Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ 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:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2023

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)
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

800 BOYLSTON STREET
SUITE 300
BOSTON, MA 02199

2b Employer Identification Number (EIN) 04-3567502

2c Plan Sponsor's telephone number 857-880-5100

2d Business code (see instructions) 624100

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.	07/29/2025	KATE ROJKOV
	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**	347
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)**	346
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	440
b	Retired or separated participants receiving benefits	**6b**	4
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	444
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

D Employer Identification Number (EIN)
04-3567502

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
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

(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
04-1045815	53228	4960508	436	01/01/2024	12/31/2024

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
82591	28548

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

BROWN & BROWN OF MASSACHUSETTS
980 WASHINGTON STREET
SUITE 325
DEDHAM, MA 02026

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
82591	28548	BONUS	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	

(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	0
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	0
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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	4223083		
(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)**	4223083
b Benefit charges (1) Claims paid	**9b(1)**	3771402		
(2) Increase (decrease) in claim reserves	**9b(2)**	41998		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	3813400
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	82591		
(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)**	39096		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**	287996		
(H) Total retention			**9c(1)(H)**	409683
(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**	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, 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

D Employer Identification Number (EIN)
04-3567502

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
SYMETRA 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
91-0742147	68608	01-020559-00	365	01/01/2024	12/31/2024

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
25023	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

BROWN & BROWN OF MASSACHUSETTS
980 WASHINGTON STREET
SUITE 325
DEDHAM, MA 02026

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
16682			3

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

INDIGO INSURANCE SERVICES LLC
100 FRONT STREET
WORCESTER, MA 01608

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8341			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	0
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	0
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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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)**	0
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)**	0
(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)**	0
(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**	166816
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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

D Employer Identification Number (EIN)
04-3567502

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
SYMETRA 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
91-0742147	68608	12595000	240	01/01/2024	12/31/2024

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
9530	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

BROWN & BROWN OF MASSACHUSETTS
980 WASHINGTON STREET
SUITE 325
DEDHAM, MA 02026

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8450			3

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

INDIGO INSURANCE SERVICES LLC
100 FRONT STREET
WORCESTER, MA 01608

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
1080			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	0
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	0
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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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)**	0
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)**	0
(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)**	0
(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**	43463
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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

D Employer Identification Number (EIN)
04-3567502

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

(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	05793A, 05793B	262	01/01/2024	12/31/2024

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
68291	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

ALLEGIANT GLOBAL PARTNERS INC
855 BOYLSTON STREET, FLOOR 10
BOSTON, MA 02116

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
68291			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	

(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	0
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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [X] 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** [X] Other (specify) ▶ EVACUATION, 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)	0
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)	0
(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)	0
(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	883631
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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
PARTNERS IN HEALTH HEALTH & WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PARTNERS IN HEALTH, A NON-PROFIT CORPORATION

D Employer Identification Number (EIN)
04-3567502

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
TRAWICK INTERNATIONAL

(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
98-1753619	52421	01530, 01531	144	01/01/2024	12/31/2024

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
3990	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

ALLEGIANT GLOBAL PARTNERS INC
855 BOYLSTON STREET, FLOOR 10
BOSTON, MA 02116

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3990			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	

(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	0
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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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)**	0
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)**	0
(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)**	0
(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**	49876
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. ▶

Blue Cross Blue Shield of Massachusetts, Inc.

FULLY INSURED #5500A WORKSHEET

ACCOUNT NAME: Partners In Health
ACCOUNT #: 4960508
PERIOD: 01/01/2024 - 12/31/2024 @ 03/31/2025
NAIC CODE: 53228
EIN CODE: 04-1045815

	MEDICAL	DENTAL	SENIOR	VISION
LAST MONTH OF PERIOD ENROLLMENT				
Employees	258	258	0	222
Employee & Dependents	436	436	0	368
PREMIUM				
Total Premium	$3,938,151	$254,259	$0	$30,674
BENEFIT CHARGES				
Incurred Claims	$3,596,105	$155,313	$0	$19,984
Incurred But Not Reported	$39,974	$1,864	$0	$160
Claims Charged	$3,636,079	$157,177	$0	$20,144
RETENTION ALLOCATION				
Base Commission	$71,647	$7,876	$0	$3,067
Taxes	$36,096	$3,000	$0	$0
Other Retention Charges	$194,328	$86,205	$0	$7,463

Copies: 1 - Sales Executive, 1 - File Copy, 1 - Group

The above information is intended to help you complete the Form 5500, Schedule A. If you require additional information please contact your representative at BCBSMA.

MASSACHUSETTS

COMMISSIONS AND BONUS BREAKDOWN

ACCOUNT NAME: Partners In Health
ACCOUNT #: 4960508
PERIOD: 01/01/2024 - 12/31/2024 @ 03/31/2025
NAIC CODE: 53228
EIN CODE: 04-1045815

	MEDICAL	DENTAL	SENIOR	VISION
COMMISSION BREAKDOWN				
BROWN & BROWN OF MA LLC	$45,215.53	$4,151.66	$0.00	$1,028.59
Brown & Brown Insurance Services, Inc	$26,431.52	$3,724.65	$0.00	$2,038.82

OTHER COMMISSION *	
Brown & Brown Insurance Services, Inc	$28,380.00

NON MONETARY COMPENSATION *	
Brown & Brown Insurance Services, Inc	$167.76

* This includes Bonus and Persistency Commissions paid to broker by BCBSMA; not billed to Account

Copies: 1 - Sales Executive, 1 - File Copy, 1 - Group

The above information is intended to help you complete the Form 5500, Schedule A and C. If you require additional information information please contact your representative at BCBSMA.

NON-EXPERIENCE - RATED CONTRACTS

CIGNA HEALTH AND LIFE INSURANCE COMPANY
NAIC COMPANY CODE: 67369
EMPLOYER IDENTIFICATION NUMBER: 591031071
Wilmington, DE 19809

This Data Required for Completion of
Schedule A
INSURANCE INFORMATION
(Form 5500)

For Policy Year beginning January 1, 2024 and ending December 31, 2024
Name of plan Partners in Health

PART I *Summary of All Insurance Contracts Included in part III. Group all contacts in the same manner as in Part III*

2. Coverage (a) Name of Insurance Carrier	(b) Contract Number or Identification	(c) Approximate number persons covered at end of policy or contract year	POLICY/CONTRACT (Year) (d) From	(e) Through
CIGNA HEALTH AND LIFE INSURANCE COMPANY	**05793A**	**57 Total Covered; 28 Employees**	**1/1/2024**	**12/31/2024**

3. Insurance fees and commissions paid to agents and brokers

(b) Contract number or Identification	(b) Name and address of the agents or brokers to whom commissions or fees were paid	(c) Amount of commissions paid	(d) Fees paid Amount	Purpose
Same as Part I 2 (b) above	**ALLEGIANT GLOBAL PARTNERS**	**$18,738**		SALES & SERVICES

4. Premiums due and unpaid at the end of the plan year $19,104.00 Contract or Identification Number 05793A

PART III Insured Welfare Plans: Provide information for each contract on a separate part III. If more than one contract covers the same group of employees of the sameemployer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as aunit. 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.

8 (a) Contract Number or Identification	(b) Type of Benefit	(c) List gross premium for each contract	(d) Premium rate or subscription charge
Same as Part I 2(b) above	**Dental Coverage**	**$19,413**	*manual rates as adjusted by formula*
	Evacuation Coverage	**$5,201**	
	Medical Coverage	**$237,467**	

10. Non-Experience rated contracts

(a) Total premiums or subscriptions charges paid to carrier **$262,081**
(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 3 above, report amount .....Specify nature of costs.

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: In addition to the commissions and other fees reported, the broker qualified for additional compensation of $0 attributable to your plan.
This amount is funded from Cigna Health & Life Insurance Company's general overhead. Contact your broker for further details.

Notes to Policyholders :

1. The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by CIGNA HEALTH AND LIFE INSURANCE COMPANY. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with CIGNA HEALTH AND LIFE INSURANCE COMPANY.
2. CIGNA HEALTH AND LIFE INSURANCE COMPANY may sponsor programs to inform brokers regarding its products and services. These events are funded through the Company's general overhead. Contact your broker, if applicable, for details regarding participation in any of these programs.
3. CIGNA provides 5500 reporting only for CIGNA policies situated in the United States.

G2050A (6-90) 501090 CIGNA HEALTH AND LIFE INSURANCE COMPANY hereby certifies that the foregoing statement is complete and accurate.

NON-EXPERIENCE - RATED CONTRACTS

LIFE INSURANCE COMPANY OF NORTH AMERICA
NAIC COMPANY CODE: 65498
EMPLOYER IDENTIFICATION NUMBER: 231503749
Wilmington, DE 19809

This Data Required for Completion of
Schedule A
INSURANCE INFORMATION
(Form 5500)

For Policy Year beginning January 1, 2024 and ending December 31, 2024
Name of plan Partners in Health

PART I *Summary of All Insurance Contracts Included in part III. Group all contacts in the same manner as in Part III*

2. Coverage (a) Name of Insurance Carrier	(b) Contract Number or Identification	(c) Approximate number persons covered at end of policy or contract year	POLICY/CONTRACT (Year) (d) From	(e) Through
LIFE INSURANCE COMPANY OF NORTH AMERICA	**05793A**	**57 Total Covered; 28 Employees**	**1/1/2024**	**12/31/2024**

3. Insurance fees and commissions paid to agents and brokers

(b) Contract number or Identification	(b) Name and address of the agents or brokers to whom commissions or fees were paid	(c) Amount of commissions paid	(d) Fees paid Amount	Purpose
Same as Part I 2 (b) above		**$**		SALES & SERVICES

4. Premiums due and unpaid at the end of the plan year $0 Contract or Identification Number 05793A

PART III Insured Welfare Plans: Provide information for each contract on a separate part III. If more than one contract covers the same group of employees of the sameemployer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as aunit. 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.

8 (a) Contract Number or Identification	(b) Type of Benefit	(c) List gross premium for each contract	(d) Premium rate or subscription charge
Same as Part I 2(b) above	**AD&D Coverage**	**$182**	*manual rates as adjusted by formula*
	Life Coverage	**$479**	
	LTD Coverage	**$1,593**	

10. Non-Experience rated contracts

(a) Total premiums or subscriptions charges paid to carrier **$2,253**
(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 3 above, report amount .....Specify nature of costs.

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

Note: In addition to the commissions and other fees reported, the broker qualified for additional compensation of $0 attributable to your plan.
This amount is funded from Cigna Health & Life Insurance Company's general overhead. Contact your broker for further details.

Notes to Policyholders :

1. The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by LIFE INSURANCE COMPANY OF NORTH AMERICA. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with LIFE INSURANCE COMPANY OF NORTH AMERICA.
2. LIFE INSURANCE COMPANY OF NORTH AMERICA may sponsor programs to inform brokers regarding its products and services. These events are funded through the Company's general overhead. Contact your broker, if applicable, for details regarding participation in any of these programs.
3. CIGNA provides 5500 reporting only for CIGNA policies situated in the United States.

G2050A (6-90) 501090 LIFE INSURANCE COMPANY OF NORTH AMERICA hereby certifies that the foregoing statement is complete and accurate.

NON-EXPERIENCE - RATED CONTRACTS

CIGNA HEALTH AND LIFE INSURANCE COMPANY
NAIC COMPANY CODE: 67369
EMPLOYER IDENTIFICATION NUMBER: 591031071
Wilmington, DE 19809

This Data Required for Completion of
Schedule A
INSURANCE INFORMATION
(Form 5500)

For Policy Year beginning January 1, 2024 and ending December 31, 2024
Name of plan Partners in Health

PART I *Summary of All Insurance Contracts Included in part III. Group all contacts in the same manner as in Part III*

2. Coverage (a) Name of Insurance Carrier	(b) Contract Number or Identification	(c) Approximate number persons covered at end of policy or contract year	POLICY/CONTRACT (Year) (d) From	(e) Through
CIGNA HEALTH AND LIFE INSURANCE COMPANY	**05793B**	**205 Total Covered; 90 Employees**	**1/1/2024**	**12/31/2024**

3. Insurance fees and commissions paid to agents and brokers

(b) Contract number or Identification	(b) Name and address of the agents or brokers to whom commissions or fees were paid	(c) Amount of commissions paid	(d) Fees paid Amount	Purpose
Same as Part I 2 (b) above	**ALLEGIANT GLOBAL PARTNERS**	**$49,299**		SALES & SERVICES

4. Premiums due and unpaid at the end of the plan year $73,284.00 Contract or Identification Number 05793B

PART III Insured Welfare Plans: Provide information for each contract on a separate part III. If more than one contract covers the same group of employees of the sameemployer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as aunit. 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.

8 (a) Contract Number or Identification	(b) Type of Benefit	(c) List gross premium for each contract	(d) Premium rate or subscription charge
Same as Part I 2(b) above	**Dental Coverage**	**$58,075**	*manual rates as adjusted by formula*
	Evacuation Coverage	**$14,842**	
	Medical Coverage	**$543,315**	

10. Non-Experience rated contracts

(a) Total premiums or subscriptions charges paid to carrier **$616,233**
(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 3 above, report amount .....Specify nature of costs.

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: In addition to the commissions and other fees reported, the broker qualified for additional compensation of $0 attributable to your plan.
This amount is funded from Cigna Health & Life Insurance Company's general overhead. Contact your broker for further details.

Notes to Policyholders :

1. The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by CIGNA HEALTH AND LIFE INSURANCE COMPANY. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with CIGNA HEALTH AND LIFE INSURANCE COMPANY.
2. CIGNA HEALTH AND LIFE INSURANCE COMPANY may sponsor programs to inform brokers regarding its products and services. These events are funded through the Company's general overhead. Contact your broker, if applicable, for details regarding participation in any of these programs.
3. CIGNA provides 5500 reporting only for CIGNA policies situated in the United States.

G2050A (6-90) 501090 CIGNA HEALTH AND LIFE INSURANCE COMPANY hereby certifies that the foregoing statement is complete and accurate.

NON-EXPERIENCE - RATED CONTRACTS

LIFE INSURANCE COMPANY OF NORTH AMERICA
NAIC COMPANY CODE: 65498
EMPLOYER IDENTIFICATION NUMBER: 231503749
Wilmington, DE 19809

This Data Required for Completion of
Schedule A
INSURANCE INFORMATION
(Form 5500)

For Policy Year beginning January 1, 2024 and ending December 31, 2024
Name of plan Partners in Health

PART I *Summary of All Insurance Contracts Included in part III. Group all contacts in the same manner as in Part III*

2. Coverage (a) Name of Insurance Carrier	(b) Contract Number or Identification	(c) Approximate number persons covered at end of policy or contract year	POLICY/CONTRACT (Year) (d) From	(e) Through
LIFE INSURANCE COMPANY OF NORTH AMERICA	**05793B**	**205 Total Covered; 90 Employees**	**1/1/2024**	**12/31/2024**

3. Insurance fees and commissions paid to agents and brokers

(b) Contract number or Identification	(b) Name and address of the agents or brokers to whom commissions or fees were paid	(c) Amount of commissions paid	(d) Fees paid Amount	Purpose
Same as Part I 2 (b) above	**ALLEGIANT GLOBAL PARTNERS**	**$300**		SALES & SERVICES

4. Premiums due and unpaid at the end of the plan year $0 Contract or Identification Number 05793B

PART III Insured Welfare Plans: Provide information for each contract on a separate part III. If more than one contract covers the same group of employees of the sameemployer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as aunit. 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.

8 (a) Contract Number or Identification	(b) Type of Benefit	(c) List gross premium for each contract	(d) Premium rate or subscription charge
Same as Part I 2(b) above	**AD&D Coverage**	**$693**	*manual rates as adjusted by formula*
	Life Coverage	**$2,817**	
	LTD Coverage	**$124**	

10. Non-Experience rated contracts

(a) Total premiums or subscriptions charges paid to carrier **$3,634**
(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 3 above, report amount .....Specify nature of costs.

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

Note: In addition to the commissions and other fees reported, the broker qualified for additional compensation of $0 attributable to your plan.
This amount is funded from Cigna Health & Life Insurance Company's general overhead. Contact your broker for further details.

Notes to Policyholders :

1. The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by LIFE INSURANCE COMPANY OF NORTH AMERICA. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with LIFE INSURANCE COMPANY OF NORTH AMERICA.
2. LIFE INSURANCE COMPANY OF NORTH AMERICA may sponsor programs to inform brokers regarding its products and services. These events are funded through the Company's general overhead. Contact your broker, if applicable, for details regarding participation in any of these programs.
3. CIGNA provides 5500 reporting only for CIGNA policies situated in the United States.

G2050A (6-90) 501090 LIFE INSURANCE COMPANY OF NORTH AMERICA hereby certifies that the foregoing statement is complete and accurate.

NON-EXPERIENCE - RATED CONTRACTS

DELAWARE AMERICAN LIFE INSURANCE OF AMERICA
NAIC COMPANY CODE: 62634
EMPLOYER IDENTIFICATION NUMBER: 510104167
Wilmington, DE 19809

This Data Required for Completion of
Schedule A
INSURANCE INFORMATION
(Form 5500)

For Policy Year beginning January 1, 2024 and ending December 31, 2024
Name of plan Partners in Health

PART I *Summary of All Insurance Contracts Included in part III. Group all contacts in the same manner as in Part III*

2. Coverage (a) Name of Insurance Carrier	(b) Contract Number or Identification	(c) Approximate number persons covered at end of policy or contract year	POLICY/CONTRACT (Year) (d) From	(e) Through
DELAWARE AMERICAN LIFE INSURANCE OF AMERICA	**05793B**	**205 Total Covered; 90 Employees**	**1/1/2024**	**12/31/2024**

3. Insurance fees and commissions paid to agents and brokers

(b) Contract number or Identification	(b) Name and address of the agents or brokers to whom commissions or fees were paid	(c) Amount of commissions paid	(d) Fees paid Amount	Purpose
Same as Part I 2 (b) above	**ALLEGIANT GLOBAL PARTNERS**	**($46)**		SALES & SERVICES

4. Premiums due and unpaid at the end of the plan year $0 Contract or Identification Number 05793B

PART III Insured Welfare Plans: Provide information for each contract on a separate part III. If more than one contract covers the same group of employees of the sameemployer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as aunit. 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.

8 (a) Contract Number or Identification	(b) Type of Benefit	(c) List gross premium for each contract	(d) Premium rate or subscription charge
Same as Part I 2(b) above	**AD&D Coverage**	**$116**	*manual rates as adjusted by formula*
	Life Coverage	**($686)**	

10. Non-Experience rated contracts

(a) Total premiums or subscriptions charges paid to carrier ..... **($570)**
(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 3 above, report amount .....Specify nature of costs.

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

Note: In addition to the commissions and other fees reported, the broker qualified for additional compensation of $0 attributable to your plan. This amount is funded from Cigna Health & Life Insurance Company's general overhead. Contact your broker for further details.

Notes to Policyholders :

1. The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by DELAWARE AMERICAN LIFE INSURANCE OF AMERICA. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with DELAWARE AMERICAN LIFE INSURANCE OF AMERICA.
2. DELAWARE AMERICAN LIFE INSURANCE OF AMERICA may sponsor programs to inform brokers regarding its products and services. These events are funded through the Company's general overhead. Contact your broker, if applicable, for details regarding participation in any of these programs.
3. CIGNA provides 5500 reporting only for CIGNA policies situated in the United States.

G2050A (6-90) 501090 DELAWARE AMERICAN LIFE INSURANCE OF AMERICA hereby certifies that the foregoing statement is complete and accurate.

SYMETRA
RETIREMENT | BENEFITS | LIFE

February 6, 2025

Partners In Health, A Non-Profit Corporation
800 Boylston St
Suite 300
Boston, MA 02199

CC: Brown & Brown Insurance Servic
980 Washington St Ste 325
Dedham, MA 02026

The following insurance information is provided for your use when completing Internal Revenue Service Schedule A (Form 5500). The numbered paragraphs correspond to those on the form. In the event that you are not required to file Schedule A to Form 5500, you may disregard this information.

Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

1 Coverage Information

(a) Insurance carrier	Symetra Life Insurance Company
(b) Symetra EIN	91-0742147
(c) Symetra NAIC Code	68608
(d) Contract or ID number	01-020559-00
(e) Number covered at end of year	Since plan coverage may fluctuate during the year, the administrator should estimate the number of persons that were covered by the contract at the end of the policy or contract year
(f) Policy or contract year - From	1/1/2024
(g) Policy or contract year - To	12/31/2024

2 Insurance fee and commission information

(a) Total amount of commissions paid	$25,023.17
(b) Total amount of fees paid	$0.00

3 Persons receiving commissions or fees

(a) Persons receiving commissions or fees	BROWN & BROWN INSURANCE SERVIC 980 WASHINGTON ST STE 325 DEDHAM, MA 02026
(b) Sales and base commissions paid	$11,453.75
(c) Fees Paid	(d) Purpose
$0.00	N/A
(e) Organization Code	3

Part III Welfare Benefit Contract Information

8 Benefit and Contract Type

(d) Life Insurance
(d) AD&D
(f) Long Term Disability

In addition, if you are utilizing the Employee Assistance Program (provided by ComPsych Corporation) in conjunction with group long-term or short-term disability insurance provided by Symetra, please also check box '(m) Other (specify)' and specify the benefit as 'employee assistance program.'

10 Nonexperience-rated contracts

(a) Total premium and subscription charges $166,816.38

Symetra Life Insurance Company certifies that the above information is complete and accurate to the best of our knowledge

SYMETRA
RETIREMENT | BENEFITS | LIFE

February 6, 2025

Partners In Health, A Non-Profit Corporation
800 Boylston St
Suite 300
Boston, MA 02199

CC: Brown & Brown Of Massachusetts
980 Washington St Ste 325
Dedham, MA 02026

The following insurance information is provided for your use when completing Internal Revenue Service Schedule A (Form 5500). The numbered paragraphs correspond to those on the form. In the event that you are not required to file Schedule A to Form 5500, you may disregard this information.

Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

1 Coverage Information

(a) Insurance carrier	Symetra Life Insurance Company
(b) Symetra EIN	91-0742147
(c) Symetra NAIC Code	68608
(d) Contract or ID number	01-020559-00
(e) Number covered at end of year	Since plan coverage may fluctuate during the year, the administrator should estimate the number of persons that were covered by the contract at the end of the policy or contract year
(f) Policy or contract year - From	1/1/2024
(g) Policy or contract year - To	12/31/2024

2 Insurance fee and commission information

(a) Total amount of commissions paid	$25,023.17
(b) Total amount of fees paid	$0.00

3 Persons receiving commissions or fees

(a) Persons receiving commissions or fees	BROWN & BROWN OF MASSACHUSETTS 980 WASHINGTON ST STE 325 DEDHAM, MA 02026
(b) Sales and base commissions paid	$5,228.19
(c) Fees Paid	(d) Purpose
$0.00	N/A
(e) Organization Code	3

Part III Welfare Benefit Contract Information

8 Benefit and Contract Type

(d) Life Insurance
(d) AD&D
(f) Long Term Disability

In addition, if you are utilizing the Employee Assistance Program (provided by ComPsych Corporation) in conjunction with group long-term or short-term disability insurance provided by Symetra, please also check box '(m) Other (specify)' and specify the benefit as 'employee assistance program.'

10 Nonexperience-rated contracts

(a) Total premium and subscription charges $166,816.38

Symetra Life Insurance Company certifies that the above information is complete and accurate to the best of our knowledge

SYMETRA
RETIREMENT | BENEFITS | LIFE

February 6, 2025

Partners In Health, A Non-Profit Corporation
800 Boylston St
Suite 300
Boston, MA 02199

CC: Indigo Insurance Services Llc
100 Front Street
Worcester, MA 01608

The following insurance information is provided for your use when completing Internal Revenue Service Schedule A (Form 5500). The numbered paragraphs correspond to those on the form. In the event that you are not required to file Schedule A to Form 5500, you may disregard this information.

Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

1 Coverage Information

(a) Insurance carrier	Symetra Life Insurance Company
(b) Symetra EIN	91-0742147
(c) Symetra NAIC Code	68608
(d) Contract or ID number	01-020559-00
(e) Number covered at end of year	Since plan coverage may fluctuate during the year, the administrator should estimate the number of persons that were covered by the contract at the end of the policy or contract year
(f) Policy or contract year - From	1/1/2024
(g) Policy or contract year - To	12/31/2024

2 Insurance fee and commission information

(a) Total amount of commissions paid	$25,023.17
(b) Total amount of fees paid	$0.00

3 Persons receiving commissions or fees

(a) Persons receiving commissions or fees	INDIGO INSURANCE SERVICES LLC 100 FRONT STREET WORCESTER, MA 01608
(b) Sales and base commissions paid	$8,341.23
(c) Fees Paid	(d) Purpose
$0.00	N/A
(e) Organization Code	3

Part III Welfare Benefit Contract Information

8 Benefit and Contract Type

(d) Life Insurance
(d) AD&D
(f) Long Term Disability

In addition, if you are utilizing the Employee Assistance Program (provided by ComPsych Corporation) in conjunction with group long-term or short-term disability insurance provided by Symetra, please also check box '(m) Other (specify)' and specify the benefit as 'employee assistance program.'

10 Nonexperience-rated contracts

(a) Total premium and subscription charges $166,816.38

Symetra Life Insurance Company certifies that the above information is complete and accurate to the best of our knowledge

Partners In Health

Plan	Plan Year	Number of Lives	Premium Paid	Commission Paid
Life - 01530	1/1/24-12/31/24	73	12786.05	8%
LTD - 01531	1/1/24-12/31/24	71	37089.92	8%

Trawick International GMBH (98-1753619)
Trawick International (63-1208219)
NAICS - 524210

SYMETRA
RETIREMENT | BENEFITS | LIFE

April 4, 2025

PARTNERS IN HEALTH, A NON-PROFIT CORPORATION
800 BOYLSTON ST
SUITE 300
BOSTON, MA 02199

The following insurance information is provided for your use when completing Internal Revenue Service Schedule A (Form 5500). The numbered paragraphs correspond to those on the form. In the event that you are not required to file Schedule A to Form 5500, you may disregard this information.

Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

1 Coverage Information

(a) Insurance carrier	Symetra Life Insurance Company
(b) Symetra EIN	91-0742147
(c) Symetra NAIC Code	68608
(d) Contract or ID number	12595000
(e) Number covered at end of year	240
(f) Policy or contract year - From	1/1/2024
(g) Policy or contract year - To	12/31/2024

2 Insurance fee and commission information

(a) Total amount of commissions paid	$9,529.99
(b) Total amount of fees paid	$0.00

3 Persons receiving commissions or fees

(a) Persons receiving commissions or fees	INDIGO INSURANCE SERVICES LLC 100 FRONT STREET WORCESTER, MA 01608
(b) Sales and base commissions paid	$1,079.64
(c) Fees Paid	$0.00
(d) Purpose	
(e) Organization Code	3

3 Persons receiving commissions or fees

(a) Persons receiving commissions or fees	BROWN & BROWN INSURANCE SERVIC 980 WASHINGTON ST STE 325 DEDHAM, MA 02026
(b) Sales and base commissions paid	$8,450.35
(c) Fees Paid	$0.00
(d) Purpose	
(e) Organization Code	3

Part III Welfare Benefit Contract Information

8 Benefit and Contract Type

(M) Other: Critical Illness
(M) Other: Accident
(L) Indemnity Contract

10 Nonexperience-rated contracts

(a) Total premium and subscription charges $43,462.66

Symetra Life Insurance Company certifies that the above information is complete and accurate to the best of our knowledge