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

2020

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of 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)

Part II Basic Plan Information—enter all requested information

1a Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 03/01/1978

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)
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

475 WIRELESS BOULEVARD
HAUPPAUGE, NY 11788-3951

475 WIRELESS BOULEVARD
HAUPPAUGE, NY 11788-3951

2b Employer Identification Number (EIN)
13-2607577

2c Plan Sponsor's telephone number
631-435-1600

2d Business code (see instructions)
221100

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.	01/19/2022	DENISE ROONEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	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:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	481
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)**	378
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	348
b	Retired or separated participants receiving benefits	**6b**	4
c	Other retired or separated participants entitled to future benefits	**6c**	101
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	453
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	5
f	Total. Add lines **6d** and **6e**	**6f**	458
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	453
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	13
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 4H 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] 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)** [ ] 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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 7 **A** (Insurance Information)
- **(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 2020 Form M-1 annual report. If the plan was not required to file the 2020 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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY

(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
13-3176850	71005	VG 185289	94	01/01/2020	12/31/2020

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
14879	942

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

BWD AGENCY INC
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
14879	38	N/A	4

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

NFP INSURANCE SERVICES INC.
1250 CAPITAL OF TX HWY S BLDG II ST
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	904	N/A	4

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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** [X] Other (specify) ▶ DEPENDENT LIFE INSURANCE

9 Experience-rated contracts:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	99196
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY

(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
13-3176850	71005	G164406	186	01/01/2020	12/31/2020

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
3984	826

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

BWD AGENCY INC
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
3980	73	N/A	3

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

NFP INSURANCE SERVICES INC.
1250 CAPITAL OF TX HWY S BLDG II ST
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
	753	N/A	3

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

DAVID KUSHNER
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
4		N/A	3

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] Other (specify) ▶ WEEKLY INCOME

9 Experience-rated contracts:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	56947
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

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

2020

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For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY

(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
13-3176850	71005	GL155200	359	01/01/2020	12/31/2020

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
3702	1369

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

BWD AGENCY INC
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
3702		N/A	3

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

NFP INSURANCE SERVICES INC.
1250 CAPITAL OF TX HWY S BLDG II ST
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	1369	N/A	3

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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** [X] Other (specify) ▶ AD&D

9 Experience-rated contracts:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	130377
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY

(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
13-3176850	71005	LTD126720	359	01/01/2020	12/31/2020

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
5361	1455

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

BWD AGENCY INC
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
5361		N/A	3

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

NFP INSURANCE SERVICES INC.
1250 CAPITAL OF TX HWY S BLDG II ST
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	1455	N/A	3

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	136141
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 [X] No

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

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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES

(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
59-1031071	67369	3329398	205	01/01/2020	12/31/2020

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
583	0

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

BWD AGENCY INC
45 EXECUTIVE DRIVE
PLAINVIEW, NY 11803

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
583		N/A	3

(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		
	(c) Amount	(d) Purpose	(e) Organization code

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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** [X] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [X] Other (specify) ▶ PREPAID DENTAL

9 Experience-rated contracts:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	44254
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
SHELTERPOINT LIFE INSURANCE CO

(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
11-2284118	81434	GVNY25926	381	04/01/2020	03/31/2021

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
5528	0

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

DAVID KUSHNER
16831 C ISLE OF PALMS DRIVE
DELRAY BEACH, FL 33484

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5528		N/A	3

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

DBL CENTER LTD
155 PINELAWN ROAD SUITE 120S
MELVILLE, NY 11747

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
		N/A	3

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	32520
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

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

2020

This Form is Open to Public Inspection

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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
SHELTERPOINT LIFE INSURANCE CO

(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
11-2284118	81434	D387938	400	01/01/2020	12/31/2020

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
8590	0

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

DAVID KUSHNER
16831 C ISLE OF PALMS DRIVE
DELRAY BEACH, FL 33484

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
8590		N/A	3

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

DBL CENTER LTD
155 PINELAWN ROAD SUITE 120S
MELVILLE, NY 11747

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
		N/A	3

(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)**	0
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)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

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** [X] 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** [X] Other (specify) ▶ PFL

9 Experience-rated contracts:				
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:				
a Total premiums or subscription charges paid to carrier			**10a**	135050
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. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] 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 Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2020** **This Form is Open to Public Inspection.**

For calendar plan year 2020 or fiscal plan year beginning 04/01/2020 and ending 03/31/2021

A Name of plan
SPELLMAN HIGH VOLTAGE GROUP LIFE AND MAJOR MEDICAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.

D Employer Identification Number (EIN)
13-2607577

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

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(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)

AETNA LIFE INSURANCE COMPANY

151 FARMINGTON AVENUE
HARTFORD, CT 06156

06-6033492

(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	THIRD PARTY ADMINISTRATOR	340330	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CIGNA HEALTH AND LIFE INSURANCE CO.

900 COTTAGE GROVE RD.
BLOOMFIELD, CT 06002

59-1031071

(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 13 31 38 49 50 56 62	THIRD PARTY ADMINISTRATOR	22571	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

(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?
			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)

(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?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

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

(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?
			Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

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

(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?
			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
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
AMERICAN SPECIALTY HEALTH 10221 WATERIDGE CIR 201 SAN DIEGO, CA 92121 33-0571188	INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR TO DEFRAY CIGNA'S INFRASTRUCTURE AND OTHER COST TO IMPLEMENT AND ADMINISTER ON AN ONGOING BASIS THE EXPANDED ACCESS TO THE PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY PROVIDER NETWORK/DISCOUNTS.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
CASTLIGHT HEALTH 121 SPEAR ST 3RD FLOOR SAN FRANCISCO, CA 94105 26-1989091	INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR (I) TO DEFRAY CIGNA'S COST FOR THE INFRASTRUCTURE CHANGES REQUIRED TO FACILITATE IMPLEMENTATION OF THIS VENDOR'S CUSTOMER TRANSPARENCY AND ENGAGEMENT SERVICES; (II) AS REIMBURSEMENT FOR ANNUAL

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
OMADA HEALTH, INC. 500 SANSOME ST., 200 SAN FRANCISCO, CA 94111 45-2355015	DIGITAL DIABETES PREVENTIVE CARE SERVICES PROVIDER - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS PROVIDER FOR SERVICES INCLUDING: (I) EXPLAINING THE OMADA SERVICES TO EXISTING AND PROSPECTIVE CLIENTS; (II) ENCOURAGING AT-RISK INDIVIDUALS WHO MA

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
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
VISION SERVICE PLAN VSP 333 QUALITY DRIVE RANCHO CORDOVA, CA 96670 06-1227840	NOTE: THE FOLLOWING IS NOT APPLICABLE TO YOUR PLAN IF YOUR CIGNA ADMINISTERED PLAN DID NOT INCLUDE BENEFITS FOR VISION SERVICES THROUGH VSP. VENDOR FOR VISION SERVICES - INDIRECT COMPENSATION RECEIVED BY CIGNA FROM THIS VENDOR FOR CIGNA'S EXPENSES AS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
SAGAMORE NETWORK HOSPITAL SEE ATTACHED SEE ATTACHED, IN 47402	NETWORK HOSPITALS LISTED BELOW HAVE CONTRACTED WITH SAGAMORE HEALTH NETWORK (AN AFFILIATE OF CIGNA) TO PAY NETWORK ADMINISTRATION FEES. FOR CALENDAR YEAR 2020, CIGNA RECEIVED INDIRECT COMPENSATION FROM THESE HOSPITALS OF APPROXIMATELY $0.08 PER PARTI

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
BANK OF AMERICA (LOCKBOX) 540 WEST MADISON STREET CHICAGO, IL 60661 59-1031071	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF CLAIM OVERPAYMENT RECOVERIES. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED BY CIGNA. FOR CALENDAR YEAR 2020, $0.00 PER PARTICIPANT WITH THE AVERAGE ANNUAL R

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
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
AMPLIFON HEARING HEALTHCARE 150 SOUTH 5TH ST., SUITE 2300 MINNEAPOLIS, MN 55402 85-0437037	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. APPLICABLE TO YOUR PLAN IF YOUR PLAN PARTICIPANTS HAVE A CIGNA ID CARD AND ACCESS TO MYCIGNA.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
FIT FOR LIFE (FORMALLY GAIAM 833 W SOUTH BOULDER RD. LOUISVILLE, CO 80027-2452 38-3983812	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. APPLICABLE TO YOUR PLAN IF YOUR PLAN PARTICIPANTS HAVE A CIGNA ID CARD AND ACCESS TO MYCIGNA.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
CITIBANK NA ONE PENNS WAY NEW CASTLE, DE 19720 59-1031071	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING CITIBANK SERVICES. ELIGIBLE INDIRECT COMPENSATION FORMULA/ESTIMATE: FOR CALENDAR YEAR 2

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
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
CHLIC CORE DEPOSITS ONE PENNS WAY NEW CASTLE, DE 19720 59-1031071	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS FOR CIGNA BEHAVIORAL HEALTH UTILIZING CITIBANK SERVICES. FOR CALENDAR YEAR 2020, $0.02 PER PARTIC

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
OMNIBUS ONE PENNS WAY NEW CASTLE, DE 19720 59-1031071	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN THE CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS FOR CIGNA BEHAVIORAL HEALTH UTILIZING CITIBANK SERVICES. FOR CALENDAR YEAR 2020, $0.01 PER PARTIC

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
DEUTSCHE BANK 60 WALL ST. NEW YORK, NY 10005-2836 59-1031071	EARNINGS CREDITS ASSOCIATED WITH BANK ACCOUNTS UTILIZED BY CIGNA IN THE ADMINISTRATION OF DISBURSING CLAIM REFUNDS. APPLICABLE TO ALL SELF-FUNDED PLANS ADMINISTERED BY CIGNA. FOR CALENDAR YEAR 2020, $0.00 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE

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
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0

(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.
JPMORGAN CHASE 3 CHASE METRO TECH CENTER, 5TH FLOO BROOKLYN, NY 11245 59-1031071	EARNINGS CREDITS ON DAILY FUND BALANCES ASSOCIATED WITH BANK ACCOUNTS UTILIZED IN CLAIM ADMINISTRATION BY CIGNA. APPLICABLE TO ALL SELF-FUNDED PLANS UTILIZING JPMORGAN CHASE SERVICES. FOR CALENDAR YEAR 2020, $.25 PER PARTICIPANT WITH THE AVERAGE ANNU

(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:

SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.
January 1, 2020 through December 31, 2020
Account Number: 3329398

TABLE OF CONTENTS

SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.
January 1, 2020 through December 31, 2020
Account Number: 3329398

POOLED PREMIUM REPORT

Products	Premium
DENTAL	44,254

** If you have elected not to receive identifiable health information, this report complies with your election. Nevertheless, please note that you may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.	B. Three-Digit Plan Number (P/N):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information — (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From (g) Through
59-1031071	67369	3329398	205 Persons	1/1/2020 - 12/31/2020

2. Insurance fees and commissions information. Enter total fees and commissions paid.

(a) Total amount of commissions paid	583		(b) Total amount of fees paid	0

3. Persons receiving commissions and fees. (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 (c) Amount*	(d) Purpose*	(e) Organization code
		*Refer to footnotes for incentive $$ amounts and purpose as applicable		
Non Experience-Rated BWD AGENCY INC. / PLAINVIEW, NY	583	0		3-Insurance Agent or Broker

Outstanding Monies Due $ 0 — Contract or Identification Number same as 1d

PART III Welfare Benefit Contract Information:

8. Benefit and contract type

- ☐ (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 (Prepaid Dental)

9. Experience-Rated Contracts

(a) Premiums	(1) Amount received	0	
	(2) Increase (decrease) in amount due but unpaid		
	Premium Due as of 2/1/2021	0	
	Retrospective Premium or Bank Account Margin Due	0	
	(4) Earned, ((1) + (2) = (4))		0
(b) Benefit charges	(1) Claims Paid	0	
	(2) Increase (decrease) in claim reserves	0	
	(3) Incurred claims, (add (1) and (2))	0	
	(4) Claims charged		0
(c) Remainder of premium	(1) Retention charges (on an accrual basis)		
	(A) Contracted Commissions	0	
	(B) Administrative service or other fees	0	
	(D) Other Expenses	0	
	(E) Taxes (Approx)	0	
	(H) Total retention		0
	(2) Dividends or retroactive rate refunds (these amounts were 1) paid in cash)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to Premium Stabilization Reserve)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to other reserves)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to accumulated deficits)		0
	Deficits arising from experience in current policy reporting year		0
	Accumulated deficits arising from experience in current and previous policy reporting years		0
(d) Status of policyholder reserves at end of year	(2) Claim reserves		0
	(3) Other reserves (Premium Stabilization Reserve)		0
	Other reserves		0
(e) Dividends or retroactive rate refunds due. (Do not include amount entered in 9c(2).)			0
from ☐ Premium Stabilization Reserve ☐ Other Reserves			
to ☐ Credited to policy year premium ☐ Credited to offset deficit ☐ Paid in cash			

10. Non-Experience Rated Contracts	(a) Total Premiums or subscriptions charges paid to carrier	44,254
	Premium Due as of 2/1/2021	0
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	
	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. Not Applicable

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information Footnotes

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.	B. Three-Digit Plan Number (P/N):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From (g) Through
59-1031071	67369	3329398	205 Persons	1/1/2020 - 12/31/2020

(Part I, line 1a) "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna companies whose contracts fund the plan are grouped as a single unit by Cigna for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna companies are grouped as a unit for purposes of this report. To reference individual contracts refer to the Appendix pages contained within this reporting package.

(Part I, line 1e) Schedule A subscriber/employee/participant and persons/members information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting.

(Part I, line 2a, 2b, 3b and/or 3c) Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

(Part I, line 2a, 2b) The following amounts were paid to your broker(s) / consultant(s) during the contract year:
Commissions: $583
Service/Gen.Agent Fees: $0
Benefit Advisor Fees: $0
Benefit Advisor Fees are not included as part of premium.

(Line 9.b.1) May include pay for performance payments to providers, vendor cost-containment, administrative and care coordination fees.

(Line 10.a) May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

(Line 10.a) May include adjustment amounts attributable to another Cigna company whose coverage may have previously terminated.

- In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services.In addition, Cigna offers agents/ broker the opportunity to receive the benefit of Cigna's favorable pricing with vendors of various goods and services. Contact your agent/ broker for specific information about their participation.
- If the contract is a minimum premium insurance policy issued by Cigna, the “claims paid” are identified in the Bank Account Reconciliation Report for the last month of the contract year. Fees reported in Section 9 do not include fees paid to all overpayment recovery vendors based upon a percentage of recoveries.
- Certain non-claim fees paid from your benefit payment account are included as claims in your settlement but not included as claims in the ERISA Form 5500 Schedule A report (provided to ERISA plans) and the Annual Reconciliation Disclosure (provided to non-ERISA plans). As a result there may be a discrepancy between the amount of claims reflected in your settlement and on the Schedule A and Annual Reconciliation Document. A report to reconcile this discrepancy is available upon request.
- If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.
- Appendix to Schedule A entities' allocation is based on averaged premium, commissions and available lives reported during the contract period.
- Appendix to Schedule A entities' allocation for broker/general agent commission amounts do not include Platinum/Supplemental bonus payments as they are paid lump sum to brokers/general agents and are included on the Schedule A summary page reporting.
- Appendix to Schedule A entities' reports the number of employees covered rather than employees and dependents.
- When referencing (Line 10.a) on the appendix page, please note, it may include adjustment amounts attributable to another Cigna company whose coverage may have previously terminated. Adjustments are allocated to a Cigna company whose coverage is active based on weighted average employees.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid and credited for any prior plan year.
- Does not include value-based payments made to entities not contracted as participating providers.
- Premium and commission associated with insurance coverage for an Employee Assistance Plan, if applicable, is included in this report.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information - Appendix to Part I, Line Items 1a, b and c

A. Plan Name SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.	
1. Coverage Information (d) Contract or Identification Number 3329398	Policy/Contract Year (f) From (g) Through 1/1/2020 - 12/31/2020

The below information is to further detail the non-experience rated premium for 5500 reporting based on applicable NAIC code:

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Pennsylvania, Inc.	Part I	line 1(e)	1 employee
EIN Code:	52-1220578		line 2(a)	$ 1
NAIC Code:	47041		line 2(b)	$ 0
			line 3(a)	BWD AGENCY INC. / PLAINVIEW, NY
			line 3(b)	$ 1
			line 3(c)	$ 0
		Part III	line 10(a)	$ -1

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna Dental Health of Texas, Inc.	Part I	line 1(e)	5 employees
EIN Code:	59-2676977		line 2(a)	$ 29
NAIC Code:	95037		line 2(b)	$ 0
			line 3(a)	BWD AGENCY INC. / PLAINVIEW, NY
			line 3(b)	$ 29
			line 3(c)	$ 0
		Part III	line 10(a)	$ 2,213

	Company Information	5500 Section	5500 Line Item	DHMO Plan
Name:	Cigna HealthCare of Connecticut, Inc.	Part I	line 1(e)	1 employee
EIN Code:	06-1141174		line 2(a)	$ 3
NAIC Code:	95660		line 2(b)	$ 0
			line 3(a)	BWD AGENCY INC. / PLAINVIEW, NY
			line 3(b)	$ 3
			line 3(c)	$ 0
		Part III	line 10(a)	$ 443

SERVICE PROVIDER INFORMATION APPLICABLE TO SCHEDULE C FOR

Cigna Health and Life Insurance Company ("Cigna")

SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.
Account Number: 3329398

For plan year beginning **January 01, 2020** and ending **December 31, 2020**

Part I Service Provider Information

1. *Information on Persons receiving Only Eligible Indirect Compensation:*
   (a) Check "No"
   (b) Not applicable

2. *Information on Other Service Providers Receiving Direct or Indirect Compensation*
   (a) Cigna Health and Life Insurance Company ("Cigna")
   Contract Identification Number: 59-1031071
   NAIC Code: 67369
   (b) Service Code(s):

12 Claims Processing	38 Participant communications	50 Direct payments from the Plan
13 Contract Administrator	49 Other Services	56 Non-monetary compensation
31 Named fiduciary-(*if indicated in ASO Agreement*)		62 Float Revenue

   (c) Cigna provides claim administration and related Services Pursuant to an Administrative Services Agreement
   (d) Direct Compensation paid by the plan

		Amount Paid
Dental Fees	$	22,571

   (e) Check "Yes." Cigna received indirect compensation.
   (f) Check "Yes", see appendix for eligible indirect compensation calculation.
   (g) See Appendix for indirect compensation calculation.
   (h) Check "Yes." See Appendix included with this reporting.

3. *For information regarding each source of indirect compensation (a) of $1,000 or more and (b) each source of indirect compensation for which Cigna provided a formula refer to:*
   (a) Reference Appendix for information on *eligible* indirect compensation including formulas
   (b) Reference Appendix for information on indirect compensation including formulas

Part II Service Providers Who Fail or Refuse to Provide Information

4. *Do not identify Cigna in this section as information for completion of Schedule C is provided in this documentation.*

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: If you have elected not to receive identifiable health information, this report complies with your election. Nevertheless, please note that you may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

SERVICE PROVIDER INFORMATION APPLICABLE TO SCHEDULE C FOR
Cigna Health and Life Insurance Company ("Cigna")

FOOTNOTE DOCUMENT

SPELLMAN HIGH VOLTAGE ELECTRONICS CORP.
Account Number: 3329398

For plan year beginning **January 01, 2020** and ending **December 31, 2020**

The following amounts were paid to your broker(s)/consultants during the plan year:

BWD AGENCY INC. / PLAINVIEW, NY

Dental	$ 3,212

Incentive compensation payments based upon persons/members in your plan and/or lump sum amount:
$ 745.00 (Broker, Service Provider and/or General Agents combined) attributable to your plan as it relates to the 2020 calendar year. These amounts are funded from Cigna companies' general overhead. Contact your broker/consultant for further details.

- Appendix refers to subscriber/participant and persons/members information for your plan that is available at the Cigna Access Employer Portal at www.cignaaccess.com. Go to the report titled, Subscriber and Membership Reporting. This subscriber/participant and membership information should be used in calculating Cigna's Indirect Compensation (using the formulas in the attached Appendix) and Eligible Indirect Compensation (using the formulas at www.cignaaccess.com).

- In addition to the commissions and other fees reported, Cigna enters into compensation programs under which certain brokers/ consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, is funded from our general overhead, and is not required to be reported on Schedule C. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services.In addition, Cigna offers agents/ broker the opportunity to receive the benefit of Cigna's favorable pricing with vendors of various goods and services. Contact your agent/ broker for specific information about their participation.

- If you have a Cigna administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor.

- Does not include value-based payments made to entities not contracted as participating providers.

- Direct compensation reported may include compensation for administrative services provided to individuals not covered under the group health plan administered by Cigna.

- Paid claims dollars may include amounts deducted from your account to pay vendors for cost containment services. This amount will have been included in claims in other reporting.

- Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium/commissions) where applicable.

- Direct compensation amount does not include the following compensation received, if any, by affiliated companies:
  - Plan benefit payments, if any, made to eviCore
  - Utilization management fees paid to eviCore
  - Plan benefit payment made to Cigna Behavioral Health
  - Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

  The amount of such compensation, if any, with respect to your plan is available upon request.

- Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

- Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:
  - eviCore
  - Cigna Behavioral Health
  - Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

APPENDIX FOR SERVICE PROVIDER INFORMATION REGARDING SOURCES OF INDIRECT COMPENSATION TO BE REPORTED ON SCHEDULE C PART I, LINE 3

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

American Specialty Health (ASH), 10221 Wateridge Cir 201, San Diego, CA 92121 EIN - 330571188

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Indirect compensation received by Cigna from this vendor to defray Cigna's infrastructure and other cost to implement and administer on an ongoing basis the expanded access to the physical therapy, and occupational therapy provider network/discounts. Your plan participants may have received covered services through this vendor's network.

Indirect Compensation Formula/Estimate: *For calendar year 2020, Cigna received indirect compensation from this vendor of approximately $0.04 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2020 in all plans insured/administered by Cigna. (including Shared Administration Repricing OAP plans)*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Castlight Health, 121 Spear St 3rd floor, San Francisco, CA 94105 EIN - 261989091

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Indirect compensation received by Cigna from this vendor (i) to defray Cigna's cost for the infrastructure changes required to facilitate implementation of this vendor's customer transparency and engagement services; (ii) as reimbursement for annually providing the vendor Cigna derived Center of Excellence (COE) and Cigna Designation (CCD) Information; (iii) as reimbursement for making available customer access to cost estimate information, and (iv) as reimbursed for access to client paid claim files.

Indirect Compensation Formula/Estimate: *For calendar year 2020, Cigna received indirect compensation from this vendor of approximately $1.41 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2020 in all plans that utilized this vendor. (excluding Shared Administration Repricing "SAR")*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Omada Health, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Digital Diabetes Preventive Care Services Provider - Indirect compensation received by Cigna from this provider for services including: (i) explaining the Omada services to existing and prospective clients; (ii) encouraging at-risk individuals who may benefit from the Omada services to utilize Omada's preventive care services, and (iii) facilitating the enrollment of at-risk individuals in the Omada program.

Indirect Compensation Formula/Estimate: *For calendar year 2020, Cigna received indirect compensation from this vendor of approximately $.48 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2020 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR"))*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Vision Service Plan "VSP", 333 Quality Drive, Rancho Cordova, CA 96670, EIN - 061227840

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

NOTE: The following is not applicable to your plan if your Cigna administered plan did not include benefits for vision services through VSP.

Vendor for Vision Services - Indirect compensation received by Cigna from this vendor for Cigna's expenses associated with administering plans with vision benefits.

Indirect Compensation Formula/Estimate: *For calendar year 2020, Cigna received indirect compensation from this vendor of approximately $1.67 per participant. (Determined by dividing total compensation received by the number of Vision Service Plan participants in participating plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid.) (excluding Shared Administration Repricing plans)*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Refer to Sagamore Network Hospital listing below *

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Network hospitals listed below have contracted with Sagamore Health Network (an affiliate of Cigna) to pay network administration fees.

Indirect Compensation Formula/Estimate: *For calendar year 2020, Cigna received indirect compensation from these hospitals of approximately $0.08 per participant. (Determined by dividing total indirect compensation received by the number of participants in all plans, including Shared Administration Repricing plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid to these hospitals.)*

Effective Date: *01/01/2020* *Cancel Date:*

* Bloomington Hospital, P. O. Box 1149, Bloomington, IN 47402, TIN = 351720796
Bloomington Hospital of Orange County, 642 W. Hospital Road, Paoli, IN 47454, TIN = 352090919
Clark Memorial Hospital, 1220 Missouri Avenue, Jeffersonville, IN 47130, TIN = 350944638
Daviess Community Hospital, P. O. Box 32, Washington, IN 47501, TIN = 356001322
Gibson General Hospital, 1808 Sherman Drive, Princeton, IN 47670, TIN = 350877575
Good Samaritan Hospital, 520 S. Seventh Street, Vincennes, IN 47591-1098, TIN = 356001532
Goshen General Hospital, P. O. Box 139, Goshen, IN 46527-0139, TIN = 356001540

Greene County General Hospital, RR#1, Box 1000, Linton, IN 47441-9457, TIN = 356001492
Home Hospital/Lafayette Home Hospital, P. O. Box 310, Mishawaka, IN 46546-0310, TIN = 352056396
Franciscan Healthcare Rensselaer (Jasper County Hospital), 1104 E. Grace Street, Rennselaer, IN 47978, TIN = 351404051
Margaret Mary Community Hospital, P. O. Box 226, Batesville, IN 47006-8953, TIN = 356067049
Meadows Hospital, 3600 N. Prow Road, Bloomington, IN 47404, TIN = 351858510
Monroe Hospital, 4011 S. Monroe Medical Park Blvd., Bloomington, IN 47403, TIN = 202069733
Oaklawn Psychiatric Center, P. O. Box 809, Goshen, IN 46527, TIN 351070041
Starke Memorial Hospital (Principal Knox LLC), P. O. Box 339, Knox, IN 46534-0339, TIN = 621763056
Pulaski Memorial Hospital, P. O. Box 279, Winamac, IN 46996, TIN = 351097674
St. Elizabeth Medical Center, P. O. Box 310, Mishawaka, IN 46546-0310, TIN = 352056396
St. Joseph Regional Medical Center -Plymouth, P. O. Box 1935, South Bend, IN 46634, TIN = 351142669
St. Joseph Regional Medical Center -South Bend, P. O. Box 1935, South Bend, IN 46634, TIN = 350868157
St. Mary's Medical Center, 3700 Washington Ave, Evansville, IN 47750, TIN = 350869065
St. Mary's Warrick Hospital, P.O. Box 2408, Indianapolis, IN 46206, TIN = 351343019
White County Memorial Hospital, 720 South 6th St., Monticello, IN 47960, TIN = 351140233
Woodlawn Hospital, 1400 E. 9th St., Rochester, IN 46975, TIN = 351171815

APPENDIX FOR SERVICE PROVIDER INFORMATION REGARDING SOURCES OF ELIGIBLE INDIRECT COMPENSATION TO BE REPORTED ON SCHEDULE C PART I, LINE 3

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Bank of America (Lockbox), 540 West Madison Street, Chicago, IL 60661 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits associated with bank accounts utilized by Cigna in the administration of claim overpayment recoveries. Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.00 per participant with the average annual rate of the earnings credit at .39%.*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Cigna Healthy Rewards Vendors

Amplifon Hearing Healthcare Fifth Street Towers 150 South 5th St., Suite 2300 Minneapolis, MN 55402 EIN# 85-0437037

Fit for Life (formally Gaiam) 833 W South Boulder Rd., Louisville, CO 80027-2452 EIN# 38-3983812

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Volume based marketing fees paid by vendors participating in the Cigna Healthy Rewards program which offers plan participants discounts on various services. Applicable to your plan if your plan participants have a Cigna ID card and access to myCigna.com or other authorized portals.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.01 PMPY (this formula is based upon total compensation received from Healthy Reward Vendors across Cigna companies' entire insured and self-insured book of business.)*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

CitiBank NA, One Penns Way, New Castle, DE 19720 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna. Applicable to all self-funded plans utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.26 per participant with the average annual rate of the earnings credit at .32%.*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

CitiBank NA (CHLIC Core Deposits), One Penns Way, New Castle, DE 19720 EIN # 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna. Applicable to all self-funded plans for Cigna Behavioral Health utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.02 per participant with the average annual rate of the earnings credit at .32%.*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

CitiBank NA (Omnibus), One Penns Way, New Castle, DE 19720 EIN # 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna. Applicable to all self-funded plans for Cigna Behavioral Health utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.01 per participant with the average annual rate of the earnings credit at .32%.*

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

Deutsche Bank, 60 Wall St., New York, NY 10005-2836 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits associated with bank accounts utilized by Cigna in the administration of disbursing claim refunds. Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $0.00 per participant with the average annual*

rate of the earnings credit at .50%.

Effective Date: *01/01/2020* *Cancel Date:*

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation: **$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

JPMorgan Chase, 3 Chase Metro Tech Center, 5th Floor, Brooklyn, NY 11245 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Earnings credits on daily fund balances associated with bank accounts utilized in claim administration by Cigna. Applicable to all self-funded plans utilizing JPMorgan Chase services.

Eligible Indirect Compensation Formula/Estimate: *For calendar year 2020, $.25 per participant with the average annual rate of the earnings credit at .27%.*

Effective Date: *01/01/2020* *Cancel Date:*
