence of Hospice Care coverage; or (4) for services provided to any person other than the patient.

PRE-ADMISSION REVIEW PROVISIONS

These provisions are a part of the Plan. They add the following limitations to the benefits that otherwise would be payable under this Summary Plan Description.

A. DEFINITIONS

Pre-Admission Review: Means a determination of the number of days, if any, of inpatient Hospital confinement which are necessary for the care or treatment of a person's diagnosed Sickness or Injury.

Emergency Admission: Means admission to a Hospital for a Sickness or Injury which, unless immediately treated on an in-patient basis, would jeopardize the person's life or cause serious health impairment; and means admission to a Hospital for childbirth.

B. PRE-ADMISSION REVIEW PROCEDURES

All Hospital admissions will be subject to Pre-Admission Review. The procedures listed next must be followed.

1. The Employee or the Covered Person's Physician must call the toll-free number shown on the Employee's Medical I.D. card at least 48 hours prior to the Hospital admission.
2. Written notice will be given to the Employee, the Physician, and the Hospital stating the number of days of Hospital confinement which will be deemed as necessary for the care or treatment of the person. This notice will be given before the Hospital confinement is to start.
3. In the case of an Emergency Admission, the call must be made within 48 hours after the admission; or within 72 hours if the admission is done on a Saturday, Sunday or Statutory Legal Holiday. But, if it is not reasonably possible to make the call within these times, Covered Charges will not be reduced for this reason if the call is made as soon as is reasonably possible.
4. The Covered Person or the Physician may ask us to re-evaluate or extend the number of days of confinement deemed necessary. The request must be submitted within 90 days from the ending date of service.

C. EFFECT OF PRE-ADMISSION REVIEW ON BENEFITS

1. Covered Charges shall not include any Hospital room, board, ancillary or general nursing care charges which are incurred on any day of confinement which is in excess of the number of days deemed by the Claims Administrator to be necessary; and no benefits will be paid for such charges.
2. An additional $500.00 copayment will be applied if the required telephone call is not made within the prescribed time.

NOTE: Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child are not restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a pre-authorization review for a length of stay not in excess of 48 hours (or 96 hours) is not required.

CARE COORDINATION OUTPATIENT PRE-CERTIFICATION

PRE-CERTIFICATION PROCEDURES

All outpatient imaging (MRI, CT Scan, PET Scan and Nuclear or Echocardiography imaging) and surgical procedures will be subject to Pre-Certification Review. The procedures listed next must be followed.

The Employee or the Covered Person or their Physician must call the toll free number shown on the Employee's Medical I.D. card prior to the services being rendered.

Written notice will be given to the Employee, Covered Person or Physician stating the approved setting for the care or treatment of the person.

In the case of an Emergency service, the call must be made within 48 hours after the services are provided; or within 72 hours if the admission is done on a Saturday, Sunday or Statutory Legal Holiday. But, if it is not reasonably possible to make the call within these times, Covered Charges will not be reduced for this reason if the call is made as soon as is reasonably possible.

The Pre-Certification will be valid for 60 days from the approval date. Charges incurred for services performed without a valid pre-certification, except for emergencies, will not be eligible under this Plan.

SITE OF SERVICE REQUIREMENT

Procedures eligible in an ambulatory surgical center (ASC) setting, as determined by CMS guidelines, are required to be performed in an ASC to be considered eligible expenses. This requirement may be waived if an ASC is not available within 50 miles or when extenuating medical conditions require a Hospital setting as determined by the Care Coordination vendor. Procedures in a Hospital setting will be limited to the Allowed Charge for ASC services based on a maximum 250% of the CMS Geographic Practice Cost Index (GPCI) rate.

WEIGHT MANAGEMENT BENEFIT

This provision allows for Covered Persons to receive additional benefits for weight management when enrolled in the Lifestyle Health Plans disease management program. Covered members participating in the program will receive the following benefits:

Generic weight control prescription medication at no cost to the patient when the medication is prescribed by your Physician and monitored on a regular basis.

Reimbursement equal to 50% of a single plan gym membership up to a monthly maximum of $30 per eligible member. Some additional certification may be required including receipt/proof of purchase and a log which documents an established minimum number of visits.

Co-pay reimbursement for weight loss counseling provided by your Preferred Provider Physician.

Continued eligibility in the program will be determined by the disease management program coaching staff.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term or lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting -- even to his or her own home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and 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 Claims Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Claims 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.

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.

ONCOLOGY PHARMACEUTICAL AND CLINICAL MANAGEMENT

This provision describes a special medical management program designed for certain aspects of care received by cancer patients who are Covered Persons under the Plan.

This Plan has entered into an arrangement with an oncology program vendor, a company specializing in oncology management, to assist you and your oncologist during the course of cancer treatment when administered in an inpatient or outpatient setting (e.g., in the Physician's office or other covered outpatient setting). The program applies to the plan of treatment and oncology pharmaceuticals to be used in connection with your cancer treatment. **In order to receive benefit payments under the Plan, your oncologist's plan of treatment must be received by the approved oncology program vendor, and must not be deemed Experimental and/or Investigational by the Plan Sponsor.**

In order to initiate these oncology management services, your oncologist should contact your Claims Administrator to verify Plan benefits. At that time, your oncologist will be asked to contact the approved oncology program vendor and to provide to your assigned program' Oncology Nurse Specialist (ONS) a copy of the treatment plan that your oncologist has prescribed for you. Once the oncologist has contacted the approved oncology program vendor, your assigned ONS will contact you periodically to provide support, education, and answer any questions you might have about your disease and your treatment plan. Your assigned ONS will remain in contact with you and your oncologist for the duration of your treatment plan.

Unless your oncologist has entered into an agreement with the approved oncology program vendor to accept other reimbursement rates, the payment for all radiation therapy, drugs and administration used in the treatment of cancer will be limited to the rate of 200% of Average Sales Price. Claims submitted by Preferred Providers will be processed with the applicable network pricing, but the Claims Administrator and/or the approved oncology program reserves the right to review the charges and can instead apply the rate limitation set forth in this paragraph. In the event the member has exhausted all other medical treatment plan options, there is an appeals process under this Plan to allow for further consideration.

Average Sales Price is calculated by the Centers for Medicare and Medicaid (CMS) or, for medication, the pharmaceutical manufacturers and submitted to CMS on a quarterly basis within thirty (30) days of the close of each quarter.

ALCOHOL ABUSE, CHEMICAL ABUSE AND MENTAL OR NERVOUS CONDITIONS BENEFITS

This Benefit is subject to all the terms and provisions of this Plan, except as herein stated.

A. DEFINITIONS

Alcohol Abuse: Means those disorders that are specified in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder qualifies as Alcohol Abuse does not mean that treatment of the disorder is a Covered Expense.

Chemical Abuse: Means those disorders that are specified in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder qualifies as Chemical Abuse does not mean that treatment of the disorder is a Covered Expense.

Mental or Nervous Conditions: Means those disorders specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. The fact that a disorder qualifies as a Mental or Nervous Condition does not mean that treatment of the disorder is a Covered Expense.

Physician: Means, in addition to the providers described in the "Definitions" section: (1) a licensed psychiatrist, psychologist, Advanced Registered Nurse Practitioner (ARNP) or Licensed Specialist Clinical Social Worker (LSCSW); (2) a Certified Alcohol/Drug Counselor only when billing out of a licensed clinic or other Treatment Center; but (3) not the Covered Person, his spouse or the children, brothers, sisters, or parents of the Covered Person or his spouse.

Treatment Center: Means: (1) a licensed medical care facility; (2) a licensed treatment facility for alcoholics; (3) a licensed treatment facility for Chemical Abusers; (4) a licensed community mental health center or clinic; or (5) a licensed psychiatric hospital.

B. BENEFITS

Benefits are payable for expenses incurred by a Covered Person for inpatient treatment for Alcohol Abuse, Chemical Abuse or Mental or Nervous Conditions and outpatient same as any other illness.

BENEFIT FOR PSYCHOTHERAPY PROVIDED BY A LICENSED SPECIALIST CLINICAL SOCIAL WORKER

This Benefit is subject to all the terms and provisions of this Plan, except as herein stated.

A. DEFINITIONS

Social Worker: Means a Licensed Specialist Clinical Social Worker (LSCSW).

Psychotherapy: Means the use of psychological and social methods within a professional relationship to: (1) assist the person to achieve a better psychosocial adaptation; (2) to acquire greater human realization of psychosocial potential and adaptation; (3) to modify internal and external conditions which affect individuals, groups or communities in respect to their intrapersonal and interpersonal processes. Forms of psychotherapy include, but are not limited to, individual psychotherapy, marital therapy, family therapy and group psychotherapy.

B. BENEFITS

Benefits will be paid for expenses incurred by a person covered for Psychotherapy provided by a Social Worker. Benefits will be paid for services which are within the scope of the Social Worker's license and which would be covered if provided by a Physician. Benefits will be paid on the same basis as benefits are paid for mental illness under the above Benefit Section.

CONDITIONS OF COVERAGE

EMPLOYEE ELIGIBILITY

Eligible Employees who are Actively at Work on a Full-Time basis are eligible to participate in the Plan as a "**Participant**" as of the applicable effective date provided below. An Eligible Employee is considered to be "**Full-Time**" if he or she normally works at least 30 hours per week, earning W-2 wages from the Employer which are equivalent of at least the Federal Minimum Wage. The determination by the Employer of whether an Eligible Employee is a Full-Time Employee shall be made in a manner consistent with Internal Revenue Code Section 4980H and its corresponding regulations to the extent applicable.

Eligibility Requirements for Employee Coverage. An Eligible Employee becomes a Participant from the first day that he or she is in a class eligible for coverage as set forth in Attachment #1.

DEPENDENT ELIGIBILITY

If an Employee has an Eligible Dependent(s) on the date of his eligibility, then such Eligible Dependent(s) will be eligible for coverage on that date.

If an Employee acquires an Eligible Dependent(s) after the date of his eligibility, then such Eligible Dependent(s) will be eligible for coverage on the date they are acquired.

Adopted children are eligible for coverage on the date the child is placed with the Employee. (Children are defined as up to age 26, terminating at the end of their 26th birthday month (except as otherwise expressly provided in the Attachment #1)).

Qualified Medical Child Support Orders (QMCSO's):

Employees with a domestic relations order may obtain a free copy of the QMCSO procedures from the Plan Administrator.

EFFECTIVE DATE

Effective Date to Become a Participant

An Eligible Employee will become a Participant as provided below:

A. If the Employee completes the required enrollment forms on or before the date he is eligible, coverage will be effective on the first day of the month following the date he is eligible.

B. If the Employee completes the required enrollment forms within 31 days after the date he is eligible, coverage will be effective on the first day of the month following the date the forms are completed.

C. If the Employee completes the required enrollment forms more than 31 days after the date he is eligible - see the provisions under "Late Requests".

D. If the Employee completes the required enrollment forms within a valid renewal open enrollment, coverage will be effective on the first day of the new Plan Year.

E. Except as required by applicable law, the Employee must be Actively at Work full time on the anticipated effective date of coverage. Employees that do not meet this condition will be eligible for coverage on the first day of the month coinciding with or next following the date he is again Actively at Work.

Dependent Effective Date

Coverage for the Employee's Eligible Dependent(s) becomes effective subject to the following conditions:

A. If the Employee has Eligible Dependents on the date he first becomes eligible, the Eligible Dependents' coverage becomes effective:

(1) on the first day of the month following the date of his eligibility, provided the enrollment forms have been signed prior to that date.

(2) if the enrollment forms are signed within 31 days after the date of his eligibility - on the first day of the month following the date the forms are signed.

(3) if the enrollment forms are signed later than 31 days after the date of his eligibility - see the provisions under Late Requests.

(4) if the enrollment forms are signed within a valid open enrollment, coverage will be effective on the first day of the new Plan Year.

B. If the Employee first acquires an Eligible Dependent after the date of his eligibility, the Dependent's coverage becomes effective:

(1) For Other Than Newborns and Adopted Children

a. on the first day of the month following the date such Dependent becomes an Eligible Dependent, provided the enrollment forms are signed prior to that date.

b. if the enrollment forms are signed within 31 days after the date such Dependent becomes an Eligible Dependent - on the first day of the month following the date the forms are signed.

c. if the enrollment forms are signed later than 31 days after the date the Dependent becomes an Eligible Dependent - see the provisions under Late Requests.

(2) For newborns

a. on the date of birth, continuing only until the mother's confinement ends and covering only professional and nursery charges for well-baby care during that time, unless the required enrollment forms are signed.

b. if the enrollment forms are signed within 31 days after the date of birth - on the date of birth.

c. if the enrollment forms are signed later than 31 days after the date of birth - see the provisions under Late Requests.

(3) For Adopted Children

a. If application is made before, on, or within 31 days after the date the child is placed with the employee, coverage will become effective on the date the child is placed with the Employee.

b. If application is made more than 31 days after the date the child is placed with the Employee, see the provision under "Late Requests".

C. If an Employee is already enrolled for full family coverage and acquires a new Eligible

Dependent, coverage for the new Dependent becomes effective on the date the Dependent becomes an Eligible Dependent.

OPEN ENROLLMENT PERIOD FOR RENEWALS

The open enrollment period cannot exceed thirty (30) days and must end no later than the renewal date. Documentation must be submitted within 7 days of the end of the enrollment period or the submission will be declined. If more than two deductible options are offered, plan election will be subject to the following guidelines:

(1) An Eligible Employee can elect to enroll in any offered plan with a higher deductible than their election the previous Plan Year.
(2) When electing a plan with a lower deductible, the Eligible Employee may only elect the plan with the next lower deductible than the plan in which they were enrolled the previous Plan Year.

LATE REQUESTS

If an Employee fails to elect to participate in this program for himself and/or his Dependents within 31 days of first becoming eligible to participate and he later wishes to apply for coverage for himself and/or his Dependents, the following rules apply:

A. If the Employee has elected not to enroll himself or his Eligible Dependents because the Employee or his Dependents had other Creditable Coverage, and if the other Creditable Coverage terminates due to the exhaustion of COBRA coverage, or the Loss of Eligibility or because employer contributions ceased, he will have a special enrollment period of 31 days beginning on the date the other coverage ended. No Waiting Period will apply. Coverage will become effective on the first day of the month beginning after the date the Plan receives the completed enrollment form.

Loss of Eligibility means that coverage has been lost as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment. Loss of Eligibility does not include a loss of coverage due to failure of the Covered Person to pay premium on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

B. Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows Employees and Eligible Dependents to enroll in the Plan if the Employee or Eligible Dependent loses Medicaid or CHIP coverage because of loss of eligibility for such coverage and the Employee requests coverage under the group health plan within 60 days of the loss of coverage; and also allows Employees and Eligible Dependents to enroll in the Plan when an Employee or Eligible Dependent become eligible for a premium assistance subsidy under CHIP and the Employee requests coverage under the group health plan within 60 days after the date the Employee or Eligible Dependent becomes eligible for premium assistance subsidy. No Waiting Period will apply. Coverage will become effective on the first day of the month beginning after the date the Plan receives the completed enrollment form.

C. If the Employee has elected not to enroll himself or his Eligible Dependents for any reason, he will have a special enrollment period of 31 days beginning on the date of marriage, birth, adoption or placement for adoption. No Waiting Period will apply. If a spouse does not enroll at the time of marriage, the spouse can elect to be covered at the time of a birth or adoption when the child is added as a Dependent.

If coverage is chosen during this time frame, it will be effective:

- For a marriage, on the first day of the month beginning after the date the Plan receives the completed enrollment form.

- For a birth, the date of birth.
- For an adoption or placement for adoption, the date of adoption or placement.

D. If the Employee has elected not to enroll himself or his Eligible Dependents within 31 days (or 60 days for CHIPRA) of first becoming eligible to participate, he will not be allowed to enroll in this Plan unless he fully meets the requirements listed above in A, B, or C.

TERMINATION OF COVERAGE

1. Participant coverage under the Plan will end: (a) if the Employee does not pay, when due, any required contributory premium; (b) if the Employee asks to end coverage (Subject to Section 125 Plan rules); (c) when the Employee becomes a member of any military, naval or air force on active duty; (d) when any continuation of coverage ends, if the Employee does not return to work for the employer; (e) when this Plan terminates; or (f) at the end of the month in which the Employee's status as an Eligible Employee ends.

2. Dependent coverage under the Plan will end: (a) if the Employee does not pay, when due, any required contributory premium for the Dependent's coverage; (b) if the Dependent asks to end the coverage (Subject to Section 125 Plan rules); (c) when the Dependent becomes a member of any military, naval or air force on active duty; (d) when employee coverage ends; (e) when the Dependent's coverage ends for his coverage class; (f) when this Plan terminates; or (g) at the end of the month in which his status as an Eligible Dependent ends.

   However, coverage can be continued for an unmarried child who reaches the limiting age but is incapable of self-support due to mental retardation or severe physical handicap. A special application is required which must be completed and submitted to the Claims Administrator within 31 days of the child's attainment of the limiting age.

RESUMPTION OF COVERAGE

If an Employee's coverage has terminated due to leave of absence, temporary layoff, reduction of hours, or re-hire of not more than three months he may resume his coverage on the first day of the month coinciding with or next following the date he is again Actively at Work. The required forms must be submitted within 31 days of the date he is again Actively at Work. Two additional conditions must also be met. He must otherwise be eligible for coverage and his premium must be paid. If the Employee is not Actively at Work on the date coverage would resume, the resumption of coverage will be delayed as provided in the Employee Effective Date provision, unless the Employee is not Actively at Work due to a health status-related factor to the extent required by applicable law. An Employee who starts Active Work after leave of absence, layoff or re-hire of more than three months must apply as a new Employee and must also complete the required length of service. Coverage shall become effective as provided by the Plan Administrator.

FAMILY AND MEDICAL LEAVE ACT CONTINUATION

If an Employee is on Leave of absence from work with the Employer under the FMLA, coverage may be continued as if the Employee was Active at Work.

FMLA Continuation will end on the earliest of:

- The end of any 12 weeks which occur within 12 months of the date Employee's FMLA absence began;
- The end of the period for which premium is paid;
- The date the Employer terminates coverage for any reason; or
- The date the Plan terminates.

The following additional leave provisions apply until the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d, or on March 1, 2021, if later:

FFCRA
FFCRA requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. Eligibility will be extended through any such leave in the same manner as for traditional FMLA leave.

Eligible Employees
In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). Employees who have been employed for at least 30 days prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below to the extent required by law.

Qualifying Reasons For Leave Related To COVID-19
An employee may, consistent with rules established by the Employer, be entitled to take leave related to COVID-19 if the employee is unable to work, including unable to telework, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

OTHER PLAN EXTENSIONS DUE TO COVID-19 OUTBREAK NATIONAL EMERGENCY

Effective during the national emergency as the result of the COVID-19 outbreak (the "**National Emergency**") beginning March 1, 2020, as described in the Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak and section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 et seq., that a national emergency exists nationwide beginning March 1, 2020, this 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 (the "**Outbreak Period**") for all Participants, beneficiaries, qualified beneficiaries, or claimants when determining the following periods and dates:

(a) The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Code section 9801(f),

(b) The 60-day election period for COBRA continuation coverage under ERISA section 605 and Code section 4980B(f)(5),

(c) The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Code section 4980B(f)(2)(B)(iii) and (C),

(d) The date for individuals to notify the Plan of a COBRA qualifying event or determination of disability under ERISA section 606(a)(3) and Code section 4980B(f)(6)(C),

(e) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1,

(f) The date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h),

(g) The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i), and

(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 pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

COORDINATION OF BENEFITS

A. DEFINITIONS

Coordination of Benefits: Taking other Plans into account when paying benefits under this Plan.

Plan: Any plan that provides benefits or services for medical, dental or vision care on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans and plans required or provided by statute, except Medicaid. "Plan" shall be treated separately for each contract or other program for benefits or services. "Plan" shall be treated separately for that part of a Plan which reserves the right to coordinate with benefits or services of other Plans and that part which does not.

Allowable Expenses: Necessary, usual and customary expenses incurred. A part of the expenses must be paid under at least one of the Plans. When a Plan provides benefits by services, the cash value of each service will be treated as both an Allowable Charge and a benefit paid.

B. WHEN COORDINATION OF BENEFITS APPLIES

Coordination will apply when benefits that would be paid under all Plans exceed Allowable Charges incurred.

C. LIMITATION OF BENEFITS UNDER COORDINATION

When Coordination of Benefits applies, benefits payable under this Plan may be reduced. Benefits will be reduced so that the sum of the benefits paid under this Plan, plus benefits payable under all other Plans, does not exceed total Allowable Charges. Benefits 'payable' under other Plans include benefits that would be paid had you made claim.

D. RULES FOR COORDINATION OF BENEFITS PROVISION

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a coordination of benefits provision that is consistent with this RULES FOR COORDINATION OF BENEFITS PROVISION is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
3. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.
4. Order of Benefit Determination

   The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

   a. Non-Dependent or Dependent

      The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is;

(1) Secondary to the plan covering the person as a dependent; and

(2) Primary to the plan, covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

b. Child Covered Under More Than One Plan

(1) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) The parents are married;

(ii) The parents are not separated (whether or not they ever have been married); or

(iii) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(2) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(3) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(4) If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses (if any) is:

(i) The plan of the custodial parent;

(ii) The plan of the spouse of the custodial parent;

(iii) The plan of the non-custodial parent; and then

(iv) The plan of the spouse of the non-custodial parent.

c. Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection 4(a).

d. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

e. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(1) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the Covered Person was eligible under the second within twenty-four (24) hours after the first ended.

(2) the start of a new plan does not include:

(i) A change in the amount of scope of a plan's benefits;

(ii) A change in the entity that pays, provides or administers the plan's benefits; or

(iii) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(3) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

f. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

E. COORDINATION BENEFITS NOT CHARGED TO BENEFIT LIMIT

If benefits paid under this Plan are reduced because of coordination, each will be reduced proportionately. Only the amount actually paid will be charged against any benefit limit.

F. RIGHT TO EXCHANGE INFORMATION

Information may be released to, or obtained from, any other organization or person necessary for Coordination of Benefits. This will not require the consent of, or notice to, any person insured. The Employee is required to provide information necessary for Coordination of Benefits.

G. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in another plan making payments which should have been made by this Plan. This Plan will then pay the other Plan all such amounts which would otherwise have been paid directly to the Covered Person.

H. RIGHT TO RECEIVE PAYMENTS

If coordination results in overpayments, the Plan has the right to recover the excess amounts paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. If this Plan covers dental benefits, these dental benefits will be treated as medical benefits for purposes of these "Third Party Recovery Provisions." If an Injury is caused by a Third Party, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. The Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not he Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan all benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount Subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

If the Covered Person obtains a Recovery, the Covered Person and his legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of the Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon receipt of the Recovery). The Covered Person must reimburse the Plan, in first priority and without any set off or reduction for attorney fees, other expenses, or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney hired by the Covered Person regardless of whether funds recovered are used to repay benefits paid by the Plan.

Conditions Precedent to Coverage. The Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms. "Covered Person" means anyone covered under the Plan, including minor Dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but it is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from Another Plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Claims Administrator. The Claims Administrator or Plan Administrator has a right to request reports on and approve of all settlements.

Assignment of Rights. As a condition to the Plan making payments for any medical charges the Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

CONTINUATION COVERAGE

As you may be aware, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**") enables Covered Persons who experience a "qualifying event" to continue group health plan coverage for 18, 29, or 36 months depending upon the nature of the "qualifying event".

COBRA continuation coverage can become available to you and to other members of your family who are covered under a group health plan when you or your covered family members would otherwise lose your group health coverage. This section of your Summary Plan Description explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Description of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage, excluding coverage under any Plan providing only an Employee Assistance Plan.

Qualifying Events

If you are an employee, you will become a qualified beneficiary if you lose group health plan coverage because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an employee, you will become a qualified beneficiary if you lose group health plan coverage because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (under Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose group health plan coverage because of any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (under Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "Dependent child."

When COBRA Continuation Coverage is Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming

enrolled in Medicare (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

Group Health Plans Subject to COBRA

COBRA generally applies to all private-sector group health plans maintained by employers that have at least 20 employees on more than 50 percent of its typical business days in the previous calendar year. Both full- and part-time employees are counted to determine whether a plan is subject to COBRA. Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full time. Small group State Continuation does not apply to self-funded or level-funded employer plans.

COBRA also applies to plans sponsored by state and local governments. The law does not apply, however, to plans sponsored by the Federal Government or by churches and certain church-related organizations.

A Qualified Beneficiary Must Give Notice of Some Qualifying Events

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), a qualified beneficiary must provide written notice of the qualifying event to the Plan Administrator within 60 days after the qualifying event occurs, using the group health plan's notice procedures. If written notice of the qualifying event is not provided to the Plan Administrator within this 60-day period, a spouse or Dependent child that would otherwise lose group health plan coverage will not be given the opportunity to continue coverage.

How COBRA Continuation Coverage is Provided

Once the Plan Administrator receives a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries who are recognized by the group health plan as being entitled to elect COBRA continuation coverage with respect to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A qualified beneficiary must elect COBRA continuation coverage within 60 days after the date notice of the right to elect COBRA continuation coverage is provided to the qualified beneficiary. If a qualified beneficiary does not elect continuation coverage within the 60-day election period, the qualified beneficiary will lose his or her right to elect continuation coverage.

The Trade Act of 2002 created a second 60-day election period for certain individuals that become eligible for trade adjustment assistance pursuant to the Trade Act of 1974 ("**TAA-eligible individuals**"). In general, if a TAA-eligible individual loses health benefits coverage as a result of becoming a TAA-eligible individual (a "**TAA-related loss of coverage**") but does not elect COBRA continuation coverage within the general 60-day COBRA election period, the TAA-eligible individual may elect COBRA continuation coverage during the 60-day period beginning on the first day of the month in which he or she is determined to be a TAA-eligible individual, so long as the election is made no later than 6 months after the date of the TAA-related loss of coverage. More information about the Trade Act of 2002 is available at www.doleta.gov/tradeact/2002act_index.asp.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child under the group health plan, COBRA continuation coverage may last for up to a total of 36 months after the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to 36 months after the date of enrollment in Medicare. For example, if a covered employee becomes enrolled in Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months after the date of the qualifying event.

Disability Extension of 18-Month Period of Continuation Coverage

If any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and a qualified beneficiary provides timely written notice of the disability to the Plan Administrator, all qualified beneficiaries receiving COBRA continuation coverage with respect to the same covered employee may be entitled to receive up to 11 additional months of COBRA continuation coverage, for a total maximum of up to 29 months after the date of the qualifying event. The SSA's determination of disability must occur during the first 60 days after the date of the qualifying event, and the disability must last at least until the end of the first 18 months after the date of the qualifying event. In general, a qualified beneficiary giving notice of a disability must provide written notice of the SSA's determination to the Plan Administrator within 60 days after the latest of (i) the date of the SSA's determination, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In all events, a qualified beneficiary must give notice of a disability before the end of the first 18 months after the date of the qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the Plan Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage with respect to the same covered employee will be entitled to the 11-month disability extension if one of them qualifies. If the disabled qualified beneficiary is determined by the SSA to no longer be disabled, written notice of that fact must be given within 30 days after the SSA's determination using the notice procedures specified below (see "Notice Procedures"). Notice must be given to the Plan Administrator. Continuation coverage will cease for all qualified beneficiaries on the first day of the month that is 30 days after the date the SSA determines that the qualified beneficiary is no longer disabled, coverage for all qualified beneficiaries may be retroactively cancelled and restitution to the group health plan may be required.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If, while receiving 18 months of COBRA continuation coverage, a qualified beneficiary experiences another qualifying event that would have caused the qualified beneficiary to lose group health plan coverage if the first qualifying event had not occurred, the qualified beneficiary may get up to 18 additional months of COBRA continuation coverage, for a maximum of up to 36 months, if timely written notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes enrolled in Medicare (Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the group health plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the group health plan had the first qualifying event not occurred. In all of these cases, timely written notice of the second qualifying event must be given within 60 days after the date of the second qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the Plan Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Health Care Flexible Spending Account Plan

Notwithstanding the foregoing provisions, COBRA continuation coverage will not be made available to any qualified beneficiary under a plan constituting a health care spending account plan for any plan year after the end of the plan year in which a qualifying event occurs if the following conditions are satisfied: (i) the plan is a health care spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum available under the plan for the plan year.

Notice Procedures

Any notice you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must deliver your written notice to the Plan Administrator. If you mail your notice, it must be postmarked no later than the last day of the required notice period.

Any notice you provide must include the following:

- The name of the group health plan.
- The name and address of the employee covered under the group health plan.
- The name(s) and address(s) of the qualified beneficiary(ies).
- If the notice is a notice of qualifying event or second qualifying even, the name of the qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, the notice also must include a copy of the divorce decree or decree of legal separation. A notice of disability also must include the name of the disabled qualified beneficiary and a copy of the SSA's determination. If a qualified beneficiary is determined by the SSA to no longer be disabled, the notice of such determination also should include a copy of the SSA's determination.

Notice of a qualifying event or disability determination must be given using the group health plan's form. A copy of the necessary form may be obtained without charge by contacting the Plan Administrator.

Electing Continuation Coverage

To elect continuation coverage, you must complete the group health plan's election form and furnish it according to the directions of the form and the notice procedures specified above (see "Notice Procedures"). A copy of the required election form may be obtained from the Plan Administrator at no charge. Failure to make a timely written election will result in loss of the right to elect continuation coverage under the group health plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all Dependent children who are qualified beneficiaries. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Cost of Continuation Coverage

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary will be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Covered Person who is not receiving continuation coverage. You should contact the Plan Administrator for the required payment for continuation coverage.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (the "**PBGC**"). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the election form, but you will not be covered under the group health plan until you make timely payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date of your election is the date the election form is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full within this 45-day period, you will lose all COBRA continuation coverage rights under the group health plan.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month of coverage. Although periodic payments are due on the applicable due date, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you do not make your payment on the applicable due date, however, the group health plan will suspend your coverage until payment is made, with coverage reinstated retroactively if payment is made within the grace period. If your coverage is suspended, any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the group health plan.

You are responsible for making sure your payment amounts are correct. You may contact the Plan Administrator to confirm the correct amount of your payments. Your payments for continuation coverage must be sent to the Plan Administrator.

Early Cessation of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the expiration date of the continuation period otherwise applicable (see "Length of COBRA Continuation Coverage" above) under the following circumstances:

- The employer (including any affiliate of the employer) ceases to provide any group health plan to any employee;
- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition (other than an exclusion or limitation that does not apply to, or is satisfied by, such beneficiary by reason of chapter 100 or title 26, part 7 of subtitle B of ERISA);

- A qualified beneficiary becomes enrolled in Medicare (Part A, Part B, or both) after electing COBRA continuation coverage; or

- If a qualified beneficiary is receiving extended disability coverage, upon a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled, in which case coverage will end the month that begins more than 30 days following the date of such determination.

Continuation coverage may also be terminated for any reason the group health plan would terminate coverage of a Covered Person not receiving continuation coverage (such as fraud).

TERMINATION OF CONTINUED COVERAGE:

Continued coverage will be terminated prior to the expiration date of the continuation period under the following circumstances. Continuation coverage would terminate on the earlier of:

1. The date the Employer ceases to provide any group health plan to its employees;
2. The date the individual fails to pay the applicable premium on a timely basis;
3. The date the individual becomes covered under Medicare.
4. The date the individual becomes covered under any other group health plan.

MEDICARE PROVISIONS

This Plan coordinates payment of benefits with Medicare in accordance with the current Medicare Secondary Payor rules, if the covered Employee and/or his covered spouse, if any, are at least 65 years of age and the Employee is Actively at Work. If the Employer employs 20 or more employees, the Plan will pay primary to Medicare Part A and Part B benefits. In the event the Employer employs fewer than 20 Employees, please contact the Claims Administrator for more detail on how coordination of benefits applies under the Plan consistent with Medicare Secondary Payor rules and applicable law.

Coverage rules outlined by this Plan (e.g., Plan exclusions and limitations) apply when the Plan is primary to Medicare. If an item or service is denied by the Plan due to a coverage exclusion or limitation, Medicare may pay, if the item or service meets Medicare coverage rules. If an item or service is not covered by either the Plan or by Medicare, you may be responsible for payment. In this instance, the Plan will have no responsibility to pay for such items or services.

If a Covered Person is disabled or has end-stage renal disease, different coordination of benefits provisions may apply. However, the Plan will coordinate all benefits in accordance with Medicare coordination of benefits rules.

To the extent that a Covered Person is covered under this Plan due to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), benefits under the Plan will be paid secondary to Medicare to the extent permitted by applicable law.

RIDER PROVIDING BENEFITS PRIMARY TO MEDICARE FOR END STAGE RENAL DISEASE

This rider is added to and made a part of the Summary Plan Description and is subject to all of the terms and provisions, of this Plan except as stated below.

Benefits payable for end stage renal disease (ESRD) will be primary to Medicare for a 30 month period, if the Employee or his Dependent:

1. are entitled to Medicare benefits solely on the basis of ESRD; and
2. began treatment for ESRD.

The 30 month period, referred to above, will begin on the earlier of:

1. the date on which the Employee or his Dependent becomes entitled under 42 USC, Section 426-1;
2. the date on which the Employee or his Dependent would have been entitled even if application under Medicare hadn't been made.

At the end of the 30 month period, ESRD benefits will be primary under Medicare and secondary under this Plan.

Regardless of network participation status, in order to receive benefit payments for ESRD, the Provider and treatment plan must be pre-certified and approved by the Plan's Utilization Review Organization.

CLAIMS PAYMENTS

PAYING BENEFITS FROM THE PLAN

This provision provides for the efficient and proper payment of benefits from this Plan. Payment by the Claims Administrator is based on data furnished by the Employee or Dependent (collectively, "**Claimants**"). In order to collect benefits under the Plan, the Claimant must first provide information as to the validity of the claim for benefits. **The initial claim must be submitted to the Claims Administrator within 6 months from the date the expense was incurred.**

Notwithstanding any provision in the Plan to the contrary, a termination of the Employer's contractual relationship with the Claims Administrator for any reason relating to services provided under the Plan ("**Administrative Services Agreement**"), including, but not limited to, Employer's termination of the Plan or a termination due to the Employer's failure to remit all required premiums as provided in the Administrative Services Agreement between the Employer and the Claims Administrator, will result in no benefits being paid by the Claims Administrator for expenses submitted after such termination date, regardless of the date the charges were incurred, except as may be determined by the Claims Administrator consistent with the Administrative Services Agreement. In such event, the Employer or successor claims administrator designated by the Employer will be solely responsible for any benefits payable under the Plan in such event and substituted for the Claims Administrator in all respects. In the event that that the Administrative Services Agreement is terminated as provided in this paragraph, the Claims Administrator will cease to have any role or responsibility under the Plan related to periods after the date of termination of the Administrative Services Agreement, except as determined by the Claims Administrator consistent with the Administrative Services Agreement. The terms of the Administrative Services Agreement are incorporated into and made part of the Plan by reference solely for purposes of this paragraph and are otherwise not part of the Plan.

For ease of administration, a "Request for Benefits" form is provided to the Claimant when requested from the Claims Administrator. These forms, when completed, contain the essential information necessary to decide on the validity of a claim for benefits. Occasionally, further information may be necessary and the Claimant should provide this to the Claims Administrator as requested.

The Claims Administrator will pay all eligible medical benefits from the Plan directly to the service provider unless satisfactory documentation is furnished to the Claims Administrator indicating that the service provider has been paid. If benefits are not payable, the Claimant will be advised in writing by the Claims Administrator. The Claimants' rights will be determined under the Plan's provisions and in conjunction with the procedures outlined below.

WHEN A CLAIMANT FILES A CLAIM

When the Claimant files a "claim," he has the right to a speedy decision. A Claimant also has the option of appealing any adverse decision regarding the claim. The Claimant will have filed a "claim" when he submits one of the Plan's Claim Forms or if he takes one of the actions listed below. In the case of the submission of a Claim Form, a "claim" will be considered filed when it is received by the appropriate person/department listed below. The Plan also recognizes the following actions and submission of forms as "claims:"

- A request by the Claimant for benefits through preauthorization or a utilization review determination in cases where *use of either preauthorization or utilization review is required in order to obtain a particular benefit*. (Preauthorization requirements are outlined elsewhere in Plan materials.)

- Requests by the Claimant's formally-designated authorized representative for preauthorization or a utilization review determination in cases where *use of either preauthorization or utilization review is required in order to obtain a particular benefit*. (Preauthorization requirements are outlined elsewhere in Plan materials.) The Plan will take reasonable steps to determine whether an individual claiming to be acting on the Claimant's behalf is, in fact, validly empowered to do so under the circumstances, and the Plan will require that the Claimant complete and file a form identifying any person authorized to act on the Claimant's behalf with respect to a claim. See "Authorized Representative" provision under the "ADMINISTRATIVE PROVISIONS." However, when inquiries by a health care provider relate to payments due to the provider—rather than due to the Claimant—under managed care contracts (where the health care provider has no recourse against the Claimant for the amounts) such inquiries by a health care provider will not be considered "claims" by the Plan.
- Requests for benefits (in the case of a claim involving urgent care) by a health care provider with knowledge of the Claimant's medical condition. For urgent care claims, the Claimant is not required to complete a form and formally designate a health care provider as an authorized representative with respect to a claim.
- Submission of a medical bill for reimbursement or payment under the terms of the Plan.

The Claimant may request the Plan's Claim Form from the Claims Administrator by contacting the phone number on the Benefit Identification Card. After the Claimant has completed the Claim Form, ***it must be submitted to the address listed on the Benefit Identification Card.***

All submitted claims and appeals will fall into one of the three categories described below. The handling of the initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time the claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

- An **urgent care** claim is one that involves serious jeopardy of life or health of the patient, or the ability of the patient to regain maximum function or, in the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be managed without the treatment at issue. Determination of "urgent care" status requires that the judgment of a prudent layperson with average knowledge of health and medicine be applied, except where a Physician with knowledge of the patient's medical condition determines that the claim involves urgent care.
- A **non-urgent pre-service** claim is one that, under the terms of the Plan, requires approval of the particular benefit or procedure prior to obtaining medical care.
- A **post-service** claim is a claim that is neither an urgent care claim nor a non-urgent pre-service claim.

INITIAL CLAIM DECISION

After the Claimant submits a claim, the Plan must make a decision on the claim within a prescribed period of time.

Urgent Care Claims

For urgent care claims, the Claims Administrator must notify the Claimant of the benefit determination (adverse or favorable) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. The notification will be given orally, and the Plan will send the Claimant written or electronic notification within three (3) days after the oral notification.

If the claim is incomplete but is properly filed, the Claims Administrator will orally notify the Claimant as soon as possible (but not later than 24 hours) after the receipt of the claim, of the specific information necessary to complete the claim. The Claimant will have at least 48 hours to provide the specified information necessary to complete the claim submission. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Claimant of the incomplete claim until the date on which he responds to the request for additional information. The Claimant will be notified of the Plan's decision as soon as possible, but no later than 48 hours after the earlier of either the time the Plan receives the specified information or the expiration of the time given to the Claimant to provide the specified information.

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the Claims Administrator must notify the Claimant (in writing or electronically) of the benefit determination (adverse or favorable) as soon as possible, but not later than 15 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

If the claim is incomplete but is properly filed, the Claims Administrator will notify the Claimant (in writing or electronically) as soon as possible after the receipt of the claim of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time if the Plan sends the Claimant a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim. The notice of extension will be sent to the Claimant before the initial 15-day period ends.

The Claimant will have at least 45 days from the receipt of the notice of incompleteness in which to complete the claim filing by supplying the required information as specified in the notice. If the Claimant fails to submit the missing information to complete the claim, it will be denied. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Claimant of the incomplete claim until the date on which the missing information is submitted to the Claims Administrator or, if earlier, the deadline provided for submitting such missing information. The Plan will then have a 15-day extension of time to make a determination of the claim.

Post-Service Claims

For post-service claims, the Claims Administrator will notify the Claimant in writing or electronically of the benefit determination as soon as possible, but not later than 30 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

If the claim is incomplete but properly filed, the Claims Administrator will notify the Claimant (in writing or electronically) as soon as possible after the receipt of the claim of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time if the Plan sends the Claimant a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim. The notice of extension will be sent to the Claimant before the initial 30-day period ends.

The Claimant will have at least 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the required information as specified in the notice. If the Claimant fails to submit the missing information to complete the claim, it will be denied. The Plan's time limit for making a determination will be suspended from the time that it provides notice to the Claimant of the incomplete claim until the date on which the Claimant submits the missing information to the Claims Administrator or, if earlier, the deadline provided for submitting such missing information. The Plan will then have a 15-day extension of time to make a determination of the claim.

Requests for Extension of Treatment

A request to extend a course of treatment beyond a particular period of time or number of treatments is a claim. If the treatment is for urgent care, the Plan will decide the claim as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements). The Plan will notify the Claimant of its benefit determination (adverse or favorable) within 24 hours after receipt of the claim by the Plan as long as the claim is submitted to the Plan at least 24 hours before the expiration of the treatment period or the number of treatments. If the request is not made at least 24 hours before the expiration of the treatment period or the number of treatments, the request will be decided as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements), but not later than 72 hours after received by the Plan. The Plan will orally notify the Claimant of its decision, and the Plan will send written or electronic notification within three (3) days after the oral notification.

Other requests to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide the claim within the timeframe appropriate to the type of claim, such as the time limits applicable to non-urgent pre-service claims or the time limits applicable to post-service claims.

ADVERSE BENEFIT DETERMINATIONS

If the claim is in the form of a medical bill that is submitted to the Plan for payment, the Plan will pay the benefit according to Plan provisions. This may mean that less than 100% of the medical claim is payable by the Plan. In each case where the Plan pays benefits or determines that it is not responsible for the medical claim, the Claimant will receive a written or electronic Explanation of Benefits which will outline the basis for the Plan's payment or denial of benefits and which constitutes an adverse benefit determination. Claimants will receive oral notification followed by written notification of the adverse benefit determination in the case of urgent care claims. In addition, the Plan's payment of less than 100% of the submitted claim (under the terms of the Plan) will entitle the Claimant to appeal the decision under the rules governing adverse benefit determinations that assure the Claimant a "full and fair" review. The Plan will provide additional information with the adverse benefit determination that will help the Claimant pursue the right to appeal. Specifically, all adverse benefit determinations will generally include the following, unless otherwise provided in any such determination:

- information sufficient to identify the claims involved and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- the specific reason(s) for the denial;
- a reference to the specific plan provisions(s) on which the determination is based;
- for an initial adverse benefit determination, a description of any additional material or information needed to perfect the claim and an explanation of why the additional material or information is needed;
- upon request, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;
- the denial code and its corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim and, in the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision;
- a description of the Plan's internal and external review procedures, how to initiate an appeal, and the time limits that apply to them, including a statement of the claimant's right to bring a civil action under ERISA if the claimant appeals and the claim denial is upheld;

- information about any internal review, guideline protocol, or other similar criterion relied upon in making the claim determination and about the claimant's right to request a copy of it free of charge;
- information about the scientific or clinical judgment for any determination based on medical necessity or Experimental treatment, or about the claimant's right to request this explanation free of charge;
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist the claimant.
- in the case of an adverse benefit determination on review, the notice must include a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

For claims involving urgent/concurrent care the Claimant's notice will also include a description of the applicable urgent/concurrent review process.

Ineligibility for Benefits

If the Claimant is denied benefits based upon the Plan's finding that the Claimant is/was ineligible for benefits, the denial of benefits is an adverse benefit determination that gives the Claimant the opportunity to appeal the Plan's decision.

Termination or Reduction of Benefit

If the Plan decides to reduce or terminate the Claimant's previously-approved course of treatment (other than upon Plan amendment or termination), the Plan's decision will be treated as an adverse benefit determination, and the Plan will provide the Claimant reasonable advance notice of the reduction or termination to allow the Claimant to appeal the Plan's decision before the benefit reduction or termination takes place. If the Claimant decides to appeal the Plan's decision, the Claimant must follow the rules for appealing a Plan's decision.

FAILURE TO FOLLOW PLAN FILING PROCEDURES

If the Claimant fails to follow the Plan's filing procedures because the request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; or 4) arrive in the correct department because it is not sent to the correct address or person, THE CLAIMANT WILL NOT HAVE SUBMITTED A CLAIM. The Claims Administrator will notify the Claimant orally or by written or electronic means within five (5) days (or for urgent care claims 24 hours) of the failure to follow the filing procedures and will remind Claimant of the proper filing procedures.

DATE CALCULATIONS

For the purposes of the Claims Payment and Appeal Provisions sections, any reference to "days" will refer to calendar days, not business days. If a deadline falls on a Saturday, Sunday, or federal holiday, the deadline will be on the next business day. If a deadline would fall on a date for which there is no corresponding date for that month, the deadline will be the first day of the following month.

APPEAL PROVISIONS

COMPLAINTS

The Plan Administrator or its designated Claims Administrator, Medova Healthcare Financial Group, LLC, is here to listen and help. Because the Plan wants the Claimant to be completely satisfied with the member services assistance received, the Plan has established a process for addressing Claimant concerns and solving Claimant problems. If a Claimant has a concern regarding a person, a service, the quality of care, or wants to inquire about what benefits are covered under the Plan, please call the phone number on the Benefit Identification Card, the Explanation of Benefits, or the Claim Form and explain the concern to one of the Plan's member services representatives. The Claimant may also express that concern in writing. The Claims Administrator will do its best to resolve the matter on initial contact. If more time is needed to review or investigate the concern, the Claims Administrator will get back to the Claimant as soon as possible, but in any case within 30 days. The Claims Administrator will not consider any of these communications to be a "claim" for benefits. A formal claim for benefits must meet certain other standards which are described in the section titled "When a Claimant Files a Claim."

APPEALING A CLAIM DECISION

This Plan has a mandatory 2-step internal appeals procedure for benefit determinations. For both levels of internal appeal, you may inspect or request reasonable access to relevant information free of charge. You may also submit written comments, documents, records, and other information during the review of your claim. The Plan also has an external appeals procedure that may be used once internal appeals have been exhausted. See section titled "External Review Request" for information on external appeals.

INTERNAL REVIEW REQUESTS

To initiate an internal appeal, the Claimant must submit a written request to the Claims Administrator at *Medova Healthcare Financial Group, LLC, Attn: Appeals, 8300 E. Thorn Drive, Suite 300, Wichita, KS, 67226* **within 180 days** of receipt of an adverse benefit determination of a pre-service, post service, or concurrent care claim. (An oral request for review is acceptable for urgent care claims and may be made by calling toll-free 866.827.6607 and asking the Plan to register an oral appeal, but such appeals must still be made within 180 days.) In order to submit a written appeal, the Claimant must: (1) identify the Eligible Employee, the Employer, the Plan, and the Claimant; (2) describe why the Claimant disagrees with the claim decision; and (3) attach any additional information or documentation that supports Claimant's position.

If the Claimant is dissatisfied with the decision made at the first level of the internal appeal process, the Claimant may request a second review. All second level internal appeals will be handled by the Claims Administrator. To initiate a second level internal appeal, the Claimant must submit a request in writing to the Claims Administrator at the above address within 60 days of the Claimant's receipt of the denial notice of the first level internal appeal from the Claims Administrator. (An oral request for second level review is acceptable for urgent care claims as described above for first level review, but still must be made within 60 days.) There is no charge for a Claimant to initiate a first or second level internal appeal.

When the Claimant appeals an adverse benefit determination at the first or second level of internal review, the Plan will provide a "full and fair review" which will include the following features:

1. The Claimant will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At the Claimant's request (and free of charge), the Claimant will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to the Claimant's claim for benefits. Included in this category are any documents, records, or other

information in the claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Claimant also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision making.

3. The review of the claim will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

4. Any appeal of an adverse benefit determination will not afford deference to the original determination, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.

5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary or appropriate), the Claims Administrator will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the original determination; neither will this health care professional report to the health care professional who was consulted in connection with the original determination.

6. The Plan will identify on request medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the claim, whether or not that advice was relied upon in making the benefit determination.

After the Claimant submits the claim for appeal at the first or second level of internal review, the Plan must make a decision on the claim within a short period of time as discussed below.

Urgent Care Claims

The Plan's expedited appeal process for urgent care claims will allow the Claimant to request (orally or in writing) an expedited first or second level internal appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Claimant by telephone, fax, or other expeditious method. The Claims Administrator will notify the Claimant (in writing or electronically) of the benefit determination as soon as possible, but not later than 36 hours after receiving the request for the first level review of the adverse benefit determination. If a second level appeal is requested, not later than 36 hours after receiving the request for the second level review of the adverse benefit determination.

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the Plan Claims Administrator must notify the Claimant (in writing or electronically) of the benefit determination on the first level of appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days. Likewise, for the second level of appeal for non-urgent pre-service claims, the Claims Administrator must notify the Claimant (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.

Post-Service Claims

For post-service claims, the Claims Administrator must notify the Claimant (in writing or electronically) of the benefit determination on the first level of appeal within a reasonable period of time, but not later than 30 days. Likewise, for the second level of appeal for non-urgent pre-service claims, the Claims

Administrator must notify the Claimant (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days.

IF AN APPEALED CLAIM IS DENIED

If the Claimant's first or second level internal appealed claim is denied, the Plan will send the Claimant written or electronic notification that will tell the Claimant why the appealed claim was denied. The Plan will also provide information that will inform the Claimant of any additional right to appeal along with the information set forth above under "ADVERSE BENEFIT DETERMINATIONS."

FAILURE TO FOLLOW PLAN FILING PROCEDURES

If a Claimant fails to follow the Plan's filing procedures because a written appeal or request for external review does not 1) identify the Eligible Employee, the Employer, the Plan, and the Claimant; 2) describe why the Claimant disagrees with this decision; or 3) arrive in the correct department because it is not sent to the correct address or person, THE CLAIMANT WILL NOT HAVE SUBMITTED AN APPEAL. The Claims Administrator will notify the Claimant orally or by written or electronic means within five (5) days of the failure to follow the filing procedures and will be remind Claimant of the proper filing procedures. Claimants may make oral requests for urgent care appeals or for external review.

EXTERNAL REVIEW REQUEST

An external review request must be initiated either by the Claimant or his authorized representative with the Claimant's written consent, when applicable. If proper authorization is not received, the Claimant will be contacted to request the authorization.

A Claimant may only request an external review after all internal appeal rights have been exhausted. However, only the following adverse benefit determinations are eligible for external review:

1. An adverse benefit determination that involves medical judgment, including those involving requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is Experimental or investigational, a determination whether a Claimant is entitled to a reasonable alternative standard for a reward under a wellness program, or a determination whether the Plan is complying with certain non-quantitative treatment limitations.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

An external review request must be in writing and received by the Claims Administrator within 4 months of the Claimant's receipt of the final internal adverse benefit determination. Requests for external review related to an urgent non-coverage determination will be accepted verbally only when they meet the urgent care claim appeal criteria.

Preliminary Review shall occur within 5 business days following the date of receipt of the external review request in order to determine:

- whether Claimant is or was covered under the Plan at the time the health care item or service was requested or provided;
- that the adverse benefit determination does not relate to eligibility under the terms of the Plan;
- that the Claimant has exhausted the Plan's internal process unless exhaustion not required; and
- that the Claimant has provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, written notification to the Claimant will be issued. If the request is complete but not eligible for external review, the notification will inform the Claimant and provide contact information for the Employee Benefits Security Administration. If the request is incomplete, the notification will inform the Claimant what information is required to complete

the request and allow the Claimant the opportunity to perfect the request within the 4 month filing period, or within 48 hours following receipt of the notification, whichever is longer.

If the request is complete, the notification to the Claimant will indicate this. The case is assigned on a rotating assignment basis to the pool of contracted IROs. The selected IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits, and the IRO process will not impose any costs, including any filing fees, on the Claimant requesting the external review. Clinical peers employed by an Independent Review Organization (IRO), of the same or similar specialty relating to the case, will be assigned to review the request and render a case determination. In all cases, individuals assigned to review and render case determinations will not have previously reviewed the case at any level of appeal or are not a direct report of those individuals involved with a previous review.

Within 5 business days after the date of assignment of the matter to an IRO, the Plan will provide to the assigned IRO the documents and information considered in making the adverse benefit determination.

IROs may receive information directly from the Claimant. If that occurs, the IRO must, within 1 business day, forward that information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider its adverse benefits determination. Reconsideration will not delay external review. If the Claims Administrator does reconsider based upon this information, and decides to overturn, this decision will be communicated to the Claimant and IRO within 1 business day after such decision is made. This will end the external review if all requested benefits will be paid or provided.

The assigned IRO will provide written notice to the Claims Administrator and the Claimant of the final external review decision within 45 days after the IRO receives the request for the external review. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the Claims Administrator will immediately provide coverage or payment for the claim as decided by the IRO.

EXPEDITED EXTERNAL REVIEW

A Claimant may request an expedited external review if the adverse benefit determination involves: (1) a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or (2) a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final 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.

Preliminary review shall occur immediately upon receipt of the request under the same standards as above under Standard Review. Notification of the preliminary review result will immediately be sent.

If eligible, the case is assigned on a rotating assignment basis to the pool of contracted IROs and the Claims Administrator must transmit all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically, by telephone, by facsimile or any other available expeditious manner.

The IRO will provide notice to the Claims Administrator and the Claimant of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Claims Administrator. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the Claims Administrator will immediately provide coverage or payment for the claim as decided by the IRO.

HIPAA PRIVACY REGULATION REQUIREMENTS

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health Information (PHI) as defined under HIPAA, to the Employer, as sponsor of the Plan ("**Plan Sponsor**").

This Plan will generally Use the Covered Persons' Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by HIPAA. Specifically, this Plan will Use and Disclose the Covered Persons' PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose the Covered Persons' PHI as required by law and as permitted by authorization. Refer to the Plan's Notice of Privacy Practices in Appendix A at the back of this document for more information about the permitted Uses and Disclosure of PHI, the individuals' right and this Plan's legal duties regarding PHI.

The **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA** within this section of the document specifies the terms under which the Plan may share PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of the Covered Persons' PHI.

Plan Sponsor agrees that it will:

- ensure that adequate separation exists between this Plan and the Plan Sponsor and that proper safeguards are established. This includes specifically identifying the Employee (s) or classes of Employees who will have access to PHI and to restrict the access to and use by these identified employees to the Plan administration functions that the Plan Sponsor performs for the Plan. These individuals are identified in Attachment #1;

- not use or disclose any PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- ensure that any agents to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for purposes of determining the Plan's compliance with the law;

- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for 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 infeasible;

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- ensure that any agent to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;

- report to the Plan any security incident of which it becomes aware;

- make available PHI in accordance with section 164.524 of the HIPAA privacy regulations;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the HIPAA privacy regulations; and

- make available the information required to provide an account of disclosures in accordance with section 164.528 of the HIPAA privacy regulations.

The Employer, as Plan Administrator, agrees that it will:

- not use or disclose any PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor without the Participant's authorization;

- not permit a health insurance issuer or HMO with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this Plan or as required by law

- not disclose and may not permit a health insurance issuer or HMO to disclose PHI to a Plan Sponsor as otherwise permitted by this Plan or the law unless the disclosure is permitted by the Privacy Notice; and

- only disclose the Covered Persons' PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA portion of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

HIPAA DEFINED TERMS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associates are entities (e.g. Medova Healthcare Financial Group, LLC) that perform or assist in the performance of any of the activities or functions of the Covered Entity involving the Use and Disclosure of Individually Identifiable Health Information, including claim processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, repricing, legal, actuarial, accounting, consulting, data aggregation management, administrative accreditation or financial services.

Covered Entities are entities directly impacted by the limitations placed on the access, Use and Disclosure of PHI. They include:

- Health care providers who actually perform the health care services (i.e. Physicians, Hospitals and clinics;
- Health Plans that provide reimbursement or Payment for such health care services; and
- Health care clearinghouses that transmit PHI in electronic format as part of the HIPAA electronic data interchange (EDI) requirements.

De-identified Information is information that does not identify an individual and under which no reasonable basis exists to believe that the information can be used to identify an individual.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Health Care Operations include general administrative and business functions necessary for the Covered Entity to remain a viable business. These activities include:

- conducting quality assessment and improvement activities;
- reviewing the competence or qualifications and accrediting/licensing of health care professionals and plans;
- evaluating health care professional and health plan performance,
- training future health care professionals;
- insurance activities relating to the renewal of a contract for insurance;
- conducting or arranging for medical review and auditing services;
- compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- contacting of health care providers and patients with information about treatment alternatives, and related functions that do not entail direct patient care; and
- activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the Health Plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information that is transmitted by electronic media; or maintained in any medium that is considered electronic media, or transmitted or maintained in any other form or medium.

Summary Health Information is information that may be Individually Identifiable Health Information that summarizes claims history, claims experience or the type of claims experience of a Covered Person with the following identifiers removed:

- Names;
- Geographic units - information more specific than a state (five-digit zip codes are allowed);
- Dates – any month or day (except the year) directly relating to individuals or their treatment including birth date, admission date, or date of death. Listing the individuals' age is allowed with the exception of individuals over the age of 89. For individuals over the age of 89, any month, day or year that reveals the individuals' age to be over 89, must be removed;
- Numbers - Social Security numbers, phone numbers, fax numbers, vehicle identifiers and all other identifying numbers as required by the regulations.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

FUNDING – SOURCES AND USES

Employee & Employer Obligations

Plan benefits are funded from the general assets of the Plan Sponsor and contributions from Covered Persons through a Section 125 Plan, as described above. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (NonCOBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the COBRA Continuation Coverage section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employer or Covered Person will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to the claims payable under the Plan.

Taxes

Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase coverage protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent with ERISA guidelines.

ADMINISTRATIVE PROVISIONS

Administration

The Plan benefits described herein are administered by a Claims Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Claims Administrator. The Claims Administrator is not an insurance company and does not assume any financial risk or obligation with respect to claims payable under the Plan.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any Covered Person:

Alter or postpone the method of payment of any benefit;

Amend any provision of these administrative provisions;

Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification or amendment or termination action can be adopted by an officer of the Employer or an authorized governing body of the Employer upon notice to the Claims Administrator. Employees will be provided with notice of the change within the time allowed by federal law.

Notwithstanding the above, the Claims Administrator is authorized and empowered to make any amendments to the Plan (other than Attachment #1) without the consent of the Plan Sponsor as necessary to comply with applicable law and to conform the administration and operation of the Plan to this Plan document, and any such amendment will be effective on the date distributed to the Plan Sponsor, or if earlier, to Covered Persons.

Anticipation, Alienation, Sale or Transfer

Except for assignments to participating Preferred Providers under the Plan, no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void except (a) as required by law, or (b) pursuant to a Qualified Medical Child Support Order; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or other payments for support of your spouse or former spouse or any of your other relatives, and any like or unlike claims.

The Plan's anti-assignment provision means that none of the benefits payable to you, any other person, entity or third party under this Plan are ever assignable or transferable to any other party, including to a Non-Network provider (or any representative or agent of a provider) or are subject to any lien by any person or party, either before or after benefits, services, or supplies are provided to you or any other person. The Claims Administrator reserves the sole right and discretion to make any benefit payments under the Plan directly to (a) you, (b) any participating Preferred Provider under the Plan, (c) any Non-Network provider, or (c) another designated person or entity. In such case, except for valid assignments to participating Preferred Providers under the Plan, the benefit payment will be made on your behalf and not on behalf of the recipient, and such payment will not constitute a waiver of this anti-assignment provision. The Plan is not liable for, or subject to, any obligation or liability (e.g., through garnishment, attachment, pledge or bankruptcy), of yours or a third-party that you, the third party or anyone else may be liable to for medical care, treatment or services but the Claims Administrator may choose to comply with such requests. In addition, you (or anyone else) cannot assign to any Non-Network provider your right to appeal any adverse benefit determination, your right to request Plan documents, along with your related right to receive any penalty related to any delay or failure to provide any such documents, or your rights related to any claim regarding or concerning a breach of fiduciary duty or to otherwise enforce any provision of ERISA.

Authorized Representative

You may appoint an authorized representative in writing to act on your behalf in accordance with procedures established by the Claims Administrator and applicable law. The Claims Administrator requires that you complete and file the "Medova Healthcare – Appointment of Authorized Representative" form identifying any person authorized to act on the claimant's behalf with respect to a claim or appeal.

Claims Administrator Discretion & Authority

The Claims Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Claims Administrator shall make determinations regarding Plan benefits.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies
In the event that there may be a discrepancy between this document provided to Employees, including the Attachment #1 ("**Summary Plan Description**"), and any other document or disclosure, this Summary Plan Description (as the Plan Document) will prevail as the official Plan Document.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have no discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, or to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Such responsibility will remain with the Claims Administrator. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Plan Document will not affect the other provisions and the Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

If an Employee, Dependent, or other beneficiary is dissatisfied with the Claims Administrator's or the Independent Review Organization's review of the decision, the Covered Person or beneficiary has the right to file suit in a federal or state court located in the State of Kansas, which suit must be filed within twelve (12) calendar months immediately following the date of such Claims Administrator's or Independent Review Organization's final decision. No action may be brought for benefits provided by this Plan or to enforce any right hereunder until after a claim has been submitted to and determined by the Claims Administrator or the Independent Review Organization and all appeal rights under the Plan have been exhausted. This means that all claims under this Plan except for urgent care claims must be appealed under this Plan before any suit for benefits may be filed by the Covered Person or beneficiary in federal court. Thereafter, the only action which may be brought is one to enforce the decision of the Claims Administrator or Independent Review Organization. The Claimant's beneficiary should follow the same claims procedure in the event of the Covered Person's death. See the Claims and Appeal Provisions section for more information.

Venue for Legal Actions
This Plan and the rights and obligations of the parties hereunder shall be construed in accordance with and governed by the laws of the State of Kansas, except as otherwise provided by ERISA or applicable federal or state laws. All judicial proceedings brought against any party arising out of or relating to this Plan or any obligation hereunder shall be brought in any federal court of competent jurisdiction located in the State of Kansas. To the fullest extent permitted by law, (a) the Covered Person and any authorized representative thereof submits to and accepts the exclusive jurisdiction of such courts for the purpose of legal action, and (b) such Covered Person and any authorized representative thereof irrevocably waives any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Covered Person might otherwise reasonably expect the Plan to provide based on the description of benefits:

an Employee's cessation of active service for the Employer;

a Covered Person's failure to pay his share of the cost of coverage, if any, in a timely manner;

a Dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorce);

a Covered Person is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Covered Persons are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Covered Person as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Covered Person, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an

enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or Covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
Claims experience
Receipt of health care
Medical history
Evidence of insurability
Disability
Genetic information

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Privacy Rules & Security Standards & Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "**Privacy Rules**") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with the HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of participating Employer(s) and their Eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party – Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Claims Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error – When, as a result of error, clerical or otherwise, benefit payment have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the

Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Administrator may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability – The Claims Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Claims Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's right under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Administrator may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer

Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or heading precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be substantive part of the Plan Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

WARNING: Fraudulent claims cause each of you to pay more each year, as the cost to pay claims increases overall. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime. A fraudulent claim includes a claim for which you or one or more of your Dependents uses the value of a prescription drug coupon or discount to wrongly satisfy, in whole or in part, the applicable medical deductible under the Plan. If you commit fraud or make an intentional misrepresentation of a material fact to obtain coverage under the Plan, you and your Dependents' coverage may be terminated or suspended in whole or in part. Finally, other action, to the extent permitted by law, including potentially criminal charges, may be pursued to reimburse the Plan for those fraudulent claims.

Worker's Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirements for coverage by Workers' Compensation Insurance laws or similar legislation.

STATEMENT OF RIGHTS

Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Covered Person shall be entitled to:

Receive Information About His/Her Plan and Benefits.

This includes the right to: examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including contracts and collective bargaining agreements, and 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; obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, and receive a summary of the Plan's annual financial report (the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report). The Plan Administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage.

This includes: the right to continue health care coverage for himself/herself, spouse or Dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Covered Persons. No one, including the Employer, may fire a Participant or discriminate against the Participant to prevent any Covered Person from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Claims Administrator review and reconsider his/her claim.

Enforce His/Her Rights

Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay/him her up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Covered Person has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, or if a Covered Person needs assistance in obtaining documents from the Plan Administrator, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Covered Person may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting Daniel Whitney (of Medova Healthcare) at (316) 616-6160 or our Privacy Official listed below.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

NPP Effective Date: 1/1/2021

Privacy Officials:

The Employer's President and Chief Executive Officer will serve as the Privacy Officer for the Plan, unless one or more different individuals are designated on Attachment #1.

Exhibit 2

EMPLOYEE GROUP BENEFIT PLAN
ADMINISTRATIVE SERVICES AGREEMENT

This Agreement, made and entered into by and between Medova Healthcare Financial Group, LLC, a Kansas Corporation with its principal offices at Wichita, Kansas ("Medova"), and _____, a Corporation with its principal offices at _____, ("Employer") in its capacity as sponsor and administrator of the Plan, as defined below, on the Effective Date of this Agreement specified below:

WITNESSETH:

WHEREAS, Employer provides welfare benefits to its employees under one or more group benefit program(s) selected by Employer, as further described in Exhibit A to this Agreement ("Plan"), using a self-funded welfare plan (except to the extent that any such benefits are otherwise insured as provided in Exhibit A);

WHEREAS, Employer desires to utilize the services of Medova to implement and manage the Plan, including, but not limited to, providing (or engaging) the consulting services and third-party administrative services needed to manage all aspects of the Plan, including the determination, validity, and adjustment of the claims incurred by "Members" (as defined below);

WHEREAS, Medova has agreed to provide these services and perform or arrange for consulting with respect to, administration, processing, and determining the validity of, and adjusting Plan claims, as required for the appropriate operation and administration of the Plan; and

WHEREAS, Employer understands and agrees that Medova will administer the Plan as an employee welfare benefit plan subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and all ERISA provisions in this Agreement shall apply contractually regardless of whether the Plan is, in fact, subject to ERISA; provided, however, that Employer affirms that the Plan is, in fact, subject to ERISA except to the extent that Employer and Medova agree otherwise in writing.

NOW, **THEREFORE**, in consideration of the mutual covenants contained herein, the parties above (each a "Party" and collectively the "Parties") agree as follows:

1. Definitions:

A. "Members" are all subscribers and enrollees entitled to receive benefits under the Plan.

B. "Provider" means duly licensed and qualified health care providers and facilities that have entered into contracts to provide healthcare services to Members.

2. Medova's Duties and Responsibilities: Medova agrees to perform or arrange for the following third party administrative services for Employer, as required by the terms and conditions set forth in the Plan, which will include "Consulting Services," "Administrative Services," and "Claims Services" and such other services as are described below:

A. **Consulting Services:**

(i) Assisting in the preparation of a combined Plan document and Summary Plan Description ("Plan Document") with respect to the eligibility, benefits and similar related provisions of the Plan, together with amendments to the Plan Document, as required from time to time;

(ii) Supporting Employer in developing, designing, and installing the procedures and systems for processing requests and claims for benefit payments, including the preparation of the following forms and materials necessary to implement the Plan:

(1) Member benefit booklet;
(2) Member ID cards;
(3) Member enrollment cards;
(4) Benefit checks;
(5) Benefits claims forms; and
(6) Other similar and related forms Medova deems necessary and incidental to the proper administration of the Plan;

(iii) Assisting Employer with planning and communicating rates and benefits to Members, including assisting Employer with rate adjustments and advising Employer of current health care field innovations and changes;

(iv) Providing non-legal consulting services with respect to the Plan, including, but not limited to, the evaluation of trends, recurring problems and possible abuses of the Plan; and

(v) Providing annual claims and expense projections to Employer relating to the Plan's funding requirements.

B. **Administrative Services:**

(i) Maintaining Member enrollment data, verifying Member eligibility (including with respect to election changes following a "Change in Status," as provided by applicable law and set forth in the Plan), effective dates, and similar data based on information provided by Employer, but only to the extent that Employer requests such services and timely and properly provides such information as is necessary for Medova to verify Employer's eligibility determination (provided, however, that Employer remains solely responsible for any such determination);

(ii) Calculating, preparing and remitting the proper amount due to vendors, including network access fees (if any), stop-loss insurance carrier premiums**,** utilization review and case management services, and other service arrangements, for vendor services required for the operation and administration of the Plan. This includes the administration of service fees due to each vendor each month based on the adjustments for changes in Member enrollment;

(iii) Processing continuation requests submitted by eligible Members;

(iv) Invoicing eligible Members directly for continued coverage, depositing such collected funds into an Employer Account, as defined below;

(v) Providing conversion information request forms to former Members upon termination of continued coverage;

(vi) Providing certifications of creditable coverage as required by HIPAA to former Members, including terminated employees and dependents, upon termination of coverage, again upon termination of continuation coverage under applicable Federal or state law ("COBRA") and upon request within 24 months of termination of employment; and

(vii) Maintaining copies of any documentation provided by Employer with respect to participant elections relating to Changes in Status as necessary to satisfy the requirements of the stop-loss insurance carrier (except to the extent that Employer has notified Medova in writing in a manner satisfactory to Medova that it intends to maintain such documentation itself, or retain another third party record keeper to do so).

C. **Claim Services:**

(i) Establishing and maintaining data on each reported claim for benefits;

(ii) Receiving, acknowledging, examining, verifying, processing and determining the validity of each request and claim for benefit payments through any appropriate investigation which Medova deems necessary, including, but not limited to, coordination of benefits provided from other sources;

(iii) Adjusting all requests and claims for benefit payments in a prompt and equitable manner in accordance with the provisions of the Plan, including preparation and distribution of payment drafts and the explanation of benefit payments;

(iv) Assisting in securing professional medical and dental consultation in peer review, legal services and other professional expertise necessary to properly determine and adjust claims;

(v) Reviewing appeals of claim denials;

(vi) Preparing regular claims analysis reports, including industry standard comparisons;

(vii) Assisting Employer with establishing policies and procedures regarding the operation and administration of the Plan as it may deem advisable or necessary but only so long as they are uniformly applicable and not inconsistent with the express provisions of the Plan;

(viii) Establishing procedures for the assignment of benefits due a Member to Providers;

(ix) Providing all forms necessary to the administration of the Plan and the filing of benefits claims which may be updated from time to time;

(x) Providing record-keeping services for the Employer Account, including, but not limited to, reconciliation of any claims paid from the Employer Account;

(xi) Administering the claims review procedure established by the Plan and settling all claims and litigation, including, but not limited to, any and all claims related to subrogation and/or third party liability, for and on behalf of the Plan and Employer, without the consent of Employer or any other Plan fiduciary, including, but not limited to, the named administrator of the Plan under ERISA; provided, however, that the Employer acknowledges and agrees that it may, notwithstanding any right that Medova has with respect to settlements, have the authority to approve or authorize any settlement of one or more claims under the Plan with the consent of Medova only in the following circumstances:

(1) Medova will, if deemed necessary by Medova, notify Employer of any difference between the portion of the proposed settlement amount below the attachment point for applicable stop-loss insurance coverage and the remaining balance in the Employer Account and the Employer promptly agrees to fund such amount as Employer acknowledges and agrees that Medova is not an insurer;

(2) Medova may charge Employer an additional Remittance Payment to the Employer Account as necessary, in Medova's determination, to fund any such settlement; and

(3) Should Employer decline to approve or actually make any such payment requested by Medova, Employer acknowledges and agrees to assume all responsibility and obligation for the settlement of any such outstanding claims that are settled, but which are not properly and adequately funded by Employer from the Employer Account or otherwise, and Employer acknowledges and agrees in such event that Medova will be absolved from any and all responsibility and obligation with respect to the settlement of any such claims;

(xii) Preparing the Summary Plan Description for Employer to furnish to its Members consistent with ERISA, following Employer's review and approval of the content thereof; and

(xiii) Providing Employer with compliance materials to assist Employer in satisfying its notice and other reporting obligations under ERISA, the Patient Protection and Affordable Care Act ("PPACA") or Health Insurance Portability and Accountability Act ("HIPAA") compliance; provided, however, that Employer acknowledges and agrees that such materials are intended only to be a general guide that has not been tailored to Employer's particular facts and circumstances and is not intended to constitute any legal advice.

D. **Incidental and Delegated Services:**

Medova may perform other services that are incidental and necessary to meet its duties and obligations under this Agreement, as well as any services or duties which may subsequently be delegated to Medova by separate agreement between the Parties or which may arise by virtue of an amendment to the Plan Document, which separate agreement (if any) or amendment shall be attached as an Exhibit to this Agreement. To the extent that the services reflected in such Exhibit exceed the scope of Medova's services as otherwise contemplated by this Agreement and any other Exhibit hereto, Medova will not be required to provide such services unless and until the Parties shall mutually agree to amend the detail rate matrix provided to Employer by Medova to take such additional services into account.

Employer acknowledges, consents to and agrees to delegate any and all authority under the Plan to Medova as Medova deems necessary or appropriate solely to the extent necessary to administer the claims services Medova provides under this Agreement, including, but not limited to, the delegation to Medova to settle any and all claims brought under, or related to, the Plan related to the services provided under this Agreement.

E. **Right to Audit:**

Medova shall, upon at least 90 days prior written notice to Medova, permit Employer or an authorized agent of Employer (as mutually agreed to by Medova and Employer) to conduct reasonable audits of Medova's records with respect to claims payments made under the Agreement. Such audit shall occur during Medova's normal business hours at a time that is least disruptive to Medova's business. The Employer and such agent, if any, agree not to disclose any proprietary or confidential information, and to hold harmless and indemnify Medova in writing of any liability from disclosure of such information. The Employer will be responsible for all costs associated with the inspection or audit. All such audits shall be subject to Medova's external audit policy and procedures and the audit period will be limited to the most recent 12 months and no more than one audit shall be conducted during a 12 consecutive–month period.

F. **Overpayments:**

When Medova becomes aware of a claim overpayment, Medova will use its best efforts to recover any such overpayment in accordance with its recovery policies and procedures, subject to the limitations of Section 5.H.

G. **Recordkeeping requirements**:

(i) Medova shall maintain at its principal administrative office, for the duration of the Agreement and for seven (7) years after termination of the Agreement (ten (10) years from the creation date of the books and records in West Virginia), adequate books and records of all transactions between Medova, Employer and Members. Such books and records shall be maintained in accordance with prudent standards of insurance record keeping. The appropriate insurance regulatory official

shall have access to such books and records for the purpose of examination, audit and inspection.

(ii) Any trade secrets contained therein, including, but not limited to, the identity and addresses of policyholders and certificate holders, shall be confidential, except the appropriate insurance regulatory official may use such information in any proceedings instituted against Medova.

(iii) Employer shall retain the right to continuing access to such books and records of Medova sufficient to permit Employer to fulfill all of its contractual obligations to Members, subject to any restrictions in the Agreement between Employer and Medova concerning the proprietary rights of the parties in such books and records.

(iv) Medova may transfer the books and records of transactions between Medova and Employer with which Medova has entered into a written agreement to a new administrator if: (A) the agreement between Medova and Employer is canceled; and (B) a written agreement for a transfer of the books and records is made between Medova and Employer. If the books and records are transferred to a new administrator, the new administrator shall acknowledge in writing that the new administrator is responsible for retaining Medova's prior books and records as required under Subsection 21.1. Employer shall reimburse Medova for reasonable costs incurred in retaining or tendering such records.

(v) Employer shall own the books and records generated by Medova pertaining to Employer. However, Medova shall retain the right to continuing access to the books and records to permit Medova to fulfill all of its contractual obligations to Members, claimants and Employer, and its obligations to maintain records available to insurance regulatory officials. Medova may retain a proprietary interest in the books and records of Employer, provided that the Agreement specifically identifies the items that will be subject to the Medova's proprietary interest. Medova may not withhold, based upon a claim of proprietary interest, any portion of Employer's books and records that would restrict the ability of Employer to comply with its statutory, regulatory, or contractual obligations.

(vi) Medova shall maintain detailed books and records that reflect all administered transactions specifically in regard to premiums, premium taxes, agents' commissions, Medova's fees, contributions received and deposited and claims and authorized expenses paid. The detailed preparation, journalizing, and posting of such books and records shall be made (a) in accordance with the terms and conditions of the Agreement, (b) consistent with ERISA, if applicable, as well as any state insurance laws that are applicable to the administrative services provided by Medova, but only to the extent not preempted by ERISA, and (c) as necessary to enable Employer to complete the National Association of Insurance Commissioners' annual financial statement, if applicable.

3. Employer's Duties and Responsibilities:

A. **Plan Services:**

Employer agrees to support and cooperate with Medova with respect to the services it provides under this Agreement, which includes, but is not limited to the following items:

(i) Furnishing Medova with current copies of the documents describing the Plan (along with other appropriate materials governing the administration of the Plan) which may include employee booklets, summary descriptions, employee communications significantly affecting the Plan, and any amendments or revisions to any such documents;

(ii) Reviewing, editing and approving, with advice of Employer's counsel and other advisors, as necessary, of any documents drafted by Medova as part of the services offered under this Agreement in a timely manner, as Employer acknowledges and agrees that:

(1) Medova cannot provide any legal advice or services;
(2) Employer must review and approve any Plan documents and corresponding communications; and
(3) Employer's approval of each respective Plan document is an express pre-condition for Medova to treat such documents as final; and
(4) Employer will provide an executed copy of the Plan Document to Medova within 90 days from: (a) the Effective Date; and also, (b) from the date any amendment to such Plan Document or other change to the Plan is adopted or effective, whichever is earlier; and
(5) Immediately upon the Effective Date of this Agreement, Employer will distribute to all participants in the Plan a copy of both the Summary of Benefits and Coverage and the welfare benefit plan proposal (related to, or concerning, the Plan) provided by Medova and executed and approved by Employer.

(iii) Performing and complying with the obligations of the "Covered Entity" as set forth in the HIPAA Business Associate Addendum, attached as Exhibit B to this Agreement;

(iv) Providing Medova with a list of the social security numbers and Medical Health Insurance Claim Numbers ("HICNs") (if applicable) for all Members upon request in order for Medova to supply such information to the Centers for Medicare and Medicaid Services in compliance with the Medicare, Medicaid and SCHIP Extension Act;

(v) Distributing to eligible Members all appropriate and necessary Plan Documents, communications and materials, including but not limited to:

(1) Member benefit booklet;
(2) Summary plan description;
(3) Member ID cards;
(4) Member enrollment cards; and

(5) Other similar and related forms and notices as may be necessary for the operation of the Plan or to satisfy the requirements of applicable laws and regulations, as determined by Employer;

(vi) Certifying to Medova within 90 days of the Effective Date that either: (1) all employees of Employer are eligible to receive electronic disclosures pursuant to ERISA and other applicable laws and regulations; or (2) Employer has, as of the date of such certification, otherwise fully complied with all participant disclosure requirements of ERISA and other applicable laws and regulations;

(vii) Monitoring the services and performance provided by Medova under this Agreement to the extent required by ERISA and other applicable law;

(viii) Administering and timely and fully funding all claims to the extent expressly provided in Section 2.C. of this Agreement; and

(ix) Delegating any and all authority under the Plan to Medova as Medova deems necessary or appropriate solely to the extent necessary to administer the claims services Medova provides under this Agreement.

B. **Form 5500 Return Preparation:**

Returns required by the Internal Revenue Service (5500, 990, etc.) shall be the responsibility of Employer, unless Employer specifically contracts with Medova to perform this service through the addition of a related Exhibit to this Agreement.

C. **Remittance Payment and Funding Provisions:**

Employer agrees to remit to Medova monthly an amount equal to the funding amounts due and invoiced to Employer, consistent with and based on the benefits elected by their Members as described in the "Remittance Agreement" between the Parties, attached as Exhibit C to this Agreement ("Remittance Payment").

The Remittance Payments shall include, but not be limited to, the amount necessary to fund the sum of the following or such other amounts contemplated by this Agreement, as determined by Medova:

(1) Anticipated claims payments to, or on behalf of, Members for benefits under the Plan, and related expenses;
(2) Stop-loss insurance premiums;
(3) Other administrative costs associated with the Plan, all of which shall be disclosed to Employer either in summary format or otherwise provided to the Employer upon request ("detail rate matrix"); and
(4) Any other amounts deemed necessary by Medova in the event of a breach of this Agreement or applicable law by the Employer, as determined in Section 5 of this Agreement.

D. **Remittance Payment Determination:**

Remittance Payments shall be determined based on the specific benefit Plan(s) selected and the participation tier elected by each Member.

(i) Remittance Payments are due on the first of each month for which benefits are effective, and is payable retrospectively on the first day of each month. All Remittance Payments due shall be based upon the number of employees participating in the Plan(s) during the coverage month to which the billing applies. Remittance Payments and fees shall be adjusted on each Plan anniversary date as mutually agreed upon by Medova and Employer.

(ii) Medova reserves the right to amend the detail rate matrix by reason of:

(1) A charge imposed by any governmental entity;
(2) A revised interpretation of an existing requirement;
(3) The enactment of a new law or regulation affecting this Agreement; or
(4) A greater than 10% change in Member enrollment at any time from the Effective Date.

In the event that Medova intends to amend the detail rate matrix for any of the reasons set forth above, Medova must notify Employer of its intent to do so and the Parties shall mutually agree to the additional fees that will be charged. If the Parties cannot agree upon the additional fees that will be charged within 30 days of Medova providing such notice to Employer, either Party may terminate this Agreement without penalty upon written notice to the other Party (though any other restrictions applicable to an early termination of this Agreement will apply).

E. **Other Obligations of Employer:**

(i) Employer shall furnish to Medova reports concerning Member eligibility and other necessary Plan data. Notwithstanding any other provision of this Agreement to the contrary, Employer is solely responsible for determining eligibility of individuals (including following a Change in Status) and advising Medova in a timely manner, but not later than the tenth day of each month, through a method agreed upon by the Parties, as to which employees, dependents, and other individuals are (a) eligible to participate in the Plan and (b) to be enrolled Members. Medova reserves the right to limit the effective date of retroactive enrollment as of a date otherwise provided by the Plan; provided, however, that Medova may also permit enrollment to a date that is no earlier than 60 days prior to the date notice is received by Medova subject to such conditions which Medova may require of Employer. Such retroactive enrollments shall also be subject to Medova's receipt of any applicable fees and Remittance Payments and other funding as otherwise provided in this Agreement. Employer shall keep copies of such records and furnish to Medova such notification and other information as may be required by Medova for the purpose of:

(1) enrolling Members,

(2) processing terminations,

(3) effecting COBRA coverage elections,

(4) effecting changes due to a Member's Change in Status,

(5) effecting changes due to a Member becoming eligible or ineligible for Medicare,

(6) effecting changes due to a leave of absence, or

(7) for any other purpose reasonably related to the administration of eligibility under this Agreement.

Employer acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely, accurate and efficient processing of claims under this Agreement. Medova shall not be responsible for any delays in the performance of its responsibilities under this Agreement or for any non-performance of its responsibilities under this Agreement which is caused in whole, or in part, by the failure of Employer to furnish the information or any other necessary information within a reasonable time.

(ii) Employer shall notify Medova in a timely manner, but not later than the tenth day of each month, through a method agreed upon by the Parties, of the Members, including, but not limited to, dependents, or other individuals that will be or have become ineligible for benefits under the Plan. Upon receipt of such notice, Medova shall terminate coverage effective as of the date specified in the Plan. Employer shall give Medova advance notice, if possible, of any Member's expected termination and/or retirement. Medova reserves the right to limit retroactive terminations to a maximum of 60 days prior to the date notice is received, except as provided by the Plan or as directed by Employer to the extent consistent with applicable law. Medova shall credit any such funding and fees for such retroactive terminations as may be reasonably determined by Medova. Employer understands and agrees that if it fails to timely notify Medova that a Member has terminated employment or otherwise has become ineligible under the Plan or that a dependent or other individual has become ineligible under the Plan, that Employer, on and after the date notice should have been provided to Medova, shall, to the extent determined by Medova, be solely responsible for:

(a) Funding all any and all claims incurred by such ineligible individual (regardless of whether such claims qualify for stop-loss insurance coverage);

(b) Paying all Member premiums for the ineligible individual; and

(c) Any applicable fees and Remittance Payments.

Further, the coverage of such individual may be terminated effective immediately as of the date Medova receives the late notice, as determined by Medova.

(iii) Employer shall promptly notify Medova in the event that it discovers an error in eligibility data previously provided to Medova under clause (i) or (ii), above. Upon receipt of such notice or its own discovery of such an error, Medova shall update its records accordingly, but Medova reserves the right to limit the retroactive effect of any related corrections (and any resulting adjustments to any fees related thereto, as reasonably determined by Medova) to a maximum of 60 days prior to the date notice is received or discovery is made.

(iv) Employer acknowledges that it or its designee(s) serves as the "plan administrator" and "named fiduciary" as those terms are defined in ERISA. Employer serves as the "plan sponsor" as that term is defined in ERISA. Employer has full and complete discretionary authority and control over the management and operation of the Plan, and all discretionary authority and responsibility for the administration of the Plan, except as expressly delegated to Medova under this Agreement, including, but not limited to, those responsibilities of Employer provided under this Agreement. Medova does not serve as "plan sponsor", "plan administrator" or as the Plan's "named fiduciary" or "fiduciary" in any respect, except with respect to claims as provided under this Agreement and such other fiduciary decisions and obligations as are expressly delegated by Employer to Medova under the terms of this Agreement. Employer retains all final authority and responsibility for the Plan (and any and all related claims), and Medova is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise agreed to by the Parties in writing.

(v) It is understood and agreed that the provision of any notice, election form, or communication and the collection of any applicable premium or fees required by or associated with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or any other applicable law governing continuation of health care coverage (i.e., "COBRA"), shall be the sole responsibility of Employer and not Medova, except as otherwise agreed to in a written agreement between the Parties.

(vi) Employer is solely responsible for compliance with the Family and Medical Leave Act ("FMLA"), and if applicable, the Americans with Disabilities Act, the Internal Revenue Code of 1986, as amended ("Internal Revenue Code"), federal and state nondiscrimination laws, and other federal and state laws and regulations governing the Plan, along with successors or replacements to such laws, including, but not limited to, laws, rules, or regulations relating to wellness programs applicable to the Plan. Employer acknowledges and agrees that it understands that the law, rules and regulations regarding wellness programs are subject to change, including without limitation retroactively, and that the Employer is solely responsible for compliance with any applicable law regarding any such wellness programs, although Medova may offer wellness programs to an Employer that are reasonably designed to comply, in good faith, with applicable law. Employer acknowledges that it has reviewed and understands the provisions of any such wellness programs applicable to the Plan offered by Medova, has voluntarily opted to utilize the wellness programs, and has had the opportunity to consult Employer's own legal counsel or other applicable consultant regarding all

compliance matters, including, without limitation, the potential for changes in the applicable laws, rules and regulations. Employer also acknowledges that it understands that it may decline participation in wellness programs administered by Medova under the Plan or may offer reasonable modifications to the wellness program. Notwithstanding the preceding, Medova may decline to accept any modification proposed by the Employer that Medova cannot (or will not) reasonably administer, or alternatively, Medova will accept administration of the wellness programs only as may be mutually agreed upon by the Parties at the direction of the Employer.

(vii) Employer agrees to, and shall, collect any applicable contributions from Members that are required by Employer for participation in the Plan solely on a pre-tax basis to the extent permitted by law. To the extent that such Member contributions are collected through payroll deductions or otherwise, such deductions or contributions will be made pursuant to, and in accordance with, the terms of a plan qualified in all material respects under section 125 of the Internal Revenue Code, and the regulations promulgated thereunder (a "125 Plan"), that is sponsored and maintained by Employer that is effective and in place as of the Effective Date, and Employer agrees to furnish proof of such 125 Plan to Medova within 90 days: (1) of the Effective Date; and also, (2) at any later date upon Medova's request.

(viii) To the extent that Medicare, Medicaid, the Veterans Administration, any Member or any other federal or state agency or entity asserts a reimbursement right against Employer, the Plan, or Medova pursuant to that agency's or entity's rights under applicable law with respect to claims processed by Medova under this Agreement, Employer shall be responsible for reimbursing Medova any such amounts determined to be owed.

(ix) Employer shall give notice to Medova of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least 30 days before the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:

(1) Change of Employer's name;
(2) Any merger between or consolidation with another entity where, after such merger or consolidation, Employer is not the controlling entity;
(3) The sale or other transfer of all or substantially all of the assets of Employer or the sale or other transfer of the equity of Employer, or;
(4) Any bankruptcy, receivership, insolvency or other inability of Employer to pay any of its debts or obligations as any such debt or obligation becomes due.

(x) Employer shall have the sole responsibility, in accordance with state or federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order. Employer shall provide notice to Medova once it has made such determination.

(xi) Employer may, with the consent of any stop-loss insurance carrier as necessary and determined by Medova, request for Medova to process and pay any claim that was denied by Medova, but which Employer determines, in its sole discretion, is properly covered by the Plan. Medova will charge Employer an additional Remittance Payment to the Employer Account as necessary, in Medova's determination, to fund such claim, and may charge a reasonable processing fee, as determined by Medova, prior to the processing of such claim. Medova shall not be responsible for any liability associated with any act or omission undertaken at the direction of, or in accordance with, instructions received from Employer under this provision, and shall in no event become responsible for paying any outstanding claims under the Plan that are not properly funded through Remittance Payments or otherwise by Employer.

(xii) Employer acknowledges and agrees that, with respect to any claim(s) related to any condition that was not disclosed by an Employee during the enrollment and/or application process as part of the "Employee Application Form," but which would otherwise be properly covered by the Plan as determined by Medova, Medova will charge Employer an additional Remittance Payment to the Employer Account as necessary, in Medova's determination, to fund such claim, regardless of whether Employer in fact directs Medova to process and pay such claim under the immediately preceding paragraph, above. Notwithstanding any other provision of this Agreement to the contrary, solely in the event of such a claim, Employer will be responsible for adjudicating any additional appeal made by an Employee of Medova's denial of such a claim after the first level of internal appeal (as provided in the Plan) has been completed by Medova.

(xiii) Employer acknowledges and agrees that: (1) Medova, upon Employer's approval (which shall not be unreasonably withheld), is authorized and empowered to make amendments to the Plan (other than to Attachment #1) that are necessary to comply with applicable law and to conform the administration and operation of the Plan to the Plan Document; (2) Employer shall adopt no amendment to the Plan without Medova's prior written approval of such amendment (which shall not be unreasonably withheld) and (3) Employer will take no action or fail to act in a manner to cause any of the benefits under the Plan to ever be assignable or transferable to any other person or be subject to any lien by any person or Party to this Agreement (except as provided by the Plan), either before or after benefits, services, or supplies are provided to the member or any other person.

F. **Integration with Other Benefit Plans:**

Employer agrees that Employer is solely responsible for integrating the Plan (and compliance with all applicable law) with respect to any other benefit plan(s) sponsored or otherwise offered by Employer for the benefit of the Members outside the scope of this Agreement, including, but not limited to, ascertaining the effect of a Member's participation in the Plan on the Member's eligibility to participate in other benefit plan(s) sponsored or otherwise offered by Employer, and Medova has no responsibility with respect to any such benefit plan(s), such as any wellness or pre-tax offerings that may be offered by an Employer. Employer acknowledges and agrees that it will rely solely upon the advice of Employer's own legal counsel or other applicable

consultant(s) in all respects with respect to all compliance and integration matters that are raised in this paragraph.

G. **Effect of Breach by Employer:**

Notwithstanding the foregoing, a breach of the terms of this Agreement by Employer that is not cured within 30 calendar days after the written notice thereof by Medova (including, but not limited to, any failure of Employer to make a timely Remittance Payment or Employer's failure to timely provide required certifications and/or executed copies of all Plan Documents as provided herein) may result in a cessation of Administrative Services and/or Claims Services, in whole or in part, as determined by Medova. Regardless of whether Medova ceases Administrative Services and/or Claims Services, in whole or in part, Employer acknowledges and agrees that Medova will be deemed relieved of any further responsibility or obligation under this Agreement back to the date of such missed Remittance Payment or other breach of this Agreement, except as expressly provided in this Agreement. Remittance Payments received after the due date may be subject to a $100.00 late fee (as determined by Medova). Following Employer's failure to make a timely Remittance Payment, Medova shall not be liable for any Provider charges which are not properly funded through any such Remittance Payment, including, but not limited to, any Provider charges claimed as a result of purported lost discounts, or for any other expenses incurred as a result of purported lost discounts. Further, Employer acknowledges and agrees that it will fully indemnify Medova (to the fullest extent provided under Section 5 of this Agreement) for any Losses (as defined in Section 5) suffered by Medova, among others, as a result of Employer's breach of this Agreement, including, but not limited to, liquidated damages as set forth in Section 5.

4. Term:

This Agreement shall commence as of the Effective Date and shall continue in full force and effect for one year, and thereafter, this Agreement shall automatically renew for subsequent terms of one year, unless a Party gives notice of non-renewal to the other Party prior to the end of the then current term, or such other period as is agreed to by the other Party in writing; provided, however, that either Party may terminate the Agreement without penalty pursuant to Section 3.D(ii) or as otherwise provided in this Section 4. Notwithstanding the foregoing, Employer's failure to submit any renewal documentation requested by Medova prior to the Effective Date of a subsequent one year term may result in a cessation of Administrative Services and/or Claims Services in whole or in part, as determined by Medova, unless and until such renewal documentation is received.

A. **Termination on Non-Renewal:**

In the event a Party gives notice of non-renewal to the other Party prior to the end of the then-current term:

(i) The Agreement will terminate at the end of the term;

(ii) Any stop-loss insurance coverage will terminate in accordance with the terms of such coverage, subject to any run-out period contained therein;

(iii) Any claims incurred but not reported prior to the termination date will be paid for a period of up to six months after the incurred service date, but only to the extent that Employer has properly funded the benefits payable under the Plan prior to the termination date in accordance with the Remittance Agreement or to the extent that stop-loss insurance coverage remains available during the run-out period; and

(iv) If Employer gives notice of non-renewal to Medova with less than ten business days written notice prior to the end of the then-current term, unless Medova agrees to a shorter notice period in writing, a fee equal to the total administrative fees charged for one month, as set forth in the Remittance Agreement, shall be immediately due and owing. All other fees due and owing shall continue to be paid as billed.

Such late notice of non-renewal fee, which Employer acknowledges and agrees constitutes a reasonable amount necessary to make Medova whole as a result of any such late notice of non-renewal, will be deducted from the balance in the Employer Account as of the date Medova receives notice of the non-renewal. Medova shall return to Employer any balance remaining in the Employer Account after the deduction of the late notice of non-renewal fee, if applicable, and after the six month run-out period described above as soon as administratively practicable after the expiration of such period, but no later than the end of the year following the year of such termination.

B. **Events of Default:**

Each of the following shall constitute an Event of Default under this Agreement, and the term "Event of Default" shall mean, whenever used in this Agreement, any or more of the following events:

(i) Upon the failure by Employer to make a Remittance Payment at the time specified herein, if such failure shall continue for 10 calendar days after the due date thereof;

(ii) Upon the failure by either Party to observe and perform any covenant, condition, or agreement hereunder, if such failure is not cured within 30 calendar days after the written notice thereof by the other Party;

(iii) Immediately upon the filing by either Party of a voluntary petition in bankruptcy or insolvency; and

(iv) Immediately on the date Employer consolidates or merges with or into or transfers substantially all of its assets to any other person, unless such merger, consolidation or sale be with, into or to another entity that shall assume in writing the due and punctual performance and observance of all covenants, agreements, along with any and all conditions of Employer under this Agreement and corresponding Employer

Account as set forth in Exhibit D hereto established by Medova for Employer, with the consent of Medova.

C. **Early Termination:**

In the event of an early termination (due to an Event of Default, as described in Section 4.B above, or Employer's written notice of its desire to terminate the Agreement as of any date other than at the end of a term as provided in Section 4.A above):

(i) The Agreement will terminate as of the early termination date set forth in Employer's written notice as provided in Section 4.A above (to the extent otherwise allowed under the Agreement) or on (or as of) the termination date selected by Medova due to an Event of Default.

(ii) Employer shall have the option to terminate this Agreement due to Medova's default under Section 4.B(ii) or Section 4.B(iii), following written notice by Employer to Medova of such failure and a 30-day opportunity to cure, by providing written notice to Medova immediately upon the end of any cure period set forth in Section 4.B(ii) or Section 4.B(iii) of the termination date.

(iii) Medova's obligation to perform any duties as outlined in this Agreement (including its Exhibits) shall cease as of the early termination date, unless Employer terminates this Agreement due to Medova's default under Section 4.B(ii), in which case Medova shall provide run-out services pursuant to, and in accordance with, Section 4.A(iii) to the extent specifically requested by Employer in writing no later than the early termination date, but in no event shall such services be provided by Medova longer than six months after such termination date unless mutually agreed upon by the Parties.

(iv) Medova will charge an early termination fee equal to the total administrative fees charged for one month, as set forth in the Remittance Agreement unless the Agreement is terminated early due to an Event of Default caused by Medova as set forth in Section 4.B(ii) or B(iii) above or is terminated without penalty pursuant to Section 3.D(ii). The early termination fee, which Employer acknowledges and agrees constitutes a reasonable amount necessary to make Medova whole as a result of any such early termination, will be deducted from the balance in the Employer Account as of such early termination date, and Medova shall return to Employer any balance remaining in the Employer Account as soon as administratively practicable after the deduction of the early termination fee, but no later than the end of the year following the year of such termination.

(v) Any stop-loss insurance coverage will terminate in accordance with the terms of any such policy, subject to any run-out period contained in any such policy, if any. Employer acknowledges its responsibility to review and understand the terms and conditions of its stop-loss insurance policies.

D. In order to entitle any Party to exercise any remedy reserved to this Agreement, it shall not be necessary to give any notice, other than such notice as may be required pursuant to this Agreement.

E. In the event this Agreement is terminated as provided herein and subject to any related privacy requirements, Medova agrees to cooperate with any succeeding administrator(s) in producing and transferring required claim and enrollment data, as determined by Employer, in Medova's then-current format as soon as administratively practicable following Employer's written request at no additional charge.

F. Employer acknowledges and agrees that (i) any termination of this Agreement does *not* result in termination of the Plan or Employer's obligations as the sponsor of a self-funded group health plan; (ii) Medova will not be responsible for processing or paying any further claims under the Plan following the effective date of any termination, or make any additional funding payments to vendors associated with Employer's group health benefit program, and (iii) Employer will be solely responsible for any claims to be paid following any termination date, consistent with the terms of the Plan, except to the extent payable by insurance properly secured by Employer separate from Medova.

5. Liability and Indemnity:

A. Medova does not (and will not) insure nor underwrite the liability of Employer under the Plan. Plan benefits shall be funded exclusively through the Employer Account by Employer and Member contributions and any related stop-loss insurance coverage, and Medova is not responsible or accountable for providing funds to pay Plan benefits under any circumstances, except as attributable to Remittance Payments allocated to the Employer Account which are not otherwise treated as compensation or other amounts due to Medova under the terms of this Agreement. The Employer acknowledges and agrees that:

(i) In performing services to the Plan under this Agreement, Medova shall use its best efforts to operate in accordance with the provisions of the Plan. In this context, Medova's normal operating procedures, practices and rules will be followed, unless they are determined by Medova to be inconsistent with the Plan.

(ii) The Employer retains the ultimately responsibility for interpreting the provisions of the Plan with respect to determining questions of eligibility for Plan participation, subject to the provisions of this Agreement relating to the Claims Services provided under this Agreement. Medova is not a fiduciary of the Plan with respect to any eligibility determinations made by Employer.

(iii) The Employer retains responsibility for the filing of the Internal Revenue Service Form 5500 and the Plan's compliance with the requirements of ERISA, PPACA, and HIPAA and other applicable law, including, but not limited to, any and all notice, disclosure, and/or reporting requirements applicable thereunder, and Employer hereby represents, acknowledges, and agrees that any electronic disclosure of any such documents will be provided solely in compliance with the applicable electronic delivery rules, including affirmative consent by Members to receive such disclosures via electronic delivery.

(iv) The Employer retains the ultimate responsibility for maintaining the Plan in compliance with ERISA, the requirements of the Internal Revenue Code or any applicable laws and regulations governing or affecting the Plan. As part of this responsibility, Employer either (a) represents and warrants that all Members will be employees of a single controlled group under Section 414(b) or (c) of the Internal Revenue Code, as applicable, or (b) to the extent that employees of an affiliated entity that is not treated as part of a single controlled group with the Employer under Section 414(b) or (c) of the Internal Revenue Code, as applicable, are permitted to become Members, the Employer acknowledges that it has reviewed and understands the current state of the law regarding multiple employer welfare arrangements and has had the opportunity to consult Employer's own legal counsel or other applicable consultant regarding all compliance matters, including, without limitation, the potential for changes in the applicable laws, rules and regulations. The Employer acknowledges and confirms that all participating employers are related by at least 50% ownership under Sections 414(b) or (c) of the Internal Revenue Code. The Employer further acknowledges and agrees that it has full liability under this Agreement for any issues, penalties and fines related to covering potentially unrelated employers under the Plan. The Employer understands and acknowledges that the law, rules and regulations regarding multiple employer welfare arrangements are uncertain in some respects and are evolving, including, without limitation, retroactively, and that the Employer is solely responsible for compliance with any applicable law regarding any such arrangements to the extent applicable, including, but not limited to, as a result of any assertion by the Department of Labor or any other government agency that the Plan is a multiple employer welfare arrangement, and that the Employer may avoid potential application of the rules applicable with respect to multiple employer welfare arrangements by limiting participation in the Plan to employees of a single controlled group under Section 414(b) or (c) of the Internal Revenue Code. Notwithstanding the preceding, Medova reserves the right to remove any Employer that is not a single employer under Section 414(b) or (c) at any time upon notice to the Employer.

(v) The Employer retains the exclusive discretionary authority to monitor Medova's performance of the services it provides under this Agreement.

(vi) With the exception of payments made by Employer to Medova in satisfaction of any administrative fees or commissions due under this Agreement, Medova shall not be considered an initial transferee of the funds provided by Employer to Medova pursuant to this Agreement, as those terms are applied to Section 550 of Title 11 of the United States Code.

(vii) Notwithstanding any provision in this Agreement to the contrary, Employer acknowledges that Employer will be responsible for any claims shortfalls to the extent that Employer has not purchased specific or aggregate stop-loss insurance coverage covering such shortfall. Further, on and after the termination of this Agreement, Employer retains all risk for (and agrees to satisfy in full) any claim payable under the terms of the Plan, except as is specifically provided in this Agreement.

B. The Employer agrees to indemnify Medova and hold Medova harmless against claims for stop-loss insurance premiums, taxes, penalties, employee benefits and any and all

losses, damages, expenses, costs or liabilities, including reasonable attorneys' fees and court costs ("Losses"), arising out of claims brought against Medova:

(i) To recover benefits under the Plan;

(ii) To recover damages for failure to pay such benefits, including any purported lost discounts;

(iii) As a result of the failure of Employer or any other agent, fiduciary or other person acting (or withholding action) of the Employer (excluding Medova) to comply with:

(A) Any of the terms of this Agreement, including, but not limited to, any representation(s) provided by Employer to Medova under this Agreement; or

(B) The requirements of the Internal Revenue Code, ERISA, PPACA, HIPAA or any other applicable law or regulation related to, or concerning the Plan; or

(iv) In connection with any other action or claim relating to the Plan, including, without limitation, any action for recovery of amounts paid to Medova for the Plan (with the exception of payments in satisfaction of administrative fees or commissions), whether under Sections 544, 547, and 548 of Title 11 of the United States Code or otherwise, unless such losses, damages, expenses, costs or liabilities are incurred solely as a result of the negligence or other misconduct of Medova.

C. Employer agrees to indemnify Medova and hold Medova harmless for penalties levied by the federal government against Medova for failure to provide all social security numbers and HICNs (when applicable) of Members to the Centers for Medicare and Medicaid Services, pursuant to the Medicare, Medicaid and SCHIP Extension Act. This section will not apply when such failure is based on the negligence of Medova.

D. If Medova has paid claims (a) that have not been properly funded by Employer as provided in this Agreement, by the Remittance Agreement, or by stop-loss insurance coverage, (b) for which payment is otherwise due under the terms of the Plan, but following early termination of this Agreement, or (c) due to a breach of any provision of this Agreement or applicable law, including, but not limited, for persons or claims not eligible under the Plan for reasons unrelated to Medova's conduct, including, but not limited to, (i) Medova having been provided inaccurate eligibility information, (ii) Medova having received notice of a retroactive change to enrollment, (iii) an Employee's failure to disclose a condition as part of the "Employee Health Application Form" during the enrollment and/or application process or (iv) a breach of any provision of applicable law, then Employer shall reimburse Medova and the Plan, if applicable (as determined by Medova), for all unrecovered paid claim amounts to the extent that the amounts have not already been paid by Employer and to fullest extent provided in this paragraph below and shall be responsible for additional liquidated damages to Medova as determined below in this paragraph. The parties acknowledge and agree that the damages that will result to Medova for breach of this Agreement by Employer may be extremely difficult

or impossible to establish or prove, and agree that liquidated damages up to the amount of $2,000 per specific breach (as solely determined by Medova) will be payable to Medova by the Employer in the event of a breach of this Agreement by Employer, or if greater, the actual administrative cost, including, attorneys' fees expended by Medova, to resolve any breach of law or this Agreement by the Employer, notwithstanding and in addition to any other payment to which Medova is entitled under the circumstances as expressly provided by the terms of this Agreement, such as, for example, due to the Employer's breach of any continuation coverage notification requirements or the failure to timely notify Medova of a participant's ineligibility for coverage under the Plan.

E. Notwithstanding any provision in this Agreement to the contrary and by way of clarification, Employer acknowledges and agrees that it shall indemnify and reimburse and hold Medova harmless for any taxes, penalties, employee benefits and any and all losses, damages, expenses, costs or liabilities, including reasonable attorneys' fees and court costs, fees, or other amounts necessary or incurred by Medova to administer the Plan or to satisfy any outstanding obligations under the Plan after the failure of Employer to make any timely Remittance Payment (and/or secure adequate stop-loss insurance coverage), including, but not limited to, reimbursing Medova in such amount as necessary to administer any run out services and claims due under the Plan or otherwise under this Agreement, determined regardless of whether Employer's failure to make a timely Remittance Payment (and/or secure adequate stop-loss insurance coverage) relates to periods before or after the termination of this Agreement or the Plan.

F. In the event of a claim, demand or lawsuit against Medova that is covered by the indemnification provisions of this Agreement, Medova agrees to promptly notify Employer in writing within 90 days after Medova knows or becomes aware of any fact or allegations which it believes may implicate such indemnification provisions, and in such event, Employer shall assume full responsibility for the cost of the defense and resolution of such claim, demand or lawsuit, subject to Medova's right to reasonably approve competent and appropriate counsel by Employer; provided, however, that (a) Medova shall be allowed to retain counsel of its choosing; and (b) Employer shall be permitted to participate in and/or monitor Medova's defense at its own expense. Employer shall not bind Medova to any settlement without the prior written consent of Medova.

G. Notwithstanding any provision in this Agreement to the contrary and to the extent permitted by law, during the continuance of this Agreement, Medova agrees to indemnify Employer and hold Employer harmless against any and all losses, damages, fines, taxes, penalties, settlements, and expenses (including attorney's fees) to the extent that they arise out of or are related to Medova's material breach of this Agreement or Exhibit B, or the negligent, reckless, dishonest, fraudulent, or criminal acts or omissions of Medova's employees; provided, however, that this indemnity and Medova's liability arising out of or relating to this Agreement or Exhibit B is subject to the limitations set forth in Section 5.H below. In the event of a claim, demand, or lawsuit against Employer that is covered by the indemnification provisions of this Agreement or Exhibit B, Employer agrees to promptly notify Medova in writing within 90 days after Employer knows or becomes aware of any fact or allegation which is believed may implicate such indemnification provision, and in such event, Medova shall assume full responsibility for such defense and resolution of such claim, demand, or lawsuit; provided, however, that Medova shall not have any responsibility, obligation or liability under

any circumstances to pay any benefits relating to any such claim, demand or lawsuit against Employer during the pendency of any such claim, demand or lawsuit unless and until such claim, demand or lawsuit is settled to the satisfaction of Medova and Medova agrees to pay such benefits.

H. Medova shall not be responsible or liable for any tax, penalty or fee due to any governmental entity as either a direct or indirect result of the existence and/or administration of the Plan. Employer agrees to indemnify, defend, hold harmless and reimburse Medova from, and in connection with, any liability related to any tax, penalty or fee assessed against Medova as either a direct or indirect result of the existence and/or administration of the Plan. This section is subject to the limitations specified in the indemnity provisions of Section 5.F above.

I. In the event of a claim, demand, or lawsuit against Employer that is covered by the indemnification provisions of this Agreement or Exhibit B, Medova shall not be liable to Employer for any such claim which is asserted by Employer: (i) more than six months after Employer is, or should have been reasonably aware of, the damage or loss giving rise to such claim, and will in no event be liable to Employer for any claim which is asserted by Employer more than 12 months after the event resulting in such damage or loss; and (ii) in no event shall Medova ever be liable to Employer for any damage or loss in excess of the amount of fees paid to Medova under the terms of this Agreement, nor shall any such damages include punitive, incidental, consequential, special or other indirect damages or penalties or extraordinary losses of any kind.

J. Medova shall not be liable for Provider charges claimed as a result of purported lost discounts, or for any other expenses incurred as a result of purported lost discounts.

K. The provisions contained within this Section 5 shall survive termination of this Agreement.

6. <u>Account Management</u>:

Medova shall establish specific to Employer an account ("Employer Account") at a financial institution selected by Medova to manage the fiduciary processes and activity of the Plan. Said management activity shall include the receipt of all funding received and the payment of all claims processed and paid by Medova in accordance with the terms of the Plan, along with any expenses directly related thereto. Medova shall maintain draft authority on the Employer Account in order to make prompt payment of meritorious claims for benefits and other expenses associated with the Plan, including, but not limited to, any health plan, program, vaccine or immunization, health claim, or claims data assessment, fee, surcharge, or tax or any other assessment, fee, surcharge, or tax assessed by any governmental agency with respect to the Plan, Plan members, or Plan claims, except to the extent that Employer elects to pay such assessment, fee, surcharge, or tax directly. Employer agrees to make monthly deposits of the Remittance Payment to Medova so that sufficient funds will be available in the Employer Account to meet all reasonably foreseeable claims for benefits and to pay other expenses associated with the Plan. The Parties acknowledge and agree that the funds held in the Employer Account will be segregated from any funds of Employer and Medova shall be responsible for administering such funds and Employer Account solely as necessary to

administer the services provided under this Agreement. Further, the Parties acknowledge and understand that, notwithstanding Medova's obligations and rights under the Agreement, including but not limited to, Medova's right to receive administrative fees under this Agreement, Employer acknowledges that Medova does not have unfettered dominion and control over the funds transferred to the Employer Account and such funds are to be administered by Medova (as signatory on any Employer Account) for the benefit of third parties without the option of redirecting such funds for Medova's benefit (except for costs and fees and/or indemnification, or other proceeds properly payable to Medova or an affiliate under the terms of this Agreement).

7. **Vendor Authority and Compensation Disclosure:**

Any of the functions to be performed by Medova under this Agreement may be performed either by third party vendors selected by Medova or by Medova, Care Advocates, LLC or any other Medova-related entities, subsidiaries, affiliates, designees, agents or assignees as determined by Medova without the consent of Employer. Employer hereby recognizes Medova's role and sole authority to enter into agreements in connection with the services it provides hereunder with Preferred Provider Organizations (PPO) or other provider networks (as applicable), Utilization Review entities, Pharmacy Management Firms, wellness related vendors, and other vendors in such time and manner as Medova determines is appropriate to carry out the services provided under this Agreement, any or all of which selected vendors may be related to or affiliated with Medova. The retention of any vendor or other service provider that is affiliated with Medova (including, but not limited to, the affiliated provider of any value-added benefit) shall be deemed agreed to and acknowledged by Employer upon notice from Medova regarding such affiliation as part of the initial proposal to Employer. Notwithstanding the foregoing, Medova shall be responsible for the services under this Agreement performed by a vendor or other service provider to the extent that Medova selected any such vendor or service provider under this first paragraph of Section 7 without the consent of Employer, as if such services were performed by Medova; provided, however, that Medova shall not under any circumstances be responsible for the performance of the services performed under this Agreement by any stop-loss insurance carrier(s), PPO or other provider networks (as applicable).

Employer further agrees and acknowledges that it has determined that the Remittance Payments and fees payable under this Agreement constitute reasonable compensation for the services provided under the Agreement, regardless of whether such functions are actually performed by Medova, any Medova affiliate, or an unrelated third party vendor. Employer is not entitled to any refund or return of any amounts deposited in the Employer Account except as provided in Section 4, above, following termination of the Agreement.

Employer understands and acknowledges that Medova receives compensation in a variety of ways in addition to the administrative fees collected as part of the administrative costs included in the Remittance Payments. Medova may receive compensation through one or a combination of the methods listed below in accordance with local law and regulation:

A. **Retail Commissions:**

A retail commission may be paid to Medova by a stop-loss insurance carrier as a percentage of the premium charged to Employer for the insurance policy. The amount

of commission may vary depending on a number of factors, including the type of insurance product sold and the insurer selected by the client. Retail commission rates can vary from transaction to transaction.

B. **Contingent Commissions:**

Some insurers may agree to pay Medova contingent commissions upon meeting certain goals for insurance policies placed with them during a given year or other time period. The set goals may include volume, profitability, retention and/or growth thresholds. The amount of contingent commission earned may vary depending on factors relating to an entire book of business over the course of the year or period. As a result, the amount of contingent commission attributable to any given insurance policy typically will not be known at the time of placement.

C. **Compensation for Insurer Administration and Other Services:**

Medova may provide certain services for some insurers in which it may receive separate compensation for administering these arrangements that is in addition to any other fee or commission earned by Medova.

D. **Service Fees and Rebates:**

Medova may receive payment of certain administrative service fees or prescription drug rebates for assisting with the administration of prescription drug benefits. In addition, to the extent that the Plan is paying claims with respect to a provider of value-added benefits that is affiliated with Medova, the amount paid by the Plan with respect to such claims will be limited to the "direct costs" associated with each product or service provided by such affiliated provider. The administration of any value-added benefits may be subject to such additional rules as Medova may implement upon notice to the Employer.

8. Miscellaneous:

A. It is understood and agreed that Medova is engaged to perform services under this Agreement as an independent contractor and not as an employee, agent, partner or joint venturer of Employer, its broker or consultant or any other vendor.

B. A Party shall not be liable for any failure or delay in the performance of this Agreement for the period that such failure or delay is due to causes beyond its reasonable control, including but not limited to acts of God, war, civil disturbance, strikes or labor disputes, embargoes, government orders or any other force majeure event.

C. This Agreement shall be binding upon and inure to the benefit of the Parties hereto, their personal representatives, successors and assigns from and after the date hereof, subject to the requirements of Section 4 of this Agreement.

D. If any one or more of the covenants, agreements, provisions, or terms of this Agreement shall for any reason whatsoever be held invalid, then such covenants, agreements, provisions or terms shall be deemed enforceable to the fullest extent permitted, and if not

permitted, shall be deemed severable from the remaining covenants, agreements, provisions or terms of this Agreement and shall in no way affect the validity or enforceability of the other provisions of this Agreement or rights of any Party thereto.

E. This Agreement (including any Exhibits hereto) represents the entire agreement between the Parties and no other representations, oral or otherwise, are binding. To the extent that there is a conflict between the terms of this Agreement and the terms of any Exhibit hereto, the explicit term(s) of such Exhibit will control; and to the extent that there is a conflict between the terms of Exhibit A and the terms of any other Exhibit hereto, the explicit terms of Exhibit A will control unless such other Exhibit explicitly provides otherwise. Any Exhibit to this Agreement is incorporated into and made a binding part of this Agreement by reference.

F. Failure of either Party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of such provision or in any way offset the validity of this Agreement or any part thereof or the right of such Party to thereafter enforce each and every provision of this Agreement. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subsequent breach.

G. Nothing contained in this Agreement, expressed or implied, is intended to confer, or shall confer, upon any individual participant in or beneficiary under the Plan any rights or remedies under or by reason of this Agreement.

H. During the term of this Agreement and for a period of 24 months following termination of this Agreement, for any reason, with or without cause, neither Party shall directly or indirectly hire or (attempt to hire) any employee or independent contractor of the other Party, or solicit or induce (or attempt to solicit or induce) any employee or independent contractor of the other Party to leave or terminate his/her employment and/or independent contractor relationship. This provision shall survive termination of this Agreement.

I. All disputes between the Parties arising out of or related to the Agreement shall be resolved exclusively by binding arbitration before an arbitrator in Kansas. This arbitration provision is governed by the Federal Arbitration Act ("FAA"), 9 U.S.C. § 1 *et seq*., and applies to all disputes covered by this paragraph, whether initiated by Medova or Employer. All negotiations pursuant to this paragraph are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence. The arbitrator in Kansas shall be selected by mutual agreement of the Parties. However, if the Parties fail to agree on the selection of the arbitrator within 30 days and the amount in contest is (i) in excess of $200, the American Arbitration Association shall recommend an arbitrator, or (ii) is $200 or less, Medova shall select an independent third party to be the arbitrator. Once an arbitrator is selected, the arbitrator shall have the exclusive authority to resolve disputes covered by this paragraph, as well as all disputes regarding the formation of this Agreement and the interpretation, enforceability, applicability, and unconscionability of this arbitration provision. The arbitrator will submit a decision within 30 days after appointment or as soon as reasonably feasible and such decision shall be binding on the Parties to this Agreement. Except as provided in this and the directly preceding paragraphs of this Agreement, arbitration expenses will be shared by the Parties. All other expenses (legal, incidental, etc.) shall be borne by the losing Party or, if both Parties prevail, be apportioned by the arbitrator to each Party. Arbitration

proceedings will be governed by the Rules of the American Arbitration Association then in effect. To the extent that any of the terms of this paragraph conflict with the Rules of the American Arbitration Association, the terms of this arbitration provision shall govern. Nothing precludes the Parties from waiving, in writing, the requirement to first pursue arbitration.

J. In any and all events, this Agreement and the rights and obligations of the Parties hereunder shall be construed in accordance with and governed by the laws of the State of Kansas, except as otherwise provided by ERISA or applicable federal or state laws. In the event binding arbitration is waived by both Parties or as needed to enforce the binding arbitration provisions of this Agreement, all judicial proceedings brought against any Party arising out of or relating to this Agreement or any obligation hereunder shall be brought in any federal or state court of competent jurisdiction located in the State of Kansas.

K. Except as otherwise provided herein, Parties may not assign its rights or obligations under this Agreement without the written consent of the other Party.

L. This Agreement may be amended from time to time by the written amendment duly executed by both Parties.

M. All notice, requests and demands to or upon the respective Parties hereto shall be in writing and shall be deemed to have been duly given or made when delivered by hand, certified mail, or courier with a traceable deliver confirmation. Notices shall be made to the respective Party to the contact person and addresses as described below:

If to Employer: _____

_____

_____

If to Medova: Medova Healthcare Financial Group, LLC
Attention: Dan Whitney, President & CEO
345 N. Riverview, Suite 600
Wichita, Kansas 67203

N. Except as specifically stated otherwise herein or as provided in the Administrative Services Agreement, this Agreement sets forth the entire understanding of the Parties relating to the subject matter hereof, and all prior understandings, written or oral are superseded by this Agreement. This Agreement may not be modified, amended, waived or supplemented except as provided herein.

O. This Agreement is effective as of_____.

WITNESS the signature of the Parties this _____ day of _____, 20____.

MEDOVA HEALTHCARE FINANCIAL GROUP, LLC

By: _____

Daniel Whitney, President

EMPLOYER

«Group_Name»

By: _____

Print Name: _____

Title: _____

Exhibit 3

APPLICATION TO NATIONAL HEALTH INSURANCE COMPANY
AND SCHEDULE OF EXCESS STOP-LOSS INSURANCE
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

POLICYHOLDER (herinafter referred to as **You, Your**) - **MAIN MAILING ADDRESS**

Name: [redacted]

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Subsidiary or affiliated companies to be included (list legal names and addresses):

None

SIC/Industry Description: [redacted] State of Jurisdiction: [redacted]

POLICY NUMBER: **5614NH**
(issued upon acceptance of this **Schedule of Excess Stop-Loss Insurance**)

Policy Period Effective Date: **07/01/2020** Expiration Date: **06/30/2021**

ADMINISTRATOR

Name: **Medova**

Address: **345 North Riverview, Suite 600**

City: **Wichita** State: **KS** Zip Code: **67203**

A. SPECIFIC EXCESS LOSS INSURANCE

Minimum Number of Full Time Employees: **26**

1. Benefits Covered:
   ☒ Medical ☒ Prescription Drugs ☐ Dental ☐ Vision ☐ Other

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** bases:
   Covered Services which are **Incurred** from **07/01/2020** to **06/30/2021**; and
   Covered Services which are **Paid** from **07/01/2020** to **12/31/2021**

3. **Specific Attachment Point: $ 50,000** per **Covered Person** for all occurrences.

4. **Specific Reimbursement Percentage 100%**

5. Specific benefit limit **Unlimited** ☒ **Policy Period** ☐ **Specific Lifetime Maximum Reimbursement**

6. ☐ **Run-In Limit** / ☐ **Run-Out Limit**: **n/a**

7. Monthly Specific Premium Rate and **Covered Units**:

	Rate:	Covered Units:
Plan: HealthConsumer 3000		
Single	$ 291.71	2
EE+SP	$ 576.50	1
EE+CH	$ 519.54	1
EE+Fam	$ 790.10	4
Plan: HealthConsumer 5000		
Single	$ 291.71	7
EE+SP	$ 576.50	1
EE+CH	$ 519.54	0
EE+Fam	$ 790.10	1
Plan: HealthyChoice 2000		
Single	$ 291.71	3
EE+SP	$ 576.50	4
EE+CH	$ 519.54	1
EE+Fam	$ 790.10	1
	Total:	26

B. AGGREGATE EXCESS LOSS INSURANCE

1. Benefits Covered:
☒ Medical ☒ Prescription Drugs ☐ Dental ☐ Vision ☐ Other

2. **Benefit Period** shall consist of the following **Incurred** and **Paid** bases:
Covered Services which are **Incurred** from 07/01/2020 to 06/30/2021; and
Covered Services which are **Paid** from 07/01/2020 to 12/31/2021

3. **Individual Claim Limit** accumulating toward the **Aggregate Excess Stop-Loss Coverage**: $ 50,000

4. **Minimum Annual Aggregate Attachment Point** $ 93,350 or 100% of the first monthly aggregate attachment point x 12 months, whichever is greater.

5. **Aggregate Reimbursement Percentage** 100%

6. **Maximum Aggregate Reimbursement** $ 1,000,000

7. ☐ **Run-In Limit** / ☐ **Run-Out Limit**: n/a

8. **Monthly Aggregate Factors** and **Covered Units**:

	Factors:	Premiums:	Covered Units:
Plan: HealthConsumer 3000			
Single	$ 136.64	$ 181.14	2
EE+SP	$ 357.19	$ 473.53	1
EE+CH	$ 311.85	$ 413.42	1
EE+Fam	$ 518.59	$ 687.50	4
Plan: HealthConsumer 5000			
Single	$ 103.28	$ 136.92	7
EE+SP	$ 286.41	$ 379.70	1
EE+CH	$ 248.61	$ 329.59	0
EE+Fam	$ 420.09	$ 556.91	1
Plan: HealthyChoice 2000			
Single	$ 177.28	$ 235.02	3
EE+SP	$ 443.43	$ 587.86	4
EE+CH	$ 388.89	$ 515.55	1
EE+Fam	$ 638.60	$ 846.60	1
		Total:	26

C. OPTIONS

		Yes	No	
1.	**Actively at Work** waived?	☒	☐	
2.	**Retired Employees** and dependents covered?	☒	☐	If yes, limited to: Only if disclosed
3.	Disabled Employees	☒	☐	If yes, limited to: Only if disclosed
4.	COBRA, FMLA and other continuee	☒	☐	If yes, limited to: Only if disclosed

D. FRAUD NOTICE

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

For Residents of Alabama

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For Residents of District of Columbia
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Residents of Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For Residents of Louisiana
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maine
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For Residents of Maryland
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For Residents of New Mexico
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For Residents of New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Residents of Tennessee
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For Residents of Virginia

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

E. CONDITIONS

As conditions precedent to the approval of this **Schedule**:

1. **You** shall furnish to **Us**, for our approval, a copy of the **Your** Employee Welfare Benefit **Plan** or **Your** PPO/HMO member booklet/certificate (herein referred to as Plan Document) describing the benefits provided by **You**. No **Policy** will be released or claim reimbursed until such time as an acceptable Plan Document is received and approved by us. In the event of a variance between the Plan Document received by us and the terms of the **Excess Stop-Loss Insurance** upon which such **Excess Stop-Loss Insurance** was based, **We**

reserve the right to revise the premium rates, factors, terms and/or conditions. **We** may decline to release the **Policy** until such time as **You** provide written acceptance of the revisions, if any;

2. The dated "Disclosure Statement", experience, census and other information provided by **You**, directly or through **Your TPA**, are primary data elements on which our proposal is based. In accepting the **Policy**, **You** represent that, to the best of **Your** knowledge and belief, such information is true;

3. The receipt by **Us** of any sum(s) referenced herein and the deposit of any check drawn in connection with this Schedule of Excess Stop-Loss Insurance shall not constitute an acceptance of liability by us. In the event we do not approve this Schedule of Excess Stop-Loss Insurance, **Our** sole obligation shall be to refund such sum(s) to **You**, and;

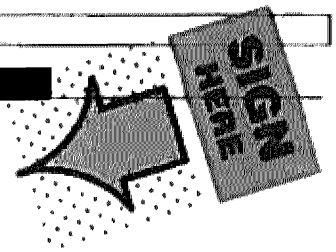
4. **You** understand and agree: (1) the **Excess Stop-Loss Insurance** applied for shall not take effect until such insurance has been approved by us and accepted as confirmed by delivery of the **Policy** to **You**, or to **Your TPA**; (2) the **Plan Document** attached and referred herein shall be the basis of the **Policy** issued by us and such **Plan Document** conforms with applicable State and Federal statutes; and (3) any reimbursement shall be determined in accordance with the **Plan Document** and the **Policy** that is the subject of this Schedule of Excess Stop-Loss Insurance.

F. FORMS AND RIDERS

Monthly Cumulative Accommodation Endorsement

G. SIGNED ACCEPTANCE

Accepted on behalf of the Applicant: [redacted]



[redacted]

Dated at 7/28/20 this _____ day of _____, _____

Tax ID # [redacted]

Witness: _____
Signature of Licensed Resident Agent

Licensed Resident Agent: Daniel Whitney

Address: 345 North Riverview, Suite 600

City Wichita State: KS Zip: 67203

Social Security or Tax ID # 27-0052339

Underwritten by National Health Insurance Company
1901 N. State Hwy. 360
Grand Prairie, TX 75050

EXCESS STOP - LOSS INSURANCE POLICY

POLICY NUMBER: 5614NH

POLICY EFFECTIVE DATE: July 01, 2020

POLICYHOLDER: [redacted]

PLEASE READ CAREFULLY

This **Policy** is issued in consideration of **Your Application** and the payment of premiums. The attached **Application** and a copy of **Your** Employee Welfare Benefit **Plan** or Your PPO/HMO member booklet/certificate on file with **Us** form a part of this Policy.

All periods of coverage will begin and end at 12:01a.m. Standard Time at **Your** Principal Address.

This **Policy** is governed by the laws of the state of **Your** Principal Address except to the extent which is pre-empted by ERISA.

This Policy is issued by **Us** or **Our** Underwriting Offices as of the Effective Date.

This is a legal contract between **You** and **Us**.

In witness whereof National Health Insurance Company has caused this **Policy** to be signed by its President and Secretary.

Signed for National Health Insurance Company

Charles W. Harris
President

Jeffrey Weissmann
Secretary

Non - Participating

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

TABLE OF CONTENTS

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

SECTION I.
DEFINITIONS

Actively at Work The definition used in the **Plan** or the PPO/HMO member booklet/certificate will apply under this Policy.

Aggregate Reimbursement Percentage means the percentage at which payment for **Covered Services** under **Your Plan**, in excess of **Your** Annual Aggregate Attachment Point, will be reimbursed by **Us**.

Aggregating Specific Deductible means the amount retained and **Paid** by **You** during the **Policy Period** for **Plan Benefits**, which are in excess of the **Specific Attachment Point**, equal to **Plan Benefits** in excess of the **Specific Attachment Point** multiplied by the **Specific Reimbursement Percentage**

Annual Aggregate Attachment Point means, for the **Policy Period** or any portion of the **Policy Period**, the **Plan Benefits** covered by this **Policy** and wholly retained by **You**. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum of **Monthly Aggregate Factor** amounts for each month of the **Policy Period**, determined by multiplying the total number of **Covered Units** by the **Monthly Aggregate Factor** amounts; or
2. the Minimum **Annual Aggregate Attachment Point** shown in the **Schedule**.

The maximum per **Covered Person** which may be applied annually to the Annual Aggregate Attachment Point, (i.e. **Individual Claim Limit**) is shown in the **Schedule**.

Application means that Excess Stop- Loss Insurance **Application** signed by **You** and attached to this Policy. The **Application** is subject to acceptance by **Us** and, if accepted, will become a part of this Policy.

Benefit Period means the period of time during which Covered Expenses must be **Incurred** by a **Covered Person** and **Paid** by **You** to be eligible for reimbursement under this Policy.

Case Management means collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

COBRA Continuee means a **Covered Unit** that elects to extend its group health coverage under the **Plan** as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company (**We**, Us, **Our**) means National Health Insurance Company.

Covered Person means an enrolled employee and/or his/her eligible dependents covered under the respective **Plan** (PPO/HMO) administered by TPA. Under the **Plan** (HMO), **Covered Person** may be referred to as the Member.

Covered Services means a service or supply specified in the **Plan** for which benefits will be provided by the **TPA**.

Covered Unit means an employee, and employee with dependents, or such other defined unit as agreed upon between **You** and **Us**, as shown in the **Application**.

Endorsement means a written amendment or addendum that alters the terms of this Policy.

Experimental or Investigational The definition used in the Plan or the PPO/HMO member booklet/certificate will apply under this Policy. If no such definition exists, a drug, device or medical care or treatment will be considered Experimental/Investigative 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;
- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigative phase, or if such a consent document is required by law;
- Either the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;

- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.
- We will not limit or deny coverage, or impose additional conditions on the payment for the coverage, of routine patient care costs of items, drugs, and services furnished to a Covered Person in connection with participation in an approved clinical trial. We will not pay for costs of items, services, or drugs that are customarily provided by the sponsors of an approved clinical trial.

Approved clinical trial means:

- A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  - (i) The National Institutes of Health;
  - (ii) The Centers for Disease Control and Prevention;
  - (iii) The Agency for Health Care Research and Quality;
  - (iv) The Centers for Medicare and Medicaid Services;
  - (v) A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
  - (vi) The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;
- A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigative new drug or device application reviewed by the FDA; or
- An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

Incurred means with respect to medical services or supplies, the date on which the **Covered Services** are rendered or supplies are received by the **Covered Person** or the Member.

Individual Claim Limit means the maximum amount of Payments for **Covered Services** that will be counted for any one **Covered Person** under Aggregate Excess Loss. The **Individual Claim Limit** is shown in the **Schedule**.

Late Entrant means a **Covered Person** whose coverage under the **Plan** was initiated at any time other than during an authorized enrollment period as allowed under the **Plan**.

Large Claim (LC) means **Paid** or pending claims reaching, or with the potential to reach, 50% of the **Specific Attachment Point** or PCL.

Minimum Annual Aggregate Attachment Point means the amount of total Payments **You** must make under **Your Plan** before **You** are eligible for reimbursement under Aggregate Excess Loss coverage. The **Minimum Annual Aggregate Attachment Point** is shown in the **Schedule**.

Monthly Aggregate Factor means the factor(s) which is/are multiplied by the number of **Covered Units** for each **Policy Month** to determine the Annual Aggregate Attachment Point. The **Monthly Aggregate Factor**(s) is/are shown in the **Schedule**.

Paid (Payment) means that a claim has been adjudicated by the **TPA** and the funds are actually disbursed by the **Plan** prior to the end of the **Benefit Period**. Payment of a claim is the unconditional and direct payment of a claim to a **Covered Person** or his

or her health care provider(s). Payment will be deemed made on the date that both:

1. the payor directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which is drawn.

Plan (Employee Welfare Benefit Plan prepared by the Plan Sponsor or PPO/HMO group benefit contract issued by the **TPA**) means the self-insured health benefit program **You** have agreed to make available to **Your** employees and their eligible dependents which is administered by the **TPA**.

Plan Benefits means expenses for **Covered Services** for health benefits covered by the **Plan** during the **Policy Period** which are **Incurred** and **Paid** by TPA during the Policy Period.

Plan Benefits will also include those health benefits covered by the **Plan** during the **Policy Period** which are **Paid** during any **Run-Out Period** or **Incurred** during any **Run-In Period** applicable to this Policy.

Plan Benefits do not include:

1. deductibles of the **Plan:**
2. co-insurance or co-payment amounts of the **Plan:**
3. services that are not covered by the **Plan** or this **Policy:**
4. amounts recovered by TPA from a third party under subrogation or
5. amounts **Paid** under a previous policy or arrangement or excess stop - loss coverage, whether issued by **Us** or another entity.

Plan Document means the written instrument which describes the **Plan** and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and administration of the **Plan**. The **Plan Document** must be in effect on the Effective Date of this Policy. The **Plan Document** may be attached to and made a part of this Policy. Any changes to the **Plan Document** must be approved by Us. (See the "Changes to **Your Plan** provision.)

Policy means this Excess Stop - Loss Insurance Policy issued by **Us** to **You**.

Policy Month means, for the first **Policy Month**, the period beginning on the Effective Date of this **Policy** and ending on the corresponding date of the following month. Subsequent **Policy Months** begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy Expiration Date.

Policy Period means the time period beginning on the Effective Date and ending on the Expiration Date.

Policyholder (Plan Sponsor, **You** or **Your**) means the Plan Sponsor, named on the face page, to whom this **Policy**'s issued.

Potentially Catastrophic Loss (PCL) means a **Paid** or pending claim that has the potential to be catastrophic. **PCL's** include, but are not limited to the conditions listed in Exhibit I.

Premium Due Date is the first day of each calendar month. If the Effective Date of this **Policy** is other than the first day of a calendar month, the first month's premium will be pro-rated.

Run-In–Limit means the maximum benefit amount **Paid** by **You** under **Your Plan** for Eligible Expenses **Incurred** by a **Covered Person** during the **Run-In-Period** which will be applied toward payment under this Policy.

Run-In-Period means the period of time shown in the **Schedule** immediately prior to the first day of a **Policy Period** during which **Covered Services** Incurred by a **Covered Person** or Member, which are **Paid** by **You** during the **Policy Period**, will be considered when determining benefit payments under this Policy.

Run-Out-Period means the period of time shown in the **Schedule** immediately following this Policy's Expiration Date during which **Plan Benefits Paid** by **You** for **Covered Services Incurred** by a **Covered Person** during the **Policy Period** will be considered when determining benefit payments under this Policy.

Schedule means the completed application that is also the Schedule of Excess Stop - Loss Insurance.

Specific Attachment Point means the amount which is retained and **Paid** by **You** during the **Policy Period** and is not eligible for coverage or reimbursement under this Policy. It is not considered for reimbursement under this Policy. The **Specific Attachment Point** applies separately to each **Covered Person**. The **Specific Attachment Point** is shown in the **Schedule**.

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

Specific Lifetime Maximum Reimbursement means the maximum amount **We** will reimburse **You** with respect to any **Covered Person** under this and prior or later Policies issued by **Us**. The Lifetime Maximum excludes the **Specific Attachment Point** amount. The Lifetime Maximum will not exceed the lessor of:

1. the amount shown in the **Schedule**; or
2. the lifetime amount set forth in the **Plan**.

Specific Reimbursement Percentage means the percentage at which Eligible Expenses, in excess of **Your Specific Attachment Point**, will be reimbursed by **Us**.

Third Party Administrator (**TPA**) means a company having a written agreement with **You** to process **Plan Benefits** and provide administrative services. The **TPA** for **Your Plan** is shown on Page 1 of this Policy.

The term **Third Party Administrator**, as used in this Policy, does not refer to the Plan Administrator or Plan Sponsor used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless **You** have specifically appointed the **Third Party Administrator** as such.

Usual and Customary - The average amount charged by the majority of providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided and as defined in the Plan Document. If not specifically described in the Plan Document, usual and customary shall be defined as the 50th percentile of amounts charged.

SECTION II.
SPECIFIC EXCESS STOP - LOSS COVERAGE

We will reimburse **You** for **Plan Benefits Paid** in excess of the **Specific Attachment Point**, not to exceed the Specific Benefit Limit shown in the **Schedule**.

We will reimburse **You** after **You** have provided proof the claim has been paid. Paid means a claim where funds are actually disbursed by You or Your TPA. Payment of a claim is the unconditional and direct payment of a claim to or on behalf of a Covered Person to their health care providers and not rebated, refunded or returned by the provider. Payment will be deemed made on the date that the following two things happen. (1) the payer directly tenders payment included in the **Schedule**.

upon which the payment is drawn has and continues to have enough funds to pay the check or draft. The Specific Excess Loss benefit applies to a **Policy Period** or fraction thereof (due to termination). As determined with regard to each **Covered Person**, it is the lesser of:

1. the Specific Lifetime Maximum; or
2. eligible **Plan Benefit** Payments made with regard to a **Covered Person**, less the **Specific Attachment Point**, or any rider Individual Specific Retention Amount, the result of which is then multiplied by the **Specific Reimbursement Percentage**.

In addition, the Specific Excess Loss Benefits Payable under this **Policy** will be reduced by the **Aggregating Specific Deductible**.

If, for any reason, **Your** Specific Excess Loss coverage terminates before the end of the **Policy Period**:

1. all coverages under this **Policy** will end immediately;
2. the **Run-Out Period**, if any, will not apply; and
3. the **Specific Attachment Point** shown in the **Schedule** will continue to apply and it will not be reduced.

SECTION III.
AGGREGATE EXCESS STOP - LOSS COVERAGE

The Aggregate Excess Loss benefit for the **Policy Period**, or fraction thereof (due to termination), is the **Plan Benefit** Payments made for **Covered Services** during the **Policy Period** less;

1. the greater of the Minimum **Annual Aggregate Attachment Point** or the calculated Annual Aggregate Attachment Point; and less
2. any Payments which exceed any limitations of coverage under this **Policy** or which are excluded under this Policy; multiplied by
3. the **Aggregate Reimbursement Percentage**.

In no event will the Aggregate Excess Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Excess Loss Coverage in the **Schedule**.

If for any reason, **Your** Aggregate Excess Loss coverage terminates before the end of the **Policy Period**:

1. all coverage under this **Policy** will end immediately;
2. the **Run-Out Period**, if any, will not apply; and

3. the Minimum **Annual Aggregate Attachment Point** shown in the **Schedule** will continue to apply and will not be reduced.

SECTION IV.
REIMBURSEMENT OF ADDITIONAL COVERAGES

Plan Benefits which **You** have **Paid** under **Your** prescription drug plan, vision plan, or dental plan will only be considered for reimbursement by **Us** under the Specific Excess Stop- Loss Policy if such coverages are as included on the **Schedule**.

Plan Benefits which **You** have **Paid** under **Your** prescription drug plan, vision plan, and/or dental plan, will only be considered for reimbursement by **Us** under this Aggregate Excess Stop- Loss Policy if such coverages are included on the **Schedule**.

SECTION V.
LIMITATIONS

Actively at Work Status and Disabled Persons

We will only reimburse **Covered Services Incurred** by individuals who, on the latter of the Effective Date of their coverage under **Your Plan** or the Effective Date of this **Policy** are eligible employees or their eligible dependents under the **Plan**.

Disabled Persons

If applicable, Expenses **Incurred** will not be eligible to satisfy the **Specific Attachment Point** or the **Annual Aggregate Attachment Point** until the day next following the date the **Covered Person**, with respect to an employee, returns to work on a full-time basis as defined in **Your Plan**. This limitation only applies to **Covered Persons** whose coverage under **Your Plan** is effective on or after the Effective Date of this Policy.

Disclosure

We have relied upon the information provided by **You** and **Your TPA** in the issuance of this Policy. Should subsequent information become known which was requested by us and not provided to us by **You**, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, **We** will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to **You**. Any fraudulent statement will render this **Policy** null and void and claims, if any, will be forfeited.

Retired Employees

We will reimburse **Paid Plan Benefits** for Retired Employees and their dependents, who are eligible under the **Plan** only if such persons are indicated as included in the **Schedule**.

COBRA Continuees

With respect to those persons qualifying as **COBRA Continuees**, and continuing coverage under **Your Plan** as such, prior to, on or after the Effective Date of this Policy, **We** will reimburse **Paid Plan Benefits** for such individuals only if **You** make timely notification to such individuals of their rights to COBRA continuation coverage.

Drug or Alcohol Abuse

If **Your Plan** covers treatment of drug or alcohol abuse, **Plan Benefits** reimbursable under this Policy for such treatment will be limited to the amount stated in the **Schedule**.

Liability for Reimbursement

We shall not be liable under this **Policy** to directly reimburse any **Covered Person** or provider of professional or medical services for any benefits that **You** have agreed to provide under the terms of the **Plan**. **Our** sole liability is to **You**, in accordance with the terms of this Policy. **You** may not assign any Excess Loss benefits to **Covered Persons** or providers of services.

SECTION VI.
EXCLUSIONS (What is Not Covered under the Policy)

In addition to the Exclusions listed in the PPO/HMO member booklet/certificate or **Plan**, the following exclusions will apply under this **Policy**.

We will not reimburse **You** for any losses or expenses caused by or resulting from:

1. Any expenses **Incurred** while **Your Plan Document** is not in force with respect to the **Covered Person**, or for a person not covered under **Your Plan Document**.
2. Any expenses covered by **Plan Document** changes made prior to **Our** written approval of such changes.
3. Any expenses resulting from any prescription card service, mail order prescription plan or any pre-paid prescription drug plan, dental plan or vision plan, unless selected as indicated in the **Schedule of Excess Stop-Loss Insurance**.
4. Any liability or obligations assumed by You under any contract or service agreement other than Your Plan Document.
5. Any expenses for services or supplies which are in violation of any law.

6. Any expenses for services or supplies billed above the reasonable and customary charges for the area where provided or which are greater than **Your Plan Document benefit.**
7. Any cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by **Your TPA**, consulting fees or expenses of any litigation.
8. Any expenses from an act while committing or attempting to commit an illegal act or felony, whether or not the **Covered Person** is arrested or prosecuted.
9. Any amount used to satisfy deductibles or coinsurance amounts under **Your Plan Document**.
10. Any expenses or any costs resulting from non-contractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties.
11. Any payments recoverable through the Coordination of Benefits or similar provision of **Your Plan Document**.
12. Any affiliated or subsidiary company not included in the **Schedule of Excess Stop-Loss Insurance**, unless added by rider to this "policy".
13. Any legal expenses or fees.
14. Any expenses **Incurred** after the Expiration Date of the **Policy** or **Your Plan Document**, whichever occurs first.
15. If this **Policy** is terminated before the Expiration Date, any expenses **Incurred** after the date of such termination.
16. Any expenses **Incurred** by any COBRA continuee whose COBRA continuation coverage was not offered in a timely manner as defined by COBRA laws.
17. Large claims that have not been specifically reviewed for Case Management Services
18. Benefits that are approved by the Plan but not expressly stated in the plan document unless such benefits are expected to reduce the cost of the claim and approved by Us.
19. Coverage while the covered person is outside the United States, its possessions or the countries of Canada and Mexico.
20. Worker's Compensation. We will not pay benefits where such benefits would be provided under any State or Federal workers' compensation, employers' liability or occupational disease law.
21. Amounts above Usual and Customary

SECTION VII.
PREMIUMS AND FACTORS

Payments of Premiums

No coverage under this **Policy** will be in effect until the first premium is **Paid**. For coverage to remain in effect, each subsequent premium must be **Paid** on or before the **Premium Due Date**. You are responsible for the payment of premiums. Payment of the premium to **Your TPA** does not constitute payment of the premium to **Us**. Premium is not considered **Paid** until the premium check is received at **Our** Underwriting Office and sufficient funds are transferred from **Your** account into **Our** account and clear

Upon termination of this Policy, or coverage hereunder, if the earned premium exceeds the premium **Paid**, You will pay the excess to **Us**; if less, We will return to **You** the unearned portion of premium **Paid**, subject to the minimum premium, if any, shown in the **Schedule**.

Grace Period

A Grace Period of 31 days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is Paid before the end of the Grace Period. If **You** do not pay the premium during the Grace Period, this **Policy** will terminate without further notice, retroactive to the date for which premiums were last **Paid**.

Changes in Premium Rates or Factors

We may change **Your** premium rates and/or Monthly Aggregate Excess Loss Factors on any of the following dates:

1. The date when the terms of this **Policy** are changed.
2. The date **You** add or delete subsidiary or affiliated companies or divisions with **Our** approval.
3. The date **You** change **Your Plan** with **Our** written approval.
4. The date there is a change in the geographical area in which **You** are located.
5. The date there is a change in the nature of business in which **You** are engaged.
6. Any month following a 10% decline in enrollment

We reserve the right to recalculate the premium rates and/or the Monthly Aggregate Excess Loss Factors retroactively up to one year for the **Policy Period**, if there is more than 10% variance between:

1. the number of **Covered Units** on any **Premium Due Date**; and
2. the number of **Covered Units** on the **Policy** Effective Date.

SECTION VIII. TERMINATION

This **Policy** and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is **Paid**, if the subsequent premium is not **Paid** as provided in the Grace Period provision.
2. On the date **You** tell **Us You** want to cancel this Policy, provided **You** have given **Us** at least 31 days advance written notice. If **You** cancel within 30 days after the Effective Date, **You** may ask for a full refund of the premium. If **You** do so, this **Policy** will terminate on the Effective Date. If **You** cancel this Policy at a later date, We may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the Effective Date, if, within 60 days after the Effective Date:
    1. **You** fail to provide **Us** any information or materials requested by **Us**; or
    2. **You** fail to comply with any condition imposed by **Us** when this **Policy** is issued.

    If so, **We** will return the premium **Paid** by **You**, less the amount of any reimbursements **We** made to **You** before the time this **Policy** was terminated. If the amount reimbursed to **You** exceeds the premium **Paid** to **Us**, **You** will pay **Us** the difference.
5. The date the **Plan** terminates.
6. The date the administrative services agreement between **You** and **Your TPA** terminates, unless We consent in writing to Your naming of a new **TPA**.
7. The last day of the third consecutive month during which **You** fail to maintain the Minimum Plan Enrollment as stated in the **Schedule**, unless **We** agree in writing to continue coverage;
8. The date You:
    1. Suspend active business operations; or
    2. are placed in bankruptcy or receivership, or
    3. dissolve.
9. Any date on which **You** do not pay claims or make funds available to pay claims as required by the **Plan**.

Concealment or Fraud
This entire Policy will be void:

1. if, before or after a claim or loss, **You** or **Your TPA** have concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, **Large Claims** or **Potentially Catastrophic Losses**.) or
2. in any case of fraud by **You** or **Your TPA** relating to this coverage.

SECTION IX. REINSTATEMENT

We may, at **Our** option, approve **Your** request to reinstate this Policy. **You** shall submit to **Us** any forms and data **We** may require, including **Your** representation as to losses **Incurred** or **Paid** as of the date of **Your** request for reinstatement. If this **Policy** is reinstated, **You** shall pay to **Us** the premiums due from the date this **Policy** terminated.

SECTION X. CLAIM PROVISIONS

Administration of Claims under Your Plan
We have no duty to settle or adjust claims filed under **Your Plan**. **You** must retain and pay a **TPA** at all times. **We** will not reimburse **You** for **Plan Benefits** resulting from benefits **Paid** by someone not authorized to do so.

You must make available sufficient funds to pay benefits when due.

The **TPA** shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the **Plan**;
2. maintain accurate records of all claim Payments;
3. maintain separate records of expenses not covered; and
4. provide **Us**, on or before the 15th day of each **Policy Month**, the following data for the preceding **Policy Month**:
    1. number of **Covered Persons** and/or **Covered Units**; and
    2. a total of claims **Paid**.

Management of Large Claims (LC's) and Potentially Catastrophic Losses (PCL's)
Notice of **LC** – **You** or **Your TPA** must notify **Us** in writing of any LC (regardless of whether charges have been **Paid** or are pending Payment) as soon as

practically possible when the claim exceeds or it appears that the claim will reach or exceed the defined limits for a LC. All LCs must be reviewed for potential Case Management services.

Notice of PCL – **You** or **Your TPA** must notify **Us** in writing of any PCL as soon as practically possible when receiving any information indicating that the claim (regardless of whether charges have been **Paid** or are pending Payment) is potentially catastrophic. (See Exhibit I of this Policy.)

Notice of Claim

Specific Excess Loss – **You** must give written notice of claim to **Us** within 30 days of the date **You** become aware of claims, with respect to a **Covered Person**, that has reached 50% of the **Specific Attachment Point**; however, **LC's** and **PCL's** should be reported within the time frame specified in the previous paragraph.

Aggregate Excess Loss – **You** must give written notice of claim to **Us** within 30 days of the date **You** become aware of claims that have reached the Annual Aggregate Attachment Point.

Your failure to furnish written notice within the time required by this **Policy** will not invalidate or reduce any claim if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event later than one year after the date written notice is first required.

You or **Your TPA** shall submit on a timely basis all proofs of claims, reports and supporting documents **We** may request.

Proof of Loss

Written proof of loss must be submitted within 60 days after the date of loss. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible and within one year of the date of loss.

Payment of Claims

Amounts payable under this **Policy** will be **Paid** upon receipt and acceptance by **Us** of all the required material. Required material shall include proof of loss and proof of Payment for Eligible Expenses under the **Plan** and any reasonably requested supporting documentation.

Benefit Determination

Determination of benefits under **Your Plan** is **Your** sole responsibility. **We** have no duty to settle or adjust claims filed under the **Plan** with **You** or **Your TPA**. **We** have the right to review each claim **You** submit to **Us** for reimbursement to determine if **You** are entitled to reimbursement.

Recoveries/Subrogation

You are required to investigate and prosecute all valid claims that **You** may have against third parties arising out of any claim for which benefits were **Paid** by the **Plan**. **You** or **Your TPA** shall account to **Us** for all amounts recovered. If **You** fail to pursue any action against a third party and **We** have made benefit payments under this Policy, **We** will be subrogated to all of **Your** rights to make recoveries. **You** are required to cooperate fully and do all things necessary and required for **Us** to pursue any action to recover against the third party.

Any amounts recovered by **You**, **Your** TPA, or the Covered Person in such action shall be used first to reimburse prior benefit Payments in accordance with plan provisions, and then to reimburse the expenses of recovery. Any amounts recovered by **Us** shall be used to reimburse **Us** for any amount that **We** may have **Paid** or become liable to reimburse to **You** under the terms of this Policy, and then to reimburse the expenses of collection. All remaining amounts shall be **Paid** to **You**. If **We** have reimbursed **You** for all or part of a particular loss and **You** or **Your Plan** later recover for that loss from a third party, **You** must repay **Us** to the extent of **Our** reimbursements, regardless of whether this **Policy** is still in force on the date **You** recover.

Notice of Appeal

Any objection, notice of legal action, or complaint received on a claim processed under **Your Plan** on which it reasonably appears an Excess Loss benefit will be payable to **You** under this Policy, shall be brought to Our immediate attention. If not, we will not cover any additional costs resulting from the lack the required immediate notification. Immediate notification shall mean notification within 30 days of date of receipt.

SECTION XI.
GENERAL PROVISIONS

If premium taxes should be assessed against **You** with respect to claims Paid under **Your Plan**, **You** shall hold **Us** harmless from any tax liability.

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

Entire Contract
This entire contract consists of:

1. this Policy, including any **Endorsements**;
2. **Your Application** and **Schedule** and any attachments thereto, a copy of which is attached to this Policy, and
3. a copy of **Your Plan**.

All statements made by **You** or any **Covered Person** are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the **Application** and **Schedule** or any attachments to the **Application** and **Schedule**.

In case of a conflict between the **Plan** and this Policy, the **Policy** will control. **We** have relied on the information **You** provided to issue this Policy. **You** represent such information is accurate. Should subsequent information become known which **We** asked for and You did not provide to us, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, **We** will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to **You**. Any fraudulent statement will render this **Policy** null and void and claims, if any, will be forfeited.

Policy Nonparticipating
This **Policy** does not entitle **You** to share in **Our** earnings.

Records and Review
You and/or **Your TPA** must:

1. keep appropriate records regarding administration of **Your Plan**; (**Your** records include records held by **Your TPA**.)
2. allow **Us** to review and copy, during normal business hours, all records affecting **Our** liability under this Policy;
3. maintain records of all **Covered Persons** under the **Plan** during the **Policy Period** and for a period of seven years after the termination of this Policy; and
4. maintain a separate record of any and all amounts **You** pay that exceed or are not covered by the benefits under **Your Plan.**

Clerical Error
If **You** or **We** make a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand **Our** obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with **Plan** or **Policy** provisions. A clerical error is not the failure to disclose the required disclosure of health history of Disabled Persons.

Large Claims or Potentially Catastrophic Losses.Changes to This Policy

Changes to this **Policy** may be made only by a **Company** officer or **Our** Underwriting Office, with **Our** approval. Any change must be by written **Endorsement**.

Changes to Your Plan
We must be notified of any changes to the **Plan** which affect this Policy. This notice must be in writing and provided to **Us** at least 31 days prior to the effective date of the change. **We** must approve the change in writing before coverage affected by this change will be provided by this Policy. If We do not receive advance written notice of the change, or We decline coverage of the changes under this Policy, We will be liable only for benefits provided by the **Plan** prior to the change. **You** must provide Us with a copy of **Your** updated **Plan** including all amendments prior to the time the change becomes effective.

Subsidiaries, Affiliated Companies Under Your Plan
You must notify **Us** in the event **You** acquire a subsidiary or affiliated company that will be included under **Your Plan**. If **You** do acquire a subsidiary or affiliated company that will be included under **Your Plan**, **You** must disclose certain required health history on persons whose coverage **You** will be assuming under **Your Plan**. Failure to do so will subject benefits under this **Policy** to certain limitations, as described in "Disclosure" in Section V.

Acquisition of a subsidiary of affiliated company that will be included under **Your Plan** may affect **Your** premium rates and/or Monthly Aggregate Excess Loss Factors, as described in "Changes in Premium Rates or Factors," in Section VII.

You must notify **Us** in the event **You** cede or dissolve a subsidiary or affiliated company that was included under **Your Plan**. Failure to do so may subject this **Policy** to termination (if Minimum **Plan** Enrollment is not maintained), or may affect **Your** premium rates and/or Monthly Aggregate Excess Loss Factors, as described in "Changes in Premium Rates and Factors," in Section VII.

Duties and Responsibilities of Your Designated Third –Party Administrator (TPA)
Your TPA must be approved by **Us**.

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

We agree to recognize **Your TPA** as **Your** agent for the administration of **Your Plan**. **You** agree that **Your TPA** will:

1. administer and pay all claims for **Covered Services** under the **Plan**;
2. prepare reports required by **Us** and keep and make available to **Us** data **We** may require; and
3. do what is necessary for **You** to comply with the terms of this Policy.

You will pay **Your TPA** for all administrative functions performed in relation to this Policy.

Your TPA is **Your** agent and not **Ours**. **You** authorize **Your TPA** to:

1. submit Notice/Proof of Loss;
2. certify the Payment of claims;
3. transmit reports and payment of premiums to **Us**; and
4. receive payments from **Us**.

Payments by **Us** to **Your TPA** are payments to **You**.

Notice
For the purpose of any notice required from **Us** under the terms of this Policy, notice to **Your TPA** is notice to **You** and notice to **You** is notice to **Your TPA**.

Disclaimer
We act only as a provider of Excess Stop- Loss Insurance coverage to **Your Plan**. **We** are not a fiduciary. **We** do not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

We have no right or obligation to pay any **Covered Person** or provider of professional or medical services. **Our** sole liability is to **You**, subject to the terms and conditions of this Policy. Nothing in this **Policy** shall be construed to permit a **Covered Person** to have a direct right of action against **Us**. **We** will not be considered a party to **Your Plan** or to any supplement or amendment to it.

Indemnification, Defense and Hold Harmless
You agree to release and hold **Us** harmless from any damages, liabilities, expenses, costs of defense and losses which result directly from:

1. any dispute involving a **Covered Person** unless it is a result of **Our** sole negligence or intentional wrongful acts; and
2. any State premium taxes **We** are assessed with respect to funds **Paid** by or to **You** under **Your Plan**. Taxes on amounts **Paid** to Us as premiums for this **Policy** are excluded.

We will notify **You** if **We** believe that **You** may have obligations to hold **Us** harmless under this Policy. **We** may participate in the defense at **Our** own expense. If **You** do not act promptly in that **We** may be prejudiced by **Your** inaction, **We** may defend and compromise or settle the claim or other matter on **Your** behalf, for **Your** account, and at **Your** sole expense.

Offset
We may offset payments due **You** under this **Policy** against claim overpayments and premium due and unpaid.

Assignment
You may not assign any of **Your** rights under this Policy.

Severability
Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this **Policy** invalid.

Insolvency
The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of **You** or **Your TPA**:

1. will not impose upon **Us** any liability or additional duties other than those defined and provided for in this Policy; (For example, **We** will have no responsibility to pay claims for **Your Plan** to ensure reimbursement under this Policy.) and
2. will not make **Us** liable to **Your** creditors, including **Covered Persons**.

Claims under **Your Plan** must continue to be funded and **Paid** within contractual time frames in order to be eligible for reimbursement under this Policy.

Parties To This Policy:
You and **We** are the only parties to this Policy. **Our** sole liability under this **Policy** is to **You**. This **Policy** does not create any right or legal relation between **Us** and a **Covered Person** under **Your Plan**. This **Policy** will not make **Us** a party to any agreement between **You** and **Your TPA**.

Legal Action
No action at law or in equity shall be brought to recover on this **Policy** prior to the expiration of 60 days after written proof of loss has been furnished in accordance

with the requirements of this Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Time Limit on Certain Defenses
In the absence of fraud, all statements made by **You** OR **Your TPA** shall be deemed representations and not warranties. If these statements appear as part of the written **Application** or other written instrument signed by **You** or **Your TPA**, **We** may use them to contest the Contract. If **We** do, **We** will furnish **You** OR **Your TPA** with a copy of the document in question. After 2 years, only fraudulent misstatements may be used to contest the contract coverage under this Policy.

Arbitration
Any controversy or claim arising out of or relating to this Policy, or the breach thereof, shall be settled by Arbitration in accordance with the rules of the American Arbitration Association, with the express stipulation that the arbitrator(s) shall strictly abide by the terms of this **Policy** and shall strictly apply rules of law applicable thereto. All matters shall be decided by a panel of one (1) arbitrator with a minimum of ten years expertise in the area of excess stop-loss coverage. The arbitrator shall not be a past or present employee, officer, partner, shareholder, and/or director of the parties nor have represented the parties if he/she is a lawyer. Discovery shall be limited to requests for production of documents and interrogatories.

Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. The prevailing party shall be entitled to its costs and fees **Incurred** in any arbitration proceeding, unless the arbitrator decides otherwise. This provision shall survive the termination or expiration of this Policy. The parties hereto may alter any of the terms of this provision only by express written agreement.

EXCESS STOP LOSS POLICY

UNDERWRITTEN BY NATIONAL HEALTH INSURANCE COMPANY

EXHIBIT I

Potentially Catastrophic Losses (**PCL's**). Claims which qualify as **PCL's** are listed below. **We** reserve the right to add to or delete from this list of **PCL's** with 31 days advance written notice to **You**.

HIGH RISK PREGNANCY AND PRE-TERM/NEONATAL

- Premature births –weighing under four pounds and/or less than 36 weeks gestation
- Multiple births (three or more infants) or expected multiple births
- Abnormal respiration/respiratory failure (APNEA)
- Congenital heart defects:
  - Ventricular and atrial septal
  - Patent ductus arteriosus
- Congenital disorders:
  - Spina – Bifida
  - Encephalocele
  - Cephalohematoma
  - Hyaline Membrane Disease
- Birth injuries or major birth traumas
- Congenital Anomalies of Digestive System
- Lack of Expected Normal Physiological Development
- Maternal causes of Prenatal Morbidity and Mortality
- Other conditions originating in the Perinatal Period

CATASTROPHIC DISEASES AND ILLNESSES

- Renal dysfunction/failure, including dialysis treatment
- Cerebral vascular accident (stroke)
- Diabetes with complications

TRAUMA

- Spinal cord injuries
- Coma
- Massive internal injuries
- Traumatic brain injury
- Brain lesion or tumors
- Multiple or serious fractures
- Severe burns (10% or more of the body with 3rd degree burns, or 30% of the body with 2nd degree burns)
- Trauma to the elderly or chronically ill
  Paralysis of any kind

DISEASE OF THE HEART AND PERICARDIUM

- Myocardial infarction
- Myocarditis
- Coronary Artery Disease
- Multiple Bypass
- CardiomyopathyCANCER

HIV Positive or AIDS (Acquired Immune Deficiency Syndrome) Related Illnesses, such as;

- Kaposi's sarcoma
- Cytomegalovirus
- Pneumocystics carinii pneumonia

ORGAN TISSUE, BONE MARROW, OR STEM CELL TRANSPLANT EVALUATION, PROCEDURE OR SURGERY

EXTENDED ILLNESS OR INJURY

- Chronic Liver Disease
- Multiple Sclerosis or Muscular Dystrophy or Cystic Fibrosis or Cerebral Palsy or Degenerative Muscular Disease
- Any illness or injury which requires intensive and prolonged treatment (such as nutritional support systems, intravenous therapies, and ventilators)
- Continuous hospitalization of 2 weeks or more
- Amputations
- Home health care greater than 20 days
- Hospitalization of $40,000 or more
- Interim/Cycle hospital billings
- Hospitalization during pregnancy, prior to delivery, or for high-risk pregnancy.
- Mental disorders requiring hospital confinement
- HepatitisC
- Multiple hospitalizations of three or more per year
- Inpatient admission greater than 10 days.
- Specialty or other prescription drugs costing more than $2,500 per month that will be used for 12 months or more

MONTHLY CUMULATIVE ACCOMMODATION FOR AGGREGATE EXCESS LOSS ENDORSEMENT

Attached to Policy No. 5614NH

Issued By

National Health Insurance Company

Endorsement Number: 1

Endorsement Effective Date: 7/1/2020

Policy Effective Date: 7/1/2020

Policyholder Name: [redacted]

ENDORSEMENT SCHEDULE

Minimum Threshold:	**$100**
Refund Due Date:	**15th of the month**
Penalty:	**8%**
Year-End Reimbursement Due Date:	**7/15/2021**
Due Date if Canceled:	**15 days after cancellation date**
Due Date if Policy Terminated:	**15 days after termination date**
Reporting Period:	**15th of the month**
Monthly Cumulative Accommodation Premium Rate:	**No additional charge.**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

1. Monthly Cumulative Accommodation

If, at the end of a **Policy Month**, **Your Cumulative Eligible Expenses** exceed the **Cumulative Aggregate Attachment Point** by an amount greater than the Minimum Threshold shown in the **Endorsement** Schedule above, **We** will release to **You** the amount by which **Your Cumulative Eligible Expenses** exceed the **Cumulative Aggregate Attachment Point** for that month.

2. Definitions

For the purposes of this **Endorsement**, the following definitions apply:

a. **Cumulative Aggregate Attachment Point** means the greater of:

1) The sum of the monthly aggregate attachment point for all **Policy Months** of the **Cumulative Period**; or
2) The monthly aggregate attachment point for the first month of the **Policy Period**, times the number of **Policy Months**.

b. **Cumulative Eligible Expenses** means the total amount of **Plan Benefits** that **You** have paid under **Your Plan Document** during the **Cumulative Period**.

Cumulative Eligible Expenses do not include amounts:

1) We have paid to **You**, or **You** are eligible to receive, as Individual Excess Loss-Loss Coverage benefits during the **Policy Period**;
2) Paid under **Your Plan Document** which exceed the **Individual Claimt Limit** shown on the **Schedule of Excess Stop-Loss Insurance**; or
3) Which are not **Plan Benefits.**

c. **Cumulative Period** means the period which:

1) Begins on the Effective Date of the **Policy** or, if later, on the Endorsement Effective Date; and
2) Ends on the last day of the summation of each and every **Policy Month** after the first, and prior to the last, month of the **Policy Period**.

d. **Net Amount** means all amounts that **We** have released to **You**, less the amounts that **You** have returned to **Us** under this **Endorsement**.

3. Amounts Released

Amounts Released by Us:

a. Will always be considered **Our** funds;
b. Will be subject to all the terms of the **Policy**, including but not limited to **Our** receipt of **Your** request for reimbursement, and proof of claim satisfactory to **Us**;
c. Will not exceed the Maximum Aggregate Reimbursement limit shown on the **Schedule of Excess Stop-Loss Insurance** payable by **Us**; and
d. Are not loans or advances of benefits payable under the **Policy**.

We will only release amounts under this **Endorsement** if **You** have paid to **Us**:

a. All premiums due through the **Cumulative Period**; and
b. All amounts which **You** are required to return to **Us**, in accordance with the **Repayment of Amounts Released** section below.

4. Repayment of Amounts Released

Amounts released under this **Endorsement** must be returned to **Us** by **You**, in their entirety, if, during any subsequent **Policy Month**, **Your Cumulative Aggregate Attachment Point** is greater than **Your Cumulative Eligible Expenses.**

Your refund to **Us**:

a. Will not exceed the amount **We** have released to **You** under this **Endorsement**;
b. Will not be carried over into any subsequent **Policy Month**, or **Policy Period**; and
c. Is due and payable within the Refund Due Date shown in the Endorsement Schedule above.

5. Year-end Adjustment

At the end of the **Policy Period**, **We** will determine the **Annual Aggregate Attachment Point** without regard to this **Endorsement**.

We will reimburse **You**, for any amount by which **Cumulative Eligible Expenses** are in excess of the greater of:

a. The **Annual Aggregate Attachment Point**, or
b. The **Minimum Annual Aggregate Attachment Point"** less any **Net Amounts** previously paid.

We will reimburse **You** only if all due premium is paid, and all amounts **You** must return to **Us** under this **Endorsement** have been paid to **Us**.

You must reimburse **Us** for any amount by which the greater of a. or b. below exceeds the **Cumulative Eligible Expenses**:

a. The **Annual Aggregate Attachment Point**, or
b. The **Minimum Annual Aggregate Attachment Point**.

No benefits will be paid under the **Policy** or under

this **Endorsement** until **We** have received all amounts **You** must return to **Us** under this **Endorsement**. If **You** do not pay amounts due within the time allowed:

a. We reserve the right to reduce any benefits payable under other terms of the **Policy** by such amounts;
b. **You** shall be assessed a penalty equal to the Penalty shown in the Endorsement Schedule above; and
c. **You** will be liable for all costs and expenses, including attorney fees, which **We** incur in the collection of such amounts.

You must reimburse amounts due **Us** by the Year-End Reimbursement Due Date shown in the Endorsement Schedule above.

6. Termination Prior to End of Policy Period
If the **Policy** is canceled or terminated prior to the end of the **Policy Period**, **You** must return to **Us** all amounts **We** have released to **You** under this **Endorsement**.

You must reimburse amounts due **Us** by the Due Date if Canceled shown in the Endorsement Schedule above.

7. Termination of this Endorsement
This **Endorsement** shall terminate automatically upon termination of the **Policy**, or the **Plan Document.** Termination of this **Endorsement** shall not terminate **Your** obligations to return to **Us** amounts due **Us** under this **Endorsement**.

You must reimburse amounts due **Us** by the Due Date if Policy Terminated shown in the Endorsement Schedule above.

8. Reporting Requirements

You must submit to **Us**, within the Reporting Period shown in the Endorsement Schedule above, a report of **Plan Benefits** paid by **You** during that month.

9. Premium

This **Endorsement** is added to the **Policy** in consideration of the Monthly Cumulative Accommodation for Aggregate Excess Loss premium. The premium is non-refundable.

Premium shall be adjusted within thirty-one (31) days of the earlier of the end of the **Policy Period** or the date of termination or cancellation of the **Policy** and shall be the greater of:

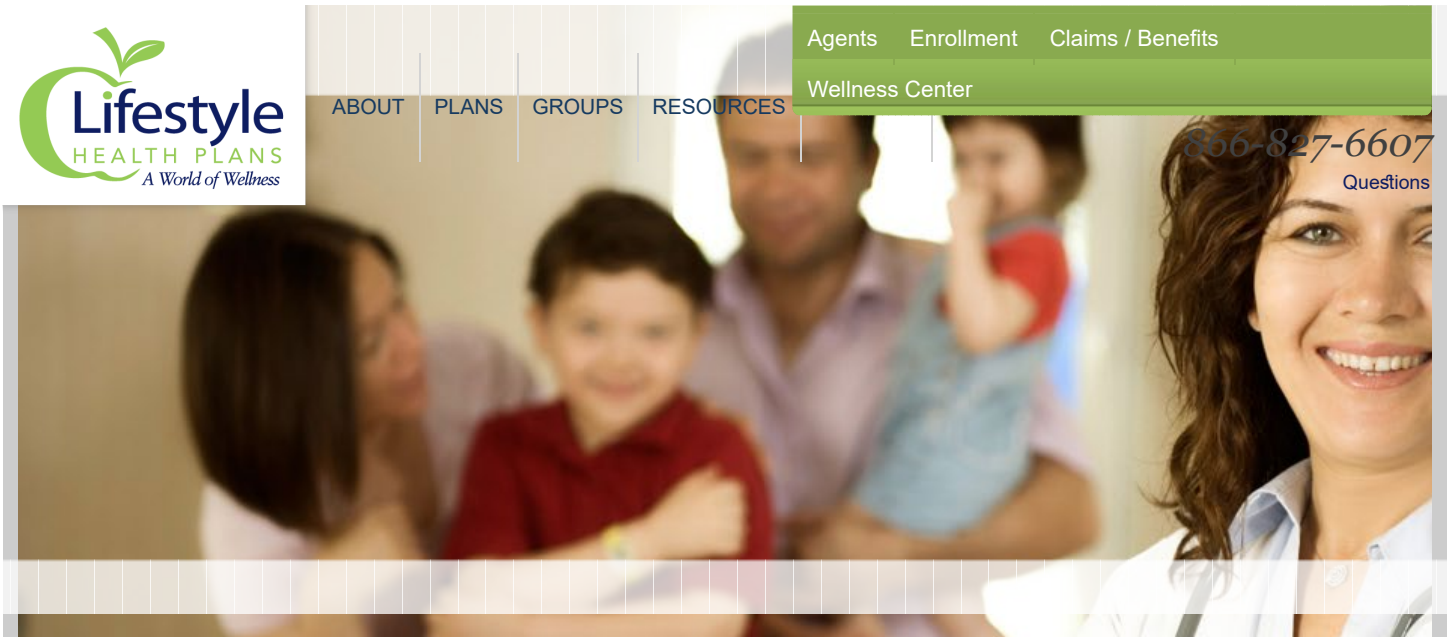
a. The Monthly Cumulative Accommodation Premium Rate shown in the Endorsement Schedule above multiplied by the number of **Covered Units** shown in item 8. under section **B. AGGREGATE EXCESS LOSS INSURANCE** of the Schedule of Excess Stop-Loss Insurance multiplied by 12 (twelve); or
b. The Monthly Cumulative Accommodation Premium Rate shown in the Endorsement Schedule above multiplied by the number of actual monthly **Covered Units** as reported to **Us** during the **Policy Period**.
c. The Provisional Monthly Cumulative Accommodation Premium shown in the Endorsement Schedule above.

Signed for National Health Insurance Company

Charles W. Harris
President

Jeffrey Weissmann
Secretary

Exhibit 4



How It Works

We know the difficulties that employers face in finding the balance in health benefits and costs. Lifestyle Health provides you with the opportunity to design the plan that's right for you. Through our insurance carrier partnerships, Lifestyle Health provides the flexibility in benefit design that employers are looking for. Based upon employer size, we can offer a fully funded health benefit program that maximizes the benefits to employees, while implementing cost saving opportunities for employers to stabilize benefit costs without reducing benefits.

We believe that employers are tired, frustrated and disenchanted with the options available to them today. Lifestyle Health provides innovative, flexible plan designs, with the protection of our insurance partnerships, to provide a unique, refreshing approach to healthcare benefits. Lifestyle Health Plan designs allow for an employer to forego the need for future state exchange hassles and work directly with their broker and benefit administrator to design and manage the best benefit program for them.

A Better Alternative for Your Group Benefits

Lifestyle Health Plans provides a great alternative to traditional, fully insured group health plans. If you are currently covered by a fully insured plan, your monthly premiums are locked in. Even if you are healthy and have no claims, you pay your premiums and the insurance company keeps any savings. Lifestyle Health provides you with the ability to receive a portion of your health benefit dollars back if your claims are below targeted claim levels. No matter how much your claims are in any plan year, you will also never pay more than the monthly cost quoted to you.

What is a Fully Funded Plan?

Lifestyle Health Plans is a group health benefits solution built on an ERISA fully funded platform and designed from an insurance perspective that differs from traditional self-funded plans. The plan is 'fully funded' meaning that by design, any risk to the sponsoring employer has been removed beyond the 12 months of premium paid. By blending a specific and aggregate custom stop loss insurance coverage, participating employers are able to gain the flexibility they desire without taking on the risk associated with traditional self-funding. Innovative and responsive, the fully funded platform design is changing benefits for many a partnering employer.

Health Plans

How it Works

The monthly group health premium paid to Lifestyle Health Plans for your group is comprised of three separate components:

Your maximum annual claims, including claims run-off liability, are predetermined and you pay 1/12 of this cost each month for the 12 months of your plan year. After you have paid this amount, there are no other charges for the claims fund. Once all claims have been paid for the plan year, each employer is eligible to receive back any unused dollars in the claims fund.

Advantages of ERISA Group Benefits

Lifestyle Health Plans are governed primarily by federal ERISA laws. ERISA plans differ from state benefit mandates, which result in lower costs and expenses for sponsoring employers. From an employee perspective, the features of an ERISA plan, as described in the Summary Plan Description (SPD), will be similar to the benefits they are familiar with in a fully insured plan, with co-pay, deductible, and pharmacy benefit options present. Each employee will be provided with a SPD detailing these benefits as they enroll in the Lifestyle Health program.

Employers | Associations | Brokers

Home

1. Select Your Plans

Select plans that meet your company's needs.

- **16 Standard Plans**
- **MEC, MVP and Buy Up**
- **Dental and Vision Plans**

2. Be Healthy

Personalize program and activities for your group.

- **Assess Health Risks**
- **Personalized Program of Healthy Actions**

3. Get Rewarded

Enjoy a lower deductible, reward perks, the works!

- **Deductible Credits**
- **Credit Match Program**
- **Bonus Buck Incentives**

Exhibit 5

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LLA5414	REDACTED	A3243	0.00		10,991.92	391,424.14		-380,432.22
	LSM3056		A2275	55.07		55,610.64	433,888.78		-378,278.14
	LSCA605		A1522	2,867.00		26,015.17	361,388.64		-335,373.47
	LMH3578		A2482	0.00		20,606.71	337,845.65	122.00	-317,360.94
	LFHC604		A1523	39,055.55		142,762.21	428,303.40		-285,541.19
	LPS2610		A2017	4,451.54		49.45	201,020.97		-200,971.52
	LAC2399		A1943	0.00		26,906.41	204,835.78	-44.40	-177,884.97
	LIMP364		A1363	291.71		84,354.53	248,532.90	25.00	-164,203.37
	LFSS224		A1287	0.01		14,264.05	147,022.72	-210.08	-132,548.59
	LAA4799		A2865	18.55		228.38	128,422.16		-128,193.78
	LA0210		A1032	0.00		747.76	119,443.56		-118,695.80
	LCCA947		A101288	664.91	9,113.18	11,120.59	122,363.54		-111,242.95
	LCC1100		A1783	0.00		7,891.11	113,691.75		-105,800.64
	LTN3739		A2475	0.00		9,269.21	103,104.07		-93,834.86
	LCT5433		A3264	6,694.96		12,183.96	93,403.59		-81,219.63
	LSN4182		A2746	0.00		5,751.04	83,726.26		-77,975.22
	LBP5365		A3194	0.00		120.70	73,959.12	25.00	-73,863.42
	LSC2694		A101537	6.42		442.10	74,193.22		-73,751.12
	LTH3842		A2964	0.00		501.41	74,140.76		-73,639.35
	LSV5555		A3395	0.00		7,734.41	79,863.28		-72,128.87
	LKC5336		A3177	0.00		114.75	69,246.07	2,365.15	-71,496.47
	LRB5986		A3777			242.95	68,719.09		-68,476.14
	LATS614		A100826			282.18	67,660.21		-67,378.03
	LPP5211		A3103	0.00		10,411.20	77,382.72		-66,971.52
	LSS5419		A3277	0.00		1,121.46	65,138.53		-64,017.07
	LLF4282		A2761	3,383.19		3,886.73	66,880.74		-62,994.01
	LPS5146		A2924	0.00		1,828.71	63,536.00		-61,707.29
	LBFE691		A1554	503.00		8,667.84	69,891.80	25.00	-61,248.96
	LMCK781		A1623	0.00		1,858.11	62,700.36		-60,842.25
	LTC3765		A101198	0.00		40.99	60,573.12		-60,532.13
	LWH3729		A100310	2,307.75		4,703.83	65,194.85	-200.00	-60,291.02
	LVT3235		A2357	0.00		387.24	60,350.49	25.00	-59,988.25
	LMM3422		A2509	0.00		29,880.62	86,236.68		-56,356.06
	LCP5877		A3761	0.00		86,945.86	141,775.42	57.00	-54,886.56
	LSK4977		A100992			1,082.84	55,398.25		-54,315.41
	LSW5341		A3206	0.00		101,953.39	154,918.00		-52,964.61
	LSB6126		A3977	0.00		5,210.76	57,371.23		-52,160.47
	LWC5907		A3654	10,832.24		28,525.12	80,134.97		-51,609.85
	LHP4473		A100656	0.00		7,978.78	59,289.15		-51,310.37
	LAW5361		A3209			2,613.81	53,652.10		-51,038.29
	LSN3511		A2645	0.00		8,594.09	58,656.97		-50,062.88
	LHH4438		A2799	0.00	16,986.09	31,421.39	79,625.04		-48,203.65
	LCD6240		A4092	0.00		21,115.16	68,088.81	25.00	-46,998.65
	LCP2718		A2129	0.00		5,705.27	52,089.69	44.60	-46,429.02
	LTM2937		A101202	19.36		506.33	46,509.96		-46,003.63
	LACS822		A1638			3,163.32	47,837.95		-44,674.63
	LKOH695		A1553			2,844.45	46,070.70		-43,226.25
	LAS2277		A100116	2,809.19		7,904.66	49,443.64		-41,538.98
	LEC5711		A3549	0.00		262.36	40,542.34		-40,279.98
	LFM3059		A101302	7.00		361.73	40,157.27		-39,795.54
	LCCA335		A100821			2,814.01	42,263.32		-39,449.31
	LPH2213		A1829			336.40	39,706.00		-39,369.60

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LAM3094	REDACTED	A2295	7.00		2,969.46	42,032.11		-39,062.65
	LHF4618		A2846	0.00		7,590.03	46,398.86		-38,808.83
	LRF2733		A100051	0.00		1,713.60	39,593.91		-37,880.31
	LSB3403		A101533	0.00		24,825.97	62,531.61		-37,705.64
	LBR5234		A3006	132.00	0.00	7,567.54	44,830.94		-37,263.40
	LRH2426		A101494	0.00		308.09	37,485.41		-37,177.32
	LBN2407		A100609	2,098.98		5,453.16	42,581.85		-37,128.69
	LCC3958		A100192	979.23		6,072.99	42,634.19		-36,561.20
	LAS4385		A100119	3.00		10,758.83	46,985.66	25.00	-36,251.83
	LSS3004		A100680	926.83		2,981.64	38,667.40		-35,685.76
	LLW5144		A2930			41.39	35,701.34		-35,659.95
	LRW5208		A3104	0.00		7,287.22	42,753.27		-35,466.05
	LCX4433		A100404			758.63	35,769.07		-35,010.44
	LWM3002		A2248	1,566.74		5,276.21	39,593.71		-34,317.50
	LTR2149		A101210	655.98		1,777.09	35,776.25		-33,999.16
	LPH2771		A100029	0.00		190.57	33,575.27		-33,384.70
	LDM3836		A2650	1,867.21		48.23	33,412.17		-33,363.94
	LNF5249		A3049	0.00		1,694.18	35,045.91		-33,351.73
	LVU5730		A3743	0.00		1,754.98	34,781.84		-33,026.86
	LAN5410		A3240	0.00		32,956.10	65,705.18	25.00	-32,774.08
	LTF5851		A3689	8.86		1,027.94	33,725.05		-32,697.11
	LEB2633		A2014	2,504.44		7,038.94	39,280.56		-32,241.62
	LCA2927		A100184			182.16	31,945.21		-31,763.05
	LSMC994		A1719			4,737.54	36,392.40		-31,654.86
	LAD2356		A100828	0.00		7,090.98	38,424.72	25.00	-31,358.74
	LMA4758		A100365	0.00		764.20	31,364.25		-30,600.05
	LTD5057		A101051			322.39	29,834.37		-29,511.98
	LPSA637		A100858	0.00		60.51	29,475.44		-29,414.93
	LPE5493		A3329			1,828.25	30,577.05	25.00	-28,773.80
	LNH5171		A2978	9.76		1,809.28	29,840.23		-28,030.95
	LKP5206		A3123			5,096.62	32,945.30		-27,848.68
	LCA2900		A2191	821.76		6,114.28	33,500.02		-27,385.74
	LXM4492		A2821	0.00		43,524.85	70,690.05		-27,165.20
	LTL6003		A3850			222.06	27,063.39		-26,841.33
	LNH2340		A1904	443.28		1,040.07	27,576.95		-26,536.88
	LRY6211		A4066	52.41		422.77	26,745.08		-26,322.31
	LCD2801		A100069	0.00		16,212.80	42,512.21		-26,299.41
	LTS3934		A100195	0.00		593.10	26,892.20		-26,299.10
	LMT5374		A3222	0.00		8,805.90	35,055.35		-26,249.45
	LMJ4953		A2898	0.00		5,818.01	31,151.62		-25,333.61
	LGM5689		A3525	379.63		3,095.80	28,281.54	25.00	-25,210.74
	LNY2803		A100027	0.00		3,180.62	28,035.14		-24,854.52
	LDE6120		A3991	0.00		4,540.61	29,271.52		-24,730.91
	LMA5337		A3168			635.76	25,281.74		-24,645.98
	LSC6087		A3953			1,724.92	26,237.75		-24,512.83
	LLD5436		A3265			1,293.00	25,713.09		-24,420.09
	LCB3580		A2520	0.00		41,744.55	66,153.95		-24,409.40
	LGL5118		A101168	0.00		578.58	24,977.79		-24,399.21
	LJP1077		A100435			314.99	24,234.50		-23,919.51
	LPC3000		A100751	488.83	5,610.10	7,012.00	30,904.07		-23,892.07
	LCC3440		A101652	30.68		1,197.62	24,472.72		-23,275.10
	LSB5224		A3000	0.00		14,798.97	37,725.28	25.00	-22,951.31

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHCA778	REDACTED	A101246	0.00		378.93	23,012.49		-22,633.56
	LPF3598		A2515	88.91		11,852.85	34,377.01		-22,524.16
	LAC5175		A2969	302.24		928.81	23,364.84		-22,436.03
	LJS4327		A100276	2,679.78		5,155.54	27,591.53		-22,435.99
	LFC6157		A4016	0.00		1,216.99	23,580.61	25.00	-22,388.62
	LKC5246		A3060	0.00		3,268.61	25,334.30		-22,065.69
	LCE4673		A100495	0.00		3,965.73	25,980.19		-22,014.46
	LKZ4779		A2869			94.28	21,924.99		-21,830.71
	LMA5548		A3382	4.00		1,975.37	23,695.83		-21,720.46
	LST4586		A101188	0.00		104.09	21,819.04		-21,714.95
	LAB4754		A100124			566.00	22,163.61		-21,597.61
	LHM4194		A100981	176.83		1,924.87	23,422.21		-21,497.34
	LPV3602		A2440	0.00		15,256.90	35,931.21	456.67	-21,130.98
	LCR5194		A3097	979.35		6,188.06	27,296.35		-21,108.29
	LJD2995		A2256	0.00		5,959.59	26,758.57		-20,798.98
	LPP5140		A2923	0.00		1,968.34	22,719.98	25.00	-20,776.64
	LTL2695		A101209	115.31		6,387.28	27,108.49		-20,721.21
	LDH5029		A2897	0.00		242.97	20,827.15		-20,584.18
	LHA5822		A3751	59.40		1,200.64	21,420.17		-20,219.53
	LSN3037		A101371	4.00		3,878.81	23,993.41		-20,114.60
	LEM2868		A101314	0.00		154.21	20,144.75		-19,990.54
	LRS5663		A3498	1,029.64		2,087.94	22,010.80		-19,922.86
	LUS4589		A100938	0.00		10,202.32	29,976.79	25.00	-19,799.47
	LDC098		A1109	7,067.48		12,291.52	31,991.72		-19,700.20
	LWC5006		A100428	0.00		2,268.29	21,812.21		-19,543.92
	LCLT811		A1630	0.00		6,513.19	25,951.09		-19,437.90
	LSMA759		A100999	0.00		63.62	19,711.49	-440.48	-19,207.39
	LSS2319		A101073	1,028.23		10,728.25	29,848.08		-19,119.83
	LBM3772		A100003			82.00	19,008.54		-18,926.54
	LAH4706		A101156	50.24		10,622.67	29,361.64	25.00	-18,763.97
	LND3496		A2525	667.78		9,381.37	28,072.72		-18,691.35
	LSD2947		A100887	0.00		2,452.49	21,128.51		-18,676.02
	LMB2821		A100133	259.61		4,452.93	23,095.41		-18,642.48
	LHV4641		A2859	0.00		246.72	18,858.78		-18,612.06
	LDH3656		A100304	3,079.05	7,689.04	15,391.68	33,994.19		-18,602.51
	LAG3831		A2961			245.17	18,783.30		-18,538.13
	LAE3971		A100085	0.00		1,063.27	19,442.80		-18,379.53
	LMD3875		A100011	0.00		224.62	18,590.97		-18,366.35
	LPV5606		A3446	0.00		3,391.87	21,474.74		-18,082.87
	LKP4584		A101304	0.00		3,322.27	21,330.15		-18,007.88
	LFM3852		A2638	0.00		3,824.29	21,705.87		-17,881.58
	LCS2461		A1974	0.00		609.73	18,456.74		-17,847.01
	LAC4284		A100118	439.62		4,621.05	22,278.52		-17,657.47
	LMC2827		A100487	718.20		10,031.14	27,605.70		-17,574.56
	LAA4340		A100414	1.00		858.71	17,897.71		-17,039.00
	LPPP726		A1583	0.00		7,869.14	24,780.27		-16,911.13
	LCZ4901		A100309	9.00		4,663.14	21,507.06		-16,843.92
	LTH2881		A101085	2,031.35		4,782.09	21,431.53		-16,649.44
	LFK5364		A3205			1,136.40	17,642.67		-16,506.27
	LRK4778		A100868	1.00		2,832.51	19,238.99		-16,406.48
	LHM2507		A101225	0.00		150.92	16,273.80		-16,122.88
	LTH3051		A100961	0.00		2,454.44	18,558.69		-16,104.25

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LLH4872	REDACTED	A101375			1,746.75	17,740.51		-15,993.76
	LGC5228		A3012	0.00		723.50	16,661.22		-15,937.72
	LSS3843		A100019	0.00		328.50	16,108.91		-15,780.41
	LTP5109		A2911			78.85	15,800.24		-15,721.39
	LCA3343		A2550	0.00		27,493.30	43,076.84	25.00	-15,608.54
	LAP6317		A4198	178.92		1,077.88	16,547.17		-15,469.29
	LGW2296		A101109	1,754.45	7,132.15	9,607.70	24,981.25		-15,373.55
	LFC2604		A2003	82.89		14,225.45	29,468.22	25.00	-15,267.77
	LEV4283		A101294	0.00		10,249.36	25,449.72	25.00	-15,225.36
	LHL6289		A4153	29,250.90		58,125.10	73,058.23		-14,933.13
	LGGM789		A101172	431.80		9,203.39	24,036.62	25.00	-14,858.23
	LHC5468		A3336	0.00		1,569.08	16,401.52		-14,832.44
	LCD5995		A3855	2,056.76		5,674.22	20,467.28		-14,793.06
	LCP4479		A101267	2.39		11,357.34	26,101.48	25.00	-14,769.14
	LSC5571		A3412			2,685.65	17,382.84		-14,697.19
	LRS5701		A3543			357.39	15,042.28		-14,684.89
	LSC5494		A3321	0.00		23,295.21	37,680.10		-14,384.89
	LDLC699		A1552	0.00		16,386.68	30,734.40		-14,347.72
	LSF3908		A2675	0.00		54,626.67	68,962.28		-14,335.61
	LTK5385		A3220	0.00		2,676.42	16,934.98		-14,258.56
	LGC2851		A2163	0.00		2,515.28	17,599.72	-1,064.00	-14,020.44
	LCC3272		A100757			1,948.38	15,800.27		-13,851.89
	LCG2469		A100553	1.00		1,000.32	14,841.64		-13,841.32
	LUM5897		A3715	3.65		3,121.86	16,702.92		-13,581.06
	LNS6084		A3938			638.60	14,206.54		-13,567.94
	LQS4718		A101601	0.00		113.76	13,630.52		-13,516.76
	LPK6208		A4067	330.40		2,112.45	15,572.26		-13,459.81
	LEA2734		A100065	0.00		2,516.66	15,959.96		-13,443.30
	LBA3519		A2631	0.00		23,193.14	36,448.69		-13,255.55
	LZM4952		A100760			1,056.89	14,302.93		-13,246.04
	LCM4012		A101306	4.00		3,095.42	16,286.67	25.00	-13,216.25
	LTD5841		A3688	0.00		4,461.17	17,577.92		-13,116.75
	LMCK589		A100226			109.77	13,184.72		-13,074.95
	LDT4225		A100406	166.98		1,992.82	13,579.40	1,466.40	-13,052.98
	LKF3728		A2588	348.41		14,908.27	27,944.89		-13,036.62
	LRN3534		A101441	7.17		5,374.18	18,182.01	25.00	-12,832.83
	LNL4850		A101180	0.00		1,439.45	14,210.81		-12,771.36
	LAW3606		A100382	4.69		1,064.48	13,656.22		-12,591.74
	LRS4937		A100815			5,484.38	17,975.64		-12,491.26
	LPW2579		A100851	0.00		360.00	12,780.03		-12,420.03
	LLM4607		A100747	136.37		2,264.22	14,679.33		-12,415.11
	LMG4580		A101176	6.00		425.61	12,754.15		-12,328.54
	LCC5594		A3425			712.78	13,011.85		-12,299.07
	LFM6088		A3941	2.00		395.67	12,445.20		-12,049.53
	LAL2285		A1870	0.00		15,489.60	27,406.00		-11,916.40
	LSP5913		A3655			365.85	12,240.17		-11,874.32
	LWK5164		A2951			5,785.59	17,599.81	25.00	-11,839.22
	LCB5874		A3692	0.00		322.69	11,906.82		-11,584.13
	LPWC918		A1693			126.79	11,505.59		-11,378.80
	LMT3677		A2468	0.00		672.13	11,952.87		-11,280.74
	LSJ3863		A2663	0.00		247.52	11,450.19		-11,202.67
	LRC3061		A101486			1,842.11	13,015.46		-11,173.35

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LKF5823	REDACTED	A3785			873.19	11,972.40		-11,099.21
	LCD6275		A4136	157.40		534.04	11,469.84		-10,935.80
	LPW3700		A2493	0.00		22,750.31	33,449.78		-10,699.47
	LBB3085		A100134			101.98	10,786.05		-10,684.07
	LHT6210		A4065			322.08	10,992.10		-10,670.02
	LTS6182		A4046			1,706.12	12,324.66		-10,618.54
	LBJ2595		A100002	384.30		3,653.37	14,179.66		-10,526.29
	LTLC815		A1632			2,803.49	13,288.43	25.00	-10,509.94
	LKE7429		A2902	6.00		3,038.38	13,433.81		-10,395.43
	LBT5989		A3843	472.50		1,523.61	11,801.76		-10,278.15
	LWE4849		A2871	0.00		18,008.98	28,271.90		-10,262.92
	LKK5429		A3258			2,703.34	12,914.43	25.00	-10,236.09
	LHB5724		A3571	0.00		2,089.40	12,279.42		-10,190.02
	LDC6108		A3965	0.00		3,926.69	14,037.10		-10,110.41
	LAF5304		A3129			-926.82	9,036.93		-9,963.75
	LTG3911		A100924	3.00		1,442.93	11,403.79		-9,960.86
	LGL5917		A3632	61.98		330.71	10,273.97		-9,943.26
	LLH2358		A1908	10.74		7,386.91	17,326.06		-9,939.15
	LARC800		A100128	0.00		1,677.83	11,496.39	25.00	-9,843.56
	LWF4948		A2885	0.00		2,444.21	12,217.42	50.00	-9,823.21
	LKC3270		A2375	1.00		3,578.22	13,377.57		-9,799.35
	LFL2778		A100531	0.00		3,271.10	12,847.99	25.00	-9,601.89
	LTT5413		A3257	209.51		4,442.34	14,027.99		-9,585.65
	LWF4963		A100322	0.00		5,077.86	14,513.06	50.00	-9,485.20
	LKC3283		A4161			43.98	9,460.35		-9,416.37
	LAS3923		A2669	5,412.28		12,203.97	21,588.52		-9,384.55
	LCE3896		A100822	199.43		4,711.84	14,042.13	25.00	-9,355.29
	LPP5771		A3669	35.31		2,217.51	11,546.28		-9,328.77
	LMCV967		A100154	402.02		1,594.31	10,917.51		-9,323.20
	LPC3394		A101141	517.95		2,442.40	11,750.32		-9,307.92
	LNG5108		A100929	0.00		69.04	9,296.26		-9,227.22
	LRS3849		A101284			2,298.67	11,514.83		-9,216.16
	LISL233		A100049	0.00		1,330.86	10,486.26		-9,155.40
	LSL4437		A101530			706.37	9,805.91		-9,099.54
	LPC3888		A100046	0.00		1,432.77	10,457.47		-9,024.70
	LBR6101		A3964			271.44	9,220.23		-8,948.79
	LFP5139		A2927	0.00		131.08	9,022.25		-8,891.17
	LTD5959		A3814	0.00		2,898.66	11,741.04	25.00	-8,867.38
	LBE2244		A6017	0.00		163.68	9,025.69		-8,862.01
	LHE3904		A100057			183.87	8,973.98		-8,790.11
	LHM4377		A100968	7.00		542.06	9,250.08	25.00	-8,733.02
	LAC5040		A100244			9,725.06	18,405.79	25.00	-8,705.73
	LMR4243		A100138	0.00		2,278.36	10,972.12		-8,693.76
	LBV5269		A3078	0.00		2,501.83	11,124.05		-8,622.22
	LDS6065		A3922	0.00		116.71	8,734.70		-8,617.99
	LCT4556		A2830	34.00		6,995.81	15,467.92		-8,472.11
	LTO5502		A3344	2,300.52		6,750.47	15,150.02		-8,399.55
	LHF2788		A2134	0.00		3,679.20	11,945.11		-8,265.91
	LHP3860		A2979			753.28	9,003.83		-8,250.55
	LWK4570		A100325	0.00		16,286.44	24,486.82	25.00	-8,225.38
	LEC3854		A101253	59.55		15,647.46	23,702.62	25.00	-8,080.16
	LQE6272		A4129	37.53		1,003.15	9,069.91		-8,066.76

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LSF5305	REDACTED	A3126			1,211.75	9,175.57	25.00	-7,988.82
	LBF5069		A101347			1,130.83	8,964.60		-7,833.77
	LRZ4414		A101416	1.00		880.70	8,618.26		-7,737.56
	LCT6050		A3906			81.84	7,731.93		-7,650.09
	LHF5141		A2994			281.47	7,915.81		-7,634.34
	LLT3798		A100283	197.28		2,389.17	10,023.05		-7,633.88
	LAF6247		A4111	0.00		437.95	7,939.35	25.00	-7,526.40
	LCJ4812		A100708			966.20	8,424.82	50.00	-7,508.62
	LCA2514		A100796	11.00		689.92	8,162.66		-7,472.74
	LGC3258		A2371	0.00		6,338.16	13,654.53		-7,316.37
	LCR3189		A100575	0.00		5,121.54	12,426.14		-7,304.60
	LRW5505		A3364	2,459.50		5,723.44	13,016.30		-7,292.86
	LAT2925		A2200	480.64		1,851.24	9,062.38		-7,211.14
	LHS2302		A101242	1.00		1,463.82	8,674.62		-7,210.80
	LMC6226		A4084	0.00		177.99	7,311.34		-7,133.35
	LFT1090		A100519	324.19		1,935.89	9,041.78		-7,105.89
	LHM5871		A3740	218.22		612.24	7,705.32		-7,093.08
	LMA4984		A100315			354.22	7,430.36		-7,076.14
	LSC5397		A3245			113.26	7,187.83		-7,074.57
	LSM4970		A2899	0.00		1,231.81	8,270.59		-7,038.78
	LTS5966		A3782			513.06	7,526.48		-7,013.42
	LTN4770		A100927	1.00		7,685.59	14,622.51	25.00	-6,961.92
	LST2619		A2984	5.00		544.92	7,420.49		-6,875.57
	LEID468		A101255	0.00		106.63	6,741.59		-6,634.96
	LHC3347		A2436			726.28	7,347.63		-6,621.35
	LAW5035		A100117	0.00		1,719.21	8,312.65		-6,593.44
	LAC3539		A101645		3,020.14	2,572.44	9,143.66		-6,571.22
	LCM3507		A101287			4,476.46	11,010.30	25.00	-6,558.84
	LDT5423		A3276	0.00		370.44	6,924.66		-6,554.22
	LCH2270		A100187			2,096.91	8,640.19		-6,543.28
	LSH3168		A100881	0.00		8,134.76	14,669.49		-6,534.73
	LSU2360		A101536	72.03		1,896.20	8,394.75		-6,498.55
	LTE5868		A3629	199.24		2,995.13	9,485.35		-6,490.22
	LJW6218		A4075	16.37		1,154.69	7,591.86		-6,437.17
	LHC5622		A3459	0.00		1,207.83	7,545.15		-6,337.32
	LGD5655		A3490	207.71	2,640.48	12,259.56	18,557.00		-6,297.44
	LCF6235		A4091	0.00		5,425.32	11,707.93		-6,282.61
	LMBC592		A100149	0.00		2,520.45	8,777.83	25.00	-6,282.38
	LCS4644		A100108	0.00		1,462.93	7,717.60		-6,254.67
	LHH5366		A3195	6.00		3,019.47	9,266.66		-6,247.19
	LFF5984		A3773			2,564.44	8,764.64	25.00	-6,225.20
	LFW5772		A3648	0.00		1,240.86	7,446.75		-6,205.89
	LSN6048		A3901		1,767.28	3,121.13	9,313.55		-6,192.42
	LBM4737		A100606	0.00		672.72	6,793.70		-6,120.98
	LGC4539		A2820	0.00		5,957.77	12,032.70		-6,074.93
	LRCM469		A101273			292.63	6,346.70		-6,054.07
	LLN2166		A1802			6,001.35	-624.97	12,558.60	-5,932.28
	LCS6338		A4267	0.00		9,513.09	15,380.97		-5,867.88
	LSP5546		A3390	1.00		366.39	6,212.33		-5,845.94
	LMA3281		A100750	115.40		1,639.72	7,445.16		-5,805.44
	LMP6047		A3907	0.00		42.91	5,821.76		-5,778.85
	LRCK936		A101397	545.94		7,623.82	13,302.36		-5,678.54

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LEC6291	REDACTED	A4154	2.00		626.48	6,294.27		-5,667.79
	LRD3641		A101493	11.11		350.28	6,005.09		-5,654.81
	LUS2905		A100022	715.00		1,221.30	6,843.46	25.00	-5,647.16
	LWA4985		A100456	2.00		1,999.93	7,616.11		-5,616.18
	LSR5483		A3331			510.59	6,118.56		-5,607.97
	LPC4130		A100571	329.64		1,199.70	6,800.76		-5,601.06
	LUW4524		A101552			1,252.64	6,823.51		-5,570.87
	LNM4072		A101114	1.00		1,094.36	6,655.90		-5,561.54
	LCLJ814		A1629	0.00		262.55	5,781.66		-5,519.11
	LMS5475		A3310	724.01		1,285.15	6,780.29		-5,495.14
	LCM5484		A3318	2,923.70		14,597.30	20,070.88		-5,473.58
	LCC3918		A2670			-16.00	5,448.44		-5,464.44
	LMM4930		A100463	0.00		3,975.22	9,382.24	25.00	-5,432.02
	LKA5866		A3643	3.00		1,988.33	7,242.81		-5,254.48
	LTH6124		A3987	0.00		3,263.92	8,487.32		-5,223.40
	LNB4651		A100736	0.00		2,070.51	7,261.92	25.00	-5,216.41
	LSF4935		A100897	8.55		785.29	6,000.94		-5,215.65
	LSC3188		A2348	0.00		24,121.43	29,335.22		-5,213.79
	LTD6362		A4254	1.00		553.77	5,728.94		-5,175.17
	LHH3859		A100159			135.14	5,291.47		-5,156.33
	LHE5231		A3046	8.45		2,820.08	7,930.32		-5,110.24
	LGC4331		A101222			68.16	5,177.56		-5,109.40
	LGL5258		A3074	1.00		1,938.46	6,938.66		-5,000.20
	LEC2223		A100070			1,360.36	6,352.35		-4,991.99
	LUN6189		A4054	44.85		1,422.54	6,382.74		-4,960.20
	LCB5677		A3520			776.88	5,698.26		-4,921.38
	LDP5196		A3095	0.00		1,419.49	6,332.96		-4,913.47
	LDS4909		A100699	626.41	2,866.81	5,281.43	10,080.30		-4,798.87
	LDJ4604		A100386			1,910.57	6,704.33		-4,793.76
	LCJ5409		A3232	0.00		2,513.47	7,246.85		-4,733.38
	LFS6253		A4120	0.00		1,060.97	5,749.42		-4,688.45
	LHP2991		A101425			515.14	5,196.39		-4,681.25
	LHC5610		A3493	0.00		3,431.66	8,004.52		-4,572.86
	LWC4848		A2882	0.00		149.27	4,711.60		-4,562.33
	LFC4756		A101619			138.96	4,700.89		-4,561.93
	LSS5214		A3105	662.36		6,796.90	11,342.83		-4,545.93
	LFC6176		A4037	0.00		105.91	4,577.79		-4,471.88
	LWA5881		A3849			2,308.76	6,727.96		-4,419.20
	LHS5407		A3235	0.00		5,529.59	9,867.55		-4,337.96
	LCR6502		A4368	0.00		305.15	4,622.53		-4,317.38
	LTM5055		A101045	199.00		542.11	4,836.28		-4,294.17
	LLA5318		A3141	1.00		1,909.37	6,177.37	25.00	-4,293.00
	LMM2190		A1825			677.00	4,900.62		-4,223.62
	LHJ4534		A101240	1,821.60		4,146.32	8,339.68		-4,193.36
	LVQ094		A1102	4,558.85		22,110.83	26,255.99		-4,145.16
	LPF4744		A100766	1,272.71		4,004.04	8,124.84		-4,120.80
	LDC3817		A100299	22.39		361.04	4,480.17		-4,119.13
	LCC3041		A2266	0.00		18,651.93	22,752.52		-4,100.59
	LAM2299		A100545	10.47		545.89	4,594.38		-4,048.49
	LPF6083		A3935	0.00	0.00	242.28	4,278.51		-4,036.23
	LLF5181		A2975	0.00		275.87	4,293.64		-4,017.77
	LHT5092		A101627	0.00		2,466.42	6,470.03		-4,003.61

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LAH5647	REDACTED	A3480	890.49		1,594.20	5,568.89		-3,974.69
	LGL4441		A101218			1,013.29	4,924.07		-3,910.78
	LBT5518		A3359	1.00		1,630.77	5,503.01		-3,872.24
	LBR3877		A100622	1.00		541.38	4,409.84		-3,868.46
	LAM5253		A3071	0.00		912.75	4,739.75		-3,827.00
	LEL6076		A3916	55.60		360.79	4,170.77		-3,809.98
	LBS4470		A101615	1.00		1,790.98	5,594.25		-3,803.27
	LTR3110		A101115	706.58		2,211.55	5,996.69		-3,785.14
	LDP2217		A1835			623.45	4,403.70		-3,780.25
	LWH6201		A4058	1.00		1,005.96	4,781.85		-3,775.89
	LPK4056		A100947	0.00		4,573.47	8,324.26		-3,750.79
	LCC4707		A101263	5.00		338.18	4,061.05	25.00	-3,747.87
	LDF5510		A3347	1.00		371.03	4,114.79		-3,743.76
	LHE3271		A100734			1,154.91	4,885.57		-3,730.66
	LBS5657		A3496	0.00		6,814.58	10,520.08		-3,705.50
	LLF6163		A4042	2.00		463.55	4,144.13		-3,680.58
	LWW6476		A4372	0.00		1,016.72	4,667.59	25.00	-3,675.87
	LHR5920		A3618	4.00		2,821.14	6,476.35		-3,655.21
	LCD3487		A100217			2,727.99	6,352.80		-3,624.81
	LSC5240		A3056			3,925.06	7,531.76		-3,606.70
	LRA3639		A101570	514.54		1,413.62	5,019.21		-3,605.59
	LSH2934		A100558	0.00		1,998.41	5,602.41		-3,604.00
	LKB2400		A1929			57.51	3,651.46		-3,593.95
	LBA4389		A100590			4,150.44	7,672.21	50.00	-3,571.77
	LSU5720		A3573	533.28		850.25	4,410.62		-3,560.37
	LRM2439		A100866			10.98	3,555.50		-3,544.52
	LNC3232		A2343	3.00		719.57	4,232.52		-3,512.95
	LUF6398		A4283	0.00		429.53	3,893.35		-3,463.82
	LCP4733		A100247			1,110.86	4,561.80		-3,450.94
	LJW4466		A100434	553.44	1,923.35	4,814.89	8,257.38		-3,442.49
	LCC4660		A101574			75.08	3,479.40		-3,404.32
	LRC4994		A101394	0.00		6,744.52	10,107.41		-3,362.89
	LFBF639		A100536	0.00		3,495.58	6,812.37		-3,316.79
	LSF6068		A3917			170.52	3,485.23		-3,314.71
	LBG3773		A100598	5.00		1,555.51	4,770.60		-3,215.09
	LST5681		A3533	2.57		591.77	3,799.14		-3,207.37
	LHC5202		A3118	5.00		2,551.65	5,727.85		-3,176.20
	LMP3111		A100228	11.00		4,354.89	7,516.82		-3,161.93
	LJN4852		A100403	0.45		4,513.47	7,649.47		-3,136.00
	LHC6005		A3799	0.00		1,363.53	4,469.92		-3,106.39
	LBH6222		A4103	6,844.26		8,583.64	11,650.99		-3,067.35
	LMV5417		A3244			1,199.84	4,226.77		-3,026.93
	LMH3675		A100261	104.00		4,642.90	7,658.22		-3,015.32
	LDT5903		A3624	23.04		2,431.27	5,439.00		-3,007.73
	LML3913		A100160			100.53	3,101.16		-3,000.63
	LCT2621		A2081	0.00		136.05	3,135.98		-2,999.93
	LGA4339		A101578	0.00		-1,709.59	1,270.93		-2,980.52
	LEA6089		A3942	0.00		243.79	3,217.43		-2,973.64
	LAC4949		A101060	2,097.30		18,357.05	21,322.46		-2,965.41
	LBC3884		A2647	413.69		1,643.52	4,558.46		-2,914.94
	LCS2643		A101250			1,415.77	4,249.93	25.00	-2,859.16
	LAP3047		A100375	0.00		15,726.93	18,584.52		-2,857.59

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LSA5869	REDACTED	A3736	129.00		14,325.46	17,149.62	25.00	-2,849.16
	LTC3421		A101675	1.00		253.12	3,067.67		-2,814.55
	LGH5382		A3221	6.12		900.55	3,712.50		-2,811.95
	LLF5923		A3662	0.00		466.64	3,180.24		-2,713.60
	LSL2264		A6031	0.00		232.30	2,941.49		-2,709.19
	LKR4351		A100912			128.52	2,792.74	25.00	-2,689.22
	LBP2986		A100619	1.00		4,268.39	6,953.00		-2,684.61
	LPR6106		A3966	1.00		1,562.39	4,201.95		-2,639.56
	LAC3970		A100219	65.05		1,692.24	4,315.84		-2,623.60
	LBM6234		A4093	1,780.28		92.29	2,711.40		-2,619.11
	LDM4900		A100345			952.58	3,541.65		-2,589.07
	LKE2688		A100918	8.31		5,198.73	7,650.03	111.00	-2,562.30
	LCC3162		A2339	6.86		2,230.93	4,757.93		-2,527.00
	LCJ5883		A3823			779.25	3,294.49		-2,515.24
	LED5017		A101357	64.32		2,033.37	4,491.70		-2,458.33
	LBM4735		A100253			2,568.52	5,024.02		-2,455.50
	LLK6194		A4053	1.00		1,584.21	3,981.12		-2,396.91
	LSTH520		A100044	0.00		1,258.84	3,655.03		-2,396.19
	LGSH702		A100644	0.00		381.92	2,755.23		-2,373.31
	LLB3331		A101252	0.00		23,767.64	26,046.95	75.00	-2,354.31
	LBT3784		A100628	0.00		1,010.63	3,347.21		-2,336.58
	LTR6356		A4242	0.00		1,193.13	3,522.37		-2,329.24
	LDM5036		A100969			340.55	2,652.02		-2,311.47
	LNT6035		A3886	562.16		310.84	2,586.24	25.00	-2,300.40
	LCC5314		A3138	0.00		954.46	3,252.14		-2,297.68
	LDS2520		A100503	0.00		22,194.67	24,354.28	25.00	-2,184.61
	LRM3566		A100873			1,473.27	3,644.84		-2,171.57
	LPB3194		A2333	38.52		6,479.76	8,613.59	25.00	-2,158.83
	LBC6440		A4324	6.00		691.84	2,831.07		-2,139.23
	LMR4811		A101628			502.93	2,615.86		-2,112.93
	LDP3927		A100083	0.00		1,405.87	3,506.20		-2,100.33
	LDC3646		A100258	152.99		1,157.27	3,208.02		-2,050.75
	LRA4522		A101230	0.00		695.42	2,734.56		-2,039.14
	LDM2318		A1893	39.18		124.93	2,135.97		-2,011.04
	LCR4614		A101618	0.00		153.60	2,157.00		-2,003.40
	LGL2137		A1804			-695.58	1,297.73		-1,993.31
	LRH2837		A100048	17.00		2,814.77	4,800.55		-1,985.78
	LDM2248		A6020			13.10	1,998.53		-1,985.43
	LQU6386		A4270			946.76	2,929.58		-1,982.82
	LES5136		A2608	137.02	1,277.72	1,692.32	3,671.29		-1,978.97
	LVAL334		A101556	156.70		1,464.56	3,375.33		-1,910.77
	LTB6268		A4133	0.00		1,148.21	3,049.00		-1,900.79
	LDC6158		A4019	2.00		2,322.82	4,216.14		-1,893.32
	LGR4869		A101359	236.98	3,237.62	4,640.02	6,497.61		-1,857.59
	LSC2416		A101185	0.00		13,587.50	15,408.47	25.00	-1,845.97
	LRF5971		A3760	0.00		931.19	2,731.13		-1,799.94
	LRR5739		A3637	0.00		355.17	2,140.66		-1,785.49
	LNH4922		A100737	0.00		1,918.06	3,696.69		-1,778.63
	LAK4547		A100450	583.79		2,017.46	3,760.86		-1,743.40
	LBS6121		A3985	0.00		1,193.15	2,923.36		-1,730.21
	LNB2309		A100741	0.00		3,390.37	5,080.06	25.00	-1,714.69
	LRM5973		A3792	383.58		1,864.06	3,569.53		-1,705.47

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LBM5307	REDACTED	A3135	2.00		4,303.74	6,003.00		-1,699.26
	LMR3127		A100465	6.00		684.69	2,363.16		-1,678.47
	LCC5733		A3713	214.34		1,366.71	3,022.26		-1,655.55
	LAS2221		A100041	939.00		5,005.63	6,645.86		-1,640.23
	LAR5914		A3617	8.64		1,236.75	2,859.11		-1,622.36
	LAF2916		A100026			5,499.12	7,096.87		-1,597.75
	LBM5892		A3732	137.50		841.64	2,432.72		-1,591.08
	LNH4658		A100691	302.69		2,851.40	4,441.80		-1,590.40
	LDS5904		A3622			1,888.15	3,473.80		-1,585.65
	LLF5703		A3548	1.00		440.76	1,994.22		-1,553.46
	LMS5384		A3215			122.02	1,663.24		-1,541.22
	LSD6483		A4385	825.73		163.10	1,684.92		-1,521.82
	LBM4704		A100608	0.00	0.00	1,332.01	2,842.79		-1,510.78
	LBH5743		A3555			80.64	1,567.77		-1,487.13
	LST6156		A4022	50.38		1,555.02	2,992.64		-1,437.62
	LBW3730		A100634	0.00		73.77	1,504.03		-1,430.26
	LST6402		A4287	56.58		907.62	2,331.42		-1,423.80
	LCC5349		A3191	119.07		1,194.37	2,611.76		-1,417.39
	LEC5805		A3603			452.83	1,863.25		-1,410.42
	LJD6110		A3972			544.29	1,945.37		-1,401.08
	LSPT353		A101190	4.85		2,651.71	4,021.00		-1,369.29
	LMM5150		A2949	1.00		4,499.00	5,835.51	25.00	-1,361.51
	LPR2689		A100859	0.00		75.35	1,423.71		-1,348.36
	LSF6523		A4429	0.00		269.90	1,617.30		-1,347.40
	LNR6450		A4357	16.94		633.77	1,977.06		-1,343.29
	LAE6053		A3909			294.99	1,634.18		-1,339.19
	LBE5895		A3804			866.03	2,173.48		-1,307.45
	LCS4773		A100719	0.00	1,788.70	4,890.18	6,120.57	50.00	-1,280.39
	LBB4649		A101165			1,152.86	2,425.35		-1,272.49
	LAC4910		A100220	332.16		1,106.02	2,375.01		-1,268.99
	LLS6324		A4202	791.61		3,434.31	4,685.68		-1,251.37
	LSM2249		A6021			64.59	1,304.08		-1,239.49
	LPC4118		A101139			583.87	1,810.00		-1,226.13
	LLA6128		A3980			240.29	1,452.37		-1,212.08
	LWD5849		A3615	4,561.17		21,434.95	22,630.29		-1,195.34
	LBS4749		A100616	3.00		295.81	1,456.06	25.00	-1,185.25
	LFP5638		A3466	2.00		786.88	1,971.86		-1,184.98
	LPD5399		A3252			1,139.72	2,291.60		-1,151.88
	LMM5342		A3176	0.00		968.29	2,115.00		-1,146.71
	LMF5884		A3794	1.00		1,164.05	2,298.98		-1,134.93
	LSF6147		A4013	323.76		955.29	2,070.91		-1,115.62
	LTS4298		A2768	0.00		4,839.73	5,954.96		-1,115.23
	LUP4924		A100937	1,313.73		4,203.67	5,314.05		-1,110.38
	LHM5598		A3437	96.52		909.99	2,001.00		-1,091.01
	LAA5885		A3747	235.61		1,118.82	2,206.88		-1,088.06
	LAP2239		A6012	0.00		866.33	1,923.34	25.00	-1,082.01
	LVE5861		A3730	0.00		1,340.80	2,396.69		-1,055.89
	LMM5605		A3445			612.50	1,661.13		-1,048.63
	LZC5176		A2956			308.67	1,347.08		-1,038.41
	LNS5079		A100658			113.81	1,150.14		-1,036.33
	LRM2870		A101419	1,896.00		16,257.93	17,282.63		-1,024.70
	LTT4813		A2883	0.00		355.69	1,357.14		-1,001.45

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LWS5699	REDACTED	A3540	0.00		375.72	1,369.52		-993.80
	LBC6328		A4210			589.20	1,575.99		-986.79
	LLP2259		A6035			444.46	1,429.60		-985.14
	LCT6154		A4015	295.09		839.91	1,808.09		-968.18
	PMH2224		A3891	181.40		5,897.69	6,858.73		-961.04
	LGC4775		A2868	136.94		13,200.33	14,134.70	25.00	-959.37
	LHF4861		A101577			947.30	1,899.60		-952.30
	LHR2908		A101226	25.52		389.38	1,338.12		-948.74
	LTS6353		A4230			3,198.98	4,121.69		-922.71
	LSE5901		A3661	0.00		7,504.14	8,398.21		-894.07
	LKE5182		A2992	0.00		515.30	1,405.52		-890.22
	LFT4830		A101622	25.00		22.58	903.12		-880.54
	LMH5090		A101006	37.59		374.11	1,238.50		-864.39
	LFT3472		A2648	0.00		68.11	925.90		-857.79
	LCM4739		A100148	42.20		1,724.60	2,575.91		-851.31
	LRL2285		A6058	0.00		389.48	1,235.99		-846.51
	LDF5987		A3853	0.00		514.07	1,342.51		-828.44
	LWA4868		A101614			1,254.48	2,057.01	25.00	-827.53
	LPE4296		A100788	2,187.60		3,896.76	4,680.26		-783.50
	LTM2630		A101323	1.00		1,729.53	2,482.71		-753.18
	LFW5200		A3119	0.00		4,131.49	4,860.54		-729.05
	LBA3887		A101160	0.00		2,576.96	3,272.21		-695.25
	LWC5764		A3641	0.00		6,010.16	6,693.81		-683.65
	LGF5815		A3778	0.00		291.32	971.41		-680.09
	LTC4205		A101022	128.55		878.94	1,558.17		-679.23
	LKE5603		A3442	342.88		2,267.43	2,935.00		-667.57
	LSA5838		A3706	2.00		950.99	1,613.84		-662.85
	LDC5469		A3308	54.82		470.97	1,124.96		-653.99
	LNA6465		A4351	102.27		329.07	973.70		-644.63
	LBH6433		A4309			357.72	1,000.00		-642.28
	LMP6518		A4422	91.59		573.45	1,202.42		-628.97
	LAC6477		A4377	0.00		463.41	1,090.65		-627.24
	LNL5424		A3256	3.00		1,484.03	2,102.68		-618.65
	LMH6461		A4344	244.26		1,143.55	1,760.86		-617.31
	LMH6195		A4057	673.18		9,130.65	9,743.61		-612.96
	LRD4847		A101422			419.83	1,020.89		-601.06
	LLC5587		A3414			2,004.36	2,600.00		-595.64
	LVT6204		A4061	0.00		1,157.81	1,750.00		-592.19
	LFCE774		A100529			2,789.45	3,349.20	25.00	-584.75
	LEA2238		A100006			251.49	821.15		-569.66
	LBM5797		A3774			1,242.80	1,800.54		-557.74
	LCN6452		A4347	0.00		286.43	831.47		-545.04
	LYL6342		A4215	279.04		964.31	1,504.00		-539.69
	LMG2273		A6045	0.00		66.30	604.70		-538.40
	LSS4668		A2858			294.30	825.66		-531.36
	LPH2180		A100017			344.53	862.65		-518.12
	LAP5709		A3539	178.49	2,416.82	6,820.68	7,323.23		-502.55
	LDW5994		A3854			187.64	686.88		-499.24
	LWG4748		A100546	0.00		2,158.15	2,655.38		-497.23
	LHM4854		A101015	198.86		1,371.43	1,850.55		-479.12
	LWE5418		A3273	7.04		437.02	908.66		-471.64
	LJE6044		A3900	0.00		9,542.80	9,995.42		-452.62

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHP4615	REDACTED	A100689	0.00		285.76	731.61		-445.85
	LGL6361		A4240	0.00		476.68	913.48		-436.80
	LAC6243		A4107	45.00		7,022.67	7,447.51		-424.84
	LAF6501		A4397	107.20		68.52	482.91		-414.39
	LTA6467		A4349	126.63		146.88	556.28		-409.40
	LMP6446		A4327	479.39		1,388.85	1,793.25		-404.40
	LHE2632		A101224	0.00		3,178.75	3,571.32		-392.57
	LLC6257		A4135	10.00		1,803.02	2,190.61		-387.59
	LRB5577		A3413	0.00		1,245.63	1,613.38		-367.75
	LMH5061		A100264			2,001.29	2,368.35		-367.06
	LJM4185		A100230			461.04	825.71		-364.67
	LFB3576		A101447	617.78	2,918.05	3,916.80	4,277.66		-360.86
	LET6170		A4052			5,646.74	5,979.94	25.00	-358.20
	LMM6399		A4281	0.00		406.66	756.60		-349.94
	LBC5133		A100251	0.00		304.10	624.42		-320.32
	LMS6408		A4292	3.00		304.60	617.55		-312.95
	LMM5024		A100485			1,292.47	1,584.24		-291.77
	LSG6002		A3800			99.74	382.34		-282.60
	LLM2234		A101414	1.00		319.59	597.55		-277.96
	LCH2342		A100832	0.00		3,621.86	3,890.66		-268.80
	LJH2421		A100280	1.00	2,310.03	3,299.86	3,567.49		-267.63
	LFRT594		A100518	6.00		2,113.13	2,370.16		-257.03
	LTS4818		A101050	0.00		1,509.30	1,755.28		-245.98
	LBF2296		A6068	504.39		1,513.16	1,748.14		-234.98
	LWR5632		A3469			470.27	698.89		-228.62
	LBC5602		A3439	5.00		1,384.35	1,583.61	25.00	-224.26
	LSS2959		A101563	6.00		1,549.80	1,772.97		-223.17
	LNE6152		A4007	3.00		124.53	342.92		-218.39
	LCW4204		A100794			2,157.09	2,374.17		-217.08
	LLC6384		A4269	8.37		1,604.27	1,773.12	25.00	-193.85
	LMT5041		A100142	15.26		1,199.22	1,389.87		-190.65
	LAT4024		A100477	3.24		5,118.50	5,301.60		-183.10
	LBH3595		A101334	16.98	2,801.66	3,831.76	4,013.29		-181.53
	LSA4980		A101473	76.57		9,147.62	9,276.90	50.00	-179.28
	LTH6132		A3995			1,160.22	1,338.17		-177.95
	LPT3763		A101634	0.00		254.04	431.73		-177.69
	LPA3897		A100045	0.75		252.09	404.42	25.00	-177.33
	LKN3990		A101566			157.76	331.46		-173.70
	LNN6337		A4268	62.67		794.83	967.21		-172.38
	LMA6350		A4228			521.94	675.23		-153.29
	LNV2726		A2109	0.00		264.54	417.42		-152.88
	LCF6159		A4021			696.53	842.64		-146.11
	LGE6094		A3958			298.82	435.89		-137.07
	LST2993		A100671	6.00		308.60	442.85		-134.25
	LBB5723		A3554	1.00		552.02	680.69		-128.67
	LTC6055		A3912			1,146.06	1,274.73		-128.67
	LAM2242		A6016	8.00		1,625.72	1,751.00		-125.28
	LHH5408		A3238	2.00		330.85	446.50		-115.65
	LDN4109		A100303	22.47		6,015.98	6,130.84		-114.86
	LAC5263		A3058	160.88		599.36	710.77		-111.41
	LMF5030		A101269			1,082.87	1,190.59		-107.72
	LMP4138		A100273	118.95		431.20	533.64		-102.44

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LGS5095	REDACTED	A101216			126.73	219.82		-93.09
	LMF5719		A3570	253.36		761.90	848.00		-86.10
	LAC6138		A3999	1.00		1,209.50	1,277.37		-67.87
	LKB4794		A100241			1,016.64	1,071.18		-54.54
	PMH2225		A3934			1,831.40	1,884.14		-52.74
	LNT6177		A4038	2.00		1,203.99	1,256.54		-52.55
	LWL5151		A2918			324.38	374.76		-50.38
	LTC6025		A3881	40.68		453.41	500.00		-46.59
	LCT6418		A4310	23.96		-16.00	5.00	25.00	-46.00
	LWLP944		A100756	2,573.37		3,809.39	3,853.54		-44.15
	LNH4014		A101112	0.00		5,393.38	5,401.89	25.00	-33.51
	LBC6366		A4250		979.58	1,821.76	1,852.84		-31.08
	LEF6073		A3918	103.00		355.19	384.19		-29.00
	LAB6405		A4290	67.35		3,076.35	3,097.54		-21.19
	LHC6001		A3832			-16.00			-16.00
	LMB4424		A100229	0.00	1,785.84	123.52	135.33		-11.81
	LPE6340		A4306	67.23		1,553.90	1,564.02		-10.12
	LDF6074		A3936			0.00	1.00		-1.00
	LAP4692		A100243			Account Closed			0.00
	LAA3207		A100378	0.00		Account Closed			0.00
	LAH3269		A2374			Account Closed			0.00
	LAC4229		A100342			Account Closed	12,909.60		0.00
	LAH3951		A100037			Account Closed			0.00
	LAS4574		A101326			0.00			0.00
	LAT4968		A101054			Account Closed	-118,956.15		0.00
	LAT4908		A101058			Account Closed			0.00
	LAK3392		A100112			Account Closed			0.00
	LAS4053		A2700			Account Closed			0.00
	LATN992		A100174			Account Closed			0.00
	LAR3451		A2438			Account Closed			0.00
	LPN2669		A2082	152.76		Account Closed	14,587.25		0.00
	LAM4962		A2888			Account Closed			0.00
	LAP2867		A100126			Account Closed			0.00
	LAM3346		A100223			Account Closed			0.00
	LAR3397		A100103			Account Closed			0.00
	LAN2829		A100075			Account Closed	-5.40		0.00
	LAD4862		A101637			Account Closed			0.00
	LAC2926		A2207			Account Closed			0.00
	LBS2362		A1906			Account Closed			0.00
	LBN3158		A2356			Account Closed			0.00
	LEG5088		A101163			Account Closed	5,952.82		0.00
	LBD4705		A100447			Account Closed			0.00
	LBM2384		A1920			Account Closed	8,437.58		0.00
	LBR4702		A100582			Account Closed			0.00
	LBB4151		A100592			Account Closed	-8.45		0.00
	LBO4375		A100557	0.00		Account Closed	6,297.49		0.00
	LBT5158		A2996			Account Closed			0.00
	LBB3157		A2326			Account Closed	250.00		0.00
	LBM1005		A1716			Account Closed	296.39		0.00
	LBE2884		A2183	0.00		Account Closed			0.00
	LBR2270		A6042			Account Closed			0.00
	LBAD968		A100586			Account Closed			0.00

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LCR1073	REDACTED	A1745	0.00		Account Closed	-965.70		0.00
	LCC3455		A101688			Account Closed			0.00
	LFSC731		A1581			Account Closed	0.00		0.00
	LCC2252		A6038			Account Closed			0.00
	LCC4442		A100613			Account Closed			0.00
	LCC4316		A2772			Account Closed	-397.04		0.00
	LCM3112		A2455			Account Closed			0.00
	LPL3823		A100185			Account Closed	-1.17		0.00
	LCL3352		A100107			Account Closed	-62.90		0.00
	LCG3651		A100216			Account Closed			0.00
	LCH4512		A100215			Account Closed			0.00
	LCV4907		A100147	0.00		Account Closed	292.48		0.00
	LCL2329		A100900			Account Closed		25.00	0.00
	LCM4516		A100716			Account Closed			0.00
	LCP3559		A2539			Account Closed			0.00
	LCA3692		A2605			Account Closed			0.00
	LCL3629		A100904			Account Closed			0.00
	LCBH385		A101336			Account Closed	36,350.52		0.00
	LCE4416		A101585			Account Closed			0.00
	LCP3010		A2278	0.00		Account Closed	-249.93		0.00
	LCH4822		A100394			Account Closed	0.00		0.00
	LCC5193		A3099			Account Closed	-13.20	323.23	0.00
	LCP3586		A101260			Account Closed	-468.38		0.00
	LCV2975		A101262			Account Closed	-300.99		0.00
	LCR2294		A6067			Account Closed			0.00
	LCC2263		A6032			Account Closed			0.00
	LCT4030		A100077			0.00			0.00
	LCS4911		A2880			Account Closed			0.00
	LCN4688		A2864			Account Closed			0.00
	LCF1106		A100793			Account Closed			0.00
	LCB2625		A100494			Account Closed			0.00
	LFRK343		A1337	3,858.46		Account Closed	43.00		0.00
	LCF1107		A1337			Account Closed			0.00
	LGRC708		A1592	0.00		Account Closed	72.50		0.00
	LCC3329		A100445			Account Closed			0.00
	LDF4149		A100306			Account Closed			0.00
	LDT2147		A100296			Account Closed	-2,366.17		0.00
	LDA3782		A2661			Account Closed			0.00
	LDA2493		A2001			Account Closed			0.00
	LDC4578		A100293			Account Closed			0.00
	LDL3903		A100072			Account Closed			0.00
	LDS3151		A2306			Account Closed	-241.36		0.00
	LDG4746		A101341			Account Closed			0.00
	LEY3456		A2433	0.00		Account Closed			0.00
	LEC2512		A101353			Account Closed			0.00
	LES4218		A2752			Account Closed			0.00
	LEW2436		A101355			Account Closed	-183.93		0.00
	LEP4304		A2766			Account Closed	-77.88		0.00
	LEC5446		A3281			Account Closed			0.00
	LEH3120		A101313			Account Closed			0.00
	LEA2518		A101097			Account Closed			0.00
	LER2705		A3171			Account Closed	-392.30		0.00

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LEP3576	REDACTED	A101301			Account Closed	-2.96		0.00
	LFB4789		A101586			Account Closed			0.00
	LFF4361		A101589			Account Closed			0.00
	LFD2244		A100528			Account Closed	63.75		0.00
	LFL2256		A1855			Account Closed			0.00
	LFC3262		A2359			Account Closed	-16.27		0.00
	LFB4732		A100515			Account Closed			0.00
	LFS3462		A2498			Account Closed	-75.54		0.00
	LFE3028		A2247			Account Closed	70.12		0.00
	LFE5167		A2955			Account Closed			0.00
	LFHC738		A2941			Account Closed		148.50	0.00
	LFB2293		A1876			Account Closed			0.00
	LFW4400		A100532			Account Closed			0.00
	LFS2253		A1867			Account Closed			0.00
	LFH3795		A2652			Account Closed			0.00
	LGA3218		A101455			Account Closed			0.00
	LGLC558		A1484			Account Closed			0.00
	LGH3819		A101106			Account Closed			0.00
	LGB4447		A101215			Account Closed			0.00
	LGH2741		A2985			Account Closed			0.00
	LGE5117		A101217			Account Closed			0.00
	LGC2856		A2173			Account Closed			0.00
	LGB4842		A2872			Account Closed			0.00
	LGM4809		A101223			Account Closed			0.00
	LGP3500		A100639			Account Closed			0.00
	LGE3676		A101360			Account Closed	5,529.14		0.00
	LGP4143		A2738			Account Closed			0.00
	LGB3236		A101580			Account Closed			0.00
	LHMC376		A1355			Account Closed	-8,333.34		0.00
	LHAR559		A1485			Account Closed	-23.93		0.00
	LHB4599		A2835			Account Closed			0.00
	LHS2661		A2093	0.00		Account Closed	15,547.38		0.00
	LHF4712		A100977			Account Closed	-196.70		0.00
	LHM2265		A6030			Account Closed			0.00
	LHH3638		A101638			Account Closed	-361.43		0.00
	LHC2494		A101429			Account Closed			0.00
	LHA2855		A2165			Account Closed			0.00
	LHR3264		A2427			Account Closed			0.00
	ALGE367		A2560			Account Closed			0.00
	ALLR314		A2327			Account Closed			0.00
	ALKC320		A2380			Account Closed	-71.48		0.00
	ALTT360		A2906			Account Closed			0.00
	LHM4559		A101063			Account Closed			0.00
	LHA3479		A2496			Account Closed	-37.09		0.00
	LHL2549		A101017			Account Closed			0.00
	LLR3146		A2334			Account Closed			0.00
	LHC3493		A101111			Account Closed	-3.18		0.00
	LNM3477		A2587			Account Closed	-5,242.62		0.00
	LNM4955		A101118			Account Closed			0.00
	LNT3459		A2458			Account Closed	431.81		0.00
	LFC2307		A1877			Account Closed			0.00
	LAV4915		A101364			Account Closed			0.00

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LSF3476	REDACTED	A2528			Account Closed			0.00
	LJP4943		A100986			Account Closed			0.00
	LJB4048		A2699			Account Closed	-147.68		0.00
	LCW5138		A2921			Account Closed			0.00
	LJT4734		A100987			Account Closed			0.00
	LJPE804		A1628			Account Closed			0.00
	LAZ5044		A100431	0.00		Unavailable in Online Banking			0.00
	LJT4609		A2841			Account Closed		24.00	0.00
	LJK3619		A4163			Account Closed			0.00
	LJV3670		A101642			Account Closed			0.00
	LJIM560		A1486			Account Closed			0.00
	LJM4678		A100338			Account Closed			0.00
	LKM5880		A3633	0.00		Account Closed			0.00
	LKV2656		A2024			Account Closed	6,823.23	-1.00	0.00
	LKL4825		A100908			Account Closed			0.00
	LKF2278		A6051			Account Closed			0.00
	LKH4965		A100916			Account Closed			0.00
	LKR3344		A2557			Account Closed	220.50		0.00
	LKC3201		A2392	0.00		Account Closed	42.72		0.00
	LKN4988		A100922			Account Closed			0.00
	LKC4650		A101459			Account Closed			0.00
	LKRI696		A1551			Account Closed		44.10	0.00
	LMK3687		A101477			Account Closed			0.00
	LLC2286		A1869			Account Closed	-188.00		0.00
	LLE4824		A101505			Account Closed	-138.15		0.00
	LAN2547		A2065			Account Closed			0.00
	LLG5547		A3389			Account Closed			0.00
	LLDF324		A101251			Account Closed			0.00
	LRL4021		A2706			0.00			0.00
	LLBB819		A3173			Account Closed	-59.60		0.00
	LCNH659		A1536			Account Closed			0.00
	LNN3848		A101128			Account Closed	-72.15		0.00
	LWC3259		A2373			Account Closed			0.00
	LLU4817		A101134			Account Closed			0.00
	LME2546		A100151			Account Closed	-250.69		0.00
	LMH4528		A2823			Account Closed			0.00
	LMD4874		A101610			Account Closed	-1,622.54		0.00
	LMM4169		A2741			Account Closed	-425.80		0.00
	LML4950		A2887			Account Closed	-18.42		0.00
	LMH2958		A100371			Account Closed			0.00
	LME1037		A1761			Account Closed		-204.65	0.00
	LMP4713		A2852			Account Closed	-374.73		0.00
	LMP3469		A2508			Account Closed	-727.70		0.00
	LMW3665		A2464			Account Closed	-613.36		0.00
	LMR5010		A101592			Account Closed	-640.57		0.00
	LMA2696		A100209			Account Closed			0.00
	LMH4521		A100464			Account Closed			0.00
	LMV1033		A1730			Account Closed			0.00
	LMR2457		A100242			Account Closed	1,008.03		0.00
	LMS5658		A3487			Account Closed	975.00		0.00
	LMB5070		A100468			Account Closed			0.00
	LMP4555		A2828			Account Closed			0.00

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LMR5100	REDACTED	A2908			Account Closed			0.00
	LMF5340		A3179			Account Closed			0.00
	LME4893		A100839			Account Closed			0.00
	LNA4638		A2842			Account Closed			0.00
	LNJ3371		A2411			Account Closed	26.65		0.00
	LNH2613		A2073			Account Closed	-565.99		0.00
	LNCG991		A1709	0.00		Account Closed			0.00
	LNA2912		A100739			Account Closed			0.00
	LNK4108		A100953			Account Closed			0.00
	LNL3360		A101020			Account Closed			0.00
	LNP3377		A100692			Account Closed			0.00
	LFC3390		A2416			Account Closed			0.00
	LOCC844		A1651			Account Closed			0.00
	LLM5096		A100749			Account Closed			0.00
	LORV630		A100754	0.00		Account Closed			0.00
	LTS4493		A2817			Account Closed			0.00
	LFP3821		A100062			Account Closed	-22,027.98		0.00
	LPH2684		A100763			Account Closed			0.00
	LPC4563		A100765			Account Closed			0.00
	LPJ2414		A1936			Account Closed	-48.33		0.00
	LPC3746		A100790			Account Closed	-153.66		0.00
	LPL3090		A100604			Account Closed			0.00
	LPM3870		A100569			Account Closed			0.00
	LPD3869		A2658			Account Closed	-572.19		0.00
	LPC3600		A2453			Account Closed			0.00
	LPP5172		A3002			Account Closed	-219.82		0.00
	LPP3356		A101184			Account Closed	-1,289.02		0.00
	LPT4530		A2826			Account Closed			0.00
	LPC3528		A2512			Account Closed			0.00
	LPS5380		A3217			Account Closed			0.00
	LPC5975		A3828			Account Closed			0.00
	LEM3694		A100857			Account Closed	325.00		0.00
	LPL2672		A2090			Account Closed	-1,521.53		0.00
	LPF3234		A2349			Account Closed			0.00
	LPM3483		A100860			Account Closed	0.00		0.00
	LPT3150		A2325			Account Closed			0.00
	LPH2639		A2013	0.00		Account Closed	2,944.85		0.00
	LPW2603		A101597			Account Closed	-100.00		0.00
	LRC3066		A101568			Account Closed			0.00
	LRM5591		A3430			Account Closed			0.00
	LRM3136		A2319			Account Closed			0.00
	LAR2220		A1843			Account Closed	-576.81		0.00
	LRJ2864		A101417	0.00		Unavailable in Online Banki	3,742.86	50.00	0.00
	LRL3089		A101445			Account Closed	-69.61		0.00
	LRK3145		A2330			Account Closed			0.00
	LRP3130		A2308			Account Closed			0.00
	LRY2219		A1838			Account Closed			0.00
	LRM3733		A2478			Account Closed	-1,469.00		0.00
	LRX3837		A100669			Account Closed			0.00
	LSC4513		A100677			Account Closed			0.00
	LSH5506		A3346			Account Closed			0.00
	LSG1022		A100684			Account Closed			0.00

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LSC1054	REDACTED	A1760			Account Closed			0.00
	LSL3486		A100883			Account Closed			0.00
	LSE3555		A2531			Account Closed	-95.73		0.00
	LSC3426		A2483			Account Closed			0.00
	LST4870		A2877			Account Closed			0.00
	LSG4329		A2775			Account Closed	386.25		0.00
	LMC4925		A2890			Account Closed			0.00
	LSP3243		A100994			Account Closed	1,115.02		0.00
	LSE4936		A101407			Account Closed			0.00
	LCC2116		A1792			Account Closed			0.00
	LSE1039		A100998			Account Closed			0.00
	LSM2589		A2002	0.00		Account Closed	9,099.47		0.00
	LSMC924		A100957			Account Closed		-146.02	0.00
	LSF2135		A100958			Account Closed			0.00
	LHS5170		A2973			Account Closed	0.00		0.00
	LSC2970		A2217			Account Closed			0.00
	LSF3796		A101532			Account Closed			0.00
	LSV3530		A101535			Account Closed	0.00	638.46	0.00
	LSP3274		A2404			Account Closed			0.00
	LSS3741		A101189			Account Closed	-25.50		0.00
	LTA1093		A1753			Account Closed			0.00
	LTH2634		A2048			Account Closed			0.00
	LTC2311		A101151			Account Closed			0.00
	LTL2266		A6040			Account Closed			0.00
	LTL2275		A6047	0.00		Account Closed		-25.00	0.00
	LTL2268		A6039			Account Closed			0.00
	LGTC767		A101082			Account Closed			0.00
	LTC3148		A2316			Account Closed			0.00
	LTG4533		A101024			Account Closed			0.00
	LTJ3461		A2591			Account Closed	-7.45		0.00
	LSG1103		A1759			Account Closed			0.00
	LTK4312		A2774			Account Closed			0.00
	LTE3365		A101048			Account Closed			0.00
	LTC3478		A101049			Account Closed	-1,815.00		0.00
	LTC2853		A2170			Account Closed			0.00
	LTP2731		A100963			Account Closed			0.00
	LTG3850		A101003			Account Closed	-3,858.40		0.00
	LTNC933		A1694			Account Closed			0.00
	LFS3433		A2641			Account Closed	-19.12		0.00
	LVN2983		A2226			Account Closed			0.00
	LVC4761		A100945			Account Closed			0.00
	LVS5169		A2937			Account Closed			0.00
	LWC3569		A100260			Account Closed	11,167.64		0.00
	LWR4388		A2783			Account Closed			0.00
	LWP3407		A2429			Account Closed			0.00
	LWTS629		A100252			Account Closed			0.00
	LWM3064		A2293			Account Closed			0.00
	LWR4101		A2728	0.00		Account Closed	0.00		0.00
	LYS2529		A2068			Account Closed	30.56		0.00
	LZF2471		A1973			Account Closed			0.00
	LGM2501		A1975	0.00		-6.00	-6.98	-1.80	2.78
	LBT6039		A3896			26.80	23.06		3.74

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LSP4683	REDACTED	A101495	17.00		861.11	849.77		11.34
	PMH2222		A3865	2,224.89		26.80	10.00		16.80
	LMF6052		A3910			158.23	137.13		21.10
	LST2199		A101409			272.72	250.00		22.72
	LAW3853		A2639			893.97	867.59		26.38
	LHE6349		A4234	394.13		772.14	740.76		31.38
	LMH3001		A100459	0.00		2,716.71	2,685.15		31.56
	LHS2260		A100061	0.00		429.10	397.00		32.10
	ALTG349		A2614			35.00			35.00
	LBA4040		A100621			143.23	105.00		38.23
	ALTS393		A4048	0.00		39.00			39.00
	ALDC473		A2862			40.87			40.87
	ALSS244		A2712	645.59		44.00			44.00
	LGC2911		A2205			50.57	1.00		49.57
	LSC5089		A100514			100.50		50.00	50.50
	ALWD317		A2844	0.00		52.00			52.00
	LWC3447		A101680			56.83			56.83
	LTC4845		A100928			66.99			66.99
	LSL3594		A4159			466.23	347.34	50.00	68.89
	LCLC810		A1625	0.00		70.08	0.00		70.08
	PMH2228		A4229	1,532.16		71.33			71.33
	LFS5865		A3691			317.20	243.98		73.22
	LCCM733		A1584			74.33			74.33
	LMS5731		A3602			353.85	277.53		76.32
	LSG5613		A3461	199.68		80.81	2.00		78.81
	LHB4790		A100966			79.07			79.07
	LFC4322		A101662	1.00		80.53	1.00		79.53
	ALCC517		A3035	24.21		80.00			80.00
	LTB5806		A3604			80.63			80.63
	LMS6096		A3952			84.00	3.00		81.00
	LCT5803		A3593	27.20		113.63	-0.15	25.00	88.78
	LCE6078		A3943			90.87			90.87
	LBW2276		A6049	16.21		630.51	538.20		92.31
	ALNY280		A2762	0.00		94.00			94.00
	LBH6443		A4328			95.40			95.40
	LWF5979		A3858	0.00		102.47	7.00		95.47
	LME4951		A100451			95.66			95.66
	LTW2257		A100092			3,381.77	3,261.10	25.00	95.67
	LKA5760		A3650	0.00		852.91	756.47		96.44
	LDL6428		A4321			99.85			99.85
	LDW5982		A3871	131.50		100.98			100.98
	LJN4843		A100233	348.96		2,865.49	2,764.17		101.32
	LMN6042		A3899			101.78			101.78
	LEC6031		A3877			105.99	4.00		101.99
	LBL6061		A3919	1.00		1,284.45	1,179.55		104.90
	LJD5534		A3369			105.18			105.18
	LBK3481		A100550			92.71	-15.47		108.18
	LLD4642		A101506	0.00		102.04	-7.68		109.72
	LSH4722		A101700			110.67			110.67
	LWM5985		A3795	2.00		169.87	3.00	50.00	116.87
	LTL5827		A3685	0.00		0.00	-118.27		118.27
	LTW6020		A3890	293.35		76.23	-45.11		121.34

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LLF5286	REDACTED	A3092	1.00		702.02	579.72		122.30
	LVL4020		A100940	0.00		1,594.94	1,471.72		123.22
	LRL4114		A101492			187.92	63.79		124.13
	LPF5107		A100570			127.32			127.32
	LTC5218		A3106			129.24			129.24
	LGC6309		A4179	35.00		129.26			129.26
	LWC3803		A100706			131.44	2.00		129.44
	LAR6095		A3955			129.47			129.47
	LRA3906		A2665			131.69			131.69
	LBG5879		A3693	12.00		135.20	2.00		133.20
	LPC2756		A2118	410.50		166.06		25.00	141.06
	LWF5222		A3001	0.00		3,165.71	2,992.66	25.00	148.05
	LPM3023		A2242	0.00		150.91			150.91
	LMS6448		A4360	4.00		352.61	201.63		150.98
	LMG5804		A3594			157.23			157.23
	LCL6536		A4433	3.00		158.69			158.69
	LWD6265		A4121	628.74		117.57	-43.01		160.58
	LCW3308		A101649	42.13		161.06			161.06
	LGT5845		A3684	0.00	879.34	479.93	318.75		161.18
	LCP2583		A1984	1,007.83		161.48			161.48
	LCW6471		A4356			161.55			161.55
	LCB5653		A3482	0.00		340.81	178.04		162.77
	LGM6500		A4402	75.74		169.02	4.00		165.02
	LMB4475		A100341	0.00		166.40			166.40
	LPH1067		A1746			227.20	56.50		170.70
	LMM5870		A3640			171.82			171.82
	LBF5722		A3562	667.29		3,560.31	3,386.62		173.69
	LWF4730		A100400			114.26	-61.11		175.37
	LAM4755		A2900			1,655.69	1,479.25		176.44
	LRS2966		A2215			273.67	90.00		183.67
	LCE3752		A100490	1,543.63		13,950.23	13,738.01	25.00	187.22
	LPB5359		A3201	0.00		143.06	-45.26		188.32
	LAC6542		A4427	0.00		598.23	409.56		188.67
	LAA6150		A4017			530.65	316.84	25.00	188.81
	LFC4832		A100533			493.83	294.46		199.37
	LDC3703		A2604			206.60			206.60
	LHC3432		A101119	3.00		1,289.29	1,068.18		221.11
	LBR6311		A4193	6.00		319.70	97.41		222.29
	LCH6081		A3949	3.00		277.07	51.00		226.07
	LMM4979		A100370	0.00		230.69	1.00		229.69
	LSH6550		A4418			231.17			231.17
	LAP5236		A3034			834.90	597.20		237.70
	LWF6541		A4440			239.46			239.46
	LAA6080		A3940			1,272.34	1,004.22	25.00	243.12
	LHC4180		A101239			161.02	-85.66		246.68
	LNN6449		A4333	0.00		284.77	3.00	25.00	256.77
	LAK5832		A3822	3.00		654.11	396.42		257.69
	ALKC533		A3174	926.35		264.21			264.21
	LFB5578		A3416	184.59		1,189.08	923.31		265.77
	LCC5925		A3801	1.00		266.08			266.08
	LLC6239		A4095	16.94		468.60	201.00		267.60
	LRP6537		A4430			293.98		25.00	268.98

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHA5846	REDACTED	A3674			474.75	205.44		269.31
	LAC5192		A3157			324.04	46.54		277.50
	LLG5751		A3588			827.71	547.79		279.92
	LBR4694		A100626			676.38	395.94		280.44
	LBC4227		A100595			284.00			284.00
	LMC5745		A3597			293.06			293.06
	LAC3040		A2257	14.25		1,762.58	1,466.55		296.03
	LAS4577		A2834			654.75	349.80		304.95
	LAH4420		A100176			915.28	606.95		308.33
	LAF6318		A4197	9.00		310.18			310.18
	LCB5934		A3752			948.71	637.94		310.77
	LBN5800		A3703	2.00		1,466.64	1,148.59		318.05
	LBB6365		A4251	11.49		385.89	66.08		319.81
	LVT4801		A100942			923.56	597.00		326.56
	LPA5058		A100777			329.87			329.87
	LDS6508		A4400	1.00		775.25	445.05		330.20
	LRB6181		A4040			1,780.40	1,420.97	25.00	334.43
	LBN1056		A1766			508.77	167.00	5.00	336.77
	LCE5569		A3410	0.00		677.69	336.31		341.38
	LTK5183		A2967	1.00		344.23			344.23
	LDS4188		A100411	79.22		1,672.48	1,321.43		351.05
	LTP5672		A3510			353.11			353.11
	LAC5599		A3436			368.04			368.04
	LCC3747		A100399			375.45			375.45
	LFW3253		A2439			381.93			381.93
	LSS6529		A4413			382.64			382.64
	LTR4569		A101293	372.42		1,628.87	1,244.08		384.79
	LPV6213		A4063	655.62		1,393.83	1,005.00		388.83
	LNC6421		A4320			390.63			390.63
	LCC3184		A2358	81.32		861.11	469.51		391.60
	LSH6286		A4183	1.00		793.37	397.36		396.01
	LGE2353		A101174	0.00		619.34	219.91		399.43
	LAB5816		A3779	0.00		401.89			401.89
	LCS5747		A3581	3.00		867.25	465.20		402.05
	LMP5241		A3036	0.00		406.38			406.38
	LMC3410		A101692			1,993.55	1,586.51		407.04
	LSR5216		A3153			712.84	296.35		416.49
	LHE4507		A100733	403.75		953.54	529.86		423.68
	LCR5595		A3426	0.00		450.15	25.64		424.51
	LPP2246		A6019			453.23	23.28		429.95
	LHP6530		A4438			815.98	354.25	25.00	436.73
	LLE4264		A101066			1,825.14	1,386.87		438.27
	LPG3054		A100775			439.38	0.00		439.38
	LHH3225		A101237	169.92		574.21	134.00		440.21
	LWS2254		A6027	92.60		1,158.56	716.00		442.56
	LHS6470		A4374			36.72	-407.95		444.67
	LSM6441		A4332	0.00		704.30	251.00		453.30
	LLC6462		A4345			453.35			453.35
	LKM3291		A101458			927.24	440.53		486.71
	LCP6466		A4362			514.32	27.37		486.95
	LBS5439		A3266	81.78		2,015.69	1,488.89	25.00	501.80
	LEF5780		A3786	0.00		502.59			502.59

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LDC4073	REDACTED	A100353	125.00		1,361.98	858.89		503.09
	LKS5636		A3468	11.33		544.01	32.61		511.40
	LMF3545		A101691			741.73	222.33		519.40
	LPN4092		A100052	0.00		504.53	-15.93		520.46
	LFA6198		A4059			672.12	149.36		522.76
	LBLT954		A100574	0.00		531.24	4.00		527.24
	LHC5463		A3301	1.00		678.80	150.00		528.80
	LWF5165		A2948	20.25		532.19			532.19
	LCC6424		A4318	28.50		540.52			540.52
	LCD5628		A3463	1.00		542.40			542.40
	LCF5953		A3812	1.00		556.96			556.96
	LCC6125		A3982	141.45		796.51	232.46		564.05
	LZF4928		A100317	0.00		1,080.17	487.40	25.00	567.77
	LWF5643		A3478			570.65	0.00		570.65
	LCD5728		A3675	1.00		880.94	308.17		572.77
	LAC5746		A3682			574.78			574.78
	LBH6151		A4011			578.29			578.29
	LDJ5961		A3802			581.62			581.62
	LKF6051		A3905			107.33	-474.50		581.83
	LMC5952		A3833			585.40	1.00		584.40
	LAR6422		A4304			586.63	0.00		586.63
	LNT6165		A4030			645.90	54.66		591.24
	LMH5230		A3011	0.00		598.60	1.00		597.60
	LDH6030		A3876			601.75	2.00		599.75
	LEA6417		A4299			599.80			599.80
	LKW6322		A4203	1.00		601.33			601.33
	LAC4750		A100178			86.90	-522.66		609.56
	LUL4253		A100930			932.38	322.20		610.18
	LRF5726		A3575	102.60		613.16			613.16
	LUD2686		A101547			688.69		75.00	613.69
	LWF6056		A3923			617.07	0.00		617.07
	LRS6486		A4392			645.55	22.76		622.79
	LMA5741		A3739			623.25			623.25
	LCC4966		A100798			711.38	83.66		627.72
	LBL6011		A3852	0.00		634.21	6.00		628.21
	LPS5302		A3130	4.00		630.05			630.05
	LMH5765		A3584	379.38		1,239.95	609.63		630.32
	LPP6169		A4025	22.73		642.22	11.00		631.22
	LBD2258		A6022			632.42			632.42
	LEP6288		A4180	9.00		641.99	6.00		635.99
	LPN4463		A101145	5.00		3,380.15	2,744.12		636.03
	LAH5630		A3481	143.60		4,141.86	3,502.00		639.86
	LKN5749		A3634	1.00		870.08	228.36		641.72
	LTF5256		A3072	628.47		1,154.69	510.68		644.01
	LTL5496		A3323	0.00		3,982.99	3,337.45		645.54
	LHC6327		A4209			648.04			648.04
	LLD5219		A3004			648.06			648.06
	LTB3891		A101703			954.25	304.03		650.22
	LAG6516		A4399			655.75	2.00		653.75
	LHA5473		A3340	459.87		1,619.63	964.87		654.76
	LMS6410		A4295	4.64		655.56			655.56
	LAV5459		A3298			658.27			658.27

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTP6388	REDACTED	A4273	115.05		659.91			659.91
	LPT6279		A4148			660.19			660.19
	LMJ5434		A3269	63.88		660.53			660.53
	LGF6379		A4261			664.53			664.53
	LAR3672		A100125	0.00		1,724.03	1,059.21		664.82
	LKL6085		A3948	0.00		691.22	21.00		670.22
	LPA6454		A4352	116.73		1,067.52	390.90		676.62
	LLB5094		A101462			1,481.63	775.91	25.00	680.72
	LDL3964		A100084	4.00		692.23	2.00		690.23
	LTS3960		A100194			1,251.40	554.87		696.53
	LTB6499		A4415	160.83		699.00			699.00
	LWD5665		A3505			720.47	9.17		711.30
	LHG6453		A4387	5.00		714.94			714.94
	LCR6334		A4221			715.48			715.48
	LNH6302		A4184			715.88			715.88
	LCT4223		A100156	0.00		839.34	117.96		721.38
	LRS6255		A4118	63.07		726.01			726.01
	LPF4320		A100805	73.85		1,081.48	352.96		728.52
	LLS5738		A3642			733.18			733.18
	LSL6455		A4350			734.59	1.00		733.59
	LDG4631		A100344	2.00		736.39			736.39
	LHD5053		A101426	0.00		740.87			740.87
	LSH5931		A3820			743.90			743.90
	LPA6425		A4307	165.31		1,030.63	283.76		746.87
	LRP6515		A4412			1,712.74	939.22	25.00	748.52
	LWS5014		A100542	407.00		752.24			752.24
	LEG6185		A4031	139.59		757.43	3.00		754.43
	LRP5291		A3115			766.21	2.00		764.21
	LTS6448		A4336			765.62	1.00		764.62
	LPE3517		A4158			4,031.19	3,257.26		773.93
	LTM3865		A100200	1,470.54		746.17	-30.98		777.15
	LKR4931		A100267			779.12			779.12
	LAC4430		A100121			781.89			781.89
	LKG6175		A4033	16.94		1,335.48	527.70	25.00	782.78
	LRD5393		A3248	195.06		791.88	4.00		787.88
	LBS1089		A100635	9.00		2,833.40	2,041.70		791.70
	LKT5725		A3561	6.17		4,122.67	3,322.91		799.76
	LBW5684		A3524			784.08	-17.04		801.12
	LAB5798		A3583	494.72		804.92			804.92
	LFH6325		A4206			808.29			808.29
	LMR6300		A4165	158.55		789.64	-21.59		811.23
	LHD4226		A100688	0.00		813.72			813.72
	LHP4187		A101062	0.00		843.82	1.00	25.00	817.82
	LMA6292		A4156			818.55			818.55
	LAS3979		A100038	3.00		818.85			818.85
	LSS2233		A6006	1.00		830.67	10.00		820.67
	LMS5504		A3345	102.00		820.88			820.88
	LBV5894		A3620			820.15	-8.02		828.17
	LSC6336		A4223	85.83		839.97	7.00		832.97
	LSE6376		A4262	93.44		1,865.03	1,006.00	25.00	834.03
	LBB5516		A3351	0.00		840.07	3.00		837.07
	LSF5687		A3517			843.05	2.00		841.05

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LAB1008	REDACTED	A100829	0.00		12,720.79	11,877.09		843.70
	LRR6498		A4403	25.22		848.00	1.00		847.00
	LHC6261		A4124			1,746.26	897.00		849.26
	LKM5297		A3131			940.68	90.36		850.32
	LBC6387		A4277	1.00		853.62	3.00		850.62
	LXF5298		A3132	4.00		851.64	1.00		850.64
	LSF6308		A4189	147.00		862.38	11.00		851.38
	LSF4710		A101542	9.00		851.68			851.68
	LAA6413		A4301			853.90	1.00		852.90
	LHS6463		A4346			883.11		25.00	858.11
	LNV6306		A4191	2.00		859.99			859.99
	LWF5032		A100427			918.45	32.00	25.00	861.45
	LMO5444		A3280	32.24	5,120.51	864.91	2.35		862.56
	LHB5956		A3831			865.24			865.24
	LKF6229		A4099	0.00		877.13	5.00		872.13
	LGW2891		A101268	4.00		1,985.62	1,109.27		876.35
	LBA2878		A2188			883.34			883.34
	LRA5960		A3789	1.00		4,907.64	4,020.99		886.65
	LCF6514		A4394	46.54		894.12	2.00		892.12
	LTC5262		A3075	2.00		1,479.46	559.81	25.00	894.65
	LGL2291		A6063	7.00		895.62			895.62
	LTX6274		A4139			1,388.89	492.81		896.08
	LSM2274		A1872	0.00		2,223.43	1,327.29		896.14
	LWA6434		A4316	5.00		930.69	2.00	25.00	903.69
	LBA4003		A101512	1.00		1,734.57	828.95		905.62
	LKW4831		A100920	2.00		944.82	13.00	25.00	906.82
	LPF5126		A100779	0.00		860.58	-46.70		907.28
	LAS5348		A3183			910.29			910.29
	LHL6022		A3840			916.06			916.06
	PNX3339		A3908	28.99		921.83	5.00		916.83
	LLR6401		A4284			917.76			917.76
	LBF5576		A3427			919.93			919.93
	LEH5501		A3339	6.00		929.52	6.00		923.52
	LDS6472		A4407			924.84			924.84
	LCA5947		A3746			928.22			928.22
	LHC5775		A3680			934.57			934.57
	LUN6299		A4171	0.00		934.57			934.57
	LRF5700		A3518	0.00		968.64	33.97		934.67
	LRT5957		A3834			935.24			935.24
	LSH5604		A3438	57.00		935.54			935.54
	LFA3525		A100517	97.93		938.25			938.25
	LBB6075		A3914	292.76		1,057.70	114.01		943.69
	LPP5742		A3563	168.82		2,871.25	1,924.34		946.91
	LAG5686		A3521	90.00		955.83			955.83
	LHC6509		A4428	291.12		956.30			956.30
	LEA2742		A100005	9.00		2,410.96	1,455.58	-1.00	956.38
	LRP6203		A4062	760.13		2,701.21	1,744.35		956.86
	LFD6476		A4379			983.90	2.00	25.00	956.90
	LAC5859		A3694	113.17		957.40			957.40
	LGC6340		A4216	0.00		957.05	-2.03		959.08
	LND2297		A6070			959.68			959.68
	LCC4716		A101335	277.50		1,244.78	281.76		963.02

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LET4015	REDACTED	A101315			898.48	-91.67	25.00	965.15
	LFC4271		A101587			968.14			968.14
	LMA3284		A100270	22.25		985.93	11.00		974.93
	LDR3589		A4160			976.78	1.00		975.78
	LMF4255		A100348	10.00		980.66	3.00		977.66
	LSW6335		A4219	6.00		1,534.43	555.30		979.13
	LSC6116		A3973			981.99	1.00		980.99
	LDG3952		A100082	75.78		988.56	3.00		985.56
	LSC6244		A4114			991.78	0.00		991.78
	LPC5992		A3848			1,022.21	2.00	25.00	995.21
	LNF4087		A100841			1,002.13			1,002.13
	LFG5045		A100183			927.05	-75.42		1,002.47
	LTCP768		A101322	0.00		3,825.24	2,819.23		1,006.01
	LDC4793		A100412			1,302.47	291.95		1,010.52
	LMA6447		A4331			1,012.23			1,012.23
	LGA3759		A2915			1,691.44	672.40		1,019.04
	LBMT904		A1677	1,087.50		3,663.14	2,640.82		1,022.32
	LWF5833		A3741	491.28		1,648.09	623.85		1,024.24
	LRA6067		A3927			1,029.65			1,029.65
	LHE6186		A4047	123.00		1,041.57			1,041.57
	LLC5682		A3529	13.00		1,082.45	14.00	25.00	1,043.45
	LHS6330		A4213			1,048.38	1.00		1,047.38
	LAB4564		A100761	31.09		1,053.19			1,053.19
	LRR5740		A3574	3.00		1,056.84	2.00		1,054.84
	LSC6098		A3960	89.16		1,063.01	3.00		1,060.01
	LVE6442		A4329			1,062.35	0.00		1,062.35
	LAP5425		A3239	71.38		1,081.13	3.00		1,078.13
	LBC4612		A100366	58.25		1,078.73			1,078.73
	LAJ4047		A100171			1,084.26			1,084.26
	LNC3413		A101695			1,251.44	164.59		1,086.85
	LMC4421		A100460	0.00		7,158.56	6,018.44	50.00	1,090.12
	LWF6436		A4312			1,090.30			1,090.30
	LGC4728		A100640	1.00		1,958.97	867.80		1,091.17
	LECN497		A1454			1,093.58			1,093.58
	LSH5266		A3067			1,112.33	18.37		1,093.96
	LSGC228		A100050	0.00		1,094.99	0.00		1,094.99
	LRC5862		A3725	328.60		5,958.73	4,862.62		1,096.11
	LTC5937		A3712			1,096.73			1,096.73
	LRE6315		A4196			1,097.68	-2.90		1,100.58
	LTS5729		A3673			1,377.25	250.73	25.00	1,101.52
	LMC6492		A4384			1,787.33	677.11		1,110.22
	LCM6406		A4293	2.00		1,113.62			1,113.62
	LRS5609		A3449	0.00		1,119.32			1,119.32
	LSE4121		A101524			1,120.19			1,120.19
	LKF5102		A100340	25.50		1,121.21			1,121.21
	LCY6219		A4080	3.00		1,122.84	1.00		1,121.84
	LCC5661		A3500			1,023.16	-101.59		1,124.75
	LSA4977		A101400	118.29		1,550.01	420.83		1,129.18
	LSP4593		A101516			1,644.82	513.36		1,131.46
	LLR5887		A3838			1,134.15			1,134.15
	LFR5734		A3606			1,140.70	1.00		1,139.70
	ALMCV96		A1706	0.00		1,135.06	-10.12		1,145.18

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LGF5668	REDACTED	A3526	0.00	1,247.05	1,498.48	344.00		1,154.48
	LWF5955		A3813	124.00		1,162.53	1.00		1,161.53
	LMR6225		A4085			1,163.67			1,163.67
	PNX3346		A4265	142.84		1,168.05			1,168.05
	LBF5908		A3803	8.53		1,168.33			1,168.33
	LNS6187		A4041	1.00		1,169.62			1,169.62
	LWW5062		A100424		1,025.58	1,201.51	2.00	25.00	1,174.51
	LET5646		A3470	0.00		747.97	-431.57		1,179.54
	LRRC319		A1333			1,182.51			1,182.51
	LBC2257		A6023	371.03		1,935.85	750.00		1,185.85
	LMC6497		A4390	239.80		1,187.91			1,187.91
	LJM4045		A100302			1,271.79	79.25		1,192.54
	LKT2281		A6054			1,197.89			1,197.89
	LCE6220		A4087	214.39		1,206.99	3.00		1,203.99
	LHH4859		A101606	0.00		1,207.01			1,207.01
	LFG6385		A4271	1.00		1,211.02			1,211.02
	ALRCK93		A2258			608.11	-612.01		1,220.12
	LSF6345		A4220	165.80		1,223.12			1,223.12
	LBC5773		A3627			1,223.82			1,223.82
	LGH5581		A3423			1,224.71			1,224.71
	LWC5585		A3415	2.00		2,109.64	883.78		1,225.86
	LKP090		A1108	536.64		1,226.13			1,226.13
	LHR6459		A4338			1,227.91			1,227.91
	LRE6196		A4056			1,227.91			1,227.91
	LBP6445		A4322	0.00		1,230.05			1,230.05
	LNW5239		A3033			5,030.84	3,799.40		1,231.44
	LHC6019		A3846	288.60	2,290.48	3,201.61	1,969.19		1,232.42
	LBV6117		A3976			1,233.44			1,233.44
	LWS6390		A4272			1,234.37			1,234.37
	LCT2843		A2161	81.75		1,234.70			1,234.70
	LDV6351		A4231			1,261.93		25.00	1,236.93
	LNA5209		A3108			2,940.98	1,695.41		1,245.57
	LAC5020		A100102	64.30	1,121.11	1,558.90	309.15		1,249.75
	LPH4815		A100801	13.71		3,174.81	1,896.86	25.00	1,252.95
	LRM6183		A4035	220.00		1,258.36			1,258.36
	LGT6180		A4039	0.00		1,468.79	209.00		1,259.79
	LMC5420		A3236	431.76		1,270.14	4.00		1,266.14
	LNL5352		A3189			1,361.98	90.89		1,271.09
	LRA5826		A3735			1,217.22	-56.18		1,273.40
	PNX3342		A4077	730.06		1,299.82	21.00		1,278.82
	LLC3974		A100080			1,283.18			1,283.18
	LCF5060		A100188	1.00		1,294.74	10.00		1,284.74
	LHT3647		A101249			1,291.17			1,291.17
	LEL6507		A4405	0.00		1,316.67		25.00	1,291.67
	LND6491		A4382			1,294.25			1,294.25
	LFB6166		A4029	3.00		1,298.41			1,298.41
	LGF5882		A3825			1,304.25			1,304.25
	LBE2768		A100600			1,260.45	-46.36		1,306.81
	LAA5190		A3098	13.00		3,096.39	1,789.13		1,307.26
	LEH4183		A101319			1,297.06	-11.19		1,308.25
	LSM5635		A3479			1,311.83			1,311.83
	LLS6371		A4244			1,314.53			1,314.53

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LFC3074	REDACTED	A2284			1,390.56	72.00		1,318.56
	LBC5005		A100631			1,319.65			1,319.65
	LPA4827		A101149	3.00		1,320.70	1.00		1,319.70
	LPC4560		A100849	7.00		1,340.37	15.00		1,325.37
	LST5300		A3145	273.84		1,334.19			1,334.19
	LKH6174		A4060	1.00		1,342.33	4.00		1,338.33
	LVA6107		A3969	93.87		1,347.39	3.86		1,343.53
	LEA5718		A3569	5.00		1,349.07	3.00		1,346.07
	LCV5189		A3015	76.16		1,289.60	-57.70		1,347.30
	LCM5666		A3508	0.00		1,158.74	-193.72		1,352.46
	LEF5457		A3342	1.00		1,365.07	3.00		1,362.07
	LCP4846		A101636	0.00		1,362.24			1,362.24
	LRZ2280		A6053	152.30		1,369.59	7.00		1,362.59
	LRF4637		A100816	2.00		1,373.75			1,373.75
	LSB6004		A3868	348.91		1,351.82	-33.36		1,385.18
	LBW5174		A2947	221.50		1,389.09			1,389.09
	LLF5659		A3502			1,393.38			1,393.38
	LTG4019		A101002	3.00		1,397.74	4.00		1,393.74
	LLF4368		A101377			1,394.86			1,394.86
	LDC6395		A4282			1,423.42		25.00	1,398.42
	LBW6333		A4212			1,400.23			1,400.23
	LCS6282		A4147	1.40		4,845.46	3,425.90		1,419.56
	LRC5850		A3611		517.28	1,422.89			1,422.89
	LMF4795		A100231	1.00		1,426.98	4.00		1,422.98
	LDC6460		A4334	14.25		1,424.49			1,424.49
	LSR5154		A2966	286.65	889.96	1,426.75	1.00		1,425.75
	LFG5309		A3134	3.00		1,426.70			1,426.70
	LRD4884		A100321			1,432.24	2.00		1,430.24
	LAC2252		A100222	704.20		1,457.26		25.00	1,432.26
	LDC6326		A4211			1,434.13			1,434.13
	LDS3867		A100197			2,600.20	1,165.70		1,434.50
	LFC4129		A101588			1,661.35	224.43		1,436.92
	LRC6485		A4383	128.62		1,438.43			1,438.43
	LFT5980		A3869			1,441.70			1,441.70
	LCRC831		A1639	0.00		967.78	143.86	-621.60	1,445.52
	LTF2477		A101023			3,377.11	1,900.99	25.00	1,451.12
	LCB5998		A3836	146.26		1,454.14			1,454.14
	LPA6447		A4335	2.00		1,455.20			1,455.20
	LMT4796		A2866	1.00		1,470.36	7.00		1,463.36
	LAV6517		A4416			1,468.17			1,468.17
	LDP6079		A3950			1,642.57	149.26	25.00	1,468.31
	LCC4957		A100448	18.35		1,473.45			1,473.45
	LCF5282		A3086	54.20		2,011.74	535.89		1,475.85
	LFT5536		A3371			1,471.40	-6.69		1,478.09
	LHF3679		A101656	183.54		1,481.40			1,481.40
	LBW6127		A3983			1,510.82	3.00	25.00	1,482.82
	LTS5936		A3716			1,260.92	-224.19		1,485.11
	LLF4676		A101513	1.00		1,485.20			1,485.20
	LBC3663		A100588	153.30	3,415.18	4,665.68	3,177.94		1,487.74
	LPE3351		A101147			3,345.78	1,829.02	25.00	1,491.76
	LLC5462		A3300	101.00		1,492.91			1,492.91
	LGB6494		A4388			1,518.97		25.00	1,493.97

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTC5783	REDACTED	A3690	1.00		1,773.54	275.73		1,497.81
	LMA6254		A4116			1,500.84	1.00		1,499.84
	LAP4435		A2794	37.72		1,500.86			1,500.86
	LBS4889		A100636			1,503.26			1,503.26
	LBH4550		A100589	0.00		1,511.95			1,511.95
	LRS6266		A4137			2,271.87	733.39	25.00	1,513.48
	LPT4399		A100781	35.50		1,531.21			1,531.21
	LMB5779		A3791			1,538.07			1,538.07
	LTF6223		A4076			1,047.25	-497.22		1,544.47
	LNA2287		A6061	1.00		1,550.18			1,550.18
	LBC6367		A4246	49.04		1,507.27	-45.00		1,552.27
	LCF4571		A101641	0.00		1,506.74	-52.15		1,558.89
	LLH2289		A6062	8.97		1,563.24	3.00		1,560.24
	LTB6059		A3929	256.00		1,560.44			1,560.44
	LTS6429		A4317	3.00		1,569.97	1.00		1,568.97
	LRF4206		A101569	267.46		1,569.44			1,569.44
	LTM4323		A101203			1,572.13	2.00		1,570.13
	LMJ4976		A100210			1,570.54			1,570.54
	LUF4958		A101554		928.02	1,571.06			1,571.06
	LBB4457		A100549			1,572.59			1,572.59
	LCN4742		A2851	0.00		12,964.76	11,381.34		1,583.42
	LAD5782		A3646	0.00		1,586.12	0.00		1,586.12
	LPF5244		A3052			1,593.29	2.00		1,591.29
	LQS3893		A100163	135.51		2,195.15	602.97		1,592.18
	LJCB707		A100439	1,893.46		435.78	-1,182.44	25.00	1,593.22
	LMC6456		A4337			1,599.81			1,599.81
	LLS5662		A3501		283.58	1,586.02	-13.98		1,600.00
	LFP6207		A4070			1,602.82			1,602.82
	LJP3621		A4164	0.00		1,623.24	18.94		1,604.30
	LTT6246		A4112			1,629.61		25.00	1,604.61
	LRF5637		A3467	20.14		1,636.08	1.00	25.00	1,610.08
	LTP4613		A101032	43.50		1,590.67	-20.52		1,611.19
	LGC3492		A101654	201.00		1,595.09	-16.51		1,611.60
	LPF5750		A3576	4.00		1,622.78			1,622.78
	LHC5977		A3859	20.08		1,624.68	1.00		1,623.68
	LWE5584		A3418	6.00		1,915.36	286.65		1,628.71
	LLR5889		A3839	1.00		1,630.25			1,630.25
	LLR6278		A4144	490.82		1,619.83	-13.08		1,632.91
	LAG4686		A100110	614.84		1,633.33	-1.95		1,635.28
	LSC6060		A3928			1,635.68			1,635.68
	LMR6383		A4266			1,638.46			1,638.46
	LAC5631		A3458	825.00		1,643.21	4.63		1,638.58
	LVA6131		A3988			1,657.92	12.00		1,645.92
	LARS796		A1633			1,650.85	1.00		1,649.85
	LTV4826		A101042			1,651.67	0.00		1,651.67
	LHA6451		A4340	82.39		5,654.82	4,002.54		1,652.28
	LDR6393		A4274			1,653.24			1,653.24
	LFM4860		A101448			1,653.84			1,653.84
	LMM6357		A4236			1,659.36	2.00		1,657.36
	LEC4231		A101295	0.00		1,649.19	-10.36		1,659.55
	LGM6341		A4217	422.00		1,670.89	4.00		1,666.89
	PNX3341		A3915	1.00		1,677.90	5.00		1,672.90

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTP6419	REDACTED	A4303			1,675.18			1,675.18
	LRF6479		A4408	5.00		1,676.43	1.00		1,675.43
	LFS4531		A100983			1,680.81	1.00		1,679.81
	LRK6293		A4173			1,683.58			1,683.58
	LHA3277		A100980			1,676.55	-11.31		1,687.86
	LCG6412		A4297	2.00		1,696.07	7.00		1,689.07
	LOEA294		A1320			1,693.30			1,693.30
	LCC5996		A3835			1,692.28	-8.17		1,700.45
	LZG5065		A100401	235.48		1,782.46	77.39		1,705.07
	LAC6134		A3992	0.00		1,735.41	26.16		1,709.25
	LVH4828		A101009	543.65		2,050.65	311.46	25.00	1,714.19
	LML4152		A100143			1,933.70	193.40	25.00	1,715.30
	LMS5621		A3452	0.00		19,970.73	18,224.94	25.00	1,720.79
	LRE6146		A4009	385.74		1,724.67	2.00		1,722.67
	LDH5741		A3553	1.00		1,725.22			1,725.22
	LSC5290		A3113	588.60		2,057.34	325.80		1,731.54
	LSC6394		A4278	20.71		1,744.33			1,744.33
	LPO6538		A4436	4.00		1,749.53			1,749.53
	LRF5774		A3679	3.00		1,752.18			1,752.18
	LBR2844		A100630	3.00		1,754.07			1,754.07
	LUPE821		A101551			1,760.85	1.00		1,759.85
	LMA6360		A4237	1.00		1,763.00	1.00		1,762.00
	LCA2828		A100035	42.96		1,770.08	5.00		1,765.08
	LMP5225		A3003	200.00		1,778.58	6.00		1,772.58
	LSL3841		A101000	123.81		1,795.78	19.00		1,776.78
	LND5679		A3530	15.19		1,795.58			1,795.58
	LMD5567		A3405	168.84		1,803.11			1,803.11
	LMC3404		A4166			1,902.31	98.00		1,804.31
	LKA3348		A2383			1,801.66	-5.00		1,806.66
	PMH2226		A3994			3,059.20	1,251.99		1,807.21
	LEM6014		A3870			1,807.47			1,807.47
	LMS6285		A4155	72.69		1,811.64			1,811.64
	LMF5939		A3764			8,896.00	7,081.90		1,814.10
	LBE4981		A100512			1,820.52	2.00		1,818.52
	LHF5946		A3810	349.27		1,826.34	3.00		1,823.34
	LDC5331		A3161	12.00		1,814.88	-8.53		1,823.41
	LLF4063		A101479	73.28		1,825.52			1,825.52
	LSDM230		A100058	238.09		1,837.37	11.00		1,826.37
	LCF6267		A4125			1,826.89			1,826.89
	LLC5306		A3137	0.00		4,321.41	2,487.62		1,833.79
	LLC3626		A4162			2,419.00	576.35		1,842.65
	LAC3449		A101644	1.00		2,128.86	275.40		1,853.46
	LRS4989		A100867			1,855.24			1,855.24
	LAF5450		A3284	2.00		1,856.49	1.00		1,855.49
	LCV6206		A4088	114.34		1,872.11	13.00		1,859.11
	LHB2261		A6034	331.99		1,861.24			1,861.24
	LWP5951		A3783	0.00		1,869.70	8.00		1,861.70
	LPP6437		A4313	7.00		1,862.23			1,862.23
	LLC3401		A101415	0.00		1,855.02	-9.51		1,864.53
	LWW4381		A100319			1,865.44			1,865.44
	LCH2769		A100074			1,873.41			1,873.41
	LLC5360		A3208	12.52		1,877.83	4.00		1,873.83

REDACTED

Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
LNM5091	REDACTED	A100743	0.00		7,755.98	5,856.57	25.00	1,874.41
LDE3892		A100505			1,879.81	3.00		1,876.81
LMM6469		A4353			1,906.46		25.00	1,881.46
LTP5732		A3762			1,891.17			1,891.17
LCC4451		A101573			1,899.30			1,899.30
LSC5886		A3826	4.00		1,903.26			1,903.26
LML4680		A101633			1,904.39			1,904.39
LSC3255		A100891			1,904.98			1,904.98
LRD6375		A4258	200.39		1,912.52	7.00		1,905.52
LML3894		A100449			1,908.43	1.00		1,907.43
LPR5260		A3055	28.94		1,921.28	4.00		1,917.28
LLP5529		A3378	0.00		1,881.06	-36.43		1,917.49
LHL6104		A3968			1,918.91			1,918.91
LPL6403		A4286	13.98		1,917.76	-4.87		1,922.63
LSS4093		A101528	223.87		1,926.45	1.00		1,925.45
LGA6115		A3986	0.00		2,110.14	183.89		1,926.25
LHC5019		A100650			1,922.07	-5.50		1,927.57
LFL4947		A101358	378.32		3,031.76	1,096.62		1,935.14
LWF5978		A3867			1,936.84			1,936.84
LAB5790		A3592	185.58	3,025.62	6,213.83	4,275.61		1,938.22
LBE4747		A101162	1.00		1,948.67	9.00		1,939.67
LNM6454		A4371	355.25		1,940.01			1,940.01
LTK6221		A4082	419.07		1,944.06			1,944.06
LHG5654		A3497		752.78	1,945.96			1,945.96
LSC4933		A101398	0.00		1,972.33		25.00	1,947.33
LBS2406		A1698	0.00		1,880.24	-68.47		1,948.71
LHAB466		A100732			1,949.81			1,949.81
LPS5583		A3417			1,951.74			1,951.74
LSC6546		A4425			1,951.89			1,951.89
LSB5031		A100878			1,954.49			1,954.49
LTR4791		A101034	51.58		2,126.38	165.39		1,960.99
LEB3957		A100081			1,538.74	-426.66		1,965.40
LAP5748		A3628	4.00		1,972.78			1,972.78
LMS3818		A2654	0.00		1,974.03			1,974.03
LLA6344		A4224	335.20	1,129.63	1,979.13	4.00		1,975.13
LPW6457		A4343			1,977.41			1,977.41
LMC6015		A3884			1,982.69			1,982.69
LAB6481		A4378	37.45	1,467.26	2,482.79	498.75		1,984.04
LEL4154		A2743			1,984.53			1,984.53
LTL5046		A101044	410.24		1,878.47	-106.26		1,984.73
LEF6310		A4187			1,985.64			1,985.64
LDC5736		A3717			1,992.40	-18.33	25.00	1,985.73
LHF5402		A3242			1,992.35			1,992.35
LTF5754		A3614	165.08		2,000.55	3.09		1,997.46
LVF5854		A3608			2,000.57			2,000.57
LNT6312		A4190	116.33		2,028.11		25.00	2,003.11
LPK5343		A3186	137.00		2,030.15		25.00	2,005.15
LCJ3337		A100390	6.00		2,009.60			2,009.60
LWC3017		A100318	87.40		2,008.33	-7.04		2,015.37
LPF6122		A3981			2,027.32	11.74		2,015.58
LSL6487		A4410	1.00		2,017.51			2,017.51
LLC6040		A3885			2,018.01			2,018.01

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LVE6199	REDACTED	A4072			2,019.68	1.00		2,018.68
	LPA4209		A100786			2,019.16			2,019.16
	LNC4411		A100846			2,042.04	2.00		2,040.04
	LRF6167		A4027	4.00		3,975.85	1,910.37	25.00	2,040.48
	LFC4645		A101503	1.00		2,041.13			2,041.13
	LPH4918		A100773	0.00		2,042.92			2,042.92
	LGJ5735		A3600	1.00		2,047.18			2,047.18
	LHC6544		A4426	120.95		2,057.51			2,057.51
	LTA4693		A101040	0.00		1,512.33	-549.83		2,062.16
	LBS4821		A100633			2,064.19			2,064.19
	LTG3498		A101025	599.35		2,068.03	2.00		2,066.03
	LFS4805		A101501	830.59		2,075.35	6.00		2,069.35
	LPA5843		A3638		1,200.78	2,084.34	3.00		2,081.34
	LAP4720		A101155	202.00		2,102.54	1.00		2,101.54
	LMP4626		A2850	15.31		2,107.03	5.00		2,102.03
	LNL6359		A4239			2,105.05			2,105.05
	LHC6216		A4073	102.62		2,108.24			2,108.24
	LCR5763		A3837			2,109.47			2,109.47
	LMA4372		A100313	0.00		2,110.51	1.00		2,109.51
	LWF5104		A100234	83.46		2,135.07		25.00	2,110.07
	LGD6380		A4259	2.40		2,113.03	2.00		2,111.03
	LUP4277		A100932	1.00		2,121.00			2,121.00
	LTC5580		A3420	0.00		4,435.83	2,289.39	25.00	2,121.44
	LMH3588		A4157			2,122.62			2,122.62
	LDR6331		A4207	124.68		2,123.42			2,123.42
	LSC3335		A2402			1,631.70	-500.00		2,131.70
	LMM5824		A3724			2,141.50	6.00		2,135.50
	LRD4142		A101489			1,074.53	-1,068.41		2,142.94
	LFH2274		A6048			2,145.36			2,145.36
	LDB4839		A100295			2,147.53			2,147.53
	LBM5452		A3287	112.19		2,174.03	1.00	25.00	2,148.03
	LZG5814		A3644	424.13		2,124.55	-24.17		2,148.72
	LSS5553		A3385	3.00		2,159.26	7.00		2,152.26
	LKR5817		A3784	0.00		2,156.84			2,156.84
	PNX3345		A4204	1,157.88		2,158.38	1.00		2,157.38
	LSP2903		A101389	35.00		3,592.84	1,408.00	25.00	2,159.84
	LFA4798		A101538	257.20		2,160.29			2,160.29
	LTU5675		A3532	1.00		2,190.30	12.00		2,178.30
	LCF5924		A3824	1.00		2,186.55			2,186.55
	LRS3919		A101438	155.15		2,059.47	-131.69		2,191.16
	LGF3769		A101519	205.78		2,217.50	2.00		2,215.50
	PNX3348		A4358	28.59	1,341.44	2,221.57			2,221.57
	LTH4888		A101204			2,190.89	-36.95		2,227.84
	LBH5271		A3082	27.89		2,232.68	2.00		2,230.68
	PMH2229		A4235	145.04		2,241.79			2,241.79
	LPF5229		A3009	99.54		2,241.91	-1.47		2,243.38
	LCE6200		A4090	2.00		2,252.98	2.00		2,250.98
	LPP6179		A4032	0.00		2,279.58	19.00		2,260.58
	LKP5660		A3506	27.94		2,261.19			2,261.19
	LCE5842		A3700	38.78		2,261.33			2,261.33
	LTX5848		A3728			2,262.92	1.00		2,261.92
	LAK4212		A101327	2.00		2,268.86	2.00		2,266.86

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LMF5512	REDACTED	A3348	271.87		2,264.42	-7.63		2,272.05
	LSN5082		A2904		1,413.39	2,297.79		25.00	2,272.79
	LCH4461		A100396			2,275.05			2,275.05
	LNV4617		A100740	189.62		2,281.27	6.00		2,275.27
	LPP4070		A100802	2.00		2,276.89			2,276.89
	LSP3985		A100193			2,283.75			2,283.75
	LSD5215		A3107	2.00		2,285.98	2.00		2,283.98
	LLG4266		A101133	5.00		2,292.42	8.00		2,284.42
	LGM6112		A3970			2,295.19			2,295.19
	LJB4628		A100436	42.13		2,298.63			2,298.63
	LTP5401		A3250			2,301.34			2,301.34
	LCWC907		A1678	0.00		2,306.97	2.00		2,304.97
	LFF6034		A3878		770.70	2,305.01			2,305.01
	LLF4511		A101131			2,310.03			2,310.03
	LSC6545		A4423			2,337.36		25.00	2,312.36
	LLC2235		A6009			2,312.90			2,312.90
	LPH6227		A4083			2,322.87			2,322.87
	LRA5023		A100812	2.00		2,327.79	1.00		2,326.79
	LBT6009		A3860			2,331.81			2,331.81
	LMM5872		A3678			2,358.21		25.00	2,333.21
	LPS3955		A100804	288.00		2,341.42	5.00		2,336.42
	LKC3982		A100272			2,362.42		25.00	2,337.42
	LSN4228		A101498	6.00		2,344.10	6.00		2,338.10
	LVL3503		A2600	331.48	2,702.56	3,310.58	966.31		2,344.27
	LMC5627		A3455			2,250.38	-122.36	25.00	2,347.74
	LKJ5926		A3808			2,352.64	1.00		2,351.64
	LNS6140		A4008			4,093.01	1,741.05		2,351.96
	LPP6038		A3892			2,359.09			2,359.09
	LZC3642		A101684	0.00		2,362.59			2,362.59
	LGM3615		A2519	211.10		2,375.27	10.35		2,364.92
	LMC5768		A3580			2,365.36			2,365.36
	LRK5962		A3759			2,380.19	1.00		2,379.19
	LPC6316		A4195			2,191.86	-195.13		2,386.99
	LBM6354		A4232	362.12		2,391.96	2.00		2,389.96
	LCC4439		A101564			2,392.74			2,392.74
	LSJ5938		A3750			2,400.18	1.00		2,399.18
	LNG5479		A3313	135.91		3,444.07	1,042.22		2,401.85
	LEH6069		A3937	0.00		2,447.75		25.00	2,422.75
	LRA6248		A4113	9.00		2,438.42	8.00		2,430.42
	LBD5844		A3697			2,490.66		50.00	2,440.66
	LVPT841		A1462	0.00		3,161.76	689.75	24.40	2,447.61
	LBA4698		A100248			2,455.07	2.00		2,453.07
	LKE6391		A4275	392.18		2,466.85	3.00		2,463.85
	LSB3861		A100091	0.00		2,469.47			2,469.47
	LSF6090		A3946	0.00		2,469.92			2,469.92
	LFP6339		A4218			2,487.37			2,487.37
	LRP4097		A101439			2,493.09	-0.79		2,493.88
	LTC6209		A4071	218.94		2,497.24			2,497.24
	LSM2240		A6014	1.00		2,513.27	11.00		2,502.27
	LPC4406		A100856		3,069.74	2,745.33	232.14		2,513.19
	LAP4407		A101053			2,514.76			2,514.76
	LMA4946		A100349	0.00		2,540.74		25.00	2,515.74

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LPQ5398	REDACTED	A3249	200.60		2,517.22			2,517.22
	LLM4682		A101381	578.56		2,520.13			2,520.13
	LFC4653		A101213	0.00		2,521.50			2,521.50
	LMC6273		A4141	2.00		2,549.82		25.00	2,524.82
	LRF6245		A4110			2,525.26			2,525.26
	LBA3474		A101159	2.00		2,531.27	2.00		2,529.27
	LRE2782		A2132	2,286.79		393.79	-2,136.90		2,530.69
	LFP2300		A6073			2,539.32			2,539.32
	LSH4591		A101467			2,544.20	3.00		2,541.20
	LPD5540		A3362			2,544.10			2,544.10
	LWC4247		A100442			2,545.91			2,545.91
	LST4211		A100682	3.00		2,550.65	4.00		2,546.65
	LCT2921		A100245	8.37		2,573.24	10.00		2,563.24
	LTK5696		A3515			2,565.92			2,565.92
	LBW4709		A100513			2,599.42		25.00	2,574.42
	LCL6161		A4020			2,574.76			2,574.76
	LBG5448		A3278	816.99		2,596.35	14.00		2,582.35
	LTH6540		A4414	84.37		2,589.28	4.00		2,585.28
	LNR5400		A3231			2,612.43		25.00	2,587.43
	LMH5480		A3316			2,430.36	-183.29	25.00	2,588.65
	LLF5233		A3007			2,589.88	1.00		2,588.88
	LFC4061		A101453			2,614.20		25.00	2,589.20
	LHIL502		A101238			2,604.26	4.00		2,600.26
	LDL4969		A100323	202.19		2,612.98			2,612.98
	LCC4265		A101617			2,638.96		25.00	2,613.96
	LSU2745		A100043	885.96	1,613.26	2,789.96	152.66		2,637.30
	LSH4837		A101522	111.85		2,659.72	7.00		2,652.72
	LKB5756		A3647	2.00		2,659.64	1.00		2,658.64
	LAT5965		A3763			2,665.67	4.00		2,661.67
	LSH4594		A100890			2,688.72		25.00	2,663.72
	LAB3898		A100202			2,603.97	-67.92		2,671.89
	LEM4840		A101591	1,663.46		4,831.90	2,158.45		2,673.45
	LBM4721		A2854	6.00		16,555.24	13,868.92		2,686.32
	LAD2291		A100257	279.43		2,693.67	3.00		2,690.67
	LGF4023		A100727	1,449.78		2,662.70	-34.37		2,697.07
	LTF5999		A3829			2,708.07			2,708.07
	LKF4905		A101475			2,718.14			2,718.14
	LGR6252		A4122		1,083.64	2,718.46			2,718.46
	LLM6188		A4043			2,720.87			2,720.87
	LGC6368		A4248			2,722.50			2,722.50
	LTH5737		A3681	1.00		2,730.66			2,730.66
	LSN3198		A2378	0.00		2,733.01	0.00		2,733.01
	LND3556		A101181	0.00		2,733.12			2,733.12
	LCR4624		A100720	194.90		2,728.12	-11.01		2,739.13
	LCF4235		A101259			2,742.60			2,742.60
	LLM4103		A101130	29.05		2,761.69	6.00		2,755.69
	LSL6250		A4108	0.00		2,783.89		25.00	2,758.89
	LEC4561		A101103	0.00		2,765.57	3.00		2,762.57
	LWS4960		A2981	4.00		2,800.25		25.00	2,775.25
	LUC6420		A4311			2,802.72		25.00	2,777.72
	LCH5905		A3660	4,072.00		19,918.72	17,139.88		2,778.84
	LSB2158		A101192	100.50	2,577.40	3,037.20	254.85		2,782.35

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LUC5552	REDACTED	A3401			2,802.55			2,802.55
	LPC4018		A100552			2,802.68			2,802.68
	LPA3473		A100780	164.40		2,836.55	6.00	25.00	2,805.55
	LBS2830		A100596	232.31		2,600.93	-208.00		2,808.93
	LSC6415		A4300	3.00		2,811.25			2,811.25
	LLT2286		A6059	0.00		2,819.28			2,819.28
	LSF3169		A101361			3,403.47	549.21	25.00	2,829.26
	LCS5499		A3324	11.00		2,852.62	4.00		2,848.62
	LCC6263		A4127			2,889.74		25.00	2,864.74
	LMT6392		A4276			2,879.43			2,879.43
	LCE5873		A3657	37.18		2,887.14	4.00		2,883.14
	LTF5243		A3069	1.00		2,887.72	1.00		2,886.72
	LKM5614		A3451			2,895.10			2,895.10
	LGS2427		A101520	936.41		2,831.75	-65.34		2,897.09
	LRT5856		A3733	34.09		2,883.53	-17.05		2,900.58
	LBC5013		A100620	1.00		2,908.73			2,908.73
	LHP6464		A4342			2,941.54	0.00	25.00	2,916.54
	LLHP238		A101464	1.00		2,924.30			2,924.30
	LRM3549		A100665	76.00		3,474.21	548.58		2,925.63
	LPS2418		A1938			2,383.18	-553.48		2,936.66
	LVC5625		A3456			2,479.42	-478.80		2,958.22
	LSE6372		A4245	432.04		2,959.82			2,959.82
	LSM6435		A4325			3,282.82	318.86		2,963.96
	LCS6264		A4138	4.00		2,975.83	2.00		2,973.83
	LVF6301		A4172	65.34		2,999.39		25.00	2,974.39
	LHS4378		A100967	494.98		6,114.69	3,139.79		2,974.90
	LDE6082		A3933			3,457.48	454.36	25.00	2,978.12
	LBVP786		A1608			1,731.95	-1,253.95		2,985.90
	LGM3222		A101235			2,984.59	-30.73	25.00	2,990.32
	LNV6072		A3954		1,180.15	2,995.11			2,995.11
	LSC5059		A100679			2,999.33			2,999.33
	LKP5825		A3738			3,011.31	1.00		3,010.31
	LAL4338		A101057	1.00	598.68	3,014.90			3,014.90
	LKT6378		A4260	15.39		3,021.71	1.00		3,020.71
	LHE6102		A3963	16.94		3,025.82	1.00		3,024.82
	LVC4358		A100944			3,029.78	0.10		3,029.68
	LMF6242		A4102		595.00	3,037.34			3,037.34
	LPT4068		A100852	0.00		3,287.23	244.56		3,042.67
	LBC3324		A2406	242.46		3,045.35	1.00		3,044.35
	LGA2237		A6010	48.00		3,049.46	1.00		3,048.46
	LCA5018		A101266	42.62		3,056.64	6.00		3,050.64
	LVS3359		A100290	5.00		3,054.96			3,054.96
	LSS2292		A6065			3,076.79	21.39		3,055.40
	LWC5990		A3864			3,061.16			3,061.16
	LDA5280		A3088	4.00		3,068.84	3.00		3,065.84
	LBC3113		A2298	65.00		3,071.32	3.00		3,068.32
	LTL4122		A101362			3,996.25	872.10	50.00	3,074.15
	LBH6511		A4439	256.89	1,988.31	3,080.86	2.00		3,078.86
	LSV6271		A4131			3,083.05			3,083.05
	LAN6192		A4049			3,086.53	0.00		3,086.53
	LCR4426		A101183	0.00		3,098.55			3,098.55
	LPRM514		A100016			3,101.63	1.00		3,100.63

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHB6041	REDACTED	A3893	0.00		3,101.81			3,101.81
	LSC3309		A2395			3,105.36			3,105.36
	LMS5969		A3817			3,110.48			3,110.48
	LHF5954		A3811			3,111.04			3,111.04
	LGC5063		A100637	300.61		3,112.82	1.00		3,111.82
	LGJ6313		A4188			3,139.50		25.00	3,114.50
	LVF6091		A3939			3,119.67			3,119.67
	LFH5950		A3754	486.43		3,128.17			3,128.17
	LWH6352		A4233			3,128.45			3,128.45
	LBL4635		A100597			3,129.48			3,129.48
	LNC4967		A100735			3,145.69			3,145.69
	LSL3799		A101500			3,153.50			3,153.50
	LGA6407		A4291	84.26		3,182.10		25.00	3,157.10
	LRR5530		A3365	109.56		3,147.46	-13.19		3,160.65
	LBD4178		A100583	628.38		3,171.88	3.00		3,168.88
	LBT6364		A4253	256.60		3,172.55			3,172.55
	LPC5786		A3796	0.00		3,174.91			3,174.91
	LWR6512		A4396	34.82		3,185.35	1.00		3,184.35
	LMF6113		A3979			3,205.90	17.51		3,188.39
	LBC3105		A2290			27,664.36	24,431.83	25.00	3,207.53
	LCC5370		A3219	100.00		3,216.92			3,216.92
	LCH5900		A3621	274.54		3,246.53	22.00		3,224.53
	LRE6262		A4130	80.39		3,251.00	1.00		3,250.00
	LTP6482		A4375			3,270.81			3,270.81
	LLC4309		A101373			3,281.96	0.00		3,281.96
	LMB5159		A2945	1.00		3,307.08		25.00	3,282.08
	LAS3704		A101331	1,788.46	3,190.15	5,463.26	2,180.62		3,282.64
	LNH6304		A4185	3.00		5,678.52	2,370.68	25.00	3,282.84
	LLT6184		A4045			3,307.37			3,307.37
	LJF4189		A100438			3,308.49			3,308.49
	LLC3448		A101667	15.25		3,312.52			3,312.52
	LAC4016		A101158	703.98		2,976.97	-342.84		3,319.81
	LSG6473		A4435	108.44		3,321.26	1.00		3,320.26
	LAC5532		A3376	0.00		3,257.09	-70.83		3,327.92
	LAP4619		A100825			3,353.13		25.00	3,328.13
	LBH4992		A100618	0.00		3,119.25	-218.52		3,337.77
	LAG5498		A3319	14.00		3,362.94		25.00	3,337.94
	LBG6143		A4006	0.00		3,349.18	7.00		3,342.18
	LAS6374		A4255			3,058.67	-285.72		3,344.39
	LSL5968		A3788	2.00		3,351.75			3,351.75
	LHL6190		A4050			3,402.12		50.00	3,352.12
	LGE5002		A101220	9.00		3,354.22	1.00		3,353.22
	LBL6453		A4341	10.90		3,356.38			3,356.38
	LPS5301		A3109	28.50		3,356.96			3,356.96
	LUF3561		A2551	0.00		17,078.14	13,687.97	25.00	3,365.17
	LSC2409		A101525	207.21		3,406.55	12.00		3,394.55
	LDK5394		A3255	3.00		3,396.54	1.00		3,395.54
	LHW2930		A100645	115.54		3,459.21	13.00	50.00	3,396.21
	LSC4210		A101517			3,408.46			3,408.46
	LTP5858		A3727			3,429.38			3,429.38
	LBF5863		A3663	4.00		3,483.40	2.00	50.00	3,431.40
	LCR2749		A100837	33.31	3,672.75	7,678.06	4,245.33		3,432.73

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LMP6329	REDACTED	A4208	1.00		3,458.76	1.00	25.00	3,432.76
	LPP6396		A4279	326.49		3,434.97			3,434.97
	LDC5921		A3623	8.00		3,461.15		25.00	3,436.15
	LRR4052		A100819	0.00		3,078.04	-365.34		3,443.38
	LPF5281		A3093			3,445.70	0.00		3,445.70
	LKC5319		A3143	5.00		3,450.49	2.00		3,448.49
	LSM3645		A101673			3,473.92		25.00	3,448.92
	LEH4034		A101311	85.22		3,451.23			3,451.23
	LHB4417		A100237			3,991.44	536.52		3,454.92
	LCN2283		A6056			3,461.35			3,461.35
	LGF6168		A4026			3,443.96	-27.68		3,471.64
	LBC5022		A100607			3,522.90		50.00	3,472.90
	LAC3753		A100095			3,477.80			3,477.80
	LKC3244		A100991	145.98		3,415.83	5.00	-95.70	3,506.53
	LBH5137		A100106			3,511.91			3,511.91
	LFM3997		A100158	34.60		3,493.63	-28.45		3,522.08
	LCE5478		A3335	197.00		3,545.86	2.00		3,543.86
	LGC4172		A100723			3,547.38			3,547.38
	LHS4566		A101061	2.00	1,450.97	3,549.74			3,549.74
	LGC4666		A101221			2,971.02	-584.46		3,555.48
	LMF5922		A3709	3.00		3,565.12	1.00		3,564.12
	LAC5702		A3566	302.18		3,566.94	1.00		3,565.94
	LLP5864		A3699	1.00		3,568.52			3,568.52
	LNA3743		A2959	3,180.71		3,581.88	13.00		3,568.88
	LRXC597		A100872	0.00		3,744.87	170.18		3,574.69
	LCC5649		A3484			3,577.73			3,577.73
	LCC5910		A3745			3,583.44			3,583.44
	LGT6064		A3921	0.00		3,634.91		50.00	3,584.91
	LDKB599		A100506			3,593.83			3,593.83
	LHA2752		A100652	0.00		3,599.41			3,599.41
	LKA3435		A101669	100.50		3,605.40			3,605.40
	LDA6346		A4225	1,369.08		7,445.56	3,808.51	25.00	3,612.05
	LBS5888		A3821			3,620.76			3,620.76
	LHE5789		A3595			3,648.90		25.00	3,623.90
	LHR3382		A101428			3,625.23			3,625.23
	LAL5784		A3656		2,046.77	3,728.49	75.50	25.00	3,627.99
	LRF6070		A3945			3,661.62		25.00	3,636.62
	LBD5289		A3114	458.15		3,647.61	2.53		3,645.08
	LFB5178		A2993	336.30		3,658.50	4.00		3,654.50
	LDG4865		A101110	231.50		4,652.48	942.65	25.00	3,684.83
	LNP2253		A6025	1,000.00	1,431.01	3,689.08	3.00		3,686.08
	LSF6513		A4417			3,686.68			3,686.68
	LSJ4606		A101514			3,691.66			3,691.66
	LDE2789		A100502	0.00		3,644.15	-47.94		3,692.09
	LSL4355		A100876	228.09		3,673.04	-32.88		3,705.92
	LGM4932		A101005	0.00		8,716.32	4,983.59	25.00	3,707.73
	LEC5801		A3701	1.00		3,743.81		25.00	3,718.81
	LAM2963		A101333	0.00		7,949.20	4,199.77	25.00	3,724.43
	LKA4782		A100914			3,725.87	0.00		3,725.87
	LAM6191		A4044	165.00		3,727.44	1.00		3,726.44
	LBAL937		A100605	0.00		3,740.23	0.00		3,740.23
	LKG3693		A100915			3,740.23			3,740.23

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTC5295	REDACTED	A3110			3,747.77	1.00		3,746.77
	LCA6294		A4175	186.20		3,744.98	-7.81		3,752.79
	LSK3488		A101463	0.00		4,814.92	1,035.96	25.00	3,753.96
	LBF5310		A3149			3,787.73			3,787.73
	LMW6332		A4214	423.21		3,792.62	2.00		3,790.62
	LSL6092		A3944	117.75		3,805.35	7.00		3,798.35
	LCC4468		A4289			3,801.37	3.00		3,798.37
	LLC5597		A3435	0.00		3,802.21	3.00		3,799.21
	LCH2565		A101348			3,850.30	4.00		3,846.30
	LFF6063		A3932	630.21		3,882.93	5.00	25.00	3,852.93
	LES2449		A101296	0.00		3,870.66	-2.79		3,873.45
	LDR5426		A3274	24.51		3,878.24	-2.84		3,881.08
	LPB6377		A4257	528.03		3,884.67	1.00		3,883.67
	LWR2242		A100054	1,201.03		3,851.45	-36.96		3,888.41
	LAR6290		A4152	20.52		3,921.16		25.00	3,896.16
	LML2592		A101611	291.02		3,882.94	-18.43		3,901.37
	LPC3411		A101697			3,904.77			3,904.77
	LEP4484		A101096	510.58		3,866.43	-42.00		3,908.43
	LBS5049		A100548			3,936.03		25.00	3,911.03
	LCC4895		A2884	365.98		3,916.32	4.00		3,912.32
	LTF5155		A2925	248.61		3,915.27			3,915.27
	LAC5629		A3457			3,920.27	1.00		3,919.27
	LRA4464		A101396			3,925.90			3,925.90
	LMV3419		A101693	7.00		3,936.63	1.00		3,935.63
	LPT3822		A2667	1.00		3,941.84			3,941.84
	LAJ5191		A3100			5,534.82	1,592.16		3,942.66
	LME4603		A100224			3,816.70	-152.46	25.00	3,944.16
	LRF4349		A101285			3,969.72		25.00	3,944.72
	LBB6281		A4150			3,972.23	2.00		3,970.23
	LFA4648		A100520			14,854.22	10,833.88	50.00	3,970.34
	LLQ6100		A3956	63.54		3,984.59	5.00		3,979.59
	LBH3442		A101686	334.75		4,007.07			4,007.07
	LFC3648		A101672			4,025.56			4,025.56
	LAT5958		A3806			4,025.82			4,025.82
	LMT6547		A4432	4.00		4,029.36			4,029.36
	LGF6478		A4373	634.14		4,036.74	2.00		4,034.74
	LDC3429		A101689			4,065.53		25.00	4,040.53
	LHF4482		A100970			3,631.25	-429.54		4,060.79
	LNS6054		A3911			4,067.81			4,067.81
	LTH6270		A4132			4,090.30			4,090.30
	LGA6032		A3895	412.60	2,959.62	4,116.96	8.00		4,108.96
	LBL5855		A3780			4,115.79			4,115.79
	LSP4807		A2863			4,130.57			4,130.57
	LDA5503		A3343	0.00		4,134.67			4,134.67
	LSC2279		A100066			4,321.37	159.67	25.00	4,136.70
	LCF5777		A3652			4,140.44			4,140.44
	LSE5590		A3431	1.00		4,149.74			4,149.74
	LLE6197		A4068	2,324.03		4,174.17	18.00		4,156.17
	LGH5486		A3332	1.00		4,162.21			4,162.21
	LLA6490		A4381	1,022.48		4,171.63			4,171.63
	LPS3708		A2584	4.60		7,317.01	3,094.24	50.00	4,172.77
	LTS6029		A3875		1,114.04	3,235.52	-963.13	25.00	4,173.65

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LNN2271	REDACTED	A6046	0.00		4,176.08			4,176.08
	LNB5778		A3790	0.00		4,182.24			4,182.24
	LGG5945		A3830			4,190.83			4,190.83
	LCN4043		A101583	2,971.77	6,700.06	10,004.84	5,811.58		4,193.26
	LBB5481		A3312			4,220.43			4,220.43
	LTW5860		A3651			17,874.66	13,646.82		4,227.84
	LAE5416		A3261			4,229.18			4,229.18
	LAC2797		A100036	0.00		4,272.08	0.00	25.00	4,247.08
	LMM5026		A100152			4,250.08	2.00		4,248.08
	LWP4509		A100324			4,275.54		25.00	4,250.54
	LCA6202		A4089			3,975.13	-276.77		4,251.90
	LTC5560		A3398			4,253.87			4,253.87
	LEH6480		A4406	4.00		4,258.11	2.00		4,256.11
	LHP4562		A101590	32.39		4,264.02	1.00		4,263.02
	LDD5226		A3013			4,263.36			4,263.36
	LCT6432		A4319	1,122.07	4,264.46	5,757.37	1,475.55		4,281.82
	LPP5145		A2968	250.12	2,931.46	4,286.07			4,286.07
	LCS3173		A100830	31.50		4,303.34			4,303.34
	LGK6426		A4314	703.09		4,312.57	6.00		4,306.57
	LSLA889		A101071			4,317.15			4,317.15
	LWC5064		A100328			4,376.21	1.00	50.00	4,325.21
	LSH6023		A3861			4,327.74			4,327.74
	LAN4959		A100115	676.68	2,690.16	4,310.14	-33.87		4,344.01
	LPP6348		A4247	253.49		4,348.24			4,348.24
	LFX6241		A4094	2.00		4,357.18			4,357.18
	LMB4675		A100372			11,231.25	6,869.58		4,361.67
	LDC4669		A100385			4,366.58	0.00		4,366.58
	LBW3125		A2423			4,276.96	-93.09		4,370.05
	LTL3098		A2321	17.00		4,374.95			4,374.95
	LEL5915		A3756	237.91		4,353.87	-29.93		4,383.80
	LTG6451		A4361	2.00		4,410.42	5.00		4,405.42
	LTP3649		A101152	941.31	2,093.30	4,411.54	-5.06		4,416.60
	LDC3327		A2397			4,446.90		25.00	4,421.90
	LSF6141		A4003	634.28		4,424.05	1.00		4,423.05
	LGL3118		A101171			4,199.63	-232.08		4,431.71
	LSH5678		A3534			4,471.43	-1.25	25.00	4,447.68
	LAH4256		A100172	24.18		4,523.28		50.00	4,473.28
	LHG4582		A100647	2,815.13		8,449.29	3,968.46		4,480.83
	LLM2232		A6005	50.94		4,498.27			4,498.27
	LGD6414		A4296			4,531.57		25.00	4,506.57
	LSV2811		A100675	94.35		4,511.52	4.00		4,507.52
	LBF6214		A4069			4,508.29			4,508.29
	LAC6343		A4222			4,519.92	1.00		4,518.92
	LKM4413		A100921	0.00		4,519.94	-1.84		4,521.78
	LAT4086		A100100	0.00		4,343.93	-179.39		4,523.32
	LPR2942		A100853	505.59		4,417.48	-110.73		4,528.21
	LBY5523		A3360	787.85		4,537.35			4,537.35
	LNS2279		A6052	125.55	876.66	4,545.85			4,545.85
	LMS4987		A100417	471.83		4,549.55	2.00		4,547.55
	LML5511		A3349			4,551.61			4,551.61
	LCC6506		A4404			4,554.76			4,554.76
	LWN4257		A100455			4,584.65		25.00	4,559.65

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	PMH2233	REDACTED	A4380	23.25		4,565.97			4,565.97
	LCA3764		A2596	0.00		4,571.59	0.00		4,571.59
	LLH2795		A2142			5,961.78	1,385.55		4,576.23
	LHC3454		A101701			4,599.86	8.00		4,591.86
	LCA6400		A4302			4,595.50			4,595.50
	PMH2234		A4386	140.23		4,640.37	35.00		4,605.37
	LHM3644		A100792			4,595.41	-12.51		4,607.92
	LMM2218		A100012			4,662.98			4,662.98
	LHM6347		A4226	5.00		4,669.72	1.00		4,668.72
	LPM2800		A100071	266.35		4,561.62	-114.00		4,675.62
	LFB4520		A101446			4,670.43	-36.67	25.00	4,682.10
	LAG6135		A3997			4,688.67			4,688.67
	LLE5902		A3668			4,698.88	3.00		4,695.88
	LHC4133		A101016	730.68		4,654.85	-41.54		4,696.39
	LAD4771		A100383			4,644.53	-52.72		4,697.25
	LLC6298		A4170	161.86		4,715.21	2.00		4,713.21
	LVC3408		A101682	1.00		4,719.94			4,719.94
	LCC3437		A101681			4,723.19			4,723.19
	LIDE457		A101369			4,732.73			4,732.73
	LSL6522		A4411	77.35		5,372.87	586.20	50.00	4,736.67
	LSC4156		A101186	0.00		17,638.30	12,874.44	25.00	4,738.86
	LMC4197		A100153	2.00		4,745.16	2.00		4,743.16
	LCF4459		A101575	2.00		4,757.19			4,757.19
	LEM2607		A101316	26.50		4,772.57			4,772.57
	LSW4326		A2776	0.00	5,576.59	4,804.60	25.42		4,779.18
	LSS4971		A100875	2.00	1,201.54	4,782.68			4,782.68
	LTT4954		A101036	0.00		4,804.81	5.00		4,799.81
	LRM5106		A101418	138.16		4,836.56	3.00	25.00	4,808.56
	LPS3267		A101140	293.68		4,658.07	-156.07		4,814.14
	LNC4352		A101177			4,827.45	1.00		4,826.45
	LBR5878		A3705			4,754.61	-79.18		4,833.79
	LDC4751		A100481	328.39		4,848.42	8.00		4,840.42
	LEF4853		A101310	0.00		4,841.70	-52.42	25.00	4,869.12
	LSC5916		A3818	14.80		6,712.61	1,816.98	25.00	4,870.63
	LNC2988		A101182	0.00		4,852.80	-32.39		4,885.19
	LGA6314		A4194			4,895.94			4,895.94
	LER5009		A100402			4,908.48	2.00		4,906.48
	LVL5354		A3187	0.00		7,551.49	2,644.98		4,906.51
	LNE2727		A100028	316.03		4,916.36			4,916.36
	LCS3609		A101676		1,662.28	4,918.46			4,918.46
	LSR6258		A4123	2.00		4,920.53			4,920.53
	LNIP818		A100744	515.50		4,908.89	-27.08		4,935.97
	LSS2653		A101404	108.44		4,943.04	3.00		4,940.04
	LAT4037		A100452	4.52		16,978.95	12,009.84	25.00	4,944.11
	LRC3681		A101674			4,996.20		50.00	4,946.20
	LMS6369		A4243	171.47		7,406.11	2,417.00	25.00	4,964.11
	LNS3992		A100989			4,991.21	-6.25	25.00	4,972.46
	LCG5819		A3776			4,984.23			4,984.23
	LMC4916		A100275	193.12		4,940.89	-49.45		4,990.34
	LKC5770		A3613			5,000.94			5,000.94
	LEA6123		A3975			7,365.76	2,344.31		5,021.45
	LAC3245		A100111	202.59		5,023.27	1.00		5,022.27

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTR3790	REDACTED	A100962	50.00	1,482.26	5,038.87			5,038.87
	LSV4823		A100985			5,007.89	-44.21		5,052.10
	LMC5698		A3547	9.00		5,058.46			5,058.46
	LKK5368		A3202	8.00		5,090.49	-0.45	25.00	5,065.94
	LSC3008		A100896	511.20		5,072.22			5,072.22
	LAM5334		A3169	0.00		4,901.71	-170.55		5,072.26
	LLT3991		A2692	0.00		5,309.11	8.00	225.00	5,076.11
	LRF4819		A100817			5,088.88			5,088.88
	LRR4990		A100240			5,094.91			5,094.91
	LFL5129		A100538	1,062.59	4,510.62	5,843.95	748.33		5,095.62
	LRC5906		A3793	0.00		5,099.39	1.00		5,098.39
	PMH2232		A4330	0.00		5,520.08	418.18		5,101.90
	LTF4369		A100926	1,744.30		5,110.13	1.00		5,109.13
	LSA5563		A3407	0.00		5,143.53	-11.45	25.00	5,129.98
	LAF6077		A3959	1.00		5,135.63			5,135.63
	sLVM4736		A100032			5,152.26			5,152.26
	LCH3541		A3925			5,370.24	-21.49	228.44	5,163.29
	LYE5808		A3687			5,170.94			5,170.94
	LMG5185		A3005	7.00		5,191.57	6.00		5,185.57
	LLU5207		A3124	0.00		6,997.88	1,810.80		5,187.08
	LTH2794		A2135	212.58		4,803.12	-22.20	-367.84	5,193.16
	LRF5829		A3707	38.52		5,194.06			5,194.06
	LUC4278		A100935	0.00		10,803.17	5,597.89		5,205.28
	LCS3402		A100042	500.74		5,175.15	-50.10		5,225.25
	LDV5085		A100307	2.00		5,227.92	2.00		5,225.92
	LPP3847		A100086			5,228.87			5,228.87
	LHM5781		A3587	1.00		5,257.71	1.00	25.00	5,231.71
	LSG2281		A1882	0.00		5,125.66	-111.00		5,236.66
	LSGP860		A101546		1,013.06	5,242.38			5,242.38
	LSC4251		A101076			5,254.91	1.00		5,253.91
	LBT4510		A100627			5,255.23			5,255.23
	LTM5757		A3653	722.21		5,324.54	9.00		5,315.54
	LMR6295		A4169	334.64		5,263.04	-58.75		5,321.79
	LSY5940		A3758			5,323.47			5,323.47
	LGB5761		A3671	18.00		5,324.24			5,324.24
	LSP5358		A3200			5,011.13	-321.14		5,332.27
	PMH2235		A4393	185.30		5,337.93	1.00		5,336.93
	LLM5345		A3185	256.00		5,358.28			5,358.28
	LDB5981		A3841	0.00		5,397.15		25.00	5,372.15
	LFD4476		A100534			5,380.30			5,380.30
	LDB5852		A3704			5,387.57	1.00		5,386.57
	LNC6066		A3913	1.00		5,391.99			5,391.99
	LLA6027		A3863			5,411.70			5,411.70
	LBR6228		A4104	167.83		5,416.96	1.00		5,415.96
	LTC5362		A3203	0.00		8,797.43	3,349.63	25.00	5,422.80
	LKF5983		A3771	7.00		5,427.29	1.00		5,426.29
	LMN3228		A100139			6,290.53	828.28	25.00	5,437.25
	LGC4116		A100724			5,440.50	-7.98		5,448.48
	LLM5600		A3440			5,453.32	1.00		5,452.32
	LTC2151		A100093			5,465.37			5,465.37
	LCE3770		A2980	137.28		5,418.10	-48.96		5,467.06
	LFC4379		A101620		1,377.72	5,498.76			5,498.76

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LCC4195	REDACTED	A100712	1,025.13		5,521.57	7.09		5,514.48
	LNW2897		A2197	740.18		5,534.67	3.00		5,531.67
	LDC4554		A101338	852.34	2,670.36	5,559.93	0.85		5,559.08
	LSS5268		A3080			5,584.78		25.00	5,559.78
	LFF4363		A100539	2,870.27		5,474.09	-86.77		5,560.86
	LMF6114		A3974			5,660.30	57.65		5,602.65
	LRP6171		A4036	0.00		6,736.63	1,093.36	25.00	5,618.27
	LPP4219		A100572			5,674.12	2.00	25.00	5,647.12
	LES6484		A4366	7.81		5,647.47			5,647.47
	LSB3467		A101399			5,594.82	-86.89	25.00	5,656.71
	LMF5898		A3635	4.00		5,717.53			5,717.53
	LZA5919		A3847			5,721.07	2.00		5,719.07
	LYA5688		A3514	209.30		5,639.13	-93.54		5,732.67
	LJM5461		A3297			5,745.45			5,745.45
	LDC5522		A3375			5,736.18	-13.34		5,749.52
	LRM4941		A100818	531.36		5,793.57		25.00	5,768.57
	LBP3205		A100560	213.27	3,885.87	5,775.63	7.00		5,768.63
	LBF3546		A101660			5,820.68		25.00	5,795.68
	LDR4272		A2760	94.54		5,849.60	-2.57		5,852.17
	LJE2174		A100337	173.95		5,857.79			5,857.79
	PMH2231		A4280			5,574.18	-287.48		5,861.66
	LRA4213		A101436	0.00		5,908.41	6.00	25.00	5,877.41
	LKE6103		A3967	0.00		5,910.48	28.50		5,881.98
	LAR5857		A3729	336.31		5,924.50	2.00	25.00	5,897.50
	LPL2759		A101412			5,908.09			5,908.09
	LOBC624		A100702			5,913.62	3.00		5,910.62
	LHC5261		A3073			5,901.43	-18.94		5,920.37
	LMC6037		A3883			5,981.61		50.00	5,931.61
	LBP5634		A3462			5,821.81	-113.66		5,935.47
	LSM5406		A3230			5,946.21	-8.79		5,955.00
	LCC4263		A100408			5,974.85	-10.95	25.00	5,960.80
	LFC2187		A100007	216.62		5,965.53			5,965.53
	LCW5195		A3094	199.50		5,981.84	2.00		5,979.84
	LFF4098		A100525			5,995.74	3.00		5,992.74
	LEK4337		A101298	1,211.51	11,535.64	13,285.74	7,286.22		5,999.52
	LSC5412		A3262	390.50		6,003.38			6,003.38
	LXC5132		A2920			6,003.61			6,003.61
	LWS4885		A101616	2.00		6,061.05		25.00	6,036.05
	LBF6277		A4145	445.55		6,021.12	-27.59		6,048.71
	LCP3563		A2644			6,048.72			6,048.72
	LFC4986		A101303	17.25		6,052.02	1.00		6,051.02
	PNX3343		A4086	3.00		6,110.59	2.00	25.00	6,083.59
	LJTS953		A1697	0.00		6,006.67	-118.68	25.00	6,100.35
	LSP3160		A2337			6,107.69	1.00		6,106.69
	LHM5476		A3317	187.88		6,132.95		25.00	6,107.95
	LSP5928		A3737	0.00		13,248.50	7,154.63	-20.00	6,113.87
	LSF5232		A3008			6,122.22			6,122.22
	LTB2714		A2976	769.13		6,160.12	2.00	25.00	6,133.12
	LAH6381		A4263			6,142.30	5.00		6,137.30
	LTW6164		A4024			6,494.73	285.00	25.00	6,184.73
	LCV4167		A100711	690.49		6,109.18	-86.30		6,195.48
	LJB5411		A3241	56.99		6,229.82	4.00	25.00	6,200.82

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LVD5963	REDACTED	A3815	738.60		6,127.96	-82.35		6,210.31
	LWM6439		A4323	11.04		6,219.94	2.00		6,217.94
	LFF4656		A101502			6,225.34			6,225.34
	LTHT914		A101194			6,231.99			6,231.99
	LMP6535		A4421	557.75		6,275.37	2.00	25.00	6,248.37
	LBJ4938		A100511	440.00		6,266.84	3.00		6,263.84
	LMV2987		A101305			6,277.59			6,277.59
	LFA5292		A3116			6,366.54		25.00	6,341.54
	PMH2227		A4134	0.00		6,037.02	-330.23		6,367.25
	LAF5991		A3872	140.48		6,414.11		25.00	6,389.11
	LSC6046		A3902		1,064.36	6,390.65			6,390.65
	LKS5227		A3010	2.00		6,411.22	1.00		6,410.22
	LDG3547		A100499			6,410.28	-7.27		6,417.55
	LBS5847		A3649	793.38		6,427.76			6,427.76
	LAF6452		A4355	18.49		6,462.49	4.00		6,458.49
	LWF4920		A100329	685.28		6,099.49	-363.26		6,462.75
	LNQ6230		A4105	813.90		6,495.56	20.00		6,475.56
	LHM6006		A3827		2,757.25	6,486.78	8.00		6,478.78
	LPE3674		A2571	148.40		6,522.29	7.00	25.00	6,490.29
	LBR4689		A100509	799.60		6,508.22	-7.60	25.00	6,490.82
	LGP4597		A2847			6,687.03	159.00	25.00	6,503.03
	LUA6043		A3894	125.00	2,109.23	6,507.39			6,507.39
	LPH4628		A101164	33.77		7,548.88	996.22	25.00	6,527.66
	LYF6172		A4034	78.58		6,529.85	2.00		6,527.85
	LDH5708		A3552	9.00		6,555.45			6,555.45
	LGC3423		A101655	5.00		6,558.09			6,558.09
	LCB6028		A3874			6,641.76		50.00	6,591.76
	LTN3213		A101047	0.00		6,595.70	1.00		6,594.70
	LGR3880		A100161	0.00		9,859.99	3,239.08	25.00	6,595.91
	LRC3543		A101690	0.00		6,700.67	97.50		6,603.17
	LSS4917		A101497	1,289.39		6,653.51	3.00	25.00	6,625.51
	LPP5818		A3721			6,631.27			6,631.27
	LMA6449		A4354	948.00		6,664.30	2.00		6,662.30
	LMB3224		A2355	10.00		6,737.28	9.00		6,728.28
	LBA4157		A101161	596.41		6,624.52	-105.70		6,730.22
	LRM3550		A101277	145.84		6,755.68			6,755.68
	PMH2223		A3866			6,917.20	158.68		6,758.52
	LRR5713		A3550	191.34		6,810.76	3.00		6,807.76
	LBR6012		A3856			6,871.35	1.00	50.00	6,820.35
	LLC3378		A101562	9.00	3,008.30	6,833.30	10.00		6,823.30
	LSE6001		A3807	0.00		6,823.51			6,823.51
	LPE4514		A100568	126.30		6,841.29	16.00		6,825.29
	LPC4319		A100774	4.44		6,843.06			6,843.06
	LRS3071		A2270	0.00		6,861.45			6,861.45
	LHF4719		A101245		6,633.42	7,051.86	185.70		6,866.16
	PNX3338		A3702	2,671.74		6,925.14	24.00		6,901.14
	LPC4851		A100704	595.11		6,911.71	1.00		6,910.71
	LME5422		A3283	264.35		6,930.37	18.00		6,912.37
	LWE4605		A100314	330.58		6,700.86	-245.99		6,946.85
	LPF6021		A3882		1,351.32	6,948.88	2.00		6,946.88
	LSC4687		A100888			6,977.12		25.00	6,952.12
	LPJG710		A100580			6,899.37	-56.22		6,955.59

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LST3027	REDACTED	A101402	2.00		6,961.69			6,961.69
	LWB5704		A3544	1.00		6,992.37		25.00	6,967.37
	LRR3122		A2299			6,979.21			6,979.21
	LET6139		A3998	543.17		7,009.95	2.00		7,007.95
	LNT3785		A100951			7,021.31	-3.89		7,025.20
	LCT5381		A3214	1,802.61		6,970.45	-79.18		7,049.63
	LSS4193		A2748	0.00		21,458.71	15,379.86	-980.00	7,058.85
	LWF4633		A100421	316.59		7,075.46	5.00		7,070.46
	LAM6155		A4018			7,072.11			7,072.11
	LSM5574		A3421	109.14		7,092.29	9.00		7,083.29
	LPF1038		A101033			7,145.14	5.00	25.00	7,115.14
	LAD3889		A2657	1,400.93		7,134.97	4.00		7,130.97
	LPF4833		A100602	15,288.97		7,178.17	25.00		7,153.17
	LSW4945		A101166	7.80		8,002.23	807.26	25.00	7,169.97
	LZA2640		A100759	2.00		7,251.20	5.00	25.00	7,221.20
	LHH4332		A101605	125.00		7,254.94	5.00		7,249.94
	LHL3265		A101027	131.00		7,252.65	2.00		7,250.65
	LMW5972		A3816			7,306.56			7,306.56
	LEL4616		A101356	0.00		7,309.14			7,309.14
	LPM4608		A2840	37.45		7,310.24			7,310.24
	LNE4398		A100847			7,349.95	2.00	25.00	7,322.95
	LJDH678		A100238			7,152.25	-170.99		7,323.24
	LTA3107		A101086	0.00		7,178.67	-151.30		7,329.97
	LSE4890		A101499			7,333.74			7,333.74
	LFA4855		A101452			7,337.26			7,337.26
	LTE5589		A3433			7,352.70			7,352.70
	LPC4961		A101600			7,284.75	-155.93	50.00	7,390.68
	LNS6045		A3898	0.00		7,357.81	-39.00		7,396.81
	LMV4592		A100136	6.00		7,404.20	5.00		7,399.20
	LGI4254		A100730			7,347.49	-55.25		7,402.74
	LVA3357		A101561	10.04	3,876.48	7,415.26	1.00		7,414.26
	LMT4425		A100211	1.00		7,427.61			7,427.61
	LNT2290		A6064	477.31	728.78	7,464.55			7,464.55
	LBB5153		A2963	6.00		7,503.79		25.00	7,478.79
	LNBS361		A1354	17,222.09		36,796.53	29,305.48		7,491.05
	LLV5840		A3698	2,764.71		7,568.41	14.00		7,554.41
	LCC5758		A3579	2,977.36		7,609.34		25.00	7,584.34
	LPMI723		A1590	58.96		7,604.36	11.00		7,593.36
	LTT6370		A4241	0.00		7,619.41	-2.34	25.00	7,596.75
	LWB6049		A3903	0.00		7,613.52	-9.46		7,622.98
	LMU3762		A100266	7,752.30		10,624.38	2,996.89		7,627.49
	LKP6409		A4294			7,636.45			7,636.45
	LUS4507		A100936	2.00		7,683.61	4.00	25.00	7,654.61
	LPH3396		A100782	836.61		7,889.58	188.25	25.00	7,676.33
	LWE6217		A4081			7,695.42			7,695.42
	LCF5294		A3151	0.00		8,412.58	678.10	25.00	7,709.48
	LDF3297		A2456	0.00		7,696.93	-16.57		7,713.50
	LCD5712		A3567			7,722.93	1.00		7,721.93
	LSFS764		A101401	3.00		7,731.65	3.00		7,728.65
	LHM4836		A101631	0.00		11,415.11	3,649.29	25.00	7,740.82
	LCR5579		A3434	2.00		7,743.94			7,743.94
	LSN3593		A2510	2,207.13		7,511.76	-239.41		7,751.17

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LAF5942	REDACTED	A3749	4.00		7,795.85		25.00	7,770.85
	LME6133		A3989			7,775.48			7,775.48
	LUC6148		A4004	148.62		7,777.42	1.00		7,776.42
	LCC4814		A101393	160.09		29,405.25	21,544.13	50.00	7,811.12
	LCH6282		A4149	180.98		7,842.58	18.00		7,824.58
	LSF5312		A3148	1,422.20		7,101.65	-751.17		7,852.82
	LJG4690		A2856	322.25		7,861.16	6.00		7,855.16
	LFP3953		A100031	3.00		7,860.69	3.00		7,857.69
	LBUR626		A100563			7,875.22			7,875.22
	LTH2657		A2112			7,909.24			7,909.24
	LTC5551		A3391			3,876.42	-4,089.01		7,965.43
	LVM5223		A2999	0.00		7,970.98	0.00		7,970.98
	LTH5162		A2995			8,011.70		25.00	7,986.70
	LBM5482		A3333	1,349.76		8,002.01	4.33		7,997.68
	PMH2236		A4391	388.31		7,743.94	-292.11		8,036.05
	LMS5626		A3454			7,916.89	-133.40		8,050.29
	LBR6105		A3984			9,034.63	983.62		8,051.01
	LDE5509		A3353	1.00		8,077.30			8,077.30
	LCP3905		A2662	177.43		8,077.61			8,077.61
	LPP3683		A100768	7.00		8,151.67		50.00	8,101.67
	LSW4472		A101193	2.00		8,114.68			8,114.68
	LVH3301		A2387			8,117.61			8,117.61
	LEC4753		A2867	685.62	6,412.12	8,129.87	9.70		8,120.17
	PNC3332		A3464			8,198.80		25.00	8,173.80
	LHE3009		A101424	2.00		8,202.01	3.00		8,199.01
	LSS5967		A3722	785.51		8,219.44			8,219.44
	LSE4894		A101391	219.22		8,220.04			8,220.04
	LFB5929		A3748	1.00		8,225.83	2.00		8,223.83
	LMG5470		A3334	6.00		8,239.74	2.00		8,237.74
	LLR4964		A101382	0.00		8,325.96			8,325.96
	LRS5316		A3162	2,706.99		8,222.50	-126.87		8,349.37
	LAH2458		A100098	0.00		8,336.88	-18.39		8,355.27
	LBM3391		A2457	691.24		8,357.92	-24.14		8,382.06
	LAF3792		A2960	38.88		8,398.20			8,398.20
	LAF1034		A1729			8,432.84			8,432.84
	LHH3325		A2400	131.22		8,461.32			8,461.32
	LSD5081		A100996	28.39		8,492.61		25.00	8,467.61
	LHC3024		A100646			8,397.50	-105.77		8,503.27
	LZP3655		A2626			8,304.26	-17.71	-208.99	8,530.96
	LDP6256		A4119	0.00		12,190.28	3,624.27	25.00	8,541.01
	LGL5652		A3483	0.00		8,327.98	-223.60		8,551.58
	LDP4394		A2804	2,048.59	2,717.75	8,556.35			8,556.35
	LSS2960		A100879	0.00		8,009.94	-568.93		8,578.87
	LBA6212		A4064	4.00		8,591.28	1.00		8,590.28
	LDP3315		A2393			8,644.28		25.00	8,619.28
	LAT3920		A100179	13.31		8,626.14	3.00		8,623.14
	LVH6232		A4100			9,314.93	648.55	40.00	8,626.38
	LHG4335		A100978	1,170.08	6,168.12	8,679.68	3.00	50.00	8,626.68
	LBB5315		A3144	28.92		8,664.79			8,664.79
	LCA4232		A100584	156.20		8,682.83	2.00		8,680.83
	LBN2262		A6033	127.00	1,758.97	8,725.96	4.00		8,721.96
	LRW4401		A100666	23.25		8,761.70	2.00		8,759.70

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHH1042	REDACTED	A1787	0.00		14,331.63	5,561.96		8,769.67
	LEJ4233		A101101	1.00		8,772.52			8,772.52
	LPC5287		A3150	247.92		8,780.92	1.00		8,779.92
	LLP4760		A101378	464.30		8,785.67	2.27		8,783.40
	LTC3830		A2986			12,360.20	3,563.52		8,796.68
	LJC5650		A3486			8,883.79			8,883.79
	LST5320		A3139			8,911.93		25.00	8,886.93
	LBG5050		A100617	340.71	8,013.58	15,158.20	6,253.84		8,904.36
	LNT3587		A101122	1.00		8,921.01	10.00		8,911.01
	LRC4499		A101444	1,405.34		8,827.47	-99.76		8,927.23
	LAG5933		A3744	197.72		8,954.52	2.00		8,952.52
	LPS4703		A100787	116.67		8,966.57	8.00		8,958.57
	LCT2773		A100795	36.54	5,600.21	8,978.38	-8.76		8,987.14
	LSH2530		A100956	66.30		9,012.52	-4.00	25.00	8,991.52
	LRC6086		A3947			9,003.64			9,003.64
	LAA5491		A3327	54.25		9,020.09	7.00		9,013.09
	LHC5664		A3504	214.59		9,022.14	4.00		9,018.14
	LMT4939		A100225	2,263.69		13,675.29	4,646.57		9,028.72
	LWA4239		A100544	32.03		9,052.88	2.00		9,050.88
	LCE6129		A3993	0.00		14,728.67	5,672.70		9,055.97
	LGJ1064		A101108	16.94		9,552.70	468.11	25.00	9,059.59
	LAB1096		A100454			9,068.72			9,068.72
	LHP3601		A2434	1,687.99		8,291.73	-777.50		9,069.23
	LWC2591		A100612	0.00		9,117.01	2.00	25.00	9,090.01
	LRE2951		A2214	616.40		9,207.42	-17.14		9,224.56
	LCP6431		A4305	932.84		9,241.16	2.00		9,239.16
	LTC3102		A2294			9,251.08	1.00		9,250.08
	LWT5970		A3772			9,278.99			9,278.99
	LWE6231		A4101	0.00		9,306.96			9,306.96
	LAF6160		A4023			9,891.16	583.86		9,307.30
	LCB5899		A3625	38.34		9,342.96			9,342.96
	LMB4685		A2889	10.00		9,441.38	3.00	25.00	9,413.38
	LNH2751		A2965			9,414.33			9,414.33
	LAS3192		A100218			9,448.86	0.00	25.00	9,423.86
	LAC6321		A4205	1,754.61		8,947.52	-490.01		9,437.53
	LRC5550		A3386	1.00		9,448.25			9,448.25
	LPP4942		A100576	0.00		9,482.39		25.00	9,457.39
	LCP3768		A2582	45.40		9,497.88			9,497.88
	LCRW488		A100472	147.58		9,502.37	1.00		9,501.37
	LMC3073		A101608	397.24		9,604.20		25.00	9,579.20
	LPS5042		A100764	39.07		9,579.88			9,579.88
	LAP6319		A4200	0.00		9,614.61	0.06	25.00	9,589.55
	LWM5034		A100541	0.00		5,532.97	-4,066.04		9,599.01
	LPR2126		A1780			9,624.05	-3.27		9,627.32
	LAV5451		A3286	1.00		9,629.83			9,629.83
	LDL5676		A3511	38.36		9,658.40	1.00	25.00	9,632.40
	LTT3781		A2544	0.00		22,099.62	12,464.55		9,635.07
	LBH3438		A101704			9,618.53	-18.61		9,637.14
	LPP2677		A2007			9,670.78			9,670.78
	LFL5949		A3753			9,736.71	-22.58	25.00	9,734.29
	LSA5403		A3263	47.10		9,785.25	-0.85	25.00	9,761.10
	LMH4301		A100758	2.00		9,763.74			9,763.74

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LVM6010	REDACTED	A3797	951.80		9,447.59	-342.09		9,789.68
	LMM5074		A100232			9,776.65	-27.10		9,803.75
	LUH6016		A3887	886.00		9,805.68			9,805.68
	LBF3599		A100561			29,406.28	19,595.10		9,811.18
	LAH6496		A4389	412.23	2,643.51	9,829.74	7.00		9,822.74
	LBS5279		A3087			9,802.18	-47.68		9,849.86
	LMM5099		A2907	57.96		9,855.91			9,855.91
	LFT4405		A100522	0.00		30,644.99	20,735.59		9,909.40
	LCC3103		A2291	1.00		9,939.60	7.00		9,932.60
	LCE3369		A101368			9,867.31	-129.75		9,997.06
	PNX3344		A4140	32,926.85		10,052.96	55.00		9,997.96
	LEVC638		A1534	0.00		10,146.30	127.74		10,018.56
	LAR6520		A4409	1,136.75		10,094.12	49.00		10,045.12
	LSB6475		A4359	104.47		10,126.72	25.00		10,101.72
	LHC3387		A2421	1.00		10,176.35			10,176.35
	LBW2618		A1989	569.00		10,190.92	6.00		10,184.92
	LLB3779		A101511			9,838.92	-419.95		10,258.87
	LVCS903		A1685	327.80		10,260.74			10,260.74
	LTE5533		A3374	0.00		10,305.49		25.00	10,280.49
	LAS2489		A1972	0.00		10,316.26		25.00	10,291.26
	LCK5447		A3294	1.00		10,341.73		25.00	10,316.73
	LRC6284		A4146	482.00	4,087.50	10,338.84	8.00		10,330.84
	LSC6280		A4151	153.16		10,348.03	1.00		10,347.03
	LTM4176		A101030		1,432.79	10,393.45	-4.44		10,397.89
	LAS3316		A2409	0.00		10,423.64		25.00	10,398.64
	LZF3133		A2342	16.85		10,418.79			10,418.79
	LHC3086		A101064	18.00		11,679.80	1,234.07		10,445.73
	LEL6098		A3957			10,506.38	6.00	50.00	10,450.38
	LZF3295		A2388			10,531.26		25.00	10,506.26
	LCS3016		A2249	282.70		10,326.54	-215.64		10,542.18
	LNS3320		A2384			10,647.23	6.00	25.00	10,616.23
	LMR2245		A1850			10,687.64			10,687.64
	LTC4241		A101041			12,863.62	2,104.46	25.00	10,734.16
	LPS4792		A2891	2.00	2,207.17	10,688.04	6.00	-60.71	10,742.75
	LSA5612		A3474	476.75		10,774.84	18.00		10,756.84
	LML3050		A100227	447.72		10,481.74	-366.00	25.00	10,822.74
	LWS5890		A3667	1,057.17		22,422.14	11,537.01	50.00	10,835.13
	LKD2215		A1833			10,848.44			10,848.44
	LBH4091		A100249	0.00		18,732.46	7,826.43	50.00	10,856.03
	LAD5497		A3322			10,867.46	1.00		10,866.46
	LFM2258		A3172	3.00		10,873.19	2.00		10,871.19
	LRH2119		A101442	0.00		10,799.53	-116.61		10,916.14
	LGW5123		A101105	0.00		11,862.74	918.45	25.00	10,919.29
	LPH4240		A100850	1.00		10,955.54		25.00	10,930.54
	LKF5988		A3809	1.00	5,299.72	11,014.89	1.00		11,013.89
	LSA5974		A3798			11,017.88			11,017.88
	LAF2333		A100221	379.84		11,125.13	19.00		11,106.13
	LGC3436		A101670			11,162.96			11,162.96
	LES5948		A3757			11,196.20			11,196.20
	LCP5893		A3610	214.20		11,292.79	2.00		11,290.79
	LSE2290		A101478	0.00		11,188.76	-113.67		11,302.43
	LSF5273		A3091			11,343.62		25.00	11,318.62

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LNC3247	REDACTED	A100695	127.13		11,413.19	-3.86		11,417.05
	LTP3379		A2485	11.00		11,493.83	6.00		11,487.83
	LGH5296		A3111	2,382.46	8,365.62	11,356.71	-220.60		11,577.31
	LEB4481		A101318	510.14		11,631.09		50.00	11,581.09
	LSS6144		A4010	527.84		11,733.58	1.00		11,732.58
	PNM3333		A2320	803.37		11,821.24	48.00		11,773.24
	LMX5245		A3050	1.00		11,849.06	5.00		11,844.06
	LPR2841		A100018	1.00		11,856.80	3.00		11,853.80
	LCR2948		A2210	692.49		11,884.36	2.00		11,882.36
	LES5197		A3096	57.06		11,891.03	5.00		11,886.03
	LJD2328		A1889		319.45	11,893.60			11,893.60
	LAH6033		A3879	4,525.21		16,346.52	4,415.49	25.00	11,906.03
	LNE2160		A1809	215.71		11,909.64			11,909.64
	LCW3278		A2381			11,991.42		25.00	11,966.42
	LPA6149		A4014	188.38		11,982.77	5.00		11,977.77
	LSS3288		A101531	15.37		11,994.62			11,994.62
	LSF6397		A4285	1,438.08		12,102.83	48.00		12,054.83
	LPE1052		A1750	0.00		12,064.92			12,064.92
	LBS6249		A4109	12.12		12,212.36	1.00		12,211.36
	LGS2990		A100638			12,194.23	-68.59	25.00	12,237.82
	LQF5830		A3734	285.76		12,326.38	3.00		12,323.38
	LHS4800		A101241	6.00		12,339.12	4.00		12,335.12
	LPF2268		A1862			12,417.54		25.00	12,392.54
	LCH4643		A101297	7.00		12,438.53			12,438.53
	LNC6193		A4055	110.69		12,459.88			12,459.88
	LHE4270		A100649	1,212.80		12,480.32	7.00		12,473.32
	LHM5828		A3672	662.75		12,475.94	-14.55		12,490.49
	LHL3311		A2422	68.69		12,529.17			12,529.17
	LCHN909		A1682	638.24		12,180.37	-417.48	25.00	12,572.85
	LLM3750		A2480	134.62		12,613.05	11.00	25.00	12,577.05
	LCC3385		A2408			12,591.22			12,591.22
	LCM6444		A4339	91.18		12,664.65	23.00	25.00	12,616.65
	LRH1017		A1718	0.00		12,687.65			12,687.65
	LPP5148		A2917	269.58		12,711.93			12,711.93
	LHT3005		A2233	8.00		12,738.57	14.00		12,724.57
	LEF6162		A4028	4,287.53		12,791.95	-8.97		12,800.92
	LME6382		A4264	58.10	7,157.92	12,847.31	1.00		12,846.31
	LBW4544		A2837	1,149.33		12,595.96	-291.86		12,887.82
	PNX3334		A3677	50.86		12,952.88		25.00	12,927.88
	LRS4354		A2791	1,498.11		13,682.31	753.30		12,929.01
	LTT3885		A2971	0.00		15,782.37	2,820.20		12,962.17
	LSH2505		A101470	1,496.77		13,027.99	15.00		13,012.99
	LLE5247		A3024			13,029.09	4.00		13,025.09
	LFV1018		A1720			13,100.89			13,100.89
	LWT5427		A3260			13,795.87	623.15		13,172.72
	LSD5521		A3357			13,102.94	-143.08		13,246.02
	LBE3738		A2612	411.77		13,245.43	-16.60		13,262.03
	LNC5526		A3380	305.75		13,300.12	6.00		13,294.12
	LVU6013		A3845	954.34		13,332.18		25.00	13,307.18
	LEH2346		A1898	0.00		14,219.91	872.40		13,347.51
	LNT5651		A3503			13,337.72	-20.44		13,358.16
	LCLN809		A1624			13,383.42			13,383.42

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LTC5927	REDACTED	A3711			13,429.43	-11.29		13,440.72
	LFV4348		A101212	1,304.48		13,547.73	11.00		13,536.73
	LST5440		A3270	4,372.43		13,568.35	2.00	25.00	13,541.35
	LFY3489		A2431			13,564.48	-21.52		13,586.00
	LDH3182		A2352	0.00		30,175.41	16,544.30	25.00	13,606.11
	LDN5127		A2926	56.50		13,659.95			13,659.95
	LMC4899		A2876	0.00		24,009.61	10,306.24		13,703.37
	LKA6363		A4252	15.90		13,709.66			13,709.66
	LAR5648		A3472	593.86		13,723.73			13,723.73
	LJL2716		A2105	15.00		13,762.94	4.20	25.00	13,733.74
	LMR3200		A2323	0.00		13,822.39	0.44		13,821.95
	LBD4625		A100089	530.00		13,830.95	-5.31		13,836.26
	LSG6297		A4181	13.74		13,867.72			13,867.72
	LCR5326		A3178	0.00		16,602.86	2,677.19		13,925.67
	LHF5339		A3181	379.55		13,765.86	-258.11		14,023.97
	LTC5566		A3406	316.96		14,030.45	-45.55		14,076.00
	LPH5097		A100432		2,045.97	13,881.06	-240.69		14,121.75
	LMD2965		A2222			13,250.18	-885.32		14,135.50
	LMB3984		A100076	220.91		14,145.46	1.00		14,144.46
	LALL894		A1674			14,192.57			14,192.57
	LMY5353		A3192	510.44		14,222.43			14,222.43
	LCA3076		A100614			14,247.13			14,247.13
	LND3165		A100660	390.80		14,277.21	9.00		14,268.21
	LWK2939		A100255	9.00		14,299.65	4.00		14,295.65
	LDD4776		A2860			14,406.70	-9.32		14,416.02
	LLQ4273		A101379	83.18		14,464.92	6.00	25.00	14,433.92
	LGHR872		A101233	871.08	2,763.88	19,301.81	4,739.38		14,562.43
	LMD4269		A100361	831.42	9,241.87	14,623.01			14,623.01
	LCC5016		A100799			14,728.69			14,728.69
	LFF3937		A100162			14,922.52	186.89		14,735.63
	LDF2943		A100073	313.51		14,788.47			14,788.47
	LMC3409		A101698			14,863.19		25.00	14,838.19
	LSF4630		A101521	23.92		14,891.72		25.00	14,866.72
	LAP5152		A2919			14,891.72	1.00		14,890.72
	LSG2806		A100055	1,247.46		14,915.39	3.00		14,912.39
	LTN1062		A1732			15,005.41		50.00	14,955.41
	LEM4558		A2827	116.30		15,084.03	21.00		15,063.03
	LFP1086		A1744			14,841.69	-276.74		15,118.43
	LBE5997		A3842	80.32	5,824.24	15,172.86	15.00		15,157.86
	LDH5592		A3444	1,076.01		15,163.25	3.00		15,160.25
	LPN6276		A4143	52.00		15,320.51		25.00	15,295.51
	LBB2971		A2219			15,361.22			15,361.22
	LLW4290		A101129	2,487.02		15,430.54	9.00		15,421.54
	LMS4409		A100208	643.18		15,464.84	-45.00		15,509.84
	LLT4579		A101504	3.00		15,663.52			15,663.52
	LHF3380		A2418			15,712.81			15,712.81
	LWPJ934		A100326			18,750.04	3,020.11		15,729.93
	LHG4667		A100979	26.28		15,780.96	7.00	25.00	15,748.96
	LMP6355		A4238	161.48		15,813.89	8.00	50.00	15,755.89
	LED5489		A3338	755.79		15,784.94	8.00		15,776.94
	LTS1006		A1713			15,902.75		25.00	15,877.75
	LSS1097		A1794	0.00		15,979.36	0.00		15,979.36

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHM5288	REDACTED	A3102	35.84		16,098.06	2.00		16,096.06
	LCS4036		A2702	0.00		16,122.50	13.00		16,109.50
	LBC2564		A101346	147.87		16,184.34	-9.56	50.00	16,143.90
	LGB1013		A1717			16,185.25		25.00	16,160.25
	LHR5303		A3128	0.00	2,876.38	16,180.21	0.00		16,180.21
	LCM5021		A100836	0.00		19,789.54	3,470.98		16,318.56
	LHS4838		A101565			16,436.31		25.00	16,411.31
	LCA5157		A2957	190.00		16,501.00			16,501.00
	LHH3862		A3170			15,706.47	-814.75		16,521.22
	LAP6142		A4002	8.00		16,549.03	4.00		16,545.03
	LTW2432		A100021	0.00		13,978.41	-2,570.39		16,548.80
	LYA6236		A4096	1,038.88		16,589.23	22.28		16,566.95
	LHF4102		A101018	4.00		16,623.56	10.00		16,613.56
	LFRA680		A100540	1.00		16,743.18	7.00		16,736.18
	LAC6145		A4005	0.00		16,590.76	-250.45		16,841.21
	LKE6259		A4128	1,524.62		17,059.74	12.00		17,047.74
	LDTA740		A100294	103.60		17,202.98	1.00		17,201.98
	LHG3176		A100686	65.06		17,216.76	8.00		17,208.76
	LWD3171		A100025	388.12		16,915.12	-313.87		17,228.99
	LUSA807		A1637			17,613.56		50.00	17,563.56
	LPE2334		A1894	215.24		17,623.56			17,623.56
	LSW2964		A101074	0.00		23,398.95	5,739.86		17,659.09
	LGM2743		A100009	767.78	4,360.55	17,690.84	2.00		17,688.84
	LJF5445		A3293	0.00		19,755.36	2,055.46		17,699.90
	PNX3336		A3686	6,960.07		17,868.40	49.00		17,819.40
	LNP3471		A101116	4,305.87	8,989.31	18,018.83	9.00		18,009.83
	LSL5328		A3166	48.88	13,676.58	18,213.77	-2.36		18,216.13
	LTS4581		A2833	0.00		28,001.91	9,740.62	25.00	18,236.29
	LRZ5114		A2914			18,237.68			18,237.68
	LZA2807		A100426	5.00		19,271.71	1,028.67		18,243.04
	LSP5831		A3708	602.74		18,172.75	-216.37	25.00	18,364.12
	LDH5834		A3695			18,489.63	-10.83		18,500.46
	LAS2298		A101345	0.00		18,606.45		25.00	18,581.45
	LLAW476		A100672	0.00		18,636.10		25.00	18,611.10
	LMP1014		A100360	552.85		18,764.06	1.00	25.00	18,738.06
	LFF5257		A3065	63.10		18,744.01	-42.27		18,786.28
	LAE2463		A101328	313.20		18,864.51			18,864.51
	LPH6531		A4437	0.00		25,983.58	6,968.30	25.00	18,990.28
	LPP6323		A4201	1,164.85		19,100.65	21.00		19,079.65
	LBP2732		A100625			20,306.33	1,194.77		19,111.56
	LFC3197		A2332			19,195.98			19,195.98
	LSC5335		A3180	124.03		19,216.17	3.00		19,213.17
	LRS2183		A1817	170.50		19,311.55			19,311.55
	LBR5270		A3077			19,319.69	0.00		19,319.69
	LHP6251		A4115	0.00		17,395.46	-2,011.99	25.00	19,382.45
	LSC6423		A4315	522.43		19,519.51	25.00		19,494.51
	LADC753		A1594			21,320.55	1,782.55		19,538.00
	LSM3354		A2399	0.00	3,145.05	19,543.49	-92.94	25.00	19,611.43
	LAS2584		A2004	48.00		20,189.28	562.06		19,627.22
	LEE4537		A101102	849.50		32,655.09	12,899.96	25.00	19,730.13
	LST4835		A100683	374.68		19,744.25	6.00		19,738.25
	LRC3643		A100894	2,596.83		25,998.45	6,172.25	25.00	19,801.20

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LHM3233	REDACTED	A2390	1,082.99		19,867.41	18.00		19,849.41
	LEH6510		A4398	4.22		20,811.93	760.00		20,051.93
	LCH1101		A1771	13.00		20,213.51	7.00		20,206.51
	LTM3881		A2659	253.26		20,331.77	3.02		20,328.75
	LLB2365		A1905			20,241.94	-349.96		20,591.90
	LBG3290		A2446	3.00		20,687.66	2.00		20,685.66
	LCR6178		A4051	994.40		20,801.91	-9.49		20,811.40
	LGF5363		A3204	0.00		32,228.32	11,126.33		21,101.99
	LGM1029		A1735	45.49		21,215.85			21,215.85
	LSC6097		A3951	0.00		21,280.25	-31.17		21,311.42
	LKF5131		A2929	319.32		21,422.23	-30.67	25.00	21,427.90
	LGP4262		A100725			21,814.40	289.10		21,525.30
	LCT6215		A4079	6,342.16		21,529.79	2.00		21,527.79
	LKS5387		A3302	641.21		21,540.47	-17.97		21,558.44
	LDA3389		A100748	12.54		23,654.16	1,484.83		22,169.33
	LNH5431		A3275	0.00		22,708.96	350.00	25.00	22,333.96
	LGH3257		A2372			22,404.24			22,404.24
	LSL2576		A2064			22,390.95	-25.00		22,415.95
	LCD2271		A100697	184.00		22,417.10	1.00		22,416.10
	LSA5644		A3473	731.57		22,434.07			22,434.07
	LGF3844		A101540	1.00		22,512.73			22,512.73
	LFS3077		A2277	29.50		22,613.05	3.00		22,610.05
	LSL2757		A100059	3.00		22,633.90	2.00		22,631.90
	LCA5011		A100493	269.47		22,726.95	2.00	50.00	22,674.95
	LBLC715		A1582	5,622.75		22,895.40	68.00	-13.05	22,840.45
	LAP3988		A2687			23,042.70			23,042.70
	LPE5964		A3787			23,159.02	13.00	25.00	23,121.02
	LAD2131		A1800	156.40		23,371.88			23,371.88
	LDD3276		A100483	53.63		23,407.38	-5.51		23,412.89
	LASS713		A101330	2,866.73		23,870.51	21.00	25.00	23,824.51
	LCC4131		A2720	3,867.80		24,003.08	3.00	25.00	23,975.08
	LQC5821		A3720	0.00		24,061.22	31.17		24,030.05
	LHH6119		A4000	0.00		27,120.46	2,982.38		24,138.08
	LCS4679		A100189	145.36	5,749.71	24,513.89	1.00		24,512.89
	LCM2542		A2070			24,545.45			24,545.45
	LGB5562		A3399	568.58		24,833.53	-31.80		24,865.33
	LEP3088		A2304	5.00	12,785.30	25,581.95			25,581.95
	LFP2214		A1832			25,584.08	-135.73		25,719.81
	LSS4672		A100995	877.09		27,543.76	1,386.07		26,157.69
	LRM6404		A4288	1,551.77		24,938.58	-1,246.08	25.00	26,159.66
	LCN2858		A2172	427.74		26,190.25	7.00		26,183.25
	LCFS867		A1661			26,495.28	-172.02	-2.00	26,669.30
	LTT1085		A1749	47.11		26,711.02	2.00		26,709.02
	LCC5752		A3564	159.81		26,767.79	-0.45	25.00	26,743.24
	LSN4119		A101544			26,944.65		25.00	26,919.65
	LSMM795		A1617	9,792.71	74,543.16	84,581.50	57,655.06		26,926.44
	LCUB584		A1507	2,803.33		29,913.00	2,982.51		26,930.49
	LJC4386		A100419			27,403.94		50.00	27,353.94
	LEE2324		A101317	3,507.68		27,375.01	7.00		27,368.01
	LMP4314		A100364	41.00	6,106.86	27,396.29	9.00		27,387.29
	LJS4190		A2745			27,473.52		25.00	27,448.52
	LVY4708		A2849	115.94		27,594.72			27,594.72

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LWC3180	REDACTED	A2335	63.42		28,615.14	904.75	25.00	27,685.39
	LPM4572		A101146	0.00		27,725.97	3.00		27,722.97
	LSS5943		A3619	68.24		28,360.96	-21.24	25.00	28,357.20
	LJK4390		A100418	140.35		28,565.35	-60.34		28,625.69
	LST3494		A100886	397.52		29,582.00	-44.10		29,626.10
	LWS2786		A100023	0.00		29,946.81	-221.45		30,168.26
	LDC4738		A100413	0.00		30,241.75			30,241.75
	PNX3335		A3599	17,611.48		30,605.43	191.00		30,414.43
	LMU2562		A100144	3,035.05		30,452.53	4.00		30,448.53
	LEF2647		A2149	895.34		30,720.95			30,720.95
	LSC2545		A1999			30,690.76	-169.97		30,860.73
	LCF3634		A100395	5,123.99		31,098.92			31,098.92
	LRD2321		A101274			36,962.11	5,780.32		31,181.79
	LUH3057		A2269			31,215.03	-125.27		31,340.30
	LLC3613		A2542			31,437.77			31,437.77
	LAP3490		A2463	2,097.06		31,423.23	-118.48		31,541.71
	LJP3800		A2640	0.00		32,639.79	873.11	50.00	31,716.68
	LPHF688		A1564			32,067.89	-225.22		32,293.11
	LDR3706		A2504			31,673.45	-771.30		32,444.75
	LPH5458		A3288	0.00		32,272.50	-174.04		32,446.54
	LEB3981		A2682	0.00		1,372.95	-31,425.58		32,798.53
	LHPL756		A1599	0.00		33,083.39			33,083.39
	LGE2115		A1786	456.97		33,121.85			33,121.85
	LTS5776		A3582	409.42		33,016.71	-308.53		33,325.24
	LFN6287		A4174	5,045.36		33,447.01	-5.19		33,452.20
	LPC3886		A100015	8,561.98		33,727.31	-38.00	25.00	33,740.31
	LTPP803		A1636	165.60		33,721.84	-37.00		33,758.84
	LAE4199		A100101	10.00		33,995.08	7.00		33,988.08
	LSC3966		A100198	222.10		34,237.94	3.00		34,234.94
	LMM2978		A100137	2,686.27	17,838.67	32,896.90	-1,441.21		34,338.11
	LAM6438		A4326	17.00		35,200.34	18.00	25.00	35,157.34
	LCB4518		A2825	0.00		35,194.80	-420.80		35,615.60
	LDE4295		A101351	594.58		50,438.67	14,807.28		35,631.39
	LSV3212		A2341	326.10		36,136.51			36,136.51
	LFS5791		A3598	0.00		35,969.00	-235.60		36,204.60
	LJNH728		A1589	234.18		36,387.82	2.00		36,385.82
	PNX3337		A3616	10,263.43		36,542.30	51.00		36,491.30
	PNX3349		A4367	2,969.86		36,792.27	63.00		36,729.27
	LHC3604		A100974	8,717.73		59,649.47	22,898.32		36,751.15
	LLW5472		A3311	277.89		37,395.99	2.89		37,393.10
	LAS1007		A100113	0.00		67,437.81	29,592.04	25.00	37,820.77
	LRR2885		A100663	0.00		35,397.28	-2,615.97		38,013.25
	LAS3137		A2300			37,799.84	-314.89	25.00	38,089.73
	LFP5542		A3363	574.59		38,415.18	12.00		38,403.18
	LSS2444		A100632	0.00		37,996.57	-460.56		38,457.13
	LBD6237		A4106	2,950.84		37,652.60	-849.70		38,502.30
	LLM2128		A101432	1,502.79		38,840.56	8.00		38,832.56
	LPP2125		A1782			40,160.06		75.00	40,085.06
	LHL6504		A4395	8,653.55		40,113.55	-1,253.50		41,367.05
	PMH2221		A3664			41,999.42	262.96		41,736.46
	LMT4120		A101607			44,048.22	53.00		43,995.22
	LFR2479		A100721	1,148.22	4,063.32	45,689.47	-97.97		45,787.44

Group Name	Group #	Bank Account	GL Account	Claims Pd This Week	AP Paid This Week	Acct Balance @3/25/21	Ready Claims	Unpaid AP	Ending Balance
REDACTED	LPR4745	REDACTED	A2861	1,095.33		46,092.29	16.36		46,075.93
	LCFI690		A1559	0.00		49,217.93	-168.40		49,386.33
	LFS2154		A100526	114.30		50,239.94	4.00	50.00	50,185.94
	LTL6017		A3888	0.00		56,546.29	6,253.82		50,292.47
	LCT4565		A2831	101.05		51,540.26	5.00		51,535.26
	LSE4373		A101388			51,141.33	-400.10		51,541.43
	PNR3331		A2843	2,438.29		52,747.41	71.00	25.00	52,651.41
	LAD1028		A1779	453.50		53,860.68	1,000.00	50.00	52,810.68
	LFC5557		A3397	2.00	3,116.97	53,101.83	4.00		53,097.83
	LMM4081		A2717	1,172.75		54,040.39	22.00	25.00	53,993.39
	LNS2442		A1947	296.54	11,447.52	55,457.35	-132.02		55,589.37
	LGF4983		A101173			67,773.82	9,456.18		58,317.64
	LTS2390		A1926	2.00		58,722.93			58,722.93
	LSP5911		A3658	0.00	8,522.76	55,457.42	-3,506.88		58,964.30
	LAM6411		A4298	1,211.57		59,670.93	-354.84		60,025.77
	LEP5277		A3085			61,210.15	-190.80	25.00	61,375.95
	LAH1083		A2939	0.00		234,695.26	6,277.15	164,868.01	63,550.10
	LOTL254		A100752	13.00	15,865.68	64,260.32	5.00		64,255.32
	LTW2267		A101205	620.14		69,101.63	3.00	25.00	69,073.63
	LMC4220		A101137	633.33		69,346.77	-55.37		69,402.14
	LBN2462		A2123	1,108.93		88,301.05	11,219.46	32.28	77,049.31
	LSF3902		A100157	0.00		85,194.68	1,484.93		83,709.75
	LEC4741		A2894	0.00		141,438.81	49,626.04		91,812.77
	LSM6205		A4074	0.00		146,773.88	48,030.37	25.00	98,718.51
	LGM3069		A2265	1,539.61		108,176.06	-23.00		108,199.06
	PPAH227		A2942			129,835.10	290.00	6,029.89	123,515.21
	LVM2922		A2239	0.00		130,379.52	-332.82		130,712.34
	LCD6238		A4098	0.00		134,393.58	401.00		133,992.58
	LTL3260		A2379	0.00		142,317.89	4,237.13	-1.00	138,081.76
	LKE6093		A3961			139,774.96			139,774.96
	LCC5177		A2989	0.00		295,214.01	151,138.10		144,075.91
	LRMW692		A1557	0.00		158,291.39	-174.64		158,466.03
	LRL4022		A100088			65,301.21	-100,075.39		165,376.60
	PPAH222		A2939	0.00		234,695.26		23,195.22	211,500.04
	PPHH229		A2943	0.00		223,071.93	3,204.23	3,841.46	216,026.24
	LHC2812		A2943	0.00		223,071.93	4,813.56	105.00	218,153.37
	LHE4714		A2874	0.00		133,766.34	-100,240.01		234,006.35
	LSG6233		A4097	0.00		272,765.55	2,893.45		269,872.10
	PPCC230		A2989			295,214.01	0.00		295,214.01
	PPFA221		A2934			319,305.92		9,398.63	309,907.29
	LGE2599		A2006	351.23		343,735.28	30,872.80	25.00	312,837.48
	LFH3787		A2934			319,305.92	295.22		319,010.70
	PPGR225		A2933			672,080.76	1,795.00	301,996.74	368,289.02
	LGRC736		A2933			672,080.76	6,692.99		665,387.77
	LRW6373		A4256	0.00		849,264.26	2,049.67	25.00	847,189.59