Bakers Union and FELRA
Health and Welfare Fund
Board of Trustees Meeting
September 13, 2023

Bakers Union and FELRA
Health and Welfare Fund

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BOARD OF TRUSTEES MEETING
SEPTEMBER 13, 2023

AGENDA

I. Call to Order

II. Minutes - Regular Meeting held June 29, 2023

III. Financial Report - Chris Little, PNC

IV. Optum Rx April – June 30, 2023 Review

V. Co-Counsel Report

VI. Administrative Managers Report

VII. Invoices

VIII. Other Fund Business

IX. 2023 Meeting Dates: Wednesday December 6, 2023

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DRAFT

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES OF THE BAKERS UNION AND FELRA HEALTH AND WELFARE FUND JUNE 29, 2023 LANDOVER, MARYLAND

The following Trustees were present:

UNION TRUSTEE	EMPLOYER TRUSTEES
L. Jones	M. Goble
G. Oskoian - Chairman	J. Williams

Also present were:
H. Agoney - OptumRx (via videoconference)
C. Atwood - OptumRx (via videoconference)
M. DeLancey - Blank Rome, LLP
J. Kimble - Morgan, Lewis & Bockius, LLP
C. Little - PNC Bank, NA
K. Phillips - Associated Administrators, LLC
D. Welch - Associated Administrators, LLC

I. CALL TO ORDER

A quorum being present, the Chairman called the meeting to order.

II. MINUTES

The Trustees reviewed the minutes of the regular Board meeting held on March 2, 2023, which were circulated in advance of the meeting.

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, that the minutes of the regular Board meeting held on March 2, 2023 are approved as presented.

III. FINANCIAL REPORT – PNC BANK, NA – SUMMARY OF ACTIVITY

The Trustees welcomed Mr. Little, of PNC Bank, NA to the meeting.

Mr. Little presented the Summary of Activity Report for the period ending May 31, 2023, a copy of which is attached to and made a part of these minutes as Exhibit A. The report showed a beginning market value of $1,495,060, net contributions and withdrawals that resulted in a gain of $3,172, investment income of $20,456, producing an ending market value of $1,145,645.

Mr. Little presented the portfolio holdings as of May 31, 2023. The Fund holds 23.7% in limited maturity bonds, with a market value of $271,399 and 76.3% in cash with a market value of $874,245. The Fund has a United States Treasury Bill in the amount of $50,000 that matures on July 13, 2023. Mr. Little noted money market interest rates are currently in line with the three and six month United States Treasury Bills rates and recommended the $50,000 be invested in the money market account upon maturity.

The Trustees thanked Mr. Little for his presentation and he was excused from the remainder of the meeting.

IV. OPTUM Rx

The Trustees welcomed Ms. Holly Agoney of OptumRx via video conference to the meeting.

Ms. Agoney reviewed the OptumRx Plan Performance Report for the period January 2023 to March 2023, a copy of which is attached to and made a part of these minutes as Exhibit B. She reviewed the Plan's drug utilization and costs for the period January 2023 to March 2023. The Plan cost per member per month (pmpm) was $157.32 for the period January 2023 to March 2023 as compared to $113.49 for the period of January 2022 through March

2022. The OptumRx Taft Hartley book of business ("BOB") per member per month cost for the period January 2023 to March 2023 was $119.55. Specialty drugs accounted for 42.3% of the Plan's drug cost. The top twenty traditional and specialty drugs paid by the Plan from January 1, 2023 to March 31, 2023 were reviewed. She also reported the Utilization Management Program savings for January 2023 through March 2023 was $93,100, Vigilant Drug Program savings was $5,726 and Variable Co-payment Program was $8,664.

The top traditional disease state is Diabetes, the top specialty disease state is Inflammatory Conditions. The top 5 disease states accounted for 77% of total plan paid.

Ms. Williams questioned if the Plan would receive any savings due to insulin manufacturers recently lowering the cost of insulin and capping the out of pocket expense to $35 per fill. Ms. Agoney stated she would discuss this with the Optum Rx Clinical Director and provide the Trustees a response.

The Trustees thanked Ms. Agoney for her presentation and excused her from the meeting

V. CO-COUNSEL REPORT

A. Consolidated Appropriations Act ("CAA") Gag Clause Prohibition Attestation

Mr. Kimble informed the Trustees the CAA prohibits plans from entering into contracts that contain gag clauses that would prevent the disclosure of cost or quality of care information or data, and certain other information to active or eligible participants, beneficiaries, and enrollees of the plan or coverage, plan sponsors, or referring providers, or restrict the plan or issuer from sharing such information with a business associate, consistent with applicable privacy regulations.

Mr. Kimble noted Plans will be required to submit an annual attestation of compliance with the applicable gag clause provisions to the Department of Labor, Treasury and Health and Human Services. The first attestation will cover the period beginning

December 27, 2020 and ending on the date of the attestation. Subsequent annual attestations will be due by December 31 of each year.

Co-Counsel will be reviewing the Plan vendor contracts to assure no gag clauses are in place and working with the Administrative Services Manager to prepare the attestation.

B. Mental Health Parity and Addition Equity Act ("MHPAEA") Comparative Analyses of Non-Quantative Treatment Limitatins ("NQTL")

Mr. Kimble reported that Co-Counsel had reviewed the NQTL Analysis Services ("NQTL") Service Agreement and suggested several edits to the agreement. NQTL responded that the standard pricing quote received was based upon the assumption that no changes would be required to the service agreement. If the service agreement changes the Plan should expect the price to change as well. They stated changing legal agreements on a client by client basis becomes very expensive and the cost of negotiating the agreement can often quickly exceed the value of the contract.

After discussion, the Trustees directed the administrative services manager to contact NQTL to determine if they would be willing to change the provision of law in the contract from South Carolina to Maryland and if so the additional cost for the change.

VI. ADMINISTRATIVE MANAGER REPORT

Ms. Welch presented the Administrative Manager Report for the first quarter of 2023. The report showed employer contribution income of $1,051,939, employee payroll deductions of $33,361, interest and dividend income of $8,753, and miscellaneous income of $44,950, producing a total income of $1,143,953. Expenses included $912,446 for medical benefits, $31,793 for CIGNA premiums, $40,001 for dental premiums, $6,114 for disability benefits, $247,395 for prescription drug benefits, $4,877 for life insurance benefits, $25,773 for stop loss insurance, $5,180 for optical benefits, and $58,951 in operating expenses, producing total expenses of $1,332,530 and resulting in a deficit of $188,577. Contributions were made on behalf of 419 active participants and that there were no delinquencies.

Ms. Welch noted that as of May 31, 2023, the Fund had $1,142,267.77 in reserves, representing 3.3 months of reserves, compared to 3.4 months as of March 31, 2023.

Ms. Welch reported the second and third quarter Optum Rx rebates were received in the amount of $44,950. She also informed the Trustees a $159,089.76 reimbursement was received on May 17, 2023 from the stop loss carrier, Gerber.

VII. INVOICES

Ms. Welch reviewed a list of invoices dated June 29, 2023. She stated that there were no additions, deletions or changes to the list. The Trustees reviewed the list and determined that all invoices represent proper Fund expenses.

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve payment of the invoices dated June 29, 2023 as presented.

VIII. APPEALS

A. #E23/108-3764

Ms. Welch reviewed an appeal from a participant requesting immediate enrollment in Fund coverage. In considering the appeal the Trustees reviewed the participants letter dated May 23, 2023, enrollment forms, and terms of the Summary Plan Description ("SPD") related to eligibility for benefits.

After reviewing the foregoing.

On MOTION made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to deny the appeal to provide immediate enrollment in Fund coverage.

B. #E23/110-0612

Ms. Welch reviewed an appeal from a participant to allow reimbursement in the amount of $2,993.22, for health coverage premiums the member paid for another policy, for the period from October 2022 through March 2023 because she was unaware she was eligible for Plan coverage. In considering the appeal the Trustees reviewed the participants letter dated May 24, 2023, the enrollment form, and terms of the Summary Plan Description ("SPD") related to eligibility for benefits.

After discussion the Board of Trustees tabled further discusion for additional information.

IX. OTHER FUND BUSINESS

A. CAA – RxDC Reporting

Ms. Welch informed the Trustees the RxDC Reporting was filed timely on June 20, 2023.

B. Patient Centered Outcomes Research Institute ("PCORI") Fee

Ms. Welch reported that the PCORI fees for self-insured plans must be filed by July 31, 2023. For the 2022 Plan year, the PCORI Fee increased from $2.79 to $3.00 per covered life. Ms. Welch noted the Board selected the snapshot method for the prior fillings to determine the average number of lives covered under the Plan. Utilizing this method, the count for the 2022 plan year would be 619. If approved, the count will be provided to the Fund's Auditor along with a Fund check in the amount of $1,857 to file along with the Form 720 prior to the July 31, 2023 deadline.

After discussion, on MOTION made and seconded, the Trustees voted unanimous approval of the following resolutions:

RESOLVED to approve payment of the PCORI premium of $1,857 for the Plan year ended December 31, 2022 based on the snapshot method of calculation.

C. **Delta Dental Renewal**

Ms. Welch reviewed the Contract Renewal Proposal and the 2022 Utilization Renewal Calculation Report provided by Delta Dental. Delta Dental proposed a 5% increase in the current rate of $41.11 per member per month ("pmpm") to $43.17 pmpm for the contract term of September 1, 2023 to August 31, 2024.

The Trustees directed Ms. Welch to contact Delta Dental and determine if they would revise there proposal to provide a two year contract term from September 1, 2023 to August 31, 2024 with a 2.5% increase in premium each year.

D. **Fidelity Bond Renewal**

Ms. Welch reported the Trustees unanimously approved renewing the Fidelity Bond with the incumbent carrier Chubb via email poll on May 26, 2023 for the policy period of June 1, 2023 to June 1, 2026. Chubb proposed a 2% ($55) increase in the premium from $2,730 to $2,785.

E. **Summary of Material Modifications ("SMM")**

Ms. Welch noted the Notice of End of Temporary COVID-19 Related Extension of Certain Plan Deadlines SMM and the Notice of End of Temporary Coverage of Out-Of-Network COVID-19 Diagnostic Tests and Vaccines SMM was mailed to Plan participants on May 26, 2023.

F. **Group Life and Accidental Death &Dismemberment ("AD&D") and Short Term Disability Insurance Options Report**

Ms Welch reviewed a Group Life, AD&D and Short Term Disability Insurance Options Report prepared by Lakeshore Benefit Group Insurance Brokerage, LLC, ("Lakeshore") as requested by the Trustees. LakeShore awarded eighteen carriers the opportunity to provide Group Life, AD&D and Short Term Disability insurance proposals and received competitively priced proposals from Boston Mutual, Guardian, Dearborn Life and The Hartford.

LakeShore obtained proposals from Short Term Disability insurance carriers to enhance the Short Term Disability benefit to 50% of gross salary with a maximum paid of $400 weekly for the first 18 weeks and 40% of gross salary for the remaining 8 weeks for a total of 26 weeks as requested by the Trustees. Boston Mutual proposed a more comprehensive benefit of 50% of gross salary with a maximum paid of $400 weekly for the entire 26 week benefit period.

Following a discussion, the Trustees directed the Administrative Services Manager to contact Boston Mutual to determine if they would provide a two year rate guarantee and to circulate an email poll to the Trustees for consideration upon receipt of the response.

X. NEXT MEETING DATE AND LOCATION

After discussion, the Trustees noted that the next regular Board meetings are scheduled to be held in the first floor conference room of Associated Administrators, LLC in Landover, Maryland on the following dates:

Wednesday, September 13, 2023 at 10:00 A.M.
Wednesday, December 6, 2023 at 10:00 A.M.

XI. ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned.

Respectfully submitted,

Michael Goble

Attachments:

Exhibit A: PNC Capital Advisors Investment Review for Period Ending March 31, 2023
Exhibit B: Optum Rx Plan Performance Report January 2023 through March 2023

BAKERS UNION AND FELRA

HEALTH AND WELFARE FUND

SECOND QUARTER 2023

ADMINISTRATIVE MANAGER'S REPORT

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 1
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 1,225.62	83	$ 305,179
SAFEWAY	FT	$ 1,225.62	137	$ 503,730
TOTAL			**220**	**$ 808,909**

EMPLOYEE PAYROLL

GIANT	$ 42.54	94	$ 14,723
SAFEWAY	$ 42.54	201	$ 23,112
TOTAL		**295**	**$ 37,835**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 1
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 380,884	
CIGNA	$ 32.06	$ 20,580	
DELTA DENTAL	$ 41.11	$ 26,598	
DISABILITY		$ 4,114	
OPTUM RX		$ 214,868	1,193 SCRIPTS
LIFE/AD&D	$3.90/.40	$ 3,110	
OPTICAL PROVIDER	$ 5.36	$ 3,302	
STOP LOSS	$ 27.83	$ 23,343	
SUB TOTAL		$ 676,799	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 22,093	
MISCELLANEOUS		$ 20,478	
SUB TOTAL		$ 42,571	

TOTAL EXPENSES	**$ 719,370**

MISCELLANEOUS EXPENSES

ACCOUNTING	$ 5,883
BONDING AND FIDUCIARY INSURANCE	$ 556
CONSULTANTS	$ -
CYBER SECURITY INSURANCE	$ -
IFEBP MEMBERSHIP DUES	$ -
INVESTMENT FEES	$ -
LEGAL	$ 13,199
MEETINGS	$ -
ACA REGULATIONS	$ -
PCORI FEE	$ -
PNC ACCOUNT FEE	$ 295
POSTAGE	$ 263
PRINTING	$ 167
RECORD SEARCH	$ -
SOFTWARE SUPPORT	$ -
TELEPHONE	$ 115
TRANSITIONAL REINSURANCE	$ -

TOTAL MISCELLANEOUS EXPENSES	**$ 20,478**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 1
QUARTERLY RECAP

INCOME	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
EMPLOYER CONTRIBUTIONS	$ 829,744	$ 808,909	$ -	$ -	$ 1,638,653
EMPLOYEE PAYROLL	$ 33,361	$ 37,835	$ -	$ -	$ 71,196
COBRA	$ 4,950	$ 3,713	$ -	$ -	$ 8,663
TOTAL INCOME	**$ 868,055**	**$ 850,457**	**$ -**	**$ -**	**$ 1,718,512**

	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
MEDICAL	$ 318,176	$ 380,884	$ -	$ -	$ 699,060
CIGNA	$ 22,307	$ 20,580	$ -	$ -	$ 42,887
DENTAL-DENEX	$ 26,434	$ 26,598	$ -	$ -	$ 53,032
DISABILITY	$ 6,114	$ 4,114	$ -	$ -	$ 10,228
DRUG	$ 178,658	$ 214,868	$ -	$ -	$ 393,526
LIFE	$ 3,255	$ 3,110	$ -	$ -	$ 6,365
OPTICAL	$ 3,374	$ 3,302	$ -	$ -	$ 6,676
STOP LOSS	$ 25,773	$ 23,343	$ -	$ -	$ 49,116
OPERATING EXPENSE	$ 34,844	$ 42,571	$ -	$ -	$ 77,415
TOTAL EXPENSE	$ 618,935	$ 719,370	$ -	$ -	$ 1,338,305
SURPLUS (DEFICIT)	**$ 249,120**	**$ 131,087**	**$ -**	**$ -**	**$ 380,207**

	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	AVERAGE
TOTAL PARTICIPANTS	225	220			223

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 3
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	FT	$ 593.00	37	$ 66,416
GIANT	PT	$ 161.42	14	$ 6,618
SAFEWAY	FT	$ 593.00	59	$ 104,368
SAFEWAY	PT	$ 161.42	68	$ 32,930
TOTAL			**178**	**$ 210,332**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 3
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ 40,478	
CIGNA	$ 32.06	$ 10,091	
DELTA DENTAL	$ 41.11	$ 12,004	
DISABILITY		$ 6,829	
OPTUM RX		$ 47,218	267 SCRIPTS
LIFE/AD&D	$ 3.90 /.40	$ 1,440	
OPTICAL PROVIDER	$ 5.36	$ 1,812	
STOP LOSS	$ 27.83	$ 10,958	
SUB TOTAL		$ 130,830	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 17,444	
MISCELLANEOUS		$ 9,457	
SUB TOTAL		$ 26,901	

TOTAL EXPENSES	**$ 157,731**

MISCELLANEOUS EXPENSES

ACCOUNTING	$ 2,717
CONSULTANTS	$ -
CYBER SECURITY INSURANCE	$ -
IFEBP MEMBERSHIP DUES	$ -
LEGAL	$ 6,095
PCORI	$ -
PNC ACCOUNT FEE	$ 136
PRINTING	$ 77
TELEPHONE	$ 53
TOTAL MISCELLANEOUS EXPENSES	**$ 9,457**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 3
QUARTERLY RECAP

INCOME	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
EMPLOYER CONTRIBUTIONS	$ 221,065	$ 210,332	$ -		$ 431,397
TOTAL INCOME	$ 221,065	$ 210,332	$ -	$ -	$ 431,397

EXPENSES	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
MEDICAL	$ 594,270	$ 40,478	$ -	$ -	$ 634,748
CIGNA	$ 9,190	$ 10,091	$ -	$ -	$ 19,281
DENTAL-DENEX	$ 11,511	$ 12,004	$ -	$ -	$ 23,515
DISABILITY	$ -	$ 6,829	$ -	$ -	$ 6,829
DRUG	$ 68,737	$ 47,218	$ -	$ -	$ 115,955
LIFE	$ 1,395	$ 1,440	$ -	$ -	$ 2,835
OPTICAL	$ 1,522	$ 1,812	$ -	$ -	$ 3,334
STOP LOSS	$ -	$ 10,958	$ -	$ -	$ 10,958
OPERATING EXPENSE	$ 22,401	$ 26,901	$ -	$ -	$ 49,302
TOTAL EXPENSE	$ 709,026	$ 157,731	$ -	$ -	$ 866,757
SURPLUS (DEFICIT)	**$ (487,961)**	**$ 52,601**	**$ -**	**$ -**	**$ (435,360)**

	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	AVERAGE
TOTAL PARTICIPANTS	179	178			179

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 4
CONTRIBUTIONS

EMPLOYER CONTRIBUTIONS

	FT/PT	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	PT	$ 25.72	4	$ 335
SAFEWAY	PT	$ 25.72	9	$ 668
TOTAL			**13**	**$ 1,003**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 4
EXPENSES

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	COMMENT
MEDICAL		$ -	
CIGNA	$ 32.06	$ -	
DELTA DENTAL	$ 41.11	$ 2,097	
DISABILITY	$ -	$ -	
LIFE/AD&D	$ 3.90 /.40	$ 250	
OPTICAL PROVIDER	$ 5.36	$ 268	
SUB TOTAL		$ 2,615	

OPERATING EXPENSES

ADMINISTRATION	$ 30.98	$ 1,232	
MISCELLANEOUS		$ -	
SUB TOTAL		$ 1,232	

TOTAL EXPENSES	**$ 3,847**

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

SECOND QUARTER 2023
PLAN 4
QUARTERLY RECAP

INCOME	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
EMPLOYER CONTRIBUTIONS	$ 1,130	$ 1,003	$ -	$ -	$ 2,133
TOTAL INCOME	$ 1,130	$ 1,003	$ -	$ -	$ 2,133

EXPENSES	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
MEDICAL	$ -	$ -	$ -	$ -	$ -
CIGNA	$ 296	$ -	$ -	$ -	$ 296
DENTAL-DENEX	$ 2,056	$ 2,097	$ -	$ -	$ 4,153
DISABILITY	$ -	$ -	$ -	$ -	$ -
DRUG	$ -	$ -	$ -	$ -	$ -
LIFE	$ 227	$ 250	$ -	$ -	$ 477
OPTICAL	$ 284	$ 268	$ -	$ -	$ 552
STOP LOSS	$ -	$ -	$ -	$ -	$ -
OPERATING EXPENSE	$ 1,706	$ 1,232	$ -	$ -	$ 2,938
TOTAL EXPENSE	$ 4,569	$ 3,847	$ -	$ -	$ 8,416
SURPLUS (DEFICIT)	**$ (3,439)**	**$ (2,844)**	**$ -**	**$ -**	**$ (6,283)**

	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	AVERAGE
TOTAL PARTICIPANTS	15	13			14

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

2023
COMBINED
QUARTERLY RECAP

INCOME	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
EMPLOYER CONTRIBUTIONS	$ 1,051,939	$ 1,020,244	$ -	$ -	$ 2,072,183
EMPLOYEE PAYROLL	$ 33,361	$ 37,835	$ -	$ -	$ 71,196
COBRA	$ 4,950	$ 3,713	$ -	$ -	$ 8,663
INTEREST & DIVIDENDS	$ 8,753	$ 3,491	$ -	$ -	$ 12,244
MISCELLANEOUS INCOME	$ 44,950	$ -	$ -	$ -	$ 44,950
TOTAL INCOME	$ 1,143,953	$ 1,065,283	$ -	$ -	$ 2,209,236

EXPENSES	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	TOTAL
MEDICAL	$ 912,446	$ 421,362	$ -	$ -	$ 1,333,808
CIGNA	$ 31,793	$ 30,671	$ -	$ -	$ 62,464
DENTAL-DENEX	$ 40,001	$ 40,699	$ -	$ -	$ 80,700
DISABILITY	$ 6,114	$ 10,943	$ -	$ -	$ 17,057
DRUG	$ 247,395	$ 262,086	$ -	$ -	$ 509,481
LIFE	$ 4,877	$ 4,800	$ -	$ -	$ 9,677
OPTICAL	$ 5,180	$ 5,382	$ -	$ -	$ 10,562
STOP LOSS	$ 25,773	$ 34,301	$ -	$ -	$ 60,074
OPERATING EXPENSE	$ 58,951	$ 70,704	$ -	$ -	$ 129,655
TOTAL EXPENSE	$ 1,332,530	$ 880,948	$ -	$ -	$ 2,213,478
SURPLUS (DEFICIT)	**$ (188,577)**	**$ 184,335**	**$ -**	**$ -**	**$ (4,242)**

	FIRST 2023	SECOND 2023	THIRD 2023	FOURTH 2023	AVERAGE
TOTAL PARTICIPANTS	419	411	0	0	415

FUND RESERVE	$ 1,161,224	$ 1,308,815	$ -	$ -

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

2022
COMBINED
QUARTERLY RECAP

INCOME	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
EMPLOYER CONTRIBUTIONS	$ 1,099,954	$ 1,104,275	$ 1,080,470	$ 1,074,034	$ 4,358,733
EMPLOYEE PAYROLL	$ 36,937	$ 38,295	$ 39,257	$ 40,306	$ 154,795
COBRA	$ 1,767	$ 4,417	$ 7,246	$ 4,242	$ 17,672
INTEREST & DIVIDENDS	$ 537	$ 980	$ 3,429	$ 9,105	$ 14,051
MISCELLANEOUS INCOME	$ 21,040	$ 20	$ 100,899	$ 43,055	$ 165,014
TOTAL INCOME	$ 1,160,235	$ 1,147,987	$ 1,231,301	$ 1,170,742	$ 4,710,265

EXPENSES	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	TOTAL
MEDICAL	$ 452,688	$ 438,750	$ 350,658	$ 605,348	$ 1,847,444
CIGNA	$ 35,086	$ 32,477	$ 31,706	$ 32,380	$ 131,649
DENTAL-DENEX	$ 45,838	$ 44,070	$ 42,672	$ 43,782	$ 176,362
DISABILITY	$ 11,457	$ 13,943	$ 7,628	$ 2,257	$ 35,285
DRUG	$ 215,002	$ 217,443	$ 237,977	$ 250,250	$ 920,672
LIFE	$ 4,411	$ 4,420	$ 4,390	$ 4,373	$ 17,594
OPTICAL	$ 6,305	$ 5,783	$ 6,152	$ 6,051	$ 24,291
STOP LOSS	$ 26,578	$ 26,883	$ 26,800	$ 26,577	$ 106,838
OPERATING EXPENSE	$ 72,551	$ 76,959	$ 76,878	$ 69,452	$ 295,840
TOTAL EXPENSE	$ 869,916	$ 860,728	$ 784,861	$ 1,040,470	$ 3,555,975
SURPLUS (DEFICIT)	**$ 290,319**	**$ 287,259**	**$ 446,440**	**$ 130,272**	**$ 1,154,290**

	FIRST 2022	SECOND 2022	THIRD 2022	FOURTH 2022	AVERAGE
TOTAL PARTICIPANTS	442	444	432	434	438

FUND RESERVE	$ 681,439	$ 836,144	$ 1,375,297	$ 1,490,791

OptumRX Pharmacy Rebate received 12/14/22 for - 2Qtr. 2022 - $43,055.00

PROPRIETARY INFORMATION: THIS REPORT BELONGS TO BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

BAKERS UNION & FELRA	
HEALTH AND WELFARE	
GAIN/LOSS STATEMENT	
Aug-23	
Beginning Bank Balance	**$1,366,351.66**
INCOME:	
Contributions	352,094.07
Investments	5,414.00
Other	603.98
TOTAL INCOME	**358,112.05**
EXPENSES:	
Medical Claims	161,312.36
Cigna	9,858.00
Drug	91,450.56
Disability	5,628.56
Life	1,575.00
Operating Expenses	30,317.20
Legal	3,564.00
Stop Loss	11,383.71
Vision	1,768.80
Other	1,195.00
Investments (change)	
TOTAL EXPENSES	**$318,053.19**
GAIN/LOSS	**$40,058.86**
Ending Bank Balance	**$1,406,410.52**
Current Months of Reserve	**4.1**
Previous Months Reserve	**4.0**

Bakers Union and FELRA
Health and Welfare Fund
As of August 31, 2023

Fund Reserve

Months of Available Fund Reserve	
Expenses	
January 1 - December 31, 2022	$ 3,555,975.00
January 1 – August 31, 2023	$ 3,309,849.94
Total	$ 6,865,824.94
Per Month	$ 343,291.25
Fund Reserve	
As of August 31, 2023	**$ 1,406,410.52**
August 31, 2023	**4.1**
July 31, 2022	4.0
June 30, 2023	3.8
May 31, 2023	3.3
March 31, 2023	3.4
January 31, 2023	5.3
December 31, 2022	4.7
November 30, 2022	4.4
September 30, 2022	4.4
August 31, 2022	3.6
July 31, 2022	3.2
May 31, 2022	2.5
April 30, 2022	2.2
March 30, 2022	2.0
February 28, 2022	1.7
January 30, 2022	1.2

	Plan 1	Plan 2	Plan 3	Plan 4
2018	F/T $830	F/T $267	F/T $262 P/T $103	$18.40
2019	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2020	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
2021	F/T $1,082	F/T $334	F/T $593 P/T $128	$24.00
June 1, 2021	F/T $ 1,225.62	F/T $ 334.00	F/T $ 593.00 P/T $ 161.42	$ 25.72

Bakers Union and FELRA Health and Welfare Fund

INVOICES

September 13, 2023

Associated Administrators, LLC		
05/01/2023	Administrative Fee for May 2023	$13,177.20
06/01/2023	Administrative Fee for June 2023	$12,640.00
07/01/2023	Miscellaneous Expenses - 800 Phone, Doyle Printing	$384.15
08/28/2023	Administrative Fee for July 2023	$13,117.20
Blank Rome, LLP		
07/11/2023	Professional Services Rendered through June 30, 2023	$3,234.00
08/10/2023	Professional Services Rendered through July 31, 2023	$3,564.00
Morgan Lewis and Brokius LLP		
07/13/2023	Professional Services Rendered through June 30, 2023	$5,125.00
08/14/2023	Professional Services Rendered through July 31, 2023	$6,380.00
09/11/2023	Professional Services Rendered through August 31, 2023	$3,096.00
Calibre CPA Group		
06/23/2023	Progress bill for professional services rendered in connection with the audit of the financial statements for Bakers Union FELRA Health & Welfare Fund for the year ended December 31, 2022.	$750.00
07/25/2023	Progress bill for professional services rendered in connection with the audit of the financial statements for Bakers Union FELRA Health & Welfare Fund for the year ended December 31, 2022.	$4,500.00

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Basic Life and Accidental Death & Dismemberment (AD&D) Benefit Summary

Designed for the Employees of

Bakers Union and FELRA Health & Welfare Fund

ELIGIBILITY & BENEFIT FEATURES

Class 1: All Active Union Members in Good Standing

Basic Life and AD&D: $20,000

COST OF COVERAGE

The premium for your coverage is paid by your employer.

GUARANTEED ISSUE

No medical questions are required for amounts up to **$20,000** for first time applicants in their initial eligibility period.

ADDITIONAL FEATURES

Accelerated Death Benefit: This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary. To be eligible, the employee must have at least $10,000 in basic life coverage.

Accidental Death & Dismemberment: Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. An additional death benefit is paid if death is the result of a covered accident.

Portability: If you leave your employer prior to age **65** , the coverage is portable for you, your spouse under age **65** and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or AD&D.

Conversion: Employees have 31 days from the date of termination to convert their basic life insurance to an individual permanent life insurance policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium or AD&D.

EXCLUSIONS

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries; suicide or attempted suicide; riot or war; diseases; ptomaine or bacterial infection; drug and/or alcohol abuse; commission of an assault or felony by an employee; accident while serving on active duty; travel or flight in any aircraft or device which can fly above the earth's surface *(does not apply to commercial flights);* or injury which occurred before the employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

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Group Short Term Disability Benefit Summary

Designed for the Employees of

Bakers Union and FELRA Health & Welfare Fund

ELIGIBILITY & BENEFIT FEATURES

Class 1:All Active Union Members in Good Standing

Coverage: Non-Occupational

Elimination Period:
Approved benefits will be paid at the end of the Elimination Period or **after the end of sick leave.**
(whichever is greater)

Your disability must continue through the elimination period before payments begin. Your benefits become payable ***after:***

1st day for accident **8th day** for illness

First Day Hospitalization: **No**

Residual Benefits: **No**

Maximum Payment Duration: **26 weeks**

Maximum Weekly Benefit: **50** % of your weekly base earnings to a maximum of **$400** , and with a minimum benefit of **$200 per week**

COST OF COVERAGE

The premium for your coverage: **is paid by your employer**

ADDITIONAL FEATURES

Offsets at Time of Claim: Benefits may be reduced by payment under Worker's Compensation law, occupational disease law, or similar law, group insurance, SSA, state or Federal Disability, pension, salary or wage continuance plans and Federal old age benefits.

EXCLUSIONS & LIMITATIONS

- We will not cover a disability if it is due to war, declared or not, or any act of war; intentionally self-inflicted injuries, active participation in a riot, attempt to commit or commission of a felony under federal/state law.
- No benefits are payable while incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.
- This coverage is not portable. If your employment is terminated, all coverage is terminated.

This information is a summary of benefits; this summary is not your certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the master policy will be resolved by the language issued in the master policy. For complete details of coverage and availability, please refer to your certificate or contact your benefits administrator.

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HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950

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GROUP LIFE CLAIM KIT

FOR SUBMITTING A CLAIM FOR LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS BY A THIRD PARTY ADMINISTRATOR

INSTRUCTIONS FOR FILING A LIFE CLAIM

On behalf of Boston Mutual Life Insurance Company, please accept our sincere condolences for your loss. We realize that this is a difficult time for you and your family and we will make every effort to process your claim promptly.

To expedite the processing of your claim, it is important that you submit all of the necessary information requested below.

1. The claim form should be fully completed by the named beneficiary or their authorized representative and signed where indicated. If more than one named beneficiary, please use the Additional Beneficiary form.
2. An original, certified death certificate for the insured. This can normally be obtained through the funeral director. Unfortunately, we cannot accept photocopies or faxes of certified death certificates.
3. The insurance policy. If the policy cannot be found, please complete the lost policy section of the claim form.
4. If claim is being made for accidental death benefits, the named beneficiary must also complete the Accidental Death Claim form. Applicable police and accident reports should also be attached.
5. Each beneficiary should complete the Life Insurance Payment Options form.
6. An authorized representative of the employer must complete the Employer's Statement. All original enrollment forms and beneficiary changes must also be included with the claim.
7. The third party administrator must complete the Administrator's Statement.
8. A HIPAA - Compliant authorization form should be completed by the named beneficiary *(or next of kin if named beneficiary is not next of kin)* if the coverage has been inforce less than two years.
9. If proceeds are assigned to a funeral home, we must be provided with the assignment form and the funeral bill.
10. Please read the "Fraud Warning Notice" for your state.

If you should need assistance in the completion of the claim form
Please call 877-212-2950
Mail forms to: Boston Mutual Life Insurance Company, 120 Royall Street • Canton MA 02021

BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950

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GROUP LIFE CLAIM FORM

Policy Numbers of the Company under which claim is made by the undersigned

#1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Full Name of Insured _____ Married ☐ Widowed ☐

Address _____ Single ☐ Divorced ☐

Is Insured Known by any other name? YES ☐ NO ☐ If YES, please advise _____

Date of Birth _____ Date of Death _____ Soc. Sec. No. _____

Date Last Worked *(if known)* _____ Name of Employer _____

Please complete the following if Policy was in force less than 2 years and include a signed HIPAA-Compliant Authorization for the release of medical records.

Full Names and Addresses of all Physicians and Hospitals where insured was treated in last 5 years

Name	Address	Telephone No.
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

BENEFICIARY'S INFORMATION

Beneficiary's Name _____ Beneficiary's Social Security No. _____

Beneficiary's Date of Birth _____ Beneficiary's Telephone No. _____ Beneficiary's Relationship _____

Beneficiary's Address _____

Beneficiary's Mailing Address *(if different)* _____

CERTIFICATION - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

STATEMENT OF POLICY LOSS *(To be completed only if original policy could not be found after a thorough search)*

Insured _____ Policy No _____

This policy was lost or destroyed. If the policy is found later, I agree to surrender it to the company without claim.

X _____ _____ _____
Signature of Beneficiary | Date | Signature of Witness

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ADDITIONAL BENEFICIARY STATEMENT

(To be completed if there is more than one beneficiary)

Name of Insured: _____ **Policy #:** _____

Beneficiary's Name: _____ Beneficiary's Social Security #_____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security #_____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

Beneficiary's Name: _____ Beneficiary's Social Security # _____

Relationship to Insured: _____ Beneficiary's Date of Birth: _____

Beneficiary's Telephone #: _____ Beneficiary's E-mail: _____

Beneficiary's Address: _____

Mailing Address, if different: _____

CERTIFICATION – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

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ACCIDENTAL DEATH CLAIM FORM

Beneficiary must fully complete this section if claiming Accidental Death Benefit

Insured's Name: _____

Date and time of accident causing death:
Date: _____ 20____ AM ☐ PM ☐

Place of Death: Highway ☐ Home ☐ Work ☐
Recreation ☐ Other ☐ _____

Describe Accident in detail: ***(Please send copies of police reports, newspaper articles etc. to help in the processing of this claim)***

_____

_____

_____

_____

_____

Names of PHYSICIANS and HOSPITALS where Insured received treatment

Name	Address

Was an Autopsy Performed? YES ☐ NO ☐ If YES, by whom, where and date.

Name	Address	Date

CERTIFICATION - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____ _____
Signature of Beneficiary | Printed Name | Date

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LIFE INSURANCE PAYMENT OPTIONS

Please review the following payment options and select your option by checking the appropriate box and signing this form. Payment options may vary based on the policy selected. Please consult the policy for available options. If you have any questions or would like to discuss other payment options, please call our Claim Services team at 1-877-212-2950. Please return this form with your claim.

❑ **Lump sum payment.** By choosing this option, you are electing to receive the proceeds due in one lump sum payment. *(This is the most common payment option)*

❑ **Sum Payable as monthly income for a fixed number of years.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. You will receive a monthly income for up to 20 years. We will pay an Income once a month for the number of years chosen and the first payment will begin one month after the payment option date. Please circle the number of years you wish to receive this monthly income. The monthly income will be the payment amount for each $1,000 of sum payable next to the number of years chosen. We will pay interest on the amount left with us at a rate of at least 2 ½% per year.

MONTHLY PAYMENT FOR EACH $1,000 OF SUM PAYABLE

YEARS	PAYMENT	YEARS	PAYMENT
1	84.28	11	8.64
2	42.66	12	8.02
3	28.79	13	7.49
4	21.86	14	7.03
5	17.70	15	6.64
6	14.93	16	6.30
7	12.95	17	6.00
8	11.47	18	5.73
9	10.32	19	5.49
10	9.39	20	5.27

❑ **Interest Income.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company. We will pay interest on the amount left on deposit at a rate of at least 2 ½ % per year. The interest will be paid once a year and the first payment will be issued one year after the Payment Option Date. You may choose the number of years, up to 15 years, to receive the interest income. The payee may withdraw all or a part of the Sum Payable at any time, but may not withdraw any amount if less than $1,000 will be left with us. In this case, the payee must withdraw the full amount. Please advise the number of years _____.

❑ **Sum Payable as monthly income of a fixed amount.** By choosing this option, you are electing to leave the Sum Payable with Boston Mutual Life Insurance Company and choosing, subject to our consent, an amount of monthly income that you will receive. Monthly payments must be at least $5.00 for each $1000 of Sum Payable. The first payment will begin as of the payment option date. We will credit interest on the balance of the Sum Payable left with us. This interest will be a rate of at least 2 ½% a year, compounded once a year. Payment will last until the Sum Payable, plus interest runs out.

_____ X _____
Date Signature of Beneficiary

_____ _____
Printed Name Insured's Name

*** Interest earned on the Sum Payable left with Boston Mutual Life Insurance Company may be taxable. Please consult your tax advisor ***

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BOSTON MUTUAL LIFE INSURANCE COMPANY

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EMPLOYER'S STATEMENT

This form must be completed by an authorized representative of the Employer if the coverage was paid for in full or in part by the Employer, or if this is group coverage and the Employer maintains the enrollment forms.

LIFE CLAIM

Name of Insured: _____ Group Policy No: _____ Div. _____

Is Insured known by any other name: YES ☐ NO ☐ If YES, please advise: _____

Address of Insured: _____ Certificate No: _____

Date Insured Last Worked: _____ Date of Death: _____ Amount of Insurance: _____

No. of Hours worked each week: _____ Annual Earnings as of date last worked: _____

Reason for leaving work: Disability ☐ Resignation ☐ Vacation ☐ Leave of Absence ☐ Retired ☐
Lay Off ☐ Dismissed ☐ Other ☐ *(Specify)* _____

Was Insured an Employee at time of death? YES ☐ NO ☐ Insured's Occupation: _____

Date Employed: _____ Date of Birth: _____ Effective Date of Insurance: _____

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

DEPENDENT LIFE CLAIM

Name of Dependent: _____ Date of Birth: _____ Date of Death: _____

Address of Dependent: _____
Street City/Town State Zip

Was Insurance terminated prior to death? YES ☐ NO ☐ If YES, date of termination and reason: _____

I hereby certify that the date through which premium for this Insured has been paid is: _____
Month/Day/Year

CERTIFICATION – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____
Signature of Authorized Representative Street City/Town State Zip

_____ _____
Employer Area Code Telephone Ext.

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ADMINISTRATOR'S STATEMENT *(To be completed by Third Party Administrator)*

Name of Insured:		Date of Death:	Date of Birth:
Name of Deceased Dependent *(if applicable)*:		Date of Death:	Date of Birth:
Policy No.	Social Security #	Amount of Insurance being claimed $	Effective date of Insurance

Was Deceased's Insurance Subject to Medical Evidence of Insurability YES ☐ NO ☐

Name of Employer	Address of Employer	
Full Name of Beneficiary	Beneficiary's Date of Birth	Relationship to Insured

I hereby certify that the date through which premium for this Insured has been paid is: _____
Month/Day/Year

CERTIFICATION – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to "Fraud Warning Notices" insert for your state.

X _____ _____
Signature of Authorized Administrator Telephone # Area Code Ext.

_____
Address Street City/Town State Zip

Please provide address of where the benefits should be mailed *(where applicable)*

_____

_____

916-724 10/15

NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

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PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

420-012 3/15

FRAUD WARNING NOTICES – For Use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.

see other side

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FRAUD WARNING NOTICES – For Use with Claim Forms *(cont.)*
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

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BOSTON MUTUAL LIFE INSURANCE COMPANY

HOME OFFICE: 120 Royall Street • Canton, MA 02021
TEL (877) 212-2950 FAX 781-770-0492

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT.

DISABILITY CLAIM KIT
FOR FILING A SHORT OR LONG TERM DISABILITY CLAIM

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

Information requested in this kit is necessary to the speedy and accurate administration of your claim. If the claim form is not completed in full, determination of benefits could be delayed until all required information has been received. If a question does not apply, please write "NA" *(not applicable)* in those spaces.

There are three (3) primary sections to be completed in this kit:

Section 1: Employee Statement
Employee should fully complete this section.

Section 2: Employer's Statement
Employer should fully complete this section.

Section 3: Physician's Statement
Attending physician should fully complete this section.

A HIPAA-Compliant Authorization Form should also be fully completed by the insured and returned with this claim kit. This can be found on our website at www.bostonmutual.com.

When all sections of this form have been completed, please send it to us at the address below.

It is the responsibility of you and your employer to inform us of any scheduled or actual return to work date as soon as possible.

If an overpayment should occur on your claim, the amount of the overpayment must be returned to us.

Where to send Claim forms:

SHORT TERM DISABILITY:

Boston Mutual Life Insurance Company
120 Royall Street • Canton, MA 02021
1-877-212-2950

LONG TERM DISABILITY:

Disability RMS
300 Southborough Drive – Suite 200
South Portland, ME 04106-6914
1-877-254-0085

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FAMILY MATTERS. NO MATTER WHAT.

SECTION 1 – EMPLOYEE'S STATEMENT *(Please Print)*

Full Name *(Last, First)*	Gender ☐M ☐F	Date of Birth *(mo-day-yr)*	Social Security Number

Address *(City, State, Zip)*

Phone Number	Cell Phone Number	E-Mail Address

Marital Status	If married, spouse's name

List all Children *(Names and Dates of Birth)*

Date of Disability *(mo-day-yr)*	Occupation at time of disability	Is this accident or illness due to employment? YES☐ NO☐

Date you returned to work on a part time basis _____ *(mo-day-yr)* Date you returned to work on a full time basis _____ *(mo-day-yr)*

If you have not returned to work, when do you expect to return: Full time _____ *(mo-day-yr)* Part time _____ *(mo-day-yr)*

Describe how and where the accident occurred or describe the first symptoms of your illness:

Date first treated _____ *(mo-day-yr)* Treated by: _____ *(name and address)*

Have you ever had the same or similar condition in the past? YES☐ NO☐ If YES, please explain:

List all Treating Physicians/Hospitals for this accident or illness:

Name	Address	Date(s)

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FAMILY MATTERS. NO MATTER WHAT.

SECTION 1 – EMPLOYEE'S STATEMENT . . . *cont. (Please Print)*

Are you now receiving, or do you expect to receive, or have you applied for:

			Amount	Begin Date	Termination Date
YES ☐	NO ☐	Social Security			
YES ☐	NO ☐	Worker's Compensation Benefits			
YES ☐	NO ☐	Pension or Retirement Benefits			
YES ☐	NO ☐	State Sick Plan			
YES ☐	NO ☐	Auto Ins. Wage Replacement			
YES ☐	NO ☐	Salary Continuation/Sick Pay			
YES ☐	NO ☐	Any Other Benefits *(specify)*			

• IF AN INSURANCE COMPANY PROVIDES ANY OF THE ABOVE BENEFITS, PLEASE COMPLETE ITEM BELOW •

Insurer Name: _____

Address: _____ Type of Insurance: _____

If benefits are approved, do you want Federal Income Taxes withheld from your check? YES ☐ NO ☐

If yes, please state dollar amount you want withheld $_____ per week ☐ per month ☐

If benefits are approved, do you want State Income Taxes withheld from your check? YES ☐ NO ☐

If yes, please state dollar amount you want withheld $_____ per week ☐ per month ☐

Authorization

I CERTIFY that the information provided is true to the best of my knowledge and belief.

I HEREBY AUTHORIZE any benefit plan administrator, business associate, employer, financial institution, governmental agency, insurance and reinsurance company, insurance support organization, the Social Security Administration, Internal Revenue Service and the Veterans Administration, to furnish or release *(verbally or in writing)* or otherwise make available *(for inspection and copying)* to Boston Mutual Life Insurance Company, or its authorized representatives, all non-medical information in its possession about me. Non-medical information includes, but is not limited to: employment earnings and history, financial, insurance benefits, claims or coverage, occupational duties and traffic accident reports.

I UNDERSTAND that any information acquired pursuant to this Authorization will be used by Boston Mutual Life Insurance Company to determine my eligibility for insurance benefits under claims submitted to it, to verify representations made by me in my application for insurance or for any other lawful purpose and may be disclosed or released by Boston Mutual Life Insurance Company to: (1) re-insuring companies, (2) other persons or insurance support organizations performing business or legal services in connection with my claim or application for insurance, or (3) as may be otherwise lawfully required.

ADDITIONALLY, I have read and signed the HIPAA Authorization form to allow Boston Mutual Life Insurance Company to obtain my medical information, as allowed by the HIPAA Authorization form, and I have received and read a copy of the Boston Mutual Life Insurance Company Notice of Information Privacy Practices.

This authorization is valid for (24) twenty four months from the date of signature below.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. Please refer to the "Fraud Warning Notices" insert for your state.

X _____ _____
Signature Date

BOSTON MUTUAL LIFE INSURANCE COMPANY

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BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

FAMILY MATTERS. NO MATTER WHAT.

SECTION 2 – EMPLOYER'S STATEMENT *(Please Print)*

Employee's Name *(Last, First)*	Policy No.	Division No.	Insurance Class

Occupation *(Please attach a copy of job description if available)*	Date of Hire	Employee's LTD/STD Effective Date	Employee's Premium Contribution
			% _____ ☐ Pre-Tax ☐ Post-Tax

Employee's Regular Work Schedule

_____ Days per Week _____ Hours per Day

☐ Full Time ☐ Part Time
☐ Exempt ☐ Non Exempt
☐ Seasonal

Salary Prior to Date Last Worked

Base Wages $_____
W-2 Earnings $_____
Overtime $_____
Commissions $_____
Bonus $_____

How was Employee Paid

☐ Hourly $ _____
☐ Salaried $ _____
Date of last pay increase: _____

Date Last Worked	Hours Worked that Day	Has employee returned to work? YES ☐ NO ☐	If YES, date _____ ☐ Full Time ☐ Part Time

Were there any changes to the employee's job responsibilities due to the medical condition before the employee stopped working? If yes, what were the changes and when were they made? YES ☐ NO ☐

Can the employee's job be modified to accommodate the disability either temporarily or permanently? If yes, please explain. YES ☐ NO ☐

Is it possible to offer the employee assistance in doing the job through use of technology or personal assistance for example? If yes, please explain. YES ☐ NO ☐

Is employee receiving or eligible to receive	YES	NO	Amount	Week	Month	Provider Name/Address *(if an insurer)*	**Date Benefits** Begin	End
Short Term Disability	☐	☐	$	☐	☐			
Salary Continuation/Sick Leave	☐	☐	$	☐	☐			
State Disability	☐	☐	$	☐	☐			
Auto Ins. Wage Replacement	☐	☐	$	☐	☐			
Social Security	☐	☐	$	☐	☐			
Worker's Compensation	☐	☐	$	☐	☐			
Has a Worker's Compensation Claim been filed?	☐	☐	If workers' compensation benefits have been denied, submit a copy of denial with the claim.					

Name and address of the employee's medical insurance carrier or HMO *(provide policy or ID No.)*

Do you have a pension plan? YES ☐ NO ☐	Is this employee eligible for your pension plan? YES ☐ NO ☐ If YES, when is employee eligible _____	What % does employee contribute? _____ %

Employer Name	Phone No.	Fax No.	
Address	City	State	Zip
Name of Person Completing this form	Title		
Signature *(The above statements are true and complete to the best of my knowledge.)*		Date	

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BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891-

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SECTION 3 – PHYSICIAN'S STATEMENT

Patient's Name _____

Patient is/was unable to work due to: *(check one)* ❑ Injury ❑ Illness ❑ Pregnancy EDC _____

Diagnosis *(include complications and ICD9)*	Is condition due to injury or illness arising out of patient's employment? YES ❑ NO ❑

Date you advised patient to stop working	Date of First Visit	Date of Last Visit

COMPLETE THE FOLLOWING ITEMS FOR NON-PREGNANCY RELATED CONDITIONS *(excluding Complicated Pregnancy)*

Has patient ever had same or similar condition? YES ❑ NO ❑ If YES, state when and describe

Objective Findings *(x-rays, EKG's, lab data and clinical findings)*	Subjective Symptoms
Nature of Treatment *(surgery, medications, etc.)*	Provide medication dosage and frequency

Has Patient been hospitalized? YES ❑ NO ❑

If YES, Name and Address of Hospital — Dates of Confinements

_____ _____

_____ _____

Restrictions and Limitations *(what the patient cannot do)*	Mental Impairment *(if applicable)* Provide 5 AXIS Diagnosis I IV II V III

If this is a cardiac condition, what is the functional capacity? *(American Heart Association)*

❑ Class 1 – No Limitation ❑ Class 3 – Marked Limitation

Blood Pressure *(last visit)* Systolic/Diastolic _____ / _____ ❑ Class 2 – Slight Limitation ❑ Class 4 – Complete Limitation

Has maximum medical improvement been achieved? YES ❑ NO ❑ If no, when do you expect a fundamental change? *(please specify)*

_____

When do you estimate patient will recover sufficiently to perform the duties of his/her occupation _____ *(mo-day-yr)*

When do you estimate patient will recover sufficiently to perform the duties of any occupation _____ *(mo-day-yr)*

If employer can accommodate patient's restrictions and limitations, is patient able to return to part time and/or light duty work?

❑ YES ❑ NO *(please explain)*

_____

Remarks:

Physician Name *(please print)*	Degree	Specialty	
Address	City	State	Zip
Phone No.	Fax No.	Tax ID No.	
Physician's Signature *(The above statements are true and complete to the best of my knowledge – No Stamps Please)*		Date	

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NOTICE OF INFORMATION PRIVACY PRACTICES

Boston Mutual Life Insurance Company
(Herein referred to as "we", "us", "our")

BOSTON MUTUAL LIFE INSURANCE COMPANY - 1891 -

FAMILY MATTERS. NO MATTER WHAT.

PROTECTING YOUR INFORMATION

To protect your nonpublic personal information, we maintain: physical, electronic and procedural safeguards.

COLLECTING INFORMATION

We collect information about you in order to conduct business. Such uses are: to process requests for insurance products, to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information from you, as well as from other sources. We restrict access to your information to those working on our behalf who have a need to know it in order for us to provide products and services to you. We require them to secure the information and keep it confidential.

- ***Information we collect may include all the information you share with us including, for example, your:***
  - name
  - address
  - telephone number
  - date of birth
  - social security or tax identification number
  - employer name and income
  - beneficiary data
  - financial account numbers
  - medical information
  - and other information you share with us
- ***We may also collect data we receive from other sources, as allowed by law, which may include:***
  - medical information
  - consumer report information in accordance with the Fair Credit Reporting Act
  - participant information from organizations that purchase products or services from us for the benefit of their members or employees, such as group insurance
  - information to assist us in complying with state and federal laws

SHARING INFORMATION

We do not share information about our customers or former customers with anyone, except as permitted or required by law.

- ***We may share your information with third parties without your authorization as permitted by law. Such information is used on our behalf by these third parties to:***
  - process or service your insurance transactions with us
  - perform underwriting, administrative, account maintenance and claims functions
  - provide customer service or reinsurance coverage
  - prevent fraud
  - perform other business functions on our behalf
- ***We may also share your information with:***
  - a consumer reporting agency in accordance with the Fair Credit Reporting Act
  - a third party to comply with federal, state or local laws, subpoenas, or summonses
  - regulators
  - or as otherwise permitted or required by law.

Third parties receiving information from us are required to: keep it confidential and to comply with all applicable federal and state privacy laws.

ACCESS TO YOUR INFORMATION WE HAVE IN OUR RECORDS

You have the right to request access to all the information we have on you. You must make your request in writing at the address below.

AMENDMENTS TO YOUR INFORMATION

You have the right to request an amendment, correction or deletion of information which we hold about you which you believe may be inaccurate. We are not obligated to make updates to your data based on your request. You must make the request in writing and state the reasons you are requesting the change. Write us at the address below.

If you have questions about this notice or would like more information about our privacy policies, please write us at:

Boston Mutual Life Insurance Company
Attention: Privacy Office
120 Royall Street • Canton, MA 02021

420-012 3/15

FRAUD WARNING NOTICES – For Use with Claim Forms
PLEASE READ THE FRAUD WARNING NOTICE FOR YOUR STATE

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

ALASKA: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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PKF O'CONNOR DAVIES
ACCOUNTANTS AND ADVISORS

REPORT ON

VENDOR DUE DILIGENCE ASSESSMENT

PRESENTED TO

Bakers Union and FELRA Health and Welfare Fund

9/6/2023

Submitted by:
Thomas J. DeMayo, CISSP, CISA, CRISC, CIPP/US, MCSE, CEH, CCFE, CHFI, CPT
Partner, Cybersecurity and Privacy Advisory
tdemayo@pkfod.com

KNOW GREATER VALUE®

PKF O'CONNOR DAVIES
ACCOUNTANTS AND ADVISORS
ESTABLISHED IN 1891

September 6, 2023

Ms. Dawn Welch
Account Executive
Associated Administrators, LLC

Dear Ms. Welch:

PKF O'Connor Davies Advisory, LLC has completed the performance of Vendor Due Diligence on behalf of the Bakers Union and FELRA Health and Welfare Fund (collectively, "the Funds"). The objective of the study was to review the alignment of the utilized Vendors' cybersecurity programs with the cybersecurity guidance issued by the Department of Labor.

Any procedures that were performed by us in connection with this assignment did not constitute an audit and were not designed to provide, and we will not express, any assurance on internal control.

Our findings are summarized within this report.

This report is intended solely for the information and use of the Funds.

We wish to thank you and your staff for the courtesy and cooperation extended to us.

Very truly yours,

PKF O'Connor Davies Advisory, LLC

PKF O'CONNOR DAVIES ADVISORY LLC
245 Park Avenue, New York, NY 10167 I Tel: 212.867.8000 or 212.286.2600 I Fax: 212.286.4080 I www.pkfod.com

PKF O'Connor Davies Advisory LLC is a member firm of the PKF International Limited network of legally independent firms and does not accept any responsibility or liability for the actions or inactions on the part of any other individual member firm or firms.

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ACCOUNTANTS AND ADVISORS
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Table of Contents

Vendor Due Diligence Assessment

RISK RANKING DEFINITION

Based on the responses provided, the below rating system was applied to the Vendors in relation to their Cybersecurity Maturity level.

1. **No Response or Response Refused** – The Vendor has not provided any information for the assessment, stopped responding for follow-up information, or never responded to the initial requests.

2. **Low Maturity**– The Vendor has not implemented many of the minimum-security controls specified by the Department of Labor.

3. **Moderate Maturity** – The Vendor meets the majority of the security controls specified by the Department of Labor.

4. **Moderate-High Maturity** – The Vendor meets almost all of the security controls specified by the Department of Labor with minor deviations.

5. **High Maturity** – The Vendor meets all the security requirements specified by the Department of Labor.

CYBERSECURITY ASSESSMENT RISK BREAKDOWN

During this assessment, we reviewed specific security controls for each vendor in accordance with the controls specified by the Department of Labor. The individual control areas assessed were:

- **A Well Documented Cybersecurity Program**– The Vendor should have a formalized and well-documented Information Security Program.
- **Annual Risk Assessments** – The Vendor performs an annual risk assessment to assist in determining any security gaps within the multiple areas within their Funds.
- **Reliable Third-Party Audit of Controls** – The Vendor performs Vulnerability scanning, Penetration Testing, or any other type of Security Testing by a reliable Outsourced company.
- **Clearly Defined Information Security Roles and Responsibilities** – The Vendor has specified employees which are placed in charge of handling Cybersecurity for their Funds and those employees understand their job responsibilities.
- **Strong Access Control Procedures**– The Vendor has implemented Two Factor authentication for any remote access into their environment and has implemented the principle of least privilege.
- **Vendor Due Diligence**– The Vendor is utilizing a third-party cloud service provider and is performing their vendor due diligence by annually reviewing their security controls by asking for a SOC 2 type II report or sending out a questionnaire verifying they are following security best practices.

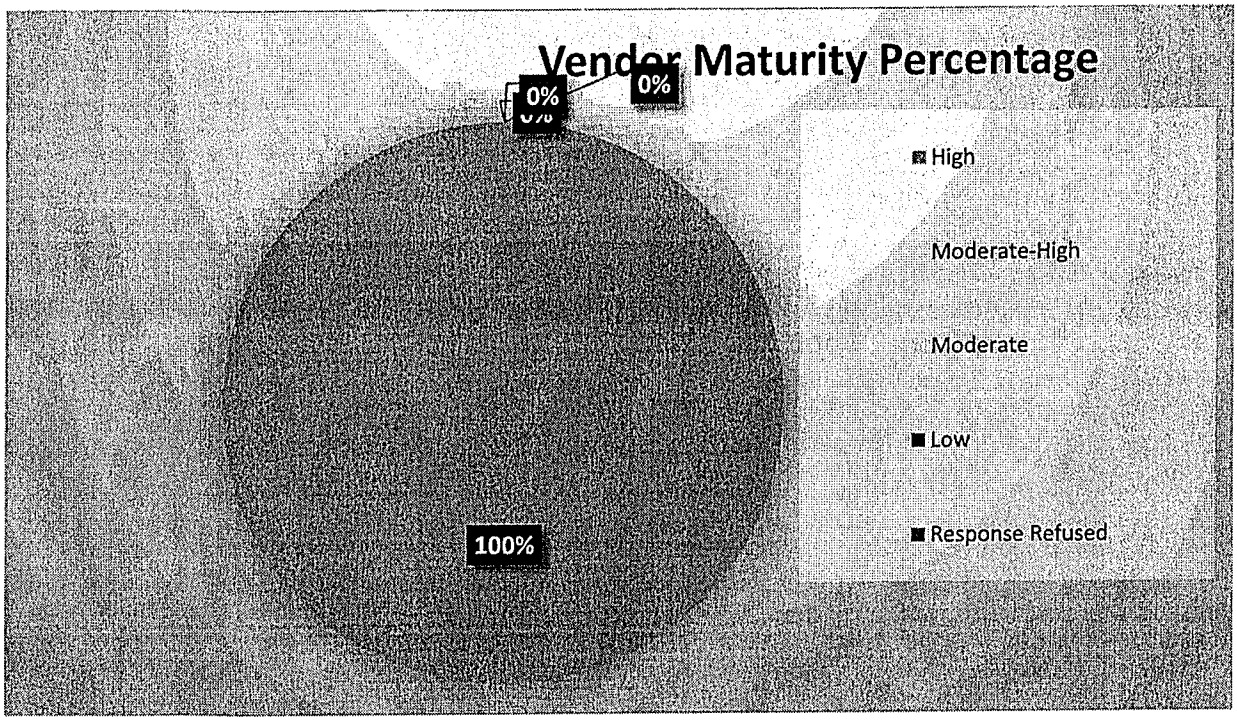
- **Annual Cybersecurity Awareness Training** – The Vendor is enforcing annual Cybersecurity Awareness training for all employees. The training includes anything new on the annual Risk Assessment report and a periodic Phishing test.
- **A Software Development Lifecycle** – The Vendor has a Software Development Lifecycle for their custom developed Software, or they do not have one because they do not custom develop software. In which case, this requirement cannot be applicable.
- **Disaster Recovery and Business Continuity Plans** – The Vendor has formalized Disaster Recovery and Business Continuity Plans in the event of a disaster event.
- **Encryption of Sensitive Data at Rest and in Transit** - The Vendor is properly encrypting all sensitive data stored on systems and being sent over a network connection.
- **Security Best Practices and Technical Controls** - The Vendor is implementing security configuration best practices (Password controls, proper access controls, etc.) and proper security appliances (firewalls with IDS/PS, web content filter, Antivirus/EDR, etc.).

EXECUTIVE SUMMARY

In total, as of the date of this report, we reviewed **10** Vendors. Each vendor was given a qualitative risk ranking of High Maturity, Moderate-High, Moderate Maturity, Low Maturity or Response Refused. Of the **10** vendors, the number of risks for each risk ranking is as follows:

Maturity Level	Total
High	10
Moderate-High	0
Moderate	0
Response Refused	0

The chart below represents the total maturity percentage of the vendors assessed.



Based on the chart above, the majority of the Funds' vendors are at a High level of Cybersecurity Maturity. For those that are deemed Moderate, we believe the program is sufficient; however, would benefit from increased control implementation. Any Vendor ranked Low, the Funds should follow up with the Vendor and request they enhance their cybersecurity program.

HIGH RISK VENDORS

All the Vendor's associated with the Funds that have been currently reviewed are of High Maturity and have well defined cybersecurity programs.

ONGOING APPROACH

The initial year review as designed was sufficient to establish a baseline of maturity and risk across the Vendors in relation to the DOL Cybersecurity Guidance. The limitations of strictly going by the DOL Guidance, as we have learned, is it has a tendency to be broad and the vendor responses reflected that. We believe that this methodology is only effective for year one to establish the general baseline and also make the Vendors accustomed to the process and expectations. For many of the Vendors, it took a lot of back and forth to make them understand a generic and limited answer was not going to be sufficient for us and the expectations were higher than they perceived. A proposed approach for year 2 would be as follows:

- A detailed questionnaire should be created that lists very specific controls that should be implemented. Controls will be weighted based on criticality. Such a method will allow us

to generate a quantitative scoring process for the Vendors. In addition, it will help advise Vendors of controls that we believe are critical and need to be implemented if not.

- For select controls, direct evidence will be required. As part of the process, it will be likely that they will request us and the Funds to sign an NDA. While this may delay the process as legal reviews will be necessary, we believe it is prudent to evolve the maturity of the program.

- Year 2 will allow for a more accurate scoring of maturity. Subsequent years, a more risk-based approach could be potentially used in which those not of High maturity are followed up with every year, while those of Higher maturity are assessed every other year.

The above is a risk-based approach to the Vendors. Should the Funds desire a full review every year or have a different proposed method, we will accommodate accordingly, should we continue to assist the Funds.

VENDOR MATURITY SUMMARY

Vendor	Maturity Level	Security Controls have been: Not Implemented/No Response, Hardly, Mostly, Partially, or Fully Implemented	Number of Cybersecurity Practice Deficiencies Discovered
Associated Administrators, LLC	High	Full Implementation	0
Calibre	High	Full Implementation	0
Cigna	High	Full Implementation	0
Delta Dental	High	Full Implementation	0
EyeMed Vision Care, LLC	High	Full Implementation	0
Group Vision Services	High	Full Implementation	0
Morgan Lewis	High	Full Implementation	0
Optum Rx	High	Full Implementation	0
PNC	High	Full Implementation	0
Blank Rome	High	Full Implementation	0

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SUMMARY ANNUAL REPORT

FOR

BAKERS UNION AND FOOD EMPLOYERS LABOR RELATIONS ASSOCIATION HEALTH AND WELFARE PLAN

This is a summary of the annual report for the BAKERS UNION AND FOOD EMPLOYERS LABOR RELATIONS ASSOCIATION HEALTH AND WELFARE PLAN, (Employer Identification No. 26-0000485, Plan No. 501) for the period January 1, 2022 to December 31, 2022. The Annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the employee retirement income security act of 1974 (ERISA).

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was $802,119 as of December 31, 2022, compared to $411,530 as of January 1, 2022. During the plan year the plan experienced an increase in its assets of $390,589. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year, or the cost of assets acquired during the year. During the plan year, the plan had total income of $4,847,077. This income included employer contributions of $4,513,935, employee contributions of $17,671 and earnings from investments of $11,997. Plan expenses were $4,456,488. These expenses included $431,596 in administrative expenses and $4,024,892 in benefits paid to participants and beneficiaries.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Assets held for investment; and
3. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of:

Board of Trustees of the
Bakers Union and FELRA Health and Welfare Fund
c/o Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
1-866-662-2537

The charge to cover copying costs will be $ 8.00 for the full report, or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the Plan:

Board of Trustees of the
Bakers Union and FELRA Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the department should be addressed to: U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue, NW, Suite N-1513, Washington, D.C. 20210.

ADDITIONAL EXPLANATION

INSURANCE INFORMATION

The Plan had a contract with Group Dental Service of Maryland from Jan 1, 2022 to August 31, 2022. The Plan has a contract with Delta Dental from September 1, 2021 through present for Dental; Group Vision Services for Vision; The Hartford for Accidental Death, Dismemberment and Life Insurance; and Gerber to pay Individual Excess Risk incurred under the terms of the Plan. The total premiums paid for the Plan year beginning January 1, 2022 and ended December 31, 2022 was $199,575.