**Form 5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

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

OMB Nos. 1210-0110
1210-0089

**2024**

**This Form is Open to Public Inspection**

## Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

**A** This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

**B** This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

**C** If the plan is a collectively-bargained plan, check here. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .. ▶ [ ]

**D** Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

**E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . . . . . . . . . . . . . . . . . . . . . .. ▶ [ ]

## Part II Basic Plan Information—enter all requested information

**1a** Name of plan
WACHTER HEALTH INSURANCE PLAN

**1b** Three-digit plan number (PN) ▶ 502

**1c** Effective date of plan
02/01/2000

**2a** Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
WACHTER, INC.

16001 W 99TH STREET
LENEXA, KS 66219-1293

**2b** Employer Identification Number (EIN)
48-1238438

**2c** Plan Sponsor's telephone number
913-541-2500

**2d** Business code (see instructions)
238900

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

| | | | |
|---|---|---|---|
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 11/13/2025 | DEANNA GILLETT |
| | **Signature of plan administrator** | Date | Enter name of individual signing as plan administrator |
| **SIGN HERE** | Filed with authorized/valid electronic signature. | 11/13/2025 | DEANNA GILLETT |
| | **Signature of employer/plan sponsor** | Date | Enter name of individual signing as employer or plan sponsor |
| **SIGN HERE** | | | |
| | **Signature of DFE** | Date | Enter name of individual signing as DFE |

| | | | |
|---|---|---|---|
| **3a** | Plan administrator's name and address [X] Same as Plan Sponsor | **3b** Administrator's EIN | |
| | | **3c** Administrator's telephone number | |
| **4** | If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: | **4b** EIN | |
| **a** | Sponsor's name | **4d** PN | |
| **c** | Plan Name | | |
| **5** | Total number of participants at the beginning of the plan year | **5** | 1362 |
| **6** | Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**). | | |
| **a(1)** | Total number of active participants at the beginning of the plan year | **6a(1)** | 1362 |
| **a(2)** | Total number of active participants at the end of the plan year | **6a(2)** | 1622 |
| **b** | Retired or separated participants receiving benefits | **6b** | 0 |
| **c** | Other retired or separated participants entitled to future benefits | **6c** | 0 |
| **d** | Subtotal. Add lines **6a(2)**, **6b**, and **6c**. | **6d** | 1622 |
| **e** | Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | **6e** | |
| **f** | Total. Add lines **6d** and **6e**. | **6f** | |
| **g(1)** | Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | **6g(1)** | |
| **g(2)** | Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | **6g(2)** | |
| **h** | Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | **6h** | |
| **7** | Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | **7** | |

**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

**b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4Q

**9a** Plan funding arrangement (check all that apply)

- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [X] General assets of the sponsor

**9b** Plan benefit arrangement (check all that apply)

- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [X] General assets of the sponsor

**10** Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

**a Pension Schedules**

- (1) [ ] **R** (Retirement Plan Information)
- (2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) [ ] **DCG** (Individual Plan Information) – Number Attached ______
- (5) [ ] **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

- (1) [ ] **H** (Financial Information)
- (2) [ ] **I** (Financial Information – Small Plan)
- (3) [X] **A** (Insurance Information) – Number Attached 1
- (4) [X] **C** (Service Provider Information)
- (5) [ ] **D** (DFE/Participating Plan Information)
- (6) [ ] **G** (Financial Transaction Schedules)

## Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ...................................... ☐ Yes ☒ No

If “Yes” is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ........... ☐ Yes ☐ No

**11c** Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code______________________

# SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Insurance Information

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

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

**A** Name of plan
WACHTER HEALTH INSURANCE PLAN

**B** Three-digit plan number (PN) ▶ 502

**C** Plan sponsor's name as shown on line 2a of Form 5500
WACHTER, INC.

**D** Employer Identification Number (EIN)
48-1238438

## Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1** Coverage Information:

**(a)** Name of insurance carrier
SEE ATTACHED

| **(b)** EIN | **(c)** NAIC code | **(d)** Contract or identification number | **(e)** Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|---|---|---|---|---|---|
| | | | | **(f)** From | **(g)** To |
| | | | | 02/01/2024 | 01/31/2025 |

**2** Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

| **(a)** Total amount of commissions paid | **(b)** Total amount of fees paid |
|---|---|
| | |

**3** Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

| **(b)** Amount of sales and base commissions paid | Fees and other commissions paid | | **(e)** Organization code |
|---|---|---|---|
| | **(c)** Amount | **(d)** Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

| (b) Amount of sales and base commissions paid | Fees and other commissions paid | | (e) Organization code |
|---|---|---|---|
| | (c) Amount | (d) Purpose | |
| | | | |

**Part II** **Investment and Annuity Contract Information**
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

| | | | |
|---|---|---|---|
| 4 | Current value of plan's interest under this contract in the general account at year end | 4 | |
| 5 | Current value of plan's interest under this contract in separate accounts at year end | 5 | |

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

| | | | |
|---|---|---|---|
| b | Premiums paid to carrier | 6b | |
| c | Premiums due but unpaid at the end of the year | 6c | |
| d | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. | 6d | |

Specify nature of costs ▶

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

| | | | | | |
|---|---|---|---|---|---|
| b | Balance at the end of the previous year | | | 7b | |
| c | Additions: (1) Contributions deposited during the year | 7c(1) | | | |
| | (2) Dividends and credits | 7c(2) | | | |
| | (3) Interest credited during the year | 7c(3) | | | |
| | (4) Transferred from separate account | 7c(4) | | | |
| | (5) Other (specify below) ▶ | 7c(5) | | | |
| | (6)Total additions | | | 7c(6) | |
| d | Total of balance and additions (add lines **7b** and **7c(6)**). | | | 7d | |
| e | Deductions: | | | | |
| | (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | | | |
| | (2) Administration charge made by carrier | 7e(2) | | | |
| | (3) Transferred to separate account | 7e(3) | | | |
| | (4) Other (specify below) ▶ | 7e(4) | | | |
| | (5) Total deductions | | | 7e(5) | |
| f | Balance at the end of the current year (subtract line **7e(5)** from line **7d**) | | | 7f | 0 |

## Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

| | | | |
|---|---|---|---|
| **a** ☐ Health (other than dental or vision) | **b** ☐ Dental | **c** ☐ Vision | **d** ☐ Life insurance |
| **e** ☐ Temporary disability (accident and sickness) | **f** ☐ Long-term disability | **g** ☐ Supplemental unemployment | **h** ☐ Prescription drug |
| **i** ☐ Stop loss (large deductible) | **j** ☐ HMO contract | **k** ☐ PPO contract | **l** ☐ Indemnity contract |
| **m** ☐ Other (specify) ▶ | | | |

**9** Experience-rated contracts:

| Item | Line | Amount | Line | Amount |
|---|---|---|---|---|
| **a** Premiums: (1) Amount received | **9a(1)** | | | |
| (2) Increase (decrease) in amount due but unpaid | **9a(2)** | | | |
| (3) Increase (decrease) in unearned premium reserve | **9a(3)** | | | |
| (4) Earned (**(1)** + **(2)** - **(3)**) | | | **9a(4)** | |
| **b** Benefit charges (1) Claims paid | **9b(1)** | | | |
| (2) Increase (decrease) in claim reserves | **9b(2)** | | | |
| (3) Incurred claims (add **(1)** and **(2)**) | | | **9b(3)** | |
| (4) Claims charged | | | **9b(4)** | |
| **c** Remainder of premium: (1) Retention charges (on an accrual basis) -- | | | | |
| (A) Commissions | **9c(1)(A)** | | | |
| (B) Administrative service or other fees | **9c(1)(B)** | | | |
| (C) Other specific acquisition costs | **9c(1)(C)** | | | |
| (D) Other expenses | **9c(1)(D)** | | | |
| (E) Taxes | **9c(1)(E)** | | | |
| (F) Charges for risks or other contingencies | **9c(1)(F)** | | | |
| (G) Other retention charges | **9c(1)(G)** | | | |
| (H) Total retention | | | **9c(1)(H)** | |
| (2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.) | | | **9c(2)** | |
| **d** Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | | **9d(1)** | |
| (2) Claim reserves | | | **9d(2)** | |
| (3) Other reserves | | | **9d(3)** | |
| **e** Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.) | | | **9e** | |

**10** Nonexperience-rated contracts:

| Item | Line | Amount |
|---|---|---|
| **a** Total premiums or subscription charges paid to carrier | **10a** | |
| **b** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | **10b** | |

Specify nature of costs.

## Part IV Provision of Information

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

**12** If the answer to line 11 is “Yes,” specify the information not provided. ▶

| SCHEDULE C (Form 5500) | Service Provider Information | OMB No. 1210-0110 |
|---|---|---|
| Department of the Treasury Internal Revenue Service | This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). | 2024 |
| Department of Labor Employee Benefits Security Administration | ▶ **File as an attachment to Form 5500.** | **This Form is Open to Public Inspection.** |
| Pension Benefit Guaranty Corporation | | |

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

| **A** Name of plan WACHTER HEALTH INSURANCE PLAN | **B** Three-digit plan number (PN) ▶ 502 |
|---|---|
| **C** Plan sponsor's name as shown on line 2a of Form 5500 WACHTER, INC. | **D** Employer Identification Number (EIN) 48-1238438 |

## Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

### 1 Information on Persons Receiving Only Eligible Indirect Compensation

**a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . . . . . . . . . . ☐ Yes ☒ No

**b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

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

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

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

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

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

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

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

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

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

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a)** Enter name and EIN or address (see instructions)

TRIA HEALTH LLC

7101 COLLEGE BLVD STE 600
OVERLAND PARK, KS 66210

27-1515235

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 | NONE | 110453 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

BENEFIT MANAGEMENT LLC

2015 16TH STREET
GREAT BEND, KS 67530

48-1168746

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 14 49 | NONE | 195520 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

6 DEGREES HEALTH DX LLC

5800 NE PINEFARM CT 200
HILLSBORO, OR 97124

81-4242649

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 49 | NONE | 497052 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a)** Enter name and EIN or address (see instructions)

NEW DIRECTIONS BEHAVIORAL HEALTH

PO BOX 6729
LEAWOOD, KS 66206

43-1698690

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 13 | NONE | 27600 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

TELADOC, INC.

2015 16TH STREET
GREAT BEND, KS 67530

04-3705970

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 10 12 49 | NONE | 19063 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

MEDWATCH, LLC

PO BOX 952679
LAKE MARY, FL 32795-2679

16-1662117

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 49 | NONE | 72165 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**2. Information on Other Service Providers Receiving Direct or Indirect Compensation.** Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

**(a)** Enter name and EIN or address (see instructions)

ZELIS CLAIMS INTEGRITY, LLC

2015 16TH STREET
GREAT BEND, KS 67530

86-1040704

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 | NONE | 16130 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

CENTIVO

199 SCOTT STREET, STE 800
BUFFALO, NY 14204

30-1095511

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 12 | NONE | 163171 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

**(a)** Enter name and EIN or address (see instructions)

MD LIVE

3350 SW 148 AVE 300
MIRAMAR, FL 33027

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|---|---|---|---|---|---|---|
| 49 | NONE | 14048 | Yes ☐ No ☒ | Yes ☐ No ☐ | | Yes ☐ No ☐ |

## Part I Service Provider Information (continued)

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

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| | | |

| **(d)** Enter name and EIN (address) of source of indirect compensation | **(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---|---|
| | |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| | | |

| **(d)** Enter name and EIN (address) of source of indirect compensation | **(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---|---|
| | |

| **(a)** Enter service provider name as it appears on line 2 | **(b)** Service Codes (see instructions) | **(c)** Enter amount of indirect compensation |
|---|---|---|
| | | |

| **(d)** Enter name and EIN (address) of source of indirect compensation | **(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|---|---|
| | |

## Part II Service Providers Who Fail or Refuse to Provide Information

**4** Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

| **(a)** Enter name and EIN or address of service provider (see instructions) | **(b)** Nature of Service Code(s) | **(c)** Describe the information that the service provider failed or refused to provide |
|---|---|---|
| | | |

## Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

**a** Name: **b** EIN:
**c** Position:
**d** Address: **e** Telephone:

Explanation:

**a** Name: **b** EIN:
**c** Position:
**d** Address: **e** Telephone:

Explanation:

**a** Name: **b** EIN:
**c** Position:
**d** Address: **e** Telephone:

Explanation:

**a** Name: **b** EIN:
**c** Position:
**d** Address: **e** Telephone:

Explanation:

**a** Name: **b** EIN:
**c** Position:
**d** Address: **e** Telephone:

Explanation:

| WACHTER,INC(56177)<br>16001 W99TH<br>LENEXA KS 66219 | <br>Allstate. BENEFITS<br><br>Plan/Contract Year:2/1/2024-1/31/2025<br>Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company<br>Part I (b) EIN: 59-0781901<br>Part I (c) NAIC Code: 60534 |
|---|---|

**Includes the Following Accounts:** 56177

| Part I, Sec 1 (d) Contract or Identification Number | Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year | Part III, Sec 10a Total Premium or Subscription Charges to carrier | Part I, Sec 3 Name and Address of the Agents | Agent Number | Part I, Sec 2 Total Commissions Paid | Part I, Sec 2 (c) Total amount of Fees paid | Part I, Sec 3 (d) Purpose of Fee |
|---|---|---|---|---|---|---|---|
| **Accident Account:** 56177 | | | | | | | |
| **Accident** | **660** | **$175,569.07** | | | **$19,356.15** | **$0.00** | |
| | | | WELSH & ASSOCIATES LLC<br><br>11121 JEFFERSON<br><br>KANSAS CITY MO 64114 | 3C3A0 | $19,356.15 | $0.00 | |

**Disclaimers:**

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

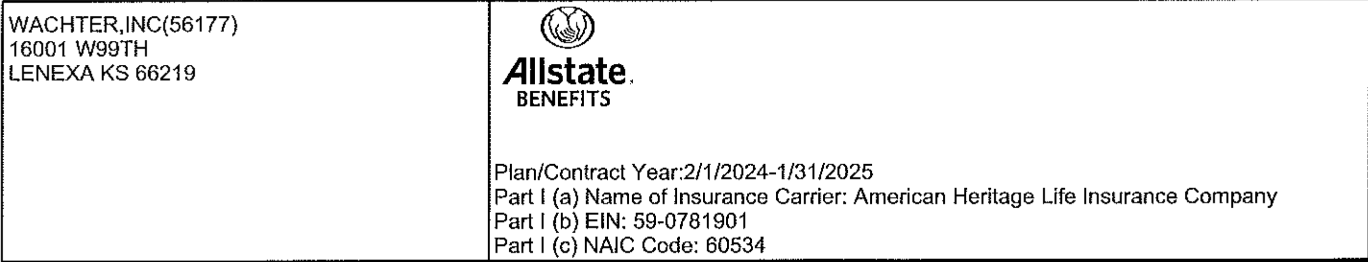
| WACHTER,INC(56177)<br>16001 W99TH<br>LENEXA KS 66219 | <br>**Allstate.**<br>BENEFITS<br><br>Plan/Contract Year:2/1/2024-1/31/2025<br>Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company<br>Part I (b) EIN: 59-0781901<br>Part I (c) NAIC Code: 60534 |
|---|---|

**Includes the Following Accounts:** 56177

| Part I, Sec 1 (d) Contract or Identification Number | Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year | Part III, Sec 10a Total Premium or Subscription Charges to carrier | Part I, Sec 3 Name and Address of the Agents | Agent Number | Part I, Sec 2 Total Commissions Paid | Part I, Sec 2 (c) Total amount of Fees paid | Part I, Sec 3 (d) Purpose of Fee |
|---|---|---|---|---|---|---|---|
| **Cancer Account:** 56177 | | | | | | | |
| **Cancer** | **372** | **$125,614.36** | | | **$10,517.36** | **$0.00** | |
| | | | WELSH & ASSOCIATES LLC<br><br>11121 JEFFERSON<br><br>KANSAS CITY MO 64114 | 3C3A0 | $10,517.36 | $0.00 | |

**Disclaimers:**

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.




WACHTER,INC(56177)
16001 W99TH
LENEXA KS 66219

Plan/Contract Year:2/1/2024-1/31/2025
Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company
Part I (b) EIN: 59-0781901
Part I (c) NAIC Code: 60534

**Includes the Following Accounts:** 56177

| Part I, Sec 1 (d) Contract or Identification Number | Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year | Part III, Sec 10a Total Premium or Subscription Charges to carrier | Part I, Sec 3 Name and Address of the Agents | Agent Number | Part I, Sec 2 Total Commissions Paid | Part I, Sec 2 (c) Total amount of Fees paid | Part I, Sec 3 (d) Purpose of Fee |
|---|---|---|---|---|---|---|---|
| **Critical Illness Account:** 56177 | | | | | | | |
| **Critical Illness** | **544** | **$93,150.90** | | | **$11,654.50** | **$0.00** | |
| | | | USI INS SVCS LLC<br>8000 NORMAN CENTER DR<br>SUITE 400<br>BLOOMINGTON MN 55437 | 9RTX0 | $97.56 | $0.00 | |
| | | | WELSH & ASSOCIATES LLC<br>11121 JEFFERSON<br>KANSAS CITY MO 64114 | 3C3A0 | $11,556.94 | $0.00 | |

**Disclaimers:**

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

| WACHTER,INC(56177)<br>16001 W99TH<br>LENEXA KS 66219 | <br>**Allstate** BENEFITS<br><br>Plan/Contract Year:2/1/2024-1/31/2025<br>Part I (a) Name of Insurance Carrier: American Heritage Life Insurance Company<br>Part I (b) EIN: 59-0781901<br>Part I (c) NAIC Code: 60534 |
|---|---|

**Includes the Following Accounts:** 56177

| Part I, Sec 1 (d) Contract or Identification Number | Part I, Sec 1 (e) Number of Persons Covered at end of Contract Year | Part III, Sec 10a Total Premium or Subscription Charges to carrier | Part I, Sec 3 Name and Address of the Agents | Agent Number | Part I, Sec 2 Total Commissions Paid | Part I, Sec 2 (c) Total amount of Fees paid | Part I, Sec 3 (d) Purpose of Fee |
|---|---|---|---|---|---|---|---|
| **Traditional Life Account:** 56177 | | | | | | | |
| **Traditional Life** | **301** | **$220,028.00** | | | **$28,145.36** | **$0.00** | |
| | | | WELSH & ASSOCIATES LLC<br>11121 JEFFERSON<br>KANSAS CITY MO 64114 | 3C3A0 | $28,145.36 | $0.00 | |
| **Grand Total** | | **$614,362.33** | | | **$69,673.37** | **$0.00** | |

**Disclaimers:**

- Number of Persons covered represents the total certificates in force on the Plan Year end date.
- Total premium represent premium that is both received and applied during the Plan Year; this is referred to as 'Paid Premium'.
- Total Commissions Paid and Total Fees Paid reflect the respective amounts paid during the Plan Year.

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation
For: WACHTER, INC.

**Policyholder and Address**

WACHTER, INC.
16001 W. 99TH STREET
LENEXA, KS 66219

**Plan/Policy Year** - 04/01/2024 to 03/31/2025

| Name of Insurance Carrier | EIN | NAIC Code | Policy Number |
|---|---|---|---|
| HARTFORD LIFE AND ACCIDENT | 06-0838648 | 70815 | 299600P<br>480141C<br>633581D |

**Premium was applied as follows during the Plan/Policy Year -**

| Policy Number | Type of Benefit | Premium Applied | Approximate # of Lives Covered |
|---|---|---|---|
| 299600P | WD-STAT | $396.62 | 1 |
| 480141C | WD-NST | $0.00 | 12 |
| 633581D | PFL-STAN | $3,123.88 | 3 |
| 633581D | WD-STAT | $215.46 | 7 |
| | | | |
| | Total | $3,735.96 | |

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at www.thehartford.com. The Hartford is the administrator for certain group benefits business written Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). © 2022 The Hartford

The Hartford
Group Benefits Division
Annual Statement of Premiums and Producer Compensation
For: WACHTER, INC.

## Insurer paid the following compensation during the Plan/Policy Year -

| Producer and Address | Org Code | Policy Number | Commissions Paid | Fees Paid | (1)Bonus Paid | (2)Additional Compensation Paid |
|---|---|---|---|---|---|---|
| WELSH & ASSOCIATES LLC<br>8016 STATE LINE RD<br>PRAIRIE VILLAGE, KS 66208 | 3 | 299600-TDI<br>633581-LNY | $0.00<br>$88.68 | $0.00<br>$0.00 | $0.00<br>$0.00 | $0.00<br>$0.00 |
| | | **Total** | **$88.68** | **$0.00** | **$0.00** | **$0.00** |

| Producer and Address | Org Code | Policy Number | Commissions Paid | Fees Paid | (1)Bonus Paid | (2)Additional Compensation Paid |
|---|---|---|---|---|---|---|
| HOME OFFICE DIRECT<br>ONE HARTFORD PLAZA<br>HARTFORD, CT 06155 | 3 | 480141-COV | $0.00 | $0.00 | $0.00 | $0.00 |
| | | **Total** | **$0.00** | **$0.00** | **$0.00** | **$0.00** |

(1)Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2)Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

WACHTER INC
LENEXA, KS

**Name of Carrier:** United of Omaha Life Insurance Company - NAIC Code 69868
**EIN Number:** 47-0322111
**Group Identification Number:** G000BX45
**Data for Period:** 01-01-2024 to 10-01-2024
**Legacy Group ID:** GLTD0BX45
**Type of Contract:**

| Benefits Provided | Persons Covered |
|---|---|
| Long Term Disability Insured | 1469 |

| Name of Each Recipient | Amount of Commission Paid | Amount of Service Fees Paid or Other Fees | Purpose for Which Paid | Organization Type |
|---|---|---|---|---|
| WELSH & ASSOCIATES LLC<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 38,324 | | Agent or Broker of Record | 3 |
| WELSH & ASSOCIATES, LLC.<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 2,829 | | | |

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums .............................................................. 274,351

Memo Items: Benefit Charges – Claims Paid ................ 0
Administrative Service Fees .................. 0

Group Office: KANSAS CITY

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

WACHTER INC
LENEXA, KS

**Name of Carrier:** United of Omaha Life Insurance Company - NAIC Code 69868
**EIN Number:** 47-0322111
**Group Identification Number:** G000BX45
**Data for Period:** 01-01-2024 to 10-01-2024
**Legacy Group ID:** GLUG0BX45
**Type of Contract:**

| Benefits Provided | Persons Covered |
|---|---|
| Life & AD&D | 1469 |

| Name of Each Recipient | Amount of Commission Paid | Amount of Service Fees Paid or Other Fees | Purpose for Which Paid | Organization Type |
|---|---|---|---|---|
| WELSH & ASSOCIATES LLC<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 6,276 | | Agent or Broker of Record | 3 |
| WELSH & ASSOCIATES, LLC.<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 469 | | | |

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums ........................................................... 67,452

Memo Items: Benefit Charges – Claims Paid ................ 0
Administrative Service Fees .................. 0

Group Office: KANSAS CITY

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

WACHTER INC
LENEXA, KS

**Name of Carrier:** United of Omaha Life Insurance Company - NAIC Code 69868
**EIN Number:** 47-0322111
**Group Identification Number:** G000BX45 **Data for Period:** 01-01-2024 to 10-01-2024
**Legacy Group ID:** GUC 0BX45
**Type of Contract:**

| Benefits Provided | Persons Covered |
|---|---|
| ShortTerm Disability Voluntary | 554 |

| Name of Each Recipient | Amount of Commission Paid | Amount of Service Fees Paid or Other Fees | Purpose for Which Paid | Organization Type |
|---|---|---|---|---|
| WELSH & ASSOCIATES LLC<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 18,443 | | Agent or Broker of Record | 3 |
| WELSH & ASSOCIATES, LLC.<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 1,471 | | | |

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums ............................................................ 132,766

Memo Items: Benefit Charges – Claims Paid ................ 0
Administrative Service Fees .................. 0

Group Office: KANSAS CITY

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

WACHTER INC
LENEXA, KS

**Name of Carrier:** United of Omaha Life Insurance Company - NAIC Code 69868
**EIN Number:** 47-0322111
**Group Identification Number:** G000BX45
**Data for Period:** 01-01-2024 to 10-01-2024
**Legacy Group ID:** GVTL0BX45
**Type of Contract:**

| Benefits Provided | Persons Covered |
|---|---|
| Life & AD&D Voluntary | 232 |

| Name of Each Recipient | Amount of Commission Paid | Amount of Service Fees Paid or Other Fees | Purpose for Which Paid | Organization Type |
|---|---|---|---|---|
| WELSH & ASSOCIATES LLC<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 26,247 | | Agent or Broker of Record | 3 |
| WELSH & ASSOCIATES, LLC.<br>8016 STATE LINE RD STE 109<br>PRAIRIE VILLAGE, KS 66208 | 2,106 | | | |

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums ............................................................ 141,764

Memo Items: Benefit Charges – Claims Paid ................ 0
Administrative Service Fees .................. 0

Group Office: KANSAS CITY

**Contract #** 1194051
**Name of Plan** WACHTER INC
**Data Period** February 1, 2024 to January 31, 2025

**Principal Life Insurance Company**
**Schedule A (Form 5500) Worksheet**

**Section 1: Coverage**

| (a) Name of Insurance Carrier Principal Life Insurance Company | (b) EIN 42-0127290 | (c) NAIC Code 61271 |
|---|---|---|

| (d) Contract or Id Number | 1194051 | Approx. no. of Persons cov. At End of Policy Year | Total (e) | 1,622 |
|---|---|---|---|---|
| Combined Numbers | | | Employees | 1,622 |
| | | | Dependents | 0 |

Policy or Contract Year From **(f)** February 1, 2024 To **(g)** January 31, 2025

**Section 2: Insurance fee and commissions information**

| | (a) Commissions Paid | (b) Fees Paid |
|---|---|---|
| Total (from below) | 0 | 0 |

**Section 3: Persons receiving commissions and fees**

| (a) Name & Address of Agents or Brokers to whom Commissions or Fees Paid | (b) Amount of Commissions Paid | Fees Paid (c) Amount / (d) Purpose | (e) Org Code |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.*

**Section 8: Benefit and Contract Type**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| (a) | Health *(other than dental or vision)* | (b) | Dental | (c) | Vision | (d) | Life Ins. |
| (e) | Temporary Disability (accident and sickness) | (f) | Long Term Disability | (g) | Supplemental Unemployment | (h) | Prescription Drug |
| (i) | Stop Loss (large deductible) | (j) | HMO Contract | (k) | PPO Contract | (l) | Indemnity Contract |
| (m) | Other: ___________ | | | | | | |

*If applicable, the Schedule A worksheet includes voluntary products. If applicable, Basic Life and VTL coverages included AD&D.*

**Section 10: Non-Experience Rated Contracts**

| (a) Total Premiums Paid to Carrier | 87,492 |
|---|---|

# Schedule A Form (5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation.

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

Group ID: **40161082**
Insurance Carrier: Vision Service Plan
Insurance Carrier NAIC Code: 39616
Insurance Carrier FEIN: **061227840**
Benefit Type: Vision Care
Policy or Contract Year: **02/01/2024 - 01/31/2025**

Group Legal Name and Address:

**WACHTER INC**
**16001 W 99th St**
**Lenexa KS 66219-1293**

Approximate Number of Persons Covered at the End of Policy or Contract Year: **1,510**

Payments:

| | |
|---|---|
| Total Administrative Fees Paid to Carrier: | **$ 14,177.35** |
| Total Payments Made to Carrier: | **$ 88,608.44** |
| Total Claims Paid by Carrier: | **$ 69,596.09** |

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 07/17/2025 .

www.deltadentalks.com

July 21, 2025

RE: Wachter

5500 information

| | | |
|---|---|---|
| 1.) | Contract Number | 50631 |
| 2.) | Type of Insurance | Dental |
| 3.) | Period Covered | 2/1/2024 through 1/31/2025 |
| 4.) | Claims Paid | $728,574.05 |
| 5.) | Administrative Fees Paid | $61,911 |
| 6.) | Number enrolled as of 1/31/2025 | 1,453 |
| 7.) | Administration Fee Rates in effect as of 1/31/2025 | $3.60 per subscriber |
| 8.) | Delta Dental of Kansas, Inc: | |
| | Federal Employer Identification Number | 48-0793267 |
| | NAIC Number | 54615 |

If you have any additional questions, please do not hesitate to contact me.

Sincerely,

*Michael Tran*

Michael Tran
Senior Underwriter
Delta Dental of Kansas
1-800-234-3375

DELTA DENTAL OF KANSAS
1619 N Waterfront Parkway
P.O. Box 789769
Wichita, KS 67278-9769

| | | | |
|---|---|---|---|
| Main Telephone | 316-264-1099 | 800-722-5823 | Fax: 316-462-3393 |
| Customer Service | 316-264-4511 | 800-234-3375 | Fax: 316-462-3392 |
| Marketing & Sales | 316-264-8413 | 800-264-9462 | Fax: 316-462-3329 |
| Eligibility & Enrollment | 316-264-4511 | 800-234-3375 | Fax: 316-462-3394 |