NAME: **SS#:**

UFCW Unions and Participating Employers Health and Welfare Fund

EMPLOYER:	Shoppers Food	**LOCAL:**	27
DATE OF HIRE:	June 21, 1988	**STATUS:**	Full Time
PLAN:	JSS2		

ISSUE: Hospital/Medical – Coordination of Benefits with Medicare-ESRD #M22/116-9067

FUND RULE:

"**Eligibility**

[…] Benefits for eligible participants disabled 24 months or more or eligible for Medicare because of End Stage Renal Disease are provided through Medicare. Your Fund coverage is automatically converted to a Medicare Supplemental Program which covers some of the costs associated with Medicare coverage. You must enroll for Medicare by contacting the Social Security Administration. […]"
(Plan JSS2 SPD, Page 29)

"**Coordination of Benefits**

[…] Medicare also becomes primary once it has been determined by Medicare that you have had End Stage Renal Disease (ESRD) for 30 months. During the 30-month interval, if you are working, the Plan is primary."
(Plan JSS2 SPD, Page 44)

SUMMARY:

Date(s) of Service:	March 1, 2022 through September 13, 2023
Claim(s) Received:	April 1, 2022 through September 22, 2023
Claim(s) Denied:	July 20, 2022 and continuing
Appeal Received:	October 13, 2023

The **provider,** DaVita, Inc. (d/b/a Landover Dialysis), has been appointed by the participant to be his authorized representative for the purposes of this appeal. DaVita, Inc. is appealing for payment of dialysis claims that were denied.

Fund records indicate the participant began dialysis treatment on or about March 28, 2018. Based upon the date dialysis began, the participant would have become entitled to Medicare due to End Stage Renal Disease (ESRD) on July 1, 2018. Pursuant to the terms of the Fund, the participant's coverage under the Fund was automatically converted to Medicare supplemental coverage effective January 1, 2021 (30 months after he became eligible for Medicare). As a result of this transition, effective as of January 1, 2021, the UFCW Unions and Participating Employers Health and Welfare Fund is the secondary payer for his claims. Claims received by the Fund on his behalf, for services rendered on and after January 1, 2021, have been pended and denied to the extent that copies of Medicare's payment EOBs (Explanations of Benefits) have not been received.

The provider states in the appeal that the participant has not enrolled in Medicare coverage, and therefore, it is in the provider's opinion that the Fund is responsible for primary payment.

After the appeal was received, the Fund office mailed letters to the participant on October 19, 2023 and November 3, 2023, requesting clarification as to why he hasn't enrolled in Medicare Part B coverage. To date, there has been no response.

Note: The provider, DaVita, Inc., appealed the denial of earlier claims in 2021, under the same circumstance. The Board of Trustees denied that appeal.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐

COMMENTS:

DaVita®

September 20, 2023

CareFirst Administrator
Attn: Appeals Department
P.O. Box 981608
El Paso, TX 79998

Re:	1st Level Appeal for Payment of Dialysis Services
Member:	
Policy #:	
Group #:	
Facility:	Landover Dialysis
Tax ID #:	952977916
Claim #:	Multiple-Please See Attached
Date of Service:	Multiple-Please See Attached

Dear Sir or Madam:

CareFirst Administrator ("BCAD") has denied payment because BCAD believes the patient has Medicare as primary coverage. The patient's Medicare Part B is not active (*please see attached Medicare eligibility response for further reference*).

The patient is not enrolled in Medicare Part B during these dates of service therefore Medicare is not the patient's primary coverage. ***It is critical to distinguish between Part A and B, since Medicare Part B is the plan under which dialysis claims are processed.*** As the patient does not have Medicare Part B and BCAD is not a secondary payer for the purpose of coordinating benefits, BCAD is liable for full contract rates.

Per our Agreement, BCAD is responsible to pay **$738.00** for CPT Code 90999 Revenue Code 821. Therefore, DaVita requests that BCAD reprocess and pay this claim.

DaVita also hereby reserves its rights to raise any and all arguments and claims available under applicable law with respect to the matters set forth herein. This letter is written without waiver of or prejudice to DaVita's rights or remedies, all of which are expressly reserved.

Thank you for the reconsideration.

Sapna Dholakia
Commercial Insurance Analyst
Phone: (949) 930-6705
E-mail: sapna.dholakia@davita.com

	Start DOS	End DOS	Payer Claim	DaVita Claim	Original Billed Amount	Paid Amount	Remaining Balance
1	3/1/2022	3/5/2022	BSZZ66	121410828101	$32,747.90	$0.00	$2,734.50
2	3/8/2022	3/12/2022	BSZZ64	121424526101	$32,747.90	$0.00	$2,734.50
3	3/15/2022	3/19/2022	BTBS47	121443441101	$32,946.50	$0.00	$2,734.50
4	3/22/2022	3/31/2022	BTLN41	121464076101	$53,273.40	$0.00	$4,557.50
5	4/2/2022	4/7/2022	BTWC35	121676906101	$32,946.50	$0.00	$2,734.50
6	4/9/2022	4/14/2022	BVBT82	121695724101	$32,946.50	$0.00	$2,734.50
7	4/16/2022	4/21/2022	BVJB06	121722886101	$32,946.50	$0.00	$2,734.50
8	4/23/2022	4/30/2022	BVLX79	121744661101	$42,544.35	$0.00	$3,646.00
9	5/3/2022	5/7/2022	0	121959299101	$32,136.20	$0.00	$2,734.50
10	5/10/2022	5/14/2022	CCXS89	121959332101	$27,305.45	$0.00	$2,474.25
11	5/17/2022	5/21/2022	0	121992648101	$26,770.55	$0.00	$2,474.25
12	5/24/2022	5/31/2022	CCXS90	122162527101	$36,858.00	$0.00	$3,299.00
13	6/2/2022	6/7/2022	BWSBS2	122226768101	$27,305.45	$0.00	$2,474.25
14	6/9/2022	6/14/2022	BWST65	122245505101	$27,506.70	$0.00	$2,474.25
15	6/16/2022	6/21/2022	BWYB18	122269543101	$27,909.20	$0.00	$2,474.25
16	6/23/2022	6/30/2022	BXCM43	122324823101	$34,591.20	$0.00	$3,299.00
17	7/2/2022	7/7/2022	BYGT93	122501107101	$21,593.30	$0.00	$2,474.25
18	7/9/2022	7/14/2022	CCXS93	122520094101	$21,460.90	$0.00	$2,474.25
19	7/16/2022	7/21/2022	BZVP10	122527374101	$21,394.70	$0.00	$2,474.25
20	7/23/2022	7/30/2022	CDPP45	122673399101	$21,394.70	$0.00	$2,474.25
21	8/2/2022	8/6/2022	BYHR16	122768691101	$21,394.70	$0.00	$2,474.25
22	8/9/2022	8/13/2022	CDPP40	122782864101	$20,798.90	$0.00	$2,474.25
23	8/16/2022	8/20/2022	BYST05, CDPP43	122794547101	$20,798.90	$0.00	$2,474.25
24	8/23/2022	8/30/2022	BYST11	122843331101	$28,360.90	$0.00	$3,299.00
25	9/1/2022	9/6/2022	CDPP38	123032981101	$20,798.90	$0.00	$2,474.25
26	9/8/2022	9/13/2022	CDPP47	123048440101	$20,798.90	$0.00	$2,474.25
27	9/15/2022	9/20/2022	BZPY57	123071830101	$20,798.90	$0.00	$2,474.25
28	9/22/2022	9/29/2022	CBDR18	123249297101	$26,577.55	$0.00	$3,212.25
29	10/1/2022	10/6/2022	CBHJ57	123296809101	$20,798.90	$0.00	$2,474.25
30	10/8/2022	10/13/2022	CBMT16	123316779101	$20,798.90	$0.00	$2,474.25
31	10/15/2022	10/20/2022	CBNP05	123335857101	$20,798.90	$0.00	$2,474.25
32	10/22/2022	10/29/2022	CBSR90	123371485101	$27,417.35	$0.00	$3,299.00
33	11/1/2022	11/5/2022	CCBT03	123560458101	$21,142.45	$0.00	$2,474.25
34	11/8/2022	11/10/2022	CCHB39	123581192101	$14,048.05	$0.00	$1,649.50
35	11/15/2022	11/19/2022	CCJL41	123596627101	$20,600.30	$0.00	$2,474.25
36	11/22/2022	11/29/2022	CCNP45	123679284101	$28,096.10	$0.00	$3,299.00
37	12/1/2022	12/6/2022	CCXS88	123821005101	$23,115.90	$0.00	$2,474.25
38	12/8/2022	12/13/2022	CDGY45	123854996101	$19,576.62	$0.00	$2,561.00
39	12/15/2022	12/20/2022	CCZDS2	123863877101	$21,963.38	$0.00	$2,474.25
40	12/22/2022	12/31/2022	CDDT67	123991048101	$30,782.55	$0.00	$4,123.75
41	1/3/2023	1/7/2023	CDJF37	124092700101	$23,508.15	$0.00	$2,474.25
42	1/10/2023	1/14/2023	CDPP41	124118954101	$20,186.10	$0.00	$2,474.25
43	1/17/2023	1/21/2023	CDSN56	124126257101	$20,171.70	$0.00	$2,474.25
44	1/24/2023	1/31/2023	CFBC56	124299739101	$32,007.80	$0.00	$3,299.00
45	2/2/2023	2/7/2023	CFFS05	124352726101	$19,159.65	$0.00	$2,474.25
46	2/9/2023	2/14/2023	CFKK92	124373415101	$19,159.65	$0.00	$2,474.25
47	2/16/2023	2/21/2023	CFPN47	124390993101	$22,947.70	$0.00	$2,474.25
48	2/23/2023	2/28/2023	0	124606665101	$19,159.65	$0.00	$2,474.25
49	3/2/2023	3/7/2023	0	124626332101	$19,159.65	$0.00	$2,474.25
50	3/9/2023	3/14/2023	0	124639007101	$19,159.65	$0.00	$2,474.25
51	3/16/2023	3/21/2023	0	124655858101	$22,481.20	$0.00	$2,474.25
52	3/23/2023	3/30/2023	0	124873988101	$25,546.20	$0.00	$3,299.00
53	4/1/2023	4/6/2023	0	124887926101	$19,159.65	$0.00	$2,474.25
54	4/8/2023	4/14/2023	0	124905285101	$25,546.20	$0.00	$3,299.00
55	4/17/2023	4/21/2023	0	124921208101	$22,481.20	$0.00	$2,474.25
56	4/24/2023	4/28/2023	0	125088214101	$20,171.70	$0.00	$2,474.25
57	5/1/2023	5/5/2023	0	125155381101	$20,171.70	$0.00	$2,474.25
58	5/9/2023	5/12/2023	0	125175133101	$20,171.70	$0.00	$2,474.25
59	5/15/2023	5/19/2023	0	125188478101	$22,593.70	$0.00	$2,387.50
60	5/22/2023	5/31/2023	0	125378106101	$33,956.85	$0.00	$4,123.75
61	6/2/2023	6/7/2023	0	125416839101	$20,171.70	$0.00	$2,474.25
62	6/9/2023	6/14/2023	0	125447851101	$23,493.25	$0.00	$2,474.25
63	6/16/2023	6/21/2023	0	125455428101	$20,171.70	$0.00	$2,474.25
64	6/23/2023	6/30/2023	0	125668353101	$26,558.25	$0.00	$3,299.00
65	7/3/2023	7/7/2023	0	125694218101	$20,171.70	$0.00	$2,474.25
66	7/10/2023	7/14/2023	0	125712054101	$23,493.25	$0.00	$2,474.25
67	7/17/2023	7/21/2023	0	125721021101	$24,759.15	$0.00	$3,125.50
68	7/24/2023	7/31/2023	0	125883392101	$27,570.30	$0.00	$3,299.00
69	8/2/2023	8/7/2023	0	125958218101	$22,593.70	$0.00	$2,387.50
70	8/9/2023	8/14/2023	0	125969998101	$20,171.70	$0.00	$2,474.25
71	8/16/2023	8/21/2023	0	125998346101	$20,171.70	$0.00	$2,474.25
72	8/23/2023	8/30/2023	0	126167609101	$31,145.70	$0.00	$3,950.25
73	9/1/2023	9/6/2023	0	126224504101	$22,593.70	$0.00	$2,387.50
74	9/8/2023	9/13/2023	0	126241584101	$20,171.70	$0.00	$2,474.25

DaVita.
Kidney Care

Patient Name:
Patient MPI:
Facility: LANDOVER DIALYSIS (03759)

00210206784513223421001O

PATIENT AUTHORIZATION & FINANCIAL RESPONSIBILITY

Purpose:

The purpose of this document is to confirm my choice to receive dialysis services at the listed facility and that I will be personally responsible for payments and other services I receive through DaVita. Further, I am assigning rights to payments from my insurer and authorizing DaVita to obtain the necessary information to obtain such payments.

Please read the following statements carefully.

By signing this Patient Acknowledgement, Authorization and Finahcial Responsibility Form ("Form"), I acknowledge and understand the following:

1. I am personally responsible for payment for dialysis treatments and other services that I receive from DaVita or its subsidiaries or affiliates (collectively, "DaVita") at or through the above listed dialysis facility ("Facility"), or any other facility which is managed or operated by DaVita.
   a. My financial responsibility will be at the full billed charges for the facility where I receive care (available for my review upon request) unless my insurance carrier has negotiated a lower rate with DaVita.
   b. My financial responsibility for my treatments continues until my primary and (if applicable) secondary insurance carriers reimburse DaVita for such services, or DaVita releases me from such responsibility.
2. I acknowledge that I have the right to choose any healthcare provider, company or dialysis service provider. I may change health care providers, including dialysis service providers, at any time.
3. By receiving education on DaVita facilities available for my treatment of ESRD from DaVita, I am under no obligation to receive treatment from DaVita or its affiliates.
4. I may consult with DaVita insurance counselors or social workers concerning my health insurance options and related matters. DaVita does not guarantee the comprehensiveness or completeness of the education provided on health insurance options. Any information that is provided to me by DaVita is based on a good faith understanding of the rights and obligations associated with each health insurance plan, and is not a representation made by DaVita as to how the plan will ultimately cover or pay for health care services.
5. I acknowledge that it is always my decision whether to apply for coverage. It is my responsibility to research my insurance options and select the plan that I determine best meets my financial and health care needs.
6. DaVita cannot and will not provide any benefit or inducement to me in exchange for applying for or obtaining a specific insurance coverage.

RECEIVED
OCT 13 2023
AA, LLC

DaVita.
Kidney Care

Patient Name:
Patient MPI:
Facility: LANDOVER DIALYSIS (03759)

00210206784513223421 0020

PATIENT AUTHORIZATION & FINANCIAL RESPONSIBILITY

In return for Facility's treatment and services, I agree to the following:

1. Authorization. I authorize DaVita, its affiliates and those acting on their behalf to:
   a. Obtain my insurance, employee benefit plan, insurance plan (including Medicare, Medicaid, and Social Security Administration), union trust fund, or similar plan ("Plan") information and financial information from my physician, the hospital from which I was referred, and my insurer/payor (including agents, administrators, or representatives), including, without limitation, benefits and coverage information.
   b. Obtain my healthcare coverage and benefits information including the benefits booklet, plan document, summary plan description, from the Plan or Plans which provide my health care coverage.
      i. If my Plan is sponsored by my employer, I understand that my employer may learn of my treatment at DaVita when DaVita requests my healthcare coverage and benefits information.
      ii. If DaVita is unable to obtain the necessary benefits information and documents from my Plan or employer, then I agree to obtain such information and documents and provide them to DaVita.
   c. When necessary for insurance claims, release my confidential medical information and/or personal financial information to my insurer/payor (including copies of medical records).
   d. Call or text me at the telephone number I provided to them using an automatic telephone dialing system and/or a prerecorded message, even if the number I provided is a cell phone.
2. Insurance Payment. I agree to assist DaVita in obtaining treatment authorization and payment for my treatment from my insurance plan, carrier and/or government program. If I am unable to obtain insurance coverage or pay for my treatment out of pocket, then I will apply for appropriate benefits under any federal or state programs (including Medicare, Medicaid, state kidney fund programs, etc.) for which I may be eligible.
3. Patient Deductible and Co-payment. I agree to pay my annual deductible, coinsurance, co-payments, or any other related costs associated with my treatment. Except when a patient has completed DaVita's Patient Financial Evaluation Policy application, DaVita will not waive any co-pays, co-insurance, or other patient responsibility.
4. Treatment Authorization. I understand that if a treatment authorization is required by my insurer or payor and DaVita cannot obtain it by the time of my third dialysis treatment (or my third dialysis treatment after the expiration of a treatment authorization), DaVita may ask me to (a) pay in cash prior to receiving any additional dialysis treatment, or (b) transfer to a non-DaVita dialysis center (a list of centers will be provided prior to transfer).
5. Assignment of Benefits; Lien. I understand that DaVita must be paid for the care that it provides to me. In order to facilitate payment, I give DaVita the right to seek payment from any Plan in my name. I assign to DaVita all of my rights to any payment due to me (or my estate) under any Plan, for services, drugs or supplies provided by DaVita to me. This assignment includes any claims or rights that I may have arising out of a Plan's failure to pay claims, including statutory penalties, interest, and tort claims. The purpose of this assignment is, in part, to create an assignment of benefits under ERISA or any other applicable law. I also hereby designate DaVita as a beneficiary under any Plan and Direct Plans that any payment should be made to and sent directly to DaVita. If I receive any payment directly from any Plan for services, drugs or supplies provided to me by DaVita, including insurance checks, I agree to immediately endorse and forward such payment to DaVita.

   I agree not to assign my benefits under any Plan to any other person or firm for services, drugs or supplies provided to me by DaVita. If I fail to perform any of my obligations under this provision, I understand that DaVita may pursue collections and legal action against me. In this case, I shall be responsible for the costs of collection (including reasonable attorney's fees) that are incurred by DaVita.

RECEIVED
OCT 19 2023
AA, LLC

DaVita
Kidney Care
Patient Name:
Patient MPI: 2044384
Facility: LANDOVER DIALYSIS (03759)

00210206784513223421003 1

PATIENT AUTHORIZATION & FINANCIAL RESPONSIBILITY

6. Collection of Benefits / Legal Action. I agree to assist and cooperate fully with DaVita to obtain payment from any Plan for services, drugs or supplies provided to me by DaVita. This includes, if DaVita requests, my participation as a plaintiff in any litigation or arbitration arising from a dispute between DaVita and any Plan relating to any payment that is alleged by DaVita to be due for services, drugs or supplies provided to me by DaVita. By agreeing to participate as a plaintiff, I am not obligating myself to pay any attorney fees. I understand that if DaVita recovers attorney fees in such litigation, DaVita will use such fees to offset the cost of the litigation.

7. Authorized Representative. I hereby authorize DaVita (including their attorneys and/or representatives) to act on behalf of me and my estate, in pursuing a benefit claim, appeal of an adverse benefit determination, and litigation or arbitration to collect amounts due from any Plan for treatment provided by DaVita. I hereby authorize DaVita and its attorneys to pursue all available legal rights and remedies that they deem appropriate in order to collect from the Plans or any other source for such services, drugs or supplies, and to pursue claims arising from a Plan's failure to pay for such services, drugs or supplies. I hereby agree to assist DaVita in acting in this capacity.

8. Change of Information. I agree to promptly notify Facility and/or DaVita of any changes to the following within 2 business days of the change: my employment, insurance coverage, financial status, or my personal information (e.g., address, last name, etc.).

9. Involuntary discharge. According to DaVita policies and procedures, DaVita may initiate procedures to involuntarily discharge me if I do not have insurance coverage , do not have or am not complying with the terms of a self-pay agreement, or do not qualify for financial assistance under DaVita's Patient Financial Evaluation policy. Prior to discharge, DaVita will make good faith efforts to help me resolve any payment issues. I understand that DaVita also may initiate procedures to involuntarily discharge me if a discharge is necessary for my welfare or that of other patients. If I am involuntarily discharged from the Facility, DaVita will transfer me to a non-DaVita center. All discharges and transfers will be pursuant to DaVita's policies and procedures, applicable regulatory requirements, and the ESRD Network requirements.

10. Transfer. DaVita may transfer me to another facility if the Facility I am treating at ceases to operate or my insurance coverage is out-of-network with the Facility. Any transfer will be pursuant to DaVita's policies and procedures, applicable regulatory requirements, and the ESRD Network requirements.

The Patient Acknowledgment, Authorization, and Responsibility Form is effective while I am receiving treatment from DaVita and thereafter, until DaVita is paid in full for services, drugs and supplies provided to me by DaVita, or the claim by DaVita for payment is settled or withdrawn. I understand that if I do not fulfill the above terms and conditions, DaVita may pursue payment from me directly and/or involuntarily discharge and transfer me to another non-DaVita dialysis center. If any part of this form is deemed unenforceable, the remaining provisions shall remain in full force and effect. I understand I can hire an attorney at my own expense to represent me in connection with this Form.

The Patient Acknowledgment, Authorization, and Responsibility Form has been read and fully explained to me and my questions relating to the consent (if any) have been fully answered to my satisfaction.

By my signature below, I acknowledge and agree to the terms and conditions contained in this Form.

Print Representative Name:___ (If Applicable)

Date: 9/26/20

Patient or Representative Signature

RECEIVED
OCT 13 2023
AA, LLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS — *Check one:* ☐ Initial ☐ Re-entitlement ☒ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Claim Number / Medicare Beneficiary Identifier | 3. Social Security Number | 4. Date of Birth

5. Patient Mailing Address *(Include City, State and Zip)* | 6. Phone Number

7. Sex: ☒ Male ☐ Female

8. Ethnicity: ☒ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

9. Country/Area of Origin or Ancestry

10. Race *(Check all that apply)*
☐ White ☐ Asian
☒ Black or African American ☐ Native Hawaiian or Other Pacific Islander*
☐ American Indian/Alaska Native

Print Name of Enrolled/Principal Tribe *complete Item 9

11. Is patient applying for ESRD Medicare coverage?
☐ Yes ☒ No

12. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☒ Employer Group Health Insurance
☐ DVA ☐ Medicare Advantage ☐ Other ☐ None

13. Height: INCHES 67 OR CENTIMETERS ____

14. Dry Weight: POUNDS ____ OR KILOGRAMS 137

15. Primary Cause of Renal Failure *(Use code from back of form)*: 129

16. Employment Status *(6 mos prior and current status)*

PRIOR	CURRENT	
☐	☐	Unemployed
☒	☒	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

17. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*
f. ☒ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Toxic nephropathy
p. ☐ Alcohol dependence
q. ☐ Drug dependence*
r. ☐ Inability to ambulate
s. ☐ Inability to transfer
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
  ☐ 1. Assisted Living
  ☐ 2. Nursing Home
  ☐ 3. Other Institution
v. ☐ Non-renal congenital abnormality
w. ☐ None

18. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent?	☐ Yes	☐ No	☒ Unknown	If Yes	☐ <6 months	☐ 6-12 months	☐ > 12 months
b. Was patient under care of a nephrologist?	☒ Yes	☐ No	☐ Unknown	If Yes	☐ <6 months	☒ 6-12 months	☐ > 12 months
c. Was patient under care of kidney dietitian?	☐ Yes	☒ No	☐ Unknown	If Yes	☐ <6 months	☐ 6-12 months	☐ > 12 months

d. For hemodialysis patients only, what access was used on first outpatient dialysis? ☐ AVF ☐ Graft ☐ Catheter ☒ Other
If not AVF, then: Is maturing AVF present? ☐ Yes ☒ No
Is maturing graft present? ☐ Yes ☒ No

19. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)			d. HbA1c	%	
a.2. Serum Albumin Lower Limit			e. Lipid Profile TC		
a.3. Lab Method Used (BCG or BCP)			LDL		
b. Serum Creatinine (mg/dl)	6.5	03/18/2018	HDL		
c. Hemoglobin (g/dl)	12.2	03/18/2018	TG		

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

20. Name of Dialysis Facility: DAVITA - CORAL HILLS DIALYSIS

21. Medicare Provider Number (for Item 20): 212683

22. Primary Dialysis Setting
☐ Home ☒ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

23. Primary Type of Dialysis
☒ Hemodialysis (Sessions per week 3/hours per session 4)
☐ CAPD ☐ CCPD ☐ Other

24. Date Regular Chronic Dialysis Began: 03/23/2018

25. Date Patient Started Chronic Dialysis at Current Facility: 03/23/2018

26. Has patient been informed of kidney transplant options?
☒ Yes ☐ No

27. If patient NOT informed of transplant options, please check all that apply:
☐ Medically unfit ☐ Patient declines information
☐ Unsuitable due to age ☐ Patient has not been assessed
☐ Psychologically unfit ☐ Other

FORM CMS-2728-U3 (04/18)

As of 02/15/2019, this form is in a Submitted status.

RECEIVED
OCT 13 2023

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

28. Date of Transplant	29. Name of Transplant Hospital	30. Medicare Provider Number for Item 29
__/__/____		

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

31. Enter Date	32. Name of Preparation Hospital	33. Medicare Provider number for Item 32
__/__/____		

34. Curent Status of Transplant (If functioning, skip items 36 and 37)
☐ Functioning ☐ Non-Functioning

35. Type of Donor:
☐ Deceased ☐ Living Related ☐ Living Unrelated

36. If Non-Functioning, Date of Return to Regular Dialysis
__/__/____

37. Current Dialysis Treatment Site
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

38. Name of Training Provider
DAVITA - CORAL HILLS DIALYSIS

39. Medicare Provider Number of Training Provider (for Item 38)
212683

40. Date Training Began
03/28/2018

41. Type of Training ☐ Hemodialysis a. ☒ Home b. ☐ In Center ☐ CAPD ☒ CCPD ☐ Other

42. This Patient is Expected to Complete (or has completed) Training and will Self-dialyze on a Regular Basis.
☒ Yes ☐ No

43. Date When Patient Completed, or is Expected to Complete, Training
04/16/2018

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

44. Printed Name and Signature of Physician personally familiar with patient's training			45. UPIN of Physician in Item 44
Roopali Gupta		02/15/2019	OTH000
a.) Printed Name	b.) Signature	c.) Date	

E. PHYSICIAN IDENTIFICATION

46. Attending Physician (Print)	47. Physician's Phone No.	48. UPIN of Physician in Item 46
Roopali Gupta	(202) 877-0698	OTH000

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

49. Attending Physician's Signature of Attestation (Same as Item 46)	50. Date	02/15/2019
51. Physician Recertification Signature	52. Date	__/__/____

53. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

54. Signature of Patient (Signature by mark must be witnessed.)	55. Date	02/15/2019

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

As of 02/15/2019, this form is in a Submitted status.

Coordination of Benefits Questionnaire

Please Print

Subscriber's Name: _____ Identification Number _____
Last First Middle Initial

Subscriber's Social Security Number: _____ Spouse's Social Security Number: _____

In addition to your Blue Cross and Blue Shield coverage, are you, your spouse or dependent children covered by another group health insurance plan or Medicare? ☐ Yes If yes, please complete the entire questionnaire below, sign and return to us. ☒ No If no, please complete the question below, sign and return to us.

If you had other health insurance coverage which cancelled when your **Blue Cross and Blue Shield** coverage became effective, please provide Name of carrier or plan _____ and Cancellation Date ___/___/___
Mo. Day Yr.

Other Health Insurance:
If Multiple Coverage Exists, Please List On A Separate Sheet Of Paper

1. Policy Holder's Name: N/A Sex: ☐ Male ☐ Female
2. Policy Holder's Social Security Number: N/A Date of Birth: ___/___/___ Mo. Day Yr.
3. Name of Employer providing coverage: N/A
4. Name of Other Insurance Company: N/A Policy Number: N/A
5. Address of Other Insurance Company: N/A Phone Number: N/A
6. Effective Date of Policy: N/A / N/A Cancellation Date of Policy (If Applicable): ___/___/___ Mo. Day Yr. Mo. Day Yr.
7. Policy Covers: Policy Holder Only _____ Two Persons _____ Family _____

Name	Relationship to Policy Holder
N/A	N/A
N/A	N/A
N/A	N/A

8. Services Covered:
   - **A.** Hospital Services ☒ Yes ☐ No
   - **B.** Physician Services ☒ Yes ☐ No
   - **C.** Dental Coverage ☒ Yes ☐ No
   - **D.** Major Medical (Out of pocket expenses not otherwise covered) ☒ Yes ☐ No
   - **E.** Eye or Vision Care ☒ Yes ☐ No
   - **F.** Catastrophic Benefits Only ☒ Yes ☐ No

To be completed for dependents whose natural parents live apart and who provide medical coverage for these dependents. Please indicate relationship to children (natural mother, natural father, step-father). If multiple children, please list on a separate sheet of paper.

	Parent's Name	Relationship to Child	Child's Name	Child's Date of Birth
Parent With Custody Of Child(ren)	N/A	N/A	N/A	N/A
Parent With Court Assigned Responsibility For Child(ren)s Medical Expenses	N/A	N/A	N/A	N/A

9. Do you or any of your dependents have Medicare? Yes ☐ No ☒ If Yes, please complete the following:

Participant's Name	Birthdate	Medicare Number	Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Eligible for Medicare as a result of (check one) ☐ Age ☐ Disability ☐ End Stage Renal Disease

Participant Actively Employed ☒ Yes ☐ No

Beginning date of renal treatment: 09 / 19 / 2016
Day Yr.

Spouse Actively Employed ☐ Yes ☒ No

Subscriber's Signature _____ Date 9/13/23 Work Phone Number

Home Phone Number

P5144014000Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

ALL FOR AADC 207
514 0.5738 AB 0.488
6

202209223308

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

ENV 514 1 OF 2 F

Statement Date: 09/21/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BTLN41			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
03/22/22-03/22/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
03/24/22-03/24/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
03/26/22-03/26/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
03/29/22-03/29/22	0270	605.25	605.25	A1	0.00	0.00		0	0.00	0.00	605.25
03/31/22-03/31/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
03/29/22-03/29/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
03/31/22-03/31/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
03/22/22-03/22/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/24/22-03/24/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/26/22-03/26/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/29/22-03/29/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/31/22-03/31/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/22/22-03/22/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/24/22-03/24/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/26/22-03/26/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/29/22-03/29/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/31/22-03/31/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/22/22-03/22/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/24/22-03/24/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/26/22-03/26/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/29/22-03/29/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/31/22-03/31/22	0636	272.10	272.10	A1	0.00	0.00		0	0.00	0.00	272.10
03/22/22-03/22/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
03/29/22-03/29/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
03/22/22-03/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/24/22-03/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/26/22-03/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/29/22-03/29/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/31/22-03/31/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	55,420.55	55,420.55		0.00	0.00			0.00	0.00	55,420.55

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BTWC35			Patient:						Patient Acct. #:		
Provider: LANDOVER DIALYSIS			Employee:						Employee #:		
04/02/22-04/02/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/05/22-04/05/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
04/07/22-04/07/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/02/22-04/02/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/05/22-04/05/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/07/22-04/07/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/02/22-04/02/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/05/22-04/05/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/07/22-04/07/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/02/22-04/02/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/05/22-04/05/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/07/22-04/07/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/05/22-04/05/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
04/02/22-04/02/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/05/22-04/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/07/22-04/07/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00

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Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 09/21/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
TOTALS		32,946.50	32,946.50		0.00	0.00			0.00	0.00	32,946.50

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BVBT82 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

04/09/22-04/09/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
04/12/22-04/12/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
04/14/22-04/14/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
04/09/22-04/09/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
04/12/22-04/12/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
04/14/22-04/14/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
04/09/22-04/09/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
04/12/22-04/12/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
04/14/22-04/14/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
04/09/22-04/09/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
04/12/22-04/12/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
04/14/22-04/14/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
04/12/22-04/12/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
04/09/22-04/09/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
04/12/22-04/12/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
04/14/22-04/14/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
TOTALS		32,946.50	32,946.50		0.00	0.00		0.00	0.00	32,946.50

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BXYB70 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

08/17/21-08/17/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
08/19/21-08/19/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
08/21/21-08/21/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
08/17/21-08/17/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
08/19/21-08/19/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
08/21/21-08/21/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
08/17/21-08/17/21	0634	381.60	381.60	A1	0.00	0.00	0	0.00	0.00	381.60
08/19/21-08/19/21	0634	381.60	381.60	A1	0.00	0.00	0	0.00	0.00	381.60
08/21/21-08/21/21	0634	381.60	381.60	A1	0.00	0.00	0	0.00	0.00	381.60
08/17/21-08/17/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
08/19/21-08/19/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
08/21/21-08/21/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
08/17/21-08/17/21	0636	3,085.20	3,085.20	A1	0.00	0.00	0	0.00	0.00	3,085.20
08/19/21-08/19/21	0636	3,085.20	3,085.20	A1	0.00	0.00	0	0.00	0.00	3,085.20
08/21/21-08/21/21	0636	3,085.20	3,085.20	A1	0.00	0.00	0	0.00	0.00	3,085.20
08/17/21-08/17/21	0636	218.00	218.00	A1	0.00	0.00	0	0.00	0.00	218.00
08/19/21-08/19/21	0636	218.00	218.00	A1	0.00	0.00	0	0.00	0.00	218.00
08/21/21-08/21/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20

P5144014000Q

20220922308

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 09/21/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	31,467.80	31,467.80		0.00	0.00			0.00	0.00	31,467.80

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC

Claim #	Code	Description
BTLN41	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BTWC35	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BVBT82	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BXYB70	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

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Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 09/21/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Description** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).
If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

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	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	152,781.35	152,781.35	0.00	0.00	0.00	0.00	152,781.35

P514401400Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

202301193307

Return Service Requested

ALL FOR AADC 207
290 0.3820 AB 0.488
5

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 01/18/23

ENV 290 1 OF 1 F

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BWSB52				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
06/02/22-06/02/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
06/04/22-06/04/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
06/07/22-06/07/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
06/02/22-06/02/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
06/04/22-06/04/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
06/07/22-06/07/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
06/02/22-06/02/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/04/22-06/04/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/07/22-06/07/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/02/22-06/02/22	0636	2,139.60	2,139.60	A1	0.00	0.00		0	0.00	0.00	2,139.60
06/04/22-06/04/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
06/07/22-06/07/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
06/07/22-06/07/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
06/02/22-06/02/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/04/22-06/04/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/07/22-06/07/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	27,305.45	27,305.45		0.00	0.00			0.00	0.00	27,305.45

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BWYW92				**Patient:**					**Patient Acct. #:**		
Provider: AREA RENAL CAPITAL PC				**Employee:**					**Employee #:**		
06/01/22-06/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC

Claim #	Code	Description
BWSB52	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BWYW92	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

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P514401400Q

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 01/18/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Description** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

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If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

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	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	27,905.45	27,905.45	0.00	0.00	0.00	0.00	27,905.45

P514401400R

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

202302163309

ALL FOR AADC 207
577 0.3820 AB 0.504
8

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

1 OF 1 F

ENV 577

Claim #: BYST05
Statement Date: 02/15/23
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 122794547101
Provider: LANDOVER DIALYSIS

Line	Dates of Service	Service Description	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	08/16/22-08/16/22	OUTPATIENT SERV	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
	08/18/22-08/18/22	OUTPATIENT SERV	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
	08/20/22-08/20/22	OUTPATIENT SERV	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
	08/16/22-08/16/22	OUTPATIENT SERV	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
	08/18/22-08/18/22	OUTPATIENT SERV	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
	08/20/22-08/20/22	OUTPATIENT SERV	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
	08/16/22-08/16/22	OUTPATIENT SERV	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
	08/18/22-08/18/22	OUTPATIENT SERV	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
	08/20/22-08/20/22	OUTPATIENT SERV	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
	08/16/22-08/16/22	OUTPATIENT SERV	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
	08/16/22-08/16/22	OUTPATIENT SERV	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	08/18/22-08/18/22	OUTPATIENT SERV	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	08/20/22-08/20/22	OUTPATIENT SERV	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
		TOTALS	20,798.90	20,798.90		0.00	0.00				0.00	20,798.90

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Total Plan Benefit:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check #	Paid Date
LANDOVER DIALYSIS	0.00	NC	02/15/23

Line#	Code	Messages
01	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
**		*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Claim #: BYST05
Statement Date: 02/15/23
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 122794547101
Provider: LANDOVER DIALYSIS

Appeal Rights

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Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de indentificación o en el resúmen descriptivo del plan.

P5144014000Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

202305253915

Return Service Requested

MIXED AADC 207
3135 2.2101 MB 0.528
77

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

ENV 3135 1 OF 10 F

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BVJB06				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
04/16/22-04/16/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/19/22-04/19/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
04/21/22-04/21/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/16/22-04/16/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/19/22-04/19/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/21/22-04/21/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/16/22-04/16/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/19/22-04/19/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/21/22-04/21/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/16/22-04/16/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/19/22-04/19/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/21/22-04/21/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/19/22-04/19/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
04/16/22-04/16/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/19/22-04/19/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/21/22-04/21/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	32,946.50	32,946.50		0.00	0.00			0.00	0.00	32,946.50

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BVLX79				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
04/23/22-04/23/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/26/22-04/26/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
04/28/22-04/28/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/30/22-04/30/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
04/23/22-04/23/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/26/22-04/26/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/28/22-04/28/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/30/22-04/30/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
04/23/22-04/23/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/26/22-04/26/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/28/22-04/28/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/30/22-04/30/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
04/23/22-04/23/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/26/22-04/26/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
04/28/22-04/28/22	0636	2,674.50	2,674.50	A1	0.00	0.00		0	0.00	0.00	2,674.50
04/30/22-04/30/22	0636	2,674.50	2,674.50	A1	0.00	0.00		0	0.00	0.00	2,674.50
04/26/22-04/26/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
04/23/22-04/23/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/26/22-04/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/28/22-04/28/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
04/30/22-04/30/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	42,544.35	42,544.35		0.00	0.00			0.00	0.00	42,544.35

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BVSH78	**Patient:**	**Patient Acct. #:**	
Provider: DIALYSIS LANDOVER	**Employee:**	**Employee #:**	

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Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
05/03/22-05/03/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
05/05/22-05/05/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/07/22-05/07/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/03/22-05/03/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/05/22-05/05/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/07/22-05/07/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/03/22-05/03/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
05/05/22-05/05/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
05/07/22-05/07/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
05/03/22-05/03/22	0636	2,674.50	2,674.50	A1	0.00	0.00		0	0.00	0.00	2,674.50
05/05/22-05/05/22	0636	2,674.50	2,674.50	A1	0.00	0.00		0	0.00	0.00	2,674.50
05/07/22-05/07/22	0636	2,674.50	2,674.50	A1	0.00	0.00		0	0.00	0.00	2,674.50
05/03/22-05/03/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
05/03/22-05/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/05/22-05/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/07/22-05/07/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	32,136.20	32,136.20		0.00	0.00			0.00	0.00	32,136.20

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BVZN85 **Patient:** **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC **Employee:** **Employee #:**

05/01/22-05/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BWDQ58 **Patient:** **Patient Acct. #:**
Provider: DIALYSIS LANDOVER **Employee:** **Employee #:**

05/17/22-05/17/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
05/19/22-05/19/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/21/22-05/21/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/17/22-05/17/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/19/22-05/19/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/21/22-05/21/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/17/22-05/17/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/19/22-05/19/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/21/22-05/21/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/17/22-05/17/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/19/22-05/19/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/21/22-05/21/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/17/22-05/17/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
05/17/22-05/17/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/19/22-05/19/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/21/22-05/21/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
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If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

ENV 3135

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	26,770.55	26,770.55		0.00	0.00			0.00	0.00	26,770.55

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BWQH31 **Patient:**
Provider: MED GROUP MEDSTAR LLC **Employee:** **Patient Acct. #:** **Employee #:**

06/17/22-06/17/22	99213 GT	190.00	190.00	A1	0.00	0.00	0	0.00	0.00	190.00
	TOTALS	190.00	190.00		0.00	0.00		0.00	0.00	190.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BWST65 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

06/09/22-06/09/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
06/11/22-06/11/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
06/14/22-06/14/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
06/09/22-06/09/22	0634	794.40	794.40	A1	0.00	0.00	0	0.00	0.00	794.40
06/11/22-06/11/22	0634	794.40	794.40	A1	0.00	0.00	0	0.00	0.00	794.40
06/14/22-06/14/22	0634	728.20	728.20	A1	0.00	0.00	0	0.00	0.00	728.20
06/09/22-06/09/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/11/22-06/11/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/14/22-06/14/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/09/22-06/09/22	0636	2,139.60	2,139.60	A1	0.00	0.00	0	0.00	0.00	2,139.60
06/11/22-06/11/22	0636	1,337.25	1,337.25	A1	0.00	0.00	0	0.00	0.00	1,337.25
06/14/22-06/14/22	0636	2,139.60	2,139.60	A1	0.00	0.00	0	0.00	0.00	2,139.60
06/14/22-06/14/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
06/09/22-06/09/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
06/11/22-06/11/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
06/14/22-06/14/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	27,506.70	27,506.70		0.00	0.00		0.00	0.00	27,506.70

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BWYB18 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

06/16/22-06/16/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
06/18/22-06/18/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
06/21/22-06/21/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
06/16/22-06/16/22	0634	728.20	728.20	A1	0.00	0.00	0	0.00	0.00	728.20
06/18/22-06/18/22	0634	728.20	728.20	A1	0.00	0.00	0	0.00	0.00	728.20
06/21/22-06/21/22	0634	728.20	728.20	A1	0.00	0.00	0	0.00	0.00	728.20
06/16/22-06/16/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/18/22-06/18/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/21/22-06/21/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
06/16/22-06/16/22	0636	2,139.60	2,139.60	A1	0.00	0.00	0	0.00	0.00	2,139.60
06/18/22-06/18/22	0636	2,139.60	2,139.60	A1	0.00	0.00	0	0.00	0.00	2,139.60
06/21/22-06/21/22	0636	1,872.15	1,872.15	A1	0.00	0.00	0	0.00	0.00	1,872.15
06/21/22-06/21/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50

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(800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
06/16/22-06/16/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/18/22-06/18/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/21/22-06/21/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	27,909.20	27,909.20		0.00	0.00			0.00	0.00	27,909.20

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BXCM43
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

06/23/22-06/23/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
06/25/22-06/25/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
06/28/22-06/28/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
06/30/22-06/30/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
06/23/22-06/23/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
06/25/22-06/25/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
06/28/22-06/28/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
06/30/22-06/30/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
06/23/22-06/23/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/25/22-06/25/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/28/22-06/28/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/30/22-06/30/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
06/25/22-06/25/22	0636	2,139.60	2,139.60	A1	0.00	0.00		0	0.00	0.00	2,139.60
06/28/22-06/28/22	0636	1,872.15	1,872.15	A1	0.00	0.00		0	0.00	0.00	1,872.15
06/30/22-06/30/22	0636	1,872.15	1,872.15	A1	0.00	0.00		0	0.00	0.00	1,872.15
06/28/22-06/28/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
06/23/22-06/23/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/25/22-06/25/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/28/22-06/28/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
06/30/22-06/30/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	34,591.20	34,591.20		0.00	0.00			0.00	0.00	34,591.20

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BXVV67
Provider: AREA RENAL CAPITAL PC
Patient: Employee:
Patient Acct. #: Employee #:

07/01/22-07/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BYGT93
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

07/02/22-07/02/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/05/22-07/05/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
07/07/22-07/07/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/02/22-07/02/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
07/05/22-07/05/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
07/07/22-07/07/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
07/02/22-07/02/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/05/22-07/05/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/07/22-07/07/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/05/22-07/05/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
07/02/22-07/02/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/05/22-07/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/07/22-07/07/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	21,593.30	21,593.30		0.00	0.00			0.00	0.00	21,593.30

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BYHR16 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

08/02/22-08/02/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
08/04/22-08/04/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/06/22-08/06/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/02/22-08/02/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
08/04/22-08/04/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
08/06/22-08/06/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
08/02/22-08/02/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/04/22-08/04/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/06/22-08/06/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/02/22-08/02/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
08/02/22-08/02/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/04/22-08/04/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/06/22-08/06/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	21,394.70	21,394.70		0.00	0.00			0.00	0.00	21,394.70

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BYRX37 — **Patient:** — **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC — **Employee:** — **Employee #:**

08/01/22-08/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BYST11 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

08/23/22-08/23/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
08/25/22-08/25/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/27/22-08/27/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/30/22-08/30/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
08/23/22-08/23/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/25/22-08/25/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/27/22-08/27/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/30/22-08/30/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/23/22-08/23/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75

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(800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
08/25/22-08/25/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/27/22-08/27/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/30/22-08/30/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/23/22-08/23/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
08/30/22-08/30/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
08/23/22-08/23/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/25/22-08/25/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/27/22-08/27/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/30/22-08/30/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	28,360.90	28,360.90		0.00	0.00			0.00	0.00	28,360.90

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BZPY26 **Patient:** **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC **Employee:** **Employee #:**

09/01/22-09/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BZPY57 **Patient:** **Patient Acct. #:**
Provider: LANDOVER DIALYSIS **Employee:** **Employee #:**

09/15/22-09/15/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/17/22-09/17/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/20/22-09/20/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
09/15/22-09/15/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/17/22-09/17/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/20/22-09/20/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/15/22-09/15/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/17/22-09/17/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/20/22-09/20/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/20/22-09/20/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
09/15/22-09/15/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/17/22-09/17/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/20/22-09/20/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	20,798.90	20,798.90		0.00	0.00			0.00	0.00	20,798.90

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BZVP10 **Patient:** **Patient Acct. #:**
Provider: LANDOVER DIALYSIS **Employee:** **Employee #:**

07/16/22-07/16/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/19/22-07/19/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
07/21/22-07/21/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/16/22-07/16/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/19/22-07/19/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/21/22-07/21/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/16/22-07/16/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

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Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
07/19/22-07/19/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/21/22-07/21/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/19/22-07/19/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
07/16/22-07/16/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/19/22-07/19/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/21/22-07/21/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	21,394.70	21,394.70		0.00	0.00			0.00	0.00	21,394.70

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CBDR18 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

09/22/22-09/22/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/24/22-09/24/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/27/22-09/27/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/29/22-09/29/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/22/22-09/22/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/24/22-09/24/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/27/22-09/27/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/29/22-09/29/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/22/22-09/22/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/24/22-09/24/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/29/22-09/29/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/27/22-09/27/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
09/22/22-09/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/24/22-09/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/27/22-09/27/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/29/22-09/29/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	26,577.55	26,577.55		0.00	0.00			0.00	0.00	26,577.55

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CBHJ57 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

10/01/22-10/01/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
10/04/22-10/04/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
10/06/22-10/06/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
10/01/22-10/01/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
10/04/22-10/04/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
10/06/22-10/06/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
10/01/22-10/01/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
10/04/22-10/04/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
10/06/22-10/06/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
10/04/22-10/04/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
10/01/22-10/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
10/04/22-10/04/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
10/06/22-10/06/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00

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If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
TOTALS		20,798.90	20,798.90		0.00	0.00			0.00	0.00	20,798.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CBMT11
Provider: AREA RENAL CAPITAL PC
Patient: Employee:
Patient Acct. #: Employee #:

10/01/22-10/01/22	90960	600.00	600.00	A1	0.00	0.00	0	0.00	0.00	600.00
TOTALS		600.00	600.00		0.00	0.00		0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CBMT16
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

10/08/22-10/08/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/11/22-10/11/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
10/13/22-10/13/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/08/22-10/08/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/11/22-10/11/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/13/22-10/13/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/08/22-10/08/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/11/22-10/11/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/13/22-10/13/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/11/22-10/11/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
10/08/22-10/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/11/22-10/11/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/13/22-10/13/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
TOTALS		20,798.90	20,798.90		0.00	0.00		0.00	0.00	20,798.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CBNP05
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

10/15/22-10/15/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/18/22-10/18/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
10/20/22-10/20/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/15/22-10/15/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/18/22-10/18/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/20/22-10/20/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/15/22-10/15/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/18/22-10/18/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/20/22-10/20/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/18/22-10/18/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
10/15/22-10/15/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/18/22-10/18/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/20/22-10/20/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

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Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	20,798.90	20,798.90		0.00	0.00			0.00	0.00	20,798.90

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CBSR90 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

10/22/22-10/22/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/25/22-10/25/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
10/27/22-10/27/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/29/22-10/29/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
10/22/22-10/22/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/25/22-10/25/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/27/22-10/27/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/29/22-10/29/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
10/22/22-10/22/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/25/22-10/25/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/27/22-10/27/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/29/22-10/29/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
10/25/22-10/25/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
10/22/22-10/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/25/22-10/25/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/27/22-10/27/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
10/29/22-10/29/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	27,417.35	27,417.35		0.00	0.00		0.00	0.00	27,417.35

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CCBT03 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

11/01/22-11/01/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
11/03/22-11/03/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
11/05/22-11/05/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
11/01/22-11/01/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
11/03/22-11/03/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
11/05/22-11/05/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
11/01/22-11/01/22	0636	184.25	184.25	A1	0.00	0.00	0	0.00	0.00	184.25
11/01/22-11/01/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
11/03/22-11/03/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
11/05/22-11/05/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
11/01/22-11/01/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
11/01/22-11/01/22	0771	159.30	159.30	A1	0.00	0.00	0	0.00	0.00	159.30
11/01/22-11/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
11/03/22-11/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
11/05/22-11/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	21,142.45	21,142.45		0.00	0.00		0.00	0.00	21,142.45

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CCHB26				**Patient:**					**Patient Acct. #:**		
Provider: AREA RENAL CAPITAL PC				**Employee:**					**Employee #:**		
11/01/22-11/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CCHB39				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
11/08/22-11/08/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
11/10/22-11/10/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
11/08/22-11/08/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/10/22-11/10/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/08/22-11/08/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/10/22-11/10/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/08/22-11/08/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
11/08/22-11/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/10/22-11/10/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	14,048.05	14,048.05		0.00	0.00			0.00	0.00	14,048.05

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CCJL41				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
11/15/22-11/15/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
11/17/22-11/17/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
11/19/22-11/19/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
11/15/22-11/15/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/17/22-11/17/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/19/22-11/19/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/15/22-11/15/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/17/22-11/17/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/19/22-11/19/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/15/22-11/15/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
11/15/22-11/15/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/17/22-11/17/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/19/22-11/19/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	20,600.30	20,600.30		0.00	0.00			0.00	0.00	20,600.30

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CCNP45				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
11/22/22-11/22/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
11/24/22-11/24/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
11/26/22-11/26/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
11/29/22-11/29/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
11/22/22-11/22/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40

P5144014000

20230525391S

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

ENV 3135

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
11/24/22-11/24/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/26/22-11/26/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/29/22-11/29/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
11/22/22-11/22/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/24/22-11/24/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/26/22-11/26/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/29/22-11/29/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
11/22/22-11/22/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
11/29/22-11/29/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
11/22/22-11/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/24/22-11/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/26/22-11/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
11/29/22-11/29/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	28,096.10	28,096.10		0.00	0.00			0.00	0.00	28,096.10

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CCXS88 **Patient:** **Patient Acct. #:**
Provider: LANDOVER DIALYSIS **Employee:** **Employee #:**

12/01/22-12/01/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
12/03/22-12/03/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
12/06/22-12/06/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
12/01/22-12/01/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
12/03/22-12/03/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
12/01/22-12/01/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/03/22-12/03/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/06/22-12/06/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/06/22-12/06/22	0636	2,979.00	2,979.00	A1	0.00	0.00		0	0.00	0.00	2,979.00
12/06/22-12/06/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
12/01/22-12/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/03/22-12/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/06/22-12/06/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	23,115.90	23,115.90		0.00	0.00			0.00	0.00	23,115.90

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CCXS89 **Patient:** **Patient Acct. #:**
Provider: LANDOVER DIALYSIS **Employee:** **Employee #:**

05/10/22-05/10/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/12/22-05/12/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/14/22-05/14/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/10/22-05/10/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
05/12/22-05/12/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/14/22-05/14/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/10/22-05/10/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/12/22-05/12/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/14/22-05/14/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/10/22-05/10/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/12/22-05/12/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/14/22-05/14/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/10/22-05/10/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
05/12/22-05/12/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/14/22-05/14/22	0636	2,139.60	2,139.60	A1	0.00	0.00		0	0.00	0.00	2,139.60
05/10/22-05/10/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
	TOTALS	27,305.45	27,305.45		0.00	0.00			0.00	0.00	27,305.45

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CCXS90 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

05/24/22-05/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/26/22-05/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/27/22-05/27/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/31/22-05/31/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
05/24/22-05/24/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
05/26/22-05/26/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/27/22-05/27/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
05/31/22-05/31/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
05/24/22-05/24/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/26/22-05/26/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/27/22-05/27/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/31/22-05/31/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
05/24/22-05/24/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/26/22-05/26/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/27/22-05/27/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/31/22-05/31/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
05/24/22-05/24/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/26/22-05/26/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/27/22-05/27/22	0636	2,139.60	2,139.60	A1	0.00	0.00		0	0.00	0.00	2,139.60
05/31/22-05/31/22	0636	1,604.70	1,604.70	A1	0.00	0.00		0	0.00	0.00	1,604.70
05/24/22-05/24/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
05/31/22-05/31/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
	TOTALS	36,858.00	36,858.00		0.00	0.00			0.00	0.00	36,858.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CCXS93 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

07/09/22-07/09/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/12/22-07/12/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/14/22-07/14/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/09/22-07/09/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/12/22-07/12/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
07/14/22-07/14/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/09/22-07/09/22	0634	794.40	794.40	A1	0.00	0.00		0	0.00	0.00	794.40
07/12/22-07/12/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/14/22-07/14/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/09/22-07/09/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/12/22-07/12/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/14/22-07/14/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/12/22-07/12/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
TOTALS		21,460.90	21,460.90		0.00	0.00			0.00	0.00	21,460.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CCZD52 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

12/15/22-12/15/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/15/22-12/15/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/17/22-12/17/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/17/22-12/17/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/20/22-12/20/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/20/22-12/20/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/15/22-12/15/22	0270	121.05	121.05	A1	0.00	0.00	0	0.00	0.00	121.05
12/17/22-12/17/22	0270	121.05	121.05	A1	0.00	0.00	0	0.00	0.00	121.05
12/20/22-12/20/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
12/15/22-12/15/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
12/17/22-12/17/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
12/20/22-12/20/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
12/20/22-12/20/22	0636	2,979.00	2,979.00	A1	0.00	0.00	0	0.00	0.00	2,979.00
12/20/22-12/20/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
12/15/22-12/15/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
12/17/22-12/17/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
12/20/22-12/20/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
TOTALS		21,963.38	21,963.38		0.00	0.00		0.00	0.00	21,963.38

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CDCX58 — **Patient:** — **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC — **Employee:** — **Employee #:**

12/01/22-12/01/22	90960	600.00	600.00	A1	0.00	0.00	0	0.00	0.00	600.00
TOTALS		600.00	600.00		0.00	0.00		0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CDDT67 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

12/22/22-12/22/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/22/22-12/22/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/24/22-12/24/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/24/22-12/24/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/27/22-12/27/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/27/22-12/27/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/29/22-12/29/22	0250	4.44	4.44	A1	0.00	0.00	0	0.00	0.00	4.44
12/29/22-12/29/22	0250	1.02	1.02	A1	0.00	0.00	0	0.00	0.00	1.02
12/31/22-12/31/22	0250	2.96	2.96	A1	0.00	0.00	0	0.00	0.00	2.96
12/31/22-12/31/22	0250	3.06	3.06	A1	0.00	0.00	0	0.00	0.00	3.06
12/22/22-12/22/22	0270	121.05	121.05	A1	0.00	0.00	0	0.00	0.00	121.05
12/24/22-12/24/22	0270	121.05	121.05	A1	0.00	0.00	0	0.00	0.00	121.05

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Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
12/27/22-12/27/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
12/29/22-12/29/22	0270	121.05	121.05	A1	0.00	0.00		0	0.00	0.00	121.05
12/31/22-12/31/22	0270	121.05	121.05	A1	0.00	0.00		0	0.00	0.00	121.05
12/22/22-12/22/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/24/22-12/24/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/27/22-12/27/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/29/22-12/29/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/31/22-12/31/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/27/22-12/27/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
12/22/22-12/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/24/22-12/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/27/22-12/27/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/29/22-12/29/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/31/22-12/31/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	30,810.41	30,810.41		0.00	0.00			0.00	0.00	30,810.41

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CDGY08
Provider: AREA RENAL CAPITAL PC
Patient: Employee:
Patient Acct. #: Employee #:

02/01/22-02/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CDGY45
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

12/10/22-12/10/22	0250	4.44	4.44	A1	0.00	0.00		0	0.00	0.00	4.44
12/10/22-12/10/22	0250	1.02	1.02	A1	0.00	0.00		0	0.00	0.00	1.02
12/13/22-12/13/22	0250	1.02	1.02	A1	0.00	0.00		0	0.00	0.00	1.02
12/13/22-12/13/22	0250	4.44	4.44	A1	0.00	0.00		0	0.00	0.00	4.44
12/08/22-12/08/22	0270	121.05	121.05	A1	0.00	0.00		0	0.00	0.00	121.05
12/10/22-12/10/22	0270	121.05	121.05	A1	0.00	0.00		0	0.00	0.00	121.05
12/13/22-12/13/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
12/08/22-12/08/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/10/22-12/10/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
12/13/22-12/13/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
12/13/22-12/13/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
12/08/22-12/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/10/22-12/10/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
12/13/22-12/13/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	19,576.62	19,576.62		0.00	0.00			0.00	0.00	19,576.62

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CDPP38
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

09/01/22-09/01/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
09/03/22-09/03/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
09/06/22-09/06/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
09/01/22-09/01/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/03/22-09/03/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/06/22-09/06/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
09/01/22-09/01/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/03/22-09/03/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/06/22-09/06/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
09/06/22-09/06/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
09/01/22-09/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/03/22-09/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
09/06/22-09/06/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	20,798.90	20,798.90		0.00	0.00			0.00	0.00	20,798.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CDPP40
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

08/09/22-08/09/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
08/11/22-08/11/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/13/22-08/13/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
08/09/22-08/09/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/11/22-08/11/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/13/22-08/13/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
08/09/22-08/09/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/11/22-08/11/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/13/22-08/13/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
08/09/22-08/09/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
08/09/22-08/09/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/11/22-08/11/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
08/13/22-08/13/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	20,798.90	20,798.90		0.00	0.00			0.00	0.00	20,798.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CDPP45
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

07/23/22-07/23/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/26/22-07/26/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
07/30/22-07/30/22	0270	242.10	242.10	A1	0.00	0.00		0	0.00	0.00	242.10
07/23/22-07/23/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/26/22-07/26/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/30/22-07/30/22	0634	728.20	728.20	A1	0.00	0.00		0	0.00	0.00	728.20
07/23/22-07/23/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/26/22-07/26/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/30/22-07/30/22	0636	718.75	718.75	A1	0.00	0.00		0	0.00	0.00	718.75
07/26/22-07/26/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
07/23/22-07/23/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/26/22-07/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
07/30/22-07/30/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00

Explanation of Benefits - This is NOT a Bill
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If you have any questions, please call
(800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	21,394.70	21,394.70		0.00	0.00			0.00	0.00	21,394.70

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CDPP47 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

09/08/22-09/08/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
09/10/22-09/10/22	0270	242.10	242.10	A1	0.00	0.00	0	0.00	0.00	242.10
09/13/22-09/13/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
09/08/22-09/08/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
09/10/22-09/10/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
09/13/22-09/13/22	0634	529.60	529.60	A1	0.00	0.00	0	0.00	0.00	529.60
09/08/22-09/08/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
09/10/22-09/10/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
09/13/22-09/13/22	0636	718.75	718.75	A1	0.00	0.00	0	0.00	0.00	718.75
09/13/22-09/13/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
09/08/22-09/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
09/10/22-09/10/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
09/13/22-09/13/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	20,798.90	20,798.90		0.00	0.00		0.00	0.00	20,798.90

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
MEDSTAR MED GRP II LLC	0.00	2049001
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC

P5144014000

20230525391S

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

ENV 3135

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
LANDOVER DIALYSIS					0.00	NC					
CAPITAL AREA RENAL ASSOC					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
CAPITAL AREA RENAL ASSOC					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
CAPITAL AREA RENAL ASSOC					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					
LANDOVER DIALYSIS					0.00	NC					

Claim #	Code	Description
BVJB06	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BVLX79	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BVSH78	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BVZN85	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. CAREFIRST BLUECROSS BLUESHIELD PROVIDES NO ADMINISTRATIVE OR CLAIMS PAYMENT SERVICES & DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS. NO BENEFITS ARE AVAILABLE FROM BLUE CROSS BLUE SHIELD PLANS & LICENSEES OUTSIDE OF THE CAREFIRST BLUESHIELD SERVICE AREA In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BWDQ58	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BWQH31	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BWST65	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BWYB18	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BXCM43	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BXVV67	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BYGT93	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service		CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BYHR16 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BYRX37 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BYST11 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BZPY26 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BZPY57 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

BZVP10 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBDR18 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBHJ57 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBMT11 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBMT16 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBNP05 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CBSR90 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCBT03 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCHB26 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCHB39 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCJL41 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCNP45 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCXS88 A1 MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

CCXS89 A1 FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21.
In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service		CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
CCXS90	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CCXS93	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CCZD52	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDCX58	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDDT67	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDGY08	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD CAREFIRST BLUECROSS BLUESHIELD PROVIDES NO ADMINISTRATIVE OR CLAIMS PAYMENT SERVICES & DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS. NO BENEFITS ARE AVAILABLE FROM BLUE CROSS BLUE SHIELD PLANS & LICENSEES OUTSIDE OF THE CAREFIRST BLUESHIELD SERVICE AREA In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDGY45	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDPP38	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDPP40	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDPP45	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
CDPP47	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										

*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

ENV 3135 10 OF 10 F

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 05/24/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Description** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA). If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	808,097.76	808,097.76	0.00	0.00	0.00	0.00	808,097.76

P514401400R

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

ALL FOR AADC 207
348 0.3820 AB 0.534
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202307273308

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Claim #: CDJF37
Statement Date: 07/26/23
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 124092700101
Provider: LANDOVER DIALYSIS

1 OF 1 F
ENV 348

Line	Dates of Service	Service Description	Amount Charged	Not Covered	Remark Codes	Allowed Amount	Deductible	Type	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	01/03/23-01/03/23	OUTPATIENT SERV	3.90	3.90	A1	0.00	0.00		0	0.00	0.00	3.90
	01/03/23-01/03/23	OUTPATIENT SERV	0.90	0.90	A1	0.00	0.00		0	0.00	0.00	0.90
	01/05/23-01/05/23	OUTPATIENT SERV	0.90	0.90	A1	0.00	0.00		0	0.00	0.00	0.90
	01/05/23-01/05/23	OUTPATIENT SERV	3.90	3.90	A1	0.00	0.00		0	0.00	0.00	3.90
	01/07/23-01/07/23	OUTPATIENT SERV	2.60	2.60	A1	0.00	0.00		0	0.00	0.00	2.60
	01/07/23-01/07/23	OUTPATIENT SERV	2.70	2.70	A1	0.00	0.00		0	0.00	0.00	2.70
	01/03/23-01/03/23	OUTPATIENT SERV	388.65	388.65	A1	0.00	0.00		0	0.00	0.00	388.65
	01/05/23-01/05/23	OUTPATIENT SERV	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
	01/07/23-01/07/23	OUTPATIENT SERV	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
	01/03/23-01/03/23	OUTPATIENT SERV	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
	01/05/23-01/05/23	OUTPATIENT SERV	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
	01/07/23-01/07/23	OUTPATIENT SERV	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
	01/03/23-01/03/23	OUTPATIENT SERV	3,192.00	3,192.00	A1	0.00	0.00		0	0.00	0.00	3,192.00
	01/03/23-01/03/23	OUTPATIENT SERV	882.50	882.50	A1	0.00	0.00		0	0.00	0.00	882.50
	01/03/23-01/03/23	OUTPATIENT SERV	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	01/05/23-01/05/23	OUTPATIENT SERV	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	01/07/23-01/07/23	OUTPATIENT SERV	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
		TOTALS	23,508.15	23,508.15		0.00	0.00				0.00	23,508.15

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Total Plan Benefit:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check #	Paid Date
LANDOVER DIALYSIS	0.00	NC	07/26/23

Line#	Code	Messages
01	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21.
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
**		*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Claim #: CDJF37
Statement Date: 07/26/23
Employee Name:
Employee #:
Patient's Name:
Patient Acct#: 124092700101
Provider: LANDOVER DIALYSIS

1 OF 1 B

ENV 348

Appeal Rights

If your claim has been wholly or partially denied (as shown in the Messages section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de indentificación o en el resúmen descriptivo del plan.

P5144014000Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

202207283306

Return Service Requested

ALL FOR AADC 207
988 1-1458 AB 0-488

11

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BNVT99			**Patient:**				**Patient Acct. #:**				
Provider: LANDOVER DIALYSIS			**Employee:**				**Employee #:**				
10/16/21-10/16/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/19/21-10/19/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/21/21-10/21/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/16/21-10/16/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
10/19/21-10/19/21	0270	581.75	581.75	A1	0.00	0.00		0	0.00	0.00	581.75
10/21/21-10/21/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
10/16/21-10/16/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/19/21-10/19/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/21/21-10/21/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/16/21-10/16/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/19/21-10/19/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/21/21-10/21/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/16/21-10/16/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/19/21-10/19/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/21/21-10/21/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/16/21-10/16/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/19/21-10/19/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/21/21-10/21/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/19/21-10/19/21	0636	790.00	790.00	A1	0.00	0.00		0	0.00	0.00	790.00
	TOTALS	34,862.45	34,862.45		0.00	0.00			0.00	0.00	34,862.45

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BPBL67			**Patient:**				**Patient Acct. #:**				
Provider: HEALTHCARE RENAL DVA			**Employee:**				**Employee #:**				
10/23/21-10/23/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/26/21-10/26/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/28/21-10/28/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/30/21-10/30/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
10/23/21-10/23/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
10/26/21-10/26/21	0270	581.75	581.75	A1	0.00	0.00		0	0.00	0.00	581.75
10/28/21-10/28/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
10/30/21-10/30/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
10/23/21-10/23/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/26/21-10/26/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/28/21-10/28/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/30/21-10/30/21	0634	381.60	381.60	A1	0.00	0.00		0	0.00	0.00	381.60
10/26/21-10/26/21	0636	177.15	177.15	A1	0.00	0.00		0	0.00	0.00	177.15
10/23/21-10/23/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/26/21-10/26/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/28/21-10/28/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/30/21-10/30/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
10/23/21-10/23/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/26/21-10/26/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/28/21-10/28/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/30/21-10/30/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
10/23/21-10/23/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/26/21-10/26/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/28/21-10/28/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/30/21-10/30/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
10/26/21-10/26/21	0636	790.00	790.00	A1	0.00	0.00		0	0.00	0.00	790.00
10/26/21-10/26/21	0771	153.15	153.15	A1	0.00	0.00		0	0.00	0.00	153.15

P5144014000Q

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	46,511.45	46,511.45		0.00	0.00			0.00	0.00	46,511.45

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BPGT98 — Patient: — Patient Acct. #:
Provider: LANDOVER DIALYSIS — Employee: — Employee #:

11/09/21-11/09/21	0270	581.75	581.75	A1	0.00	0.00	0	0.00	0.00	581.75
11/11/21-11/11/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/13/21-11/13/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/09/21-11/09/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/11/21-11/11/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/13/21-11/13/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/09/21-11/09/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/11/21-11/11/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/13/21-11/13/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/09/21-11/09/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/11/21-11/11/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/13/21-11/13/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/09/21-11/09/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/11/21-11/11/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/13/21-11/13/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/09/21-11/09/21	0636	790.00	790.00	A1	0.00	0.00	0	0.00	0.00	790.00
11/09/21-11/09/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
11/11/21-11/11/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
11/13/21-11/13/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
	TOTALS	35,053.25	35,053.25		0.00	0.00		0.00	0.00	35,053.25

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BPXB84 — Patient: — Patient Acct. #:
Provider: LANDOVER DIALYSIS — Employee: — Employee #:

11/23/21-11/23/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/25/21-11/25/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/27/21-11/27/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/30/21-11/30/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
11/23/21-11/23/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/25/21-11/25/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/27/21-11/27/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/30/21-11/30/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
11/23/21-11/23/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/25/21-11/25/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/27/21-11/27/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/30/21-11/30/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
11/23/21-11/23/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/25/21-11/25/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/27/21-11/27/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/30/21-11/30/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
11/23/21-11/23/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/25/21-11/25/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/27/21-11/27/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
11/30/21-11/30/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
11/23/21-11/23/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
11/25/21-11/25/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
11/27/21-11/27/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
11/30/21-11/30/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
	TOTALS	45,529.20	45,529.20		0.00	0.00			0.00	0.00	45,529.20

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BQBN58 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

12/02/21-12/02/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
12/04/21-12/04/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
12/02/21-12/02/21	0634	445.20	445.20	A1	0.00	0.00		0	0.00	0.00	445.20
12/04/21-12/04/21	0634	445.20	445.20	A1	0.00	0.00		0	0.00	0.00	445.20
12/02/21-12/02/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
12/04/21-12/04/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
12/02/21-12/02/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
12/04/21-12/04/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
12/02/21-12/02/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
12/04/21-12/04/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
12/02/21-12/02/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
12/04/21-12/04/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
	TOTALS	22,764.60	22,764.60		0.00	0.00			0.00	0.00	22,764.60

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BQMP02 — **Patient:** — **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC — **Employee:** — **Employee #:**

12/01/21-12/01/21	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BRRF52 — **Patient:** — **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC — **Employee:** — **Employee #:**

01/01/22-01/01/22	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BSLG75 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

12/09/21-12/09/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
12/11/21-12/11/21	0270	465.40	465.40	A1	0.00	0.00		0	0.00	0.00	465.40
12/13/21-12/13/21	0270	349.05	349.05	A1	0.00	0.00		0	0.00	0.00	349.05

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
12/09/21-12/09/21	0634	445.20	445.20	A1	0.00	0.00		0	0.00	0.00	445.20
12/11/21-12/11/21	0634	445.20	445.20	A1	0.00	0.00		0	0.00	0.00	445.20
12/13/21-12/13/21	0634	445.20	445.20	A1	0.00	0.00		0	0.00	0.00	445.20
12/09/21-12/09/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
12/11/21-12/11/21	0636	1,380.00	1,380.00	A1	0.00	0.00		0	0.00	0.00	1,380.00
12/09/21-12/09/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
12/11/21-12/11/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
12/13/21-12/13/21	0636	3,856.50	3,856.50	A1	0.00	0.00		0	0.00	0.00	3,856.50
12/09/21-12/09/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
12/11/21-12/11/21	0636	305.20	305.20	A1	0.00	0.00		0	0.00	0.00	305.20
12/13/21-12/13/21	0636	261.60	261.60	A1	0.00	0.00		0	0.00	0.00	261.60
12/09/21-12/09/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
12/11/21-12/11/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
12/13/21-12/13/21	0821	4,930.00	4,930.00	A1	0.00	0.00		0	0.00	0.00	4,930.00
	TOTALS	32,606.95	32,606.95		0.00	0.00			0.00	0.00	32,606.95

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BSYW56
Provider: MEDICAL GROUP MEDSTAR LLC
Patient: Employee:
Patient Acct. #: Employee #:

03/18/22-03/18/22	99204	401.00	401.00	A1	0.00	0.00		0	0.00	0.00	401.00
	TOTALS	401.00	401.00		0.00	0.00			0.00	0.00	401.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BSZZ63
Provider: LANDOVER DIALYSIS
Patient: Employee:
Patient Acct. #: Employee #:

01/08/22-01/08/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
01/11/22-01/11/22	0270	605.25	605.25	A1	0.00	0.00		0	0.00	0.00	605.25
01/13/22-01/13/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
01/08/22-01/08/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
01/11/22-01/11/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
01/13/22-01/13/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
01/08/22-01/08/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
01/11/22-01/11/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
01/13/22-01/13/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
01/08/22-01/08/22	0636	4,011.75	4,011.75	A1	0.00	0.00		0	0.00	0.00	4,011.75
01/11/22-01/11/22	0636	4,279.20	4,279.20	A1	0.00	0.00		0	0.00	0.00	4,279.20
01/13/22-01/13/22	0636	4,279.20	4,279.20	A1	0.00	0.00		0	0.00	0.00	4,279.20
01/08/22-01/08/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
01/11/22-01/11/22	0636	226.75	226.75	A1	0.00	0.00		0	0.00	0.00	226.75
01/13/22-01/13/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
01/11/22-01/11/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
01/08/22-01/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
01/11/22-01/11/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
01/13/22-01/13/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	36,914.65	36,914.65		0.00	0.00			0.00	0.00	36,914.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BSZZ64
Provider: HEALTHCARE RENAL DVA
Patient:
Employee:
Patient Acct. #:
Employee #:

03/08/22-03/08/22	0270	605.25	605.25	A1	0.00	0.00	0	0.00	0.00	605.25
03/10/22-03/10/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
03/12/22-03/12/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
03/08/22-03/08/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/10/22-03/10/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/12/22-03/12/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/08/22-03/08/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/10/22-03/10/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/12/22-03/12/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/08/22-03/08/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/10/22-03/10/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/12/22-03/12/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/08/22-03/08/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/10/22-03/10/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/12/22-03/12/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/08/22-03/08/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
03/08/22-03/08/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
03/10/22-03/10/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
03/12/22-03/12/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	34,063.40	34,063.40		0.00	0.00		0.00	0.00	34,063.40

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: BSZZ65
Provider: LANDOVER DIALYSIS
Patient:
Employee:
Patient Acct. #:
Employee #:

12/16/21-12/16/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
12/18/21-12/18/21	0270	465.40	465.40	A1	0.00	0.00	0	0.00	0.00	465.40
12/21/21-12/21/21	0270	581.75	581.75	A1	0.00	0.00	0	0.00	0.00	581.75
12/16/21-12/16/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
12/18/21-12/18/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
12/21/21-12/21/21	0634	445.20	445.20	A1	0.00	0.00	0	0.00	0.00	445.20
12/16/21-12/16/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
12/18/21-12/18/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
12/21/21-12/21/21	0636	1,380.00	1,380.00	A1	0.00	0.00	0	0.00	0.00	1,380.00
12/16/21-12/16/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
12/18/21-12/18/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
12/21/21-12/21/21	0636	3,856.50	3,856.50	A1	0.00	0.00	0	0.00	0.00	3,856.50
12/16/21-12/16/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
12/18/21-12/18/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
12/21/21-12/21/21	0636	305.20	305.20	A1	0.00	0.00	0	0.00	0.00	305.20
12/21/21-12/21/21	0636	790.00	790.00	A1	0.00	0.00	0	0.00	0.00	790.00
12/16/21-12/16/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
12/18/21-12/18/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00
12/21/21-12/21/21	0821	4,930.00	4,930.00	A1	0.00	0.00	0	0.00	0.00	4,930.00

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	35,053.25	35,053.25		0.00	0.00			0.00	0.00	35,053.25

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BSZZ66 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

03/01/22-03/01/22	0270	605.25	605.25	A1	0.00	0.00	0	0.00	0.00	605.25
03/03/22-03/03/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
03/05/22-03/05/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
03/01/22-03/01/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/03/22-03/03/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/05/22-03/05/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
03/01/22-03/01/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/03/22-03/03/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/05/22-03/05/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
03/01/22-03/01/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/03/22-03/03/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/05/22-03/05/22	0636	3,209.40	3,209.40	A1	0.00	0.00	0	0.00	0.00	3,209.40
03/01/22-03/01/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/03/22-03/03/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/05/22-03/05/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
03/01/22-03/01/22	0636	822.50	822.50	A1	0.00	0.00	0	0.00	0.00	822.50
03/01/22-03/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
03/03/22-03/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
03/05/22-03/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	34,063.40	34,063.40		0.00	0.00		0.00	0.00	34,063.40

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: BSZZ67 — **Patient:** — **Patient Acct. #:**
Provider: LANDOVER DIALYSIS — **Employee:** — **Employee #:**

02/03/22-02/03/22	0270	363.15	363.15	A1	0.00	0.00	0	0.00	0.00	363.15
02/05/22-02/05/22	0270	484.20	484.20	A1	0.00	0.00	0	0.00	0.00	484.20
02/03/22-02/03/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
02/05/22-02/05/22	0634	463.40	463.40	A1	0.00	0.00	0	0.00	0.00	463.40
02/05/22-02/05/22	0636	1,437.50	1,437.50	A1	0.00	0.00	0	0.00	0.00	1,437.50
02/03/22-02/03/22	0636	4,279.20	4,279.20	A1	0.00	0.00	0	0.00	0.00	4,279.20
02/05/22-02/05/22	0636	4,279.20	4,279.20	A1	0.00	0.00	0	0.00	0.00	4,279.20
02/03/22-02/03/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
02/05/22-02/05/22	0636	317.45	317.45	A1	0.00	0.00	0	0.00	0.00	317.45
02/02/22-02/02/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
02/03/22-02/03/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
02/05/22-02/05/22	0821	5,128.00	5,128.00	A1	0.00	0.00	0	0.00	0.00	5,128.00
	TOTALS	27,788.95	27,788.95		0.00	0.00		0.00	0.00	27,788.95

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

P514401400Q

20220728306

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BSZZ68			**Patient:**						**Patient Acct. #:**		
Provider: HEALTHCARE RENAL DVA			**Employee:**						**Employee #:**		
02/22/22-02/22/22	0270	605.25	605.25	A1	0.00	0.00		0	0.00	0.00	605.25
02/24/22-02/24/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
02/26/22-02/26/22	0270	363.15	363.15	A1	0.00	0.00		0	0.00	0.00	363.15
02/22/22-02/22/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
02/24/22-02/24/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
02/26/22-02/26/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
02/22/22-02/22/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
02/24/22-02/24/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
02/22/22-02/22/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
02/24/22-02/24/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
02/26/22-02/26/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
02/22/22-02/22/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
02/24/22-02/24/22	0636	226.75	226.75	A1	0.00	0.00		0	0.00	0.00	226.75
02/26/22-02/26/22	0636	226.75	226.75	A1	0.00	0.00		0	0.00	0.00	226.75
02/22/22-02/22/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
02/22/22-02/22/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
02/24/22-02/24/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
02/26/22-02/26/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	32,323.45	32,323.45		0.00	0.00			0.00	0.00	32,323.45

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BSZZ69			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
01/01/22-01/01/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
01/06/22-01/06/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
01/01/22-01/01/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
01/06/22-01/06/22	0634	463.40	463.40	A1	0.00	0.00		0	0.00	0.00	463.40
01/01/22-01/01/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
01/06/22-01/06/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
01/01/22-01/01/22	0636	4,011.75	4,011.75	A1	0.00	0.00		0	0.00	0.00	4,011.75
01/06/22-01/06/22	0636	4,011.75	4,011.75	A1	0.00	0.00		0	0.00	0.00	4,011.75
01/01/22-01/01/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
01/06/22-01/06/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
01/01/22-01/01/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
01/06/22-01/06/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	23,684.60	23,684.60		0.00	0.00			0.00	0.00	23,684.60

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: BTBS47			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
03/15/22-03/15/22	0270	605.25	605.25	A1	0.00	0.00		0	0.00	0.00	605.25
03/17/22-03/17/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
03/19/22-03/19/22	0270	484.20	484.20	A1	0.00	0.00		0	0.00	0.00	484.20
03/15/22-03/15/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
03/17/22-03/17/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
03/19/22-03/19/22	0634	529.60	529.60	A1	0.00	0.00		0	0.00	0.00	529.60
03/15/22-03/15/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
03/17/22-03/17/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/19/22-03/19/22	0636	1,437.50	1,437.50	A1	0.00	0.00		0	0.00	0.00	1,437.50
03/15/22-03/15/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/17/22-03/17/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/19/22-03/19/22	0636	3,209.40	3,209.40	A1	0.00	0.00		0	0.00	0.00	3,209.40
03/15/22-03/15/22	0636	272.10	272.10	A1	0.00	0.00		0	0.00	0.00	272.10
03/17/22-03/17/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/19/22-03/19/22	0636	317.45	317.45	A1	0.00	0.00		0	0.00	0.00	317.45
03/15/22-03/15/22	0636	822.50	822.50	A1	0.00	0.00		0	0.00	0.00	822.50
03/15/22-03/15/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/17/22-03/17/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
03/19/22-03/19/22	0821	5,128.00	5,128.00	A1	0.00	0.00		0	0.00	0.00	5,128.00
	TOTALS	34,216.65	34,216.65		0.00	0.00			0.00	0.00	34,216.65

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
LANDOVE BIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC
MEDSTAR MED GRP II LLC	0.00	2040646
LANDOVER DIALYSIS	0.00	NC
LADDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LADDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC

Claim #	Code	Description
BNVT99	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BPBL67	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BPGT98	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BPXB84	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BQBN58	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
BQMP02	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD

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Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

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If you have any questions, please call (800) 638-2972

ENV 988 5 OF 5 F

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service		CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BRRF52	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSLG75	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSYW56	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ63	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ64	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ65	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ66	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ67	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ68	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BSZZ69	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										
BTBS47	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD										
		In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.										

*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

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Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 07/27/22

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Description** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).
If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

	Amount Charged	Not Covered		Amount Allowed	Deductible		Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	477,037.25	477,037.25		0.00	0.00		0.00	0.00	477,037.25

P514401400Q

20230816430S

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

LANDOVER DIALYSIS
PO BOX 402946
ATLANTA, GA 30384-2946

Explanation of Benefits - This is NOT a Bill
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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 08/16/23

ENV 751

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CDPP41			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
01/10/23-01/10/23	0250	3.90	3.90	A1	0.00	0.00		0	0.00	0.00	3.90
01/10/23-01/10/23	0250	0.90	0.90	A1	0.00	0.00		0	0.00	0.00	0.90
01/12/23-01/12/23	0250	0.90	0.90	A1	0.00	0.00		0	0.00	0.00	0.90
01/12/23-01/12/23	0250	3.90	3.90	A1	0.00	0.00		0	0.00	0.00	3.90
01/14/23-01/14/23	0250	3.90	3.90	A1	0.00	0.00		0	0.00	0.00	3.90
01/14/23-01/14/23	0250	0.90	0.90	A1	0.00	0.00		0	0.00	0.00	0.90
01/10/23-01/10/23	0270	259.10	259.10	A1	0.00	0.00		0	0.00	0.00	259.10
01/12/23-01/12/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/14/23-01/14/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/10/23-01/10/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/12/23-01/12/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/14/23-01/14/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/10/23-01/10/23	0636	882.50	882.50	A1	0.00	0.00		0	0.00	0.00	882.50
01/10/23-01/10/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/12/23-01/12/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/14/23-01/14/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	20,186.10	20,186.10		0.00	0.00			0.00	0.00	20,186.10

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CDSN56			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
01/17/23-01/17/23	0270	259.10	259.10	A1	0.00	0.00		0	0.00	0.00	259.10
01/19/23-01/19/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/21/23-01/21/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/17/23-01/17/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/19/23-01/19/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/21/23-01/21/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/17/23-01/17/23	0636	882.50	882.50	A1	0.00	0.00		0	0.00	0.00	882.50
01/17/23-01/17/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/19/23-01/19/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/21/23-01/21/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	20,171.70	20,171.70		0.00	0.00			0.00	0.00	20,171.70

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CFBC56			**Patient:**						**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS			**Employee:**						**Employee #:**		
01/24/23-01/24/23	0270	388.65	388.65	A1	0.00	0.00		0	0.00	0.00	388.65
01/26/23-01/26/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/28/23-01/28/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/31/23-01/31/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
01/24/23-01/24/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/26/23-01/26/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/28/23-01/28/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/31/23-01/31/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
01/24/23-01/24/23	0636	5,320.00	5,320.00	A1	0.00	0.00		0	0.00	0.00	5,320.00
01/24/23-01/24/23	0636	882.50	882.50	A1	0.00	0.00		0	0.00	0.00	882.50
01/24/23-01/24/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 08/16/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
01/26/23-01/26/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/28/23-01/28/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
01/31/23-01/31/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	32,007.80	32,007.80		0.00	0.00			0.00	0.00	32,007.80

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CFFS05 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

02/02/23-02/02/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/04/23-02/04/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/07/23-02/07/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/02/23-02/02/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/04/23-02/04/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/07/23-02/07/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/02/23-02/02/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/04/23-02/04/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/07/23-02/07/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	19,159.65	19,159.65		0.00	0.00			0.00	0.00	19,159.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CFKK92 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

02/09/23-02/09/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/11/23-02/11/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/14/23-02/14/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/09/23-02/09/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/11/23-02/11/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/14/23-02/14/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/09/23-02/09/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/11/23-02/11/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/14/23-02/14/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	19,159.65	19,159.65		0.00	0.00			0.00	0.00	19,159.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Claim #: CFPN47 **Patient:**
Provider: LANDOVER DIALYSIS **Employee:** **Patient Acct. #:** **Employee #:**

02/16/23-02/16/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/18/23-02/18/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/21/23-02/21/23	0270	259.10	259.10	A1	0.00	0.00		0	0.00	0.00	259.10
02/21/23-02/21/23	0636	296.00	296.00	A1	0.00	0.00		0	0.00	0.00	296.00
02/16/23-02/16/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/18/23-02/18/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/21/23-02/21/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/21/23-02/21/23	0636	3,192.00	3,192.00	A1	0.00	0.00		0	0.00	0.00	3,192.00
02/21/23-02/21/23	0771	170.50	170.50	A1	0.00	0.00		0	0.00	0.00	170.50

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 08/16/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
02/16/23-02/16/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/18/23-02/18/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/21/23-02/21/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	22,947.70	22,947.70		0.00	0.00			0.00	0.00	22,947.70

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC

Claim #	Code	Description
CDPP41	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CDSN56	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CFBC56	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CFFS05	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CFKK92	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CFPN47	A1	MUST RECEIVE EOB FROM PRIMARY CARRIER TO PROCESS CLAIM.SEE P 42 IN SPD In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 08/16/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the **Description** section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).
If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "**Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator**". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	133,632.60	133,632.60	0.00	0.00	0.00	0.00	133,632.60

P5144014000Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

202309283308

Return Service Requested

ALL FOR AADC 207
634 0.3820 AB 0.534
8

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 09/27/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CFVR01 **Provider:** LANDOVER DIALYSIS				**Patient:** **Employee:**					**Patient Acct. #:** **Employee #:**		
02/23/23-02/23/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/25/23-02/25/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/28/23-02/28/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
02/23/23-02/23/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/25/23-02/25/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/28/23-02/28/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
02/23/23-02/23/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/25/23-02/25/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
02/28/23-02/28/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	19,159.65	19,159.65		0.00	0.00			0.00	0.00	19,159.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CFWP74 **Provider:** AREA RENAL CAPITAL PC				**Patient:** **Employee:**					**Patient Acct. #:** **Employee #:**		
02/01/23-02/01/23	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CFZK59 **Provider:** LANDOVER DIALYSIS				**Patient:** **Employee:**					**Patient Acct. #:** **Employee #:**		
03/02/23-03/02/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/04/23-03/04/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/07/23-03/07/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/02/23-03/02/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/04/23-03/04/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/07/23-03/07/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/02/23-03/02/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/04/23-03/04/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/07/23-03/07/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	19,159.65	19,159.65		0.00	0.00			0.00	0.00	19,159.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC
LANDOVER DIALYSIS	0.00	NC

Claim #	Code	Description
CFVR01	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CFWP74	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21.

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 09/27/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
				CAREFIRST BLUECROSS BLUESHIELD PROVIDES NO ADMINISTRATIVE OR CLAIMS PAYMENT SERVICES & DOES NOT ASSUME ANY FINANCIAL RISK OR OBLIGATION WITH RESPECT TO CLAIMS. NO BENEFITS ARE AVAILABLE FROM BLUE CROSS BLUE SHIELD PLANS & LICENSEES OUTSIDE OF THE CAREFIRST BLUESHIELD SERVICE AREA In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.								
CFZKS9	A1			FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.							

*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

Appeal Rights

If your claim has been wholly or partially denied (as shown in the Description section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).
If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "Associated **Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator".** You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	38,919.30	38,919.30	0.00	0.00	0.00	0.00	38,919.30

P514401400Q

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Return Service Requested

ALL FOR AADC 207
295 0.5738 AB 0.534
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202310053309

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UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 10/04/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CGHM32				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
03/09/23-03/09/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/11/23-03/11/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/14/23-03/14/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/09/23-03/09/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/11/23-03/11/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/14/23-03/14/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/09/23-03/09/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/11/23-03/11/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/14/23-03/14/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	19,159.65	19,159.65		0.00	0.00			0.00	0.00	19,159.65

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CGLN59				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
03/16/23-03/16/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/18/23-03/18/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/21/23-03/21/23	0270	259.10	259.10	A1	0.00	0.00		0	0.00	0.00	259.10
03/16/23-03/16/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/18/23-03/18/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/21/23-03/21/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/21/23-03/21/23	0636	3,192.00	3,192.00	A1	0.00	0.00		0	0.00	0.00	3,192.00
03/16/23-03/16/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/18/23-03/18/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/21/23-03/21/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
	TOTALS	22,481.20	22,481.20		0.00	0.00			0.00	0.00	22,481.20

Total Plan Pays: 0.00
Less COB Adjustment: 0.00
Less Provider Discount: 0.00
Less Provider Payment Adjustment: 0.00
Total Benefits Paid: 0.00

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
Claim #: CGSK90				**Patient:**					**Patient Acct. #:**		
Provider: LANDOVER DIALYSIS				**Employee:**					**Employee #:**		
03/23/23-03/23/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/25/23-03/25/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/28/23-03/28/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/30/23-03/30/23	0270	129.55	129.55	A1	0.00	0.00		0	0.00	0.00	129.55
03/23/23-03/23/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/25/23-03/25/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/28/23-03/28/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/30/23-03/30/23	0636	770.00	770.00	A1	0.00	0.00		0	0.00	0.00	770.00
03/23/23-03/23/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/25/23-03/25/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/28/23-03/28/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00
03/30/23-03/30/23	0821	5,487.00	5,487.00	A1	0.00	0.00		0	0.00	0.00	5,487.00

P514401400Q

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call
(800) 638-2972

Statement Date: 10/04/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
	TOTALS	25,546.20	25,546.20		0.00	0.00			0.00	0.00	25,546.20

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Claim #: CGVG31 **Patient:** **Patient Acct. #:**
Provider: AREA RENAL CAPITAL PC **Employee:** **Employee #:**

03/01/23-03/01/23	90960	600.00	600.00	A1	0.00	0.00		0	0.00	0.00	600.00
	TOTALS	600.00	600.00		0.00	0.00			0.00	0.00	600.00

Total Plan Pays:	0.00
Less COB Adjustment:	0.00
Less Provider Discount:	0.00
Less Provider Payment Adjustment:	0.00
Total Benefits Paid:	0.00

Payment To	Amount	Check Number
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
LANDOVER DIALYSIS	0.00	NC
CAPITAL AREA RENAL ASSOC	0.00	NC

Claim #	Code	Description
CGHM32	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. YOUR INDIVIDUAL $ ANNUAL DEDUCTIBLE HAS BEEN SATISFIED. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CGLN59	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CGSK90	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.
CGVG31	A1	FUND OFFICE NEVER RECEIVED MEDICARE STATEMENT OF PAYMENT. SEE P. 21. In light of the ongoing COVID-19 national emergency, certain specified deadlines related to the submission of claims and appeals have been extended. The Plan will disregard the period between March 1,2020 and 60 days after the end of the COVID-19 declared national emergency.

*** This is not a bill. It is an explanation of benefits payable under your medical plan. Please keep this form for your records. Plan provisions specify that you must be eligible (see "Eligibility" in your SPD), that services must be covered (see "Covered Services" and "Exclusions" in your SPD), and that claims must be submitted properly (see "Claims Filing and Review in your SPD). A participant may appeal a total or partial denial of benefits by writing to the Board of Trustees within 60 days of notice of denial. For more on the appeal procedure, see the Appeal Rights printed at the bottom of this document.

Associated Administrators, LLC.
911 Ridgebrook Road
Sparks, MD 21152-9451

Explanation of Benefits - This is NOT a Bill
Please retain for Tax Purposes

UFCW UNIONS & PART. EMP. H&W

If you have any questions, please call (800) 638-2972

Statement Date: 10/04/23

TYPE	DESCRIPTION
B	Basic Benefit
M	Major Medical Benefit

Dates of Service	CPT Code	Amount Charged	Not Covered	Remark Codes*	Amount Allowed	Deductible	TYPE	%	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility

Appeal Rights

If your claim has been wholly or partially denied (as shown in the Description section on the front of this Explanation of Benefits or "EOB"), you have the right to appeal this decision within 180 days of your receipt of the EOB. You may submit written comments, documents and other information relating to your claim. You have the right to designate, in writing, a representative to act on your behalf. You must provide the Fund with the representative's name, address and telephone number. The Fund will direct all future communications to the representative.

If the Fund relied upon an internal rule, guideline or protocol in making the decision, it will be available upon request, free of charge. If the Fund based its determination upon medical necessity, experimental treatment or similar exclusion or limit, such explanation is available upon request and free of charge. If the Fund obtained any advice from a medical expert on the claim (even if the advice was not relied upon) the Fund will identify, upon request, the firm providing the medical expert's advice.

The Board of Trustees will review your appeal at its next scheduled meeting unless the appeal is filed within 30 days of that meeting, in which case it will be reviewed at the following meeting. If circumstances require more time for a decision, you will be notified in writing. The notice will describe the reason for the delay and the approximate date a decision will be made. The decision will be made no later than the third Board of Trustees meeting following the date the Fund receives your appeal. The review will take into account all information you submit relating to your claim. The Fund will notify you in writing of the Board of Trustees' decision within five days after the decision is made. In the event your appeal is denied, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA).
If your situation meets the definition of urgent under law, your review will be conducted within the urgent time frames established by law. An appeal of an Urgent Care Claim denial may be oral or in writing. You or your doctor should supply all information for an Urgent Care Claim appeal by hand delivery to the Fund Office or by telephone to **1-410-683-6500, toll free 1-800-638-2972 or by fax to 1-877-227-3536.**

If your claim is denied, in whole or in part, you are not required to appeal the decision. Further, you have the right to file suit in federal court under Section 502(a) of ERISA on your claim for benefits. However you must exhaust your administrative remedies by appealing the denial to the Board of Trustees before you have the right to file suit in federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit, as described in the ERISA Rights statement in your Summary Plan Description. If you wish to file suit based on a denial of a claim for benefits, you must do so within three years from the date on which the Board of Trustees makes its final decision on appeal. Additionally, if you wish to file suit against the Fund or the Trustees, you must file suit in the United States District Court for the District of Maryland.

Should you have any questions about your appeal rights, please contact Participant Services at the number shown in your SPD or mail your appeal to "Associated Administrators, LLC, 911 Ridgebrook Road, Sparks, Maryland 21152-9451, Attn: Appeals Coordinator". You may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

	Amount Charged	Not Covered	Amount Allowed	Deductible	Plan Pays	Medicare/ Other Pymnt	Patient Responsibility
STATEMENT TOTALS	67,787.05	67,787.05	0.00	0.00	0.00	0.00	67,787.05

United Food and Commercial Workers Unions
And Participating Employers
Health And Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

SECOND REQUEST

Date: November 3, 2023

COPY

RE:
ID #:
DOS: March 1, 2022 through September 13, 2023

Dear Mr. :

This letter follows up on our previous letter dated October 19, 2023. The UFCW Unions and Participating Employers Health and Welfare Fund (the "Fund") received an appeal from DaVita, Inc. requesting the reprocessing of medical claims for services provided to you from March 1, 2022 through September 13, 2023.

Based upon the information on file, our records indicate that Medicare-ESRD should have become your primary carrier effective January 1, 2021. DaVita, Inc. has advised this office that you have not enrolled for Medicare coverage. **Please advise this office, in writing, as to why you are not enrolled in Medicare Part B. If you are not *qualified* for Medicare, we must have a copy of Medicare's notice confirming why you are not qualified for coverage.**

Please forward this information to the Fund office at the Sparks, Maryland address noted on the letterhead **within 14 days (by November 17, 2023).** You may also fax this information directly to the Appeals Department at (410) 683-7725.

Thank you for your cooperation. If you should have any questions, you may contact this office.

Sincerely,

Chris Brown

Chris Brown, Appeals Supervisor
Associated Administrators, LLC

cc: DaVita, Inc.
Attn: Sapna Dholakia, Commercial Insurance Analyst
15271 Laguna Canyon Road
Irvine, CA 92618

United Food and Commercial Workers Unions
And Participating Employers
Health And Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

COPY

Date: October 19, 2023

RE:
ID #:
DOS: March 1, 2022 through September 13, 2023

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The UFCW Unions and Participating Employers Health and Welfare Fund (the "Fund") received an appeal from DaVita, Inc. requesting the reprocessing of medical claims for services provided to you from March 1, 2022 through September 13, 2023.

Based upon the information on file, our records indicate that Medicare-ESRD should have become your primary carrier effective January 1, 2021. DaVita, Inc. has advised this office that you have not enrolled for Medicare coverage. **Please advise this office, in writing, as to why you are not enrolled in Medicare Part B. If you are not *qualified* for Medicare, we must have a copy of Medicare's notice confirming why you are not qualified for coverage.**

Please forward this information to the Fund office at the Sparks, Maryland address noted on the letterhead **within 14 days (by November 2, 2023).** You may also fax this information directly to the Appeals Department at (410) 683-7725.

Thank you for your cooperation. If you should have any questions, you may contact this office.

Sincerely,

Chris Brown

Chris Brown, Appeals Supervisor
Associated Administrators, LLC

cc: DaVita, Inc.
Attn: Sapna Dholakia, Commercial Insurance Analyst
15271 Laguna Canyon Road
Irvine, CA 92618