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

2019

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 04/01/2019 and ending 03/31/2020

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CCNG INC. WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/2013

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)
CCNG, INC.

13453 HIGHWAY 71 WEST
BEE CAVE, TX 78738

2b Employer Identification Number (EIN)
74-2413025

2c Plan Sponsor's telephone number
512-524-7296

2d Business code (see instructions)
541600

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	01/07/2022	BECKY LUNNEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.		
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Filed with authorized/valid electronic signature.		
	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**	104
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)**	104
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	100
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	100
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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**	0

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 4L

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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 2 **A** (Insurance Information)
- **(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 2019 Form M-1 annual report. If the plan was not required to file the 2019 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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 04/01/2019 and ending 03/31/2020

A Name of plan
CCNG INC. WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
74-2413025

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
BLUECROSS BLUESHIELD OF TEXAS

(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
36-1236610	70670	267651	101	04/01/2019	03/31/2020

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
41095	3526

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

USI INSURANCE SERVICES LLC
PO BOX 61187
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
41095	3526	SPECIAL PROGRAMS	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

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** [ ] Dental
- **c** [ ] 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** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	662884
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? [X] Yes [ ] No

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

DID NOT PROVIDE THE ADDRESS FOR THE AGENT/BROKER.

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).

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OMB No. 1210-0110

2019

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A Name of plan
CCNG INC. WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
74-2413025

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
STANDARD 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
93-0242990	69019	163077	99	04/01/2019	03/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
8747	1234

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

USI INSURANCE SERVICES LLC
PO BOX 61187
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8555	0		3

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

USI INSURANCE SERVICES LLC
555 PLEASANTVILLE ROAD
BRIARCLIFF MANOR, NY 10510

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
0	1136	CONTINGENT COMPENSATION	3

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

IMA, INC.

1705 17TH STREET, SUITE 100
DENVER, CO 80202

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
192	98	CONTINGENT COMPENSATION	3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

m ☒ Other (specify) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT,ACCIDENT, CRITICAL ILLNESS

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	72952		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	-861		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	73813
b Benefit charges (1) Claims paid	**9b(1)**	42115		
(2) Increase (decrease) in claim reserves	**9b(2)**	-227		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	41888
(4) Claims charged			**9b(4)**	41888
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	6513		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	16088		
(E) Taxes	**9c(1)(E)**	1292		
(F) Charges for risks or other contingencies	**9c(1)(F)**	2947		
(G) Other retention charges	**9c(1)(G)**	10722		
(H) Total retention			**9c(1)(H)**	37562
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	6125
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	13839
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 ☒ No

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

DocuSign Envelope ID: 228F22D1-C134-456C-B2EA-D365BF6C1ECC

Authorization to Electronically Sign and File Health and Welfare Form 5500

I hereby authorize any employee of Wrangle, a division of Ascensus, LLC ("Service Provider") to electronically sign and transmit Health and Welfare (H&W) Form 5500s on my behalf through EFAST 2.

I further understand the following in granting authority:

I, the Plan Administrator/Plan Sponsor and signer, have the final responsibility for the H&W Form 5500, and therefore, I must review the filing carefully before I sign and agree to have it transmitted.

I must provide to Wrangle a signed and dated copy of the Form 5500. These signed copies are required per Department of Labor (DOL) rules and will be attached to the H&W Form 5500 when transmitted.

Wrangle is not liable for and does not have a duty to indemnify or hold the Plan Administrator/Plan Sponsor harmless from any penalties, damages, incidental charges or consequential damages imposed or caused as a result of the transmission of the H&W Form 5500 on my behalf. Wrangle, LLC is merely providing an option to me that will make the filing process easier should I elect this option. Wrangle, LLC or its employees shall not be deemed an administrator or other fiduciary with respect to any plan. I understand that I do have the option to obtain signing credentials and to directly submit the H&W Form 5500 to the DOL electronically.

I must sign and keep a paper copy of the completed H&W Form 5500 in my files, per ERISA.

I acknowledge that the signature as submitted through DocuSign is my adopted signature, and that I have reviewed and signed the Form 5500 as myself. Further, I accept this as my legal and binding signature.

By the signature below, I am acknowledging that I am the person responsible for the H&W Form 5500 for the entity listed below and am authorizing Wrangle to submit all Health and Welfare Form 5500s for the Form Year(s) checked below.

I may revoke or change authorization at any time by written notification to the Service Provider.

Company/Entity Name: CCNG, INC.

Plan Administrator Name: Becky Lunney

Please print your name clearly, or type in from your computer. Thank you!

Plan Administrator Signature: DocuSigned by: Becky Lunney 08660C043C58413...

Date: 1/7/2022

Note: A copy of this authorization must be kept in your records.

Failure to follow these instructions and complete this form in its entirety, including signature, will delay transmission of the 5500.

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DocuSign Envelope ID: 228F22D1-C134-456C-B2EA-D365BF6C1ECC

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

2019

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Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 04/01/2019 and ending 03/31/2020

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CCNG INC. WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/2013

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)
CCNG, INC.

13453 HIGHWAY 71 WEST
BEE CAVE, TX 78738

2b Employer Identification Number (EIN)
74-2413025

2c Plan Sponsor's telephone number
512-524-7296

2d Business code (see instructions)
541600

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	DocuSigned by: Becky Lunney 08660C043C58413...	1/7/2022	Becky Lunney
	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

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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**	104
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)**	104
a(2) Total number of active participants at the end of the plan year	**6a(2)**	100
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	100
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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 4L

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

b General Schedules

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

HRA INCLUDED.

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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 2019 Form M-1 annual report. If the plan was not required to file the 2019 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_____

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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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 04/01/2019 and ending 03/31/2020

A Name of plan
CCNG INC. WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
74-2413025

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
BLUECROSS BLUESHIELD OF TEXAS

(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	Policy or contract year (g) To
36-1236610	70670	267651	101	04/01/2019	03/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
41095	3526

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

USI INSURANCE SERVICES LLC
PO BOX 61187
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
41095	3526	SPECIAL PROGRAMS	3

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

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

DocuSign Envelope ID: 228F22D1-C134-456C-B2EA-D365BF6C1ECC

(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	

DocuSign Envelope ID: 228F22D1-C134-456C-B2EA-D365BF6C1ECC

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

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** [ ] Dental
- **c** [ ] 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** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	662884
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? [X] Yes [ ] No

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

DID NOT PROVIDE THE ADDRESS FOR THE AGENT/BROKER.

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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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 04/01/2019 and ending 03/31/2020

A Name of plan
CCNG INC. WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

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

D Employer Identification Number (EIN)
74-2413025

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
STANDARD 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
93-0242990	69019	163077	99	04/01/2019	03/31/2020

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
8747	1234

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
USI INSURANCE SERVICES LLC
PO BOX 61187
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
8555			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
USI INSURANCE SERVICES LLC
555 PLEASANTVILLE ROAD
BRIARCLIFF MANOR, NY 10510

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	1136	CONTINGENT COMPENSATION	3

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

IMA, INC.
1705 17TH STREET, SUITE 100
DENVER, CO 80202

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
192	98	CONTINGENT COMPENSATION	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	

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Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

a [ ] Health (other than dental or vision)	**b** [X] Dental	**c** [X] Vision	**d** [X] Life insurance
e [X] 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) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT,ACCIDENT, CRITICAL ILLNESS

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	72952		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	-861		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	73813
b Benefit charges (1) Claims paid	**9b(1)**	42115		
(2) Increase (decrease) in claim reserves	**9b(2)**	-227		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	41888
(4) Claims charged			**9b(4)**	41888
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	6513		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	16088		
(E) Taxes	**9c(1)(E)**	1292		
(F) Charges for risks or other contingencies	**9c(1)(F)**	2947		
(G) Other retention charges	**9c(1)(G)**	10722		
(H) Total retention			**9c(1)(H)**	37562
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	6125
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	13839
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. ▶

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Carriers' Schedules

DS BL I have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

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DocuSign Envelope ID: 228F22D1-C134-456C-B2EA-D365BF6C1ECC

FORM 5500 INFORMATION

Name of Plan: CCNG, INC.

Group Number(s): 267651

From: 4/1/2019 Through: 3/31/2020

1. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY OR CONTRACT PERIOD:			101
2. EXPERIENCE RATED CONTRACTS			
Premiums:			
Amount Received		$0.00	
Amount Due but Unpaid		$0.00	
Total Premiums Earned			$0.00
Benefit Charges:			
Net Claims Incurred*		$0.00	
Change in Claim Reserves		$0.00	
Change in other Reserves		$0.00	
Total Claims Incurred			$0.00
Remainder of Premium:			
Retention Charges:			
Commissions		$0.00	
Service Fees		$0.00	
Administrative Expenses		$0.00	
Other (Interest Credit)		$0.00	
Total Retention			$0.00
Experience or Retroactive Rate Refunds			$0.00
Status of Policyholder Reserves at End of Year:			
Amount Held for Benefits After Retirement			$0.00
Claim Reserves			$0.00
Other Reserves			$0.00
3. NON EXPERIENCE RATED CONTRACTS			
Total Premiums Earned			$662,884.17

4. COMMISSIONS AND CONSULTANT SERVICE FEES

	Name of Recipient:	Amount Paid:
a. Base Commissions **	USI SOUTHWEST INC	$41,095.45
b. Other Commissions ***		$0.00
c. Special Programs ****	USI SOUTHWEST INC	$3,525.98

STATEMENT PREPARED BY HEALTH CARE SERVICE CORPORATION 10/20/2021

* Based on the rates, terms and conditions specified in the Agreement between the Plan and HCSC.

NOTE: The above information is provided from business records of BCBSTX maintained in the ordinary course of BCBSTX's business to assist the plan administrator in complying with certain plan reporting requirements for Form 5500.

BCBSTX certifies that this information is accurate and complete to the best of its knowledge and belief.

** - Basic commissions paid on your contract or policy.

*** - Other commissions paid on your contract or policy such as General Agent commissions.

**** - Special programs and/or bonuses that are paid based on a broker/consultant's total volume. To calculate the proportion of the bonus allocated to your contract or policy, your eligible volume is divided by the broker/consultant's total volume.

That fraction is multiplied by the total bonus to get the allocated portion.

The amounts shown in sections 4b and 4c do not directly impact your overall premium and administrative fees.

FEIN (Federal Employer Identification Number): 36 - 1236610

NAIC Company Code: 70670

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October 20, 2021

Becky Lunney
CCNG, INC.
13453 HWY 71 West
Bee Cave, TX 78738-3106

RE: INFORMATION YOU NEED TO COMPLETE FORM 5500
Policy Period From 4/1/2019 to 3/31/2020
Group Number(s) and/or Control Number: 267651

NOTE: This information is being forwarded to the main account contact name in our records. You may find it appropriate to pass this information along to the person or department responsible for completing your company's tax information.

In accordance with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), attached is the information you need to complete the Form 5500 for the plan year and group numbers referenced above. Our procedures and processes now require us to provide this information to you automatically. Therefore, even though you may not have requested the information in the past, you are now receiving it for your records.

If you have seen this type of information in the past, you may note some changes as a result of our updated procedures. In particular, the section near the bottom of the exhibit now includes more detailed broker commission information, if applicable. The additional details are provided as the result of a recent Advisory Opinion issued by the Department of Labor regarding what information is to be reported on Form 5500 regarding compensation and fees paid to brokers, agents and others. The footnotes on the exhibit itself will provide further information for your reference.

If you have any questions, please contact your Blue Cross Blue Shield of Texas account representative.

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Long Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - B) DENTAL

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 163077
E) Number of persons covered: 68
F) From: 04/01/2019
G) To: 03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $2,035.14
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$1,613.49	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$421.65*	$0.00	N/A	3

Total commissions paid: $1,613.49

Total contingent compensation paid: $421.65*

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Long Form Information

Part III - 163077
7) Benefit Type
B) DENTAL

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$41,989.92	
(2) Increase (decrease) in amount due but unpaid	$0.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$41,990.00
b) Benefit charges (1) Claims paid	$35,622.25	
(2) Increase (decrease) in claim reserves	$-358.00	
(3) Incurred claims (add(1) and (2))		$35,264.25
(4) Claims charged		$35,264.25
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$2,035.14	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$8,369.00	
(E) Taxes	$735.00	
(F) Charges for risks or other contingencies	$628.35	
(G) Other retention charges	$0.00	
(H) Total retention		$11,767.49
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$1,380.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - H) VISION

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 163077
E) Number of persons covered: 57
F) From: 04/01/2019
G) To: 03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $692.92
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$629.15	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$63.77*	$0.00	N/A	3

Total commissions paid: $629.15

Total contingent compensation paid: $63.77*

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Long Form Information

Part III - 163077
7) Benefit Type
H) VISION

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$6,297.66	
(2) Increase (decrease) in amount due but unpaid	$0.00	
(3) Increase (decrease) in unearned premium reserve	$0.00	
(4) Earned ((1) + (2) - (3))		$6,298.00
b) Benefit charges (1) Claims paid	$3,954.08	
(2) Increase (decrease) in claim reserves	$-2.00	
(3) Incurred claims (add(1) and (2))		$3,952.08
(4) Claims charged		$3,952.08
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$692.92	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$2,044.00	
(E) Taxes	$110.00	
(F) Charges for risks or other contingencies	$93.23	
(G) Other retention charges	$0.00	
(H) Total retention		$2,940.15
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$532.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
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if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - D) LIFE INSURANCE

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 163077
E) Number of persons covered: 99
F) From: 04/01/2019
G) To: 03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $627.16
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$548.26	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$78.90*	$0.00	N/A	3

Total commissions paid: $548.26

Total contingent compensation paid: $78.90*

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Long Form Information

Part III - 163077
7) Benefit Type
D) LIFE INSURANCE

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$3,655.22	
(2) Increase (decrease) in amount due but unpaid	$0.00	
(3) Increase (decrease) in unearned premium reserve	$-128.00	
(4) Earned ((1) + (2) - (3))		$3,783.00
b) Benefit charges (1) Claims paid	$0.00	
(2) Increase (decrease) in claim reserves	$-37.00	
(3) Incurred claims (add(1) and (2))		$-37.00
(4) Claims charged		$-37.00
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$627.16	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$1,051.00	
(E) Taxes	$66.00	
(F) Charges for risks or other contingencies	$303.00	
(G) Other retention charges	$1,772.84	
(H) Total retention		$3,820.00
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$646.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

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if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - E) TEMPORARY DISABILITY

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 163077
E) Number of persons covered: 99
F) From: 04/01/2019
G) To: 03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $2,001.68
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$1,729.10	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$272.58*	$0.00	N/A	3

Total commissions paid: $1,729.10

Total contingent compensation paid: $272.58*

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Long Form Information

Part III - 163077
7) Benefit Type
E) TEMPORARY DISABILITY

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$13,301.24	
(2) Increase (decrease) in amount due but unpaid	$0.00	
(3) Increase (decrease) in unearned premium reserve	$-442.00	
(4) Earned ((1) + (2) - (3))		$13,743.00
b) Benefit charges (1) Claims paid	$2,538.44	
(2) Increase (decrease) in claim reserves	$80.00	
(3) Incurred claims (add(1) and (2))		$2,618.44
(4) Claims charged		$2,618.44
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$2,001.68	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$3,013.00	
(E) Taxes	$241.00	
(F) Charges for risks or other contingencies	$962.00	
(G) Other retention charges	$4,906.88	
(H) Total retention		$11,124.56
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$1,465.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Long Form Information

The financial data below is provided for your information.
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if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - F) LONG TERM DISABILITY

a) Carrier: Standard Insurance Company
b) EIN: 93-0242990
c) NAIC code: 000-69019
D) Contract number: 163077
E) Number of persons covered: 26
F) From: 04/01/2019
G) To: 03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:
Amount of commissions paid: $1,155.60
Fees paid / amount: $0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$1,002.08	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$153.52*	$0.00	N/A	3

Total commissions paid: $1,002.08

Total contingent compensation paid: $153.52*

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Long Form Information

Part III - 163077
7) Benefit Type
F) LONG TERM DISABILITY

8) Experience Rated Contracts

a) Premiums: (1) Amount Received	$7,707.67	
(2) Increase (decrease) in amount due but unpaid	$0.00	
(3) Increase (decrease) in unearned premium reserve	$-291.00	
(4) Earned ((1) + (2) - (3))		$7,999.00
b) Benefit charges (1) Claims paid	$0.00	
(2) Increase (decrease) in claim reserves	$90.00	
(3) Incurred claims (add(1) and (2))		$90.00
(4) Claims charged		$90.00
c) Remainder of premium: (1) Retention charges(on an accrual basis)		
(A) Commissions	$1,155.60	
(B) Administrative service or other fees	$0.00	
(C) Other specific acquisition costs	$0.00	
(D) Other expenses	$1,611.00	
(E) Taxes	$140.00	
(F) Charges for risks or other contingencies	$960.00	
(G) Other retention charges	$4,042.40	
(H) Total retention		$7,909.00
(2) Dividends or retroactive rate refunds		$0.00
d) Status of policyholder reserves at end of year:		
(1) Amount held to provide benefits after retirement		$0.00
(2) Claim reserves		$2,102.00
(3) Other reserves		$0.00
e) Dividends or retroactive rate refunds due		$0.00

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Short Form Information

The financial data below is provided for your information.
It can be used to complete the schedule a for the form 5500,
if your plan is required to file such a schedule.

c) Plan Sponsor: CCNG, INC.

Part I
1) Coverage: - L) INDEMNITY CONTRACT

a) Carrier:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC code:	000-69019
D) Contract number:	163077
E) Number of persons covered:	29
F) From:	04/01/2019
G) To:	03/31/2020

2) Insurance fees and commissions paid to agents, brokers, and other persons:

Amount of commissions paid:	$3,468.51
Fees paid / amount:	$0.00

a) Name & address of agent or broker to whom commission or fees were paid	b) Amount of Commission paid	Fees paid c) Amount	d) Purpose	e) Organization Code
USI SOUTHWEST INC PO BOX 61187 VIRGINIA BEACH, VA 23466	$3,033.21	$0.00	N/A	3
USI NORTHEAST INC 555 PLEASANTVILLE RD BRIARCLIFF MANOR, NY 10510	$145.78*	$0.00	N/A	3
IMA INC 1705 17TH ST STE 100 DENVER, CO 80202	$97.74*	$0.00	N/A	3
IMA INC 1705 17TH ST STE 100 DENVER, CO 80202	$191.78	$0.00	N/A	3

Total commissions paid: $3,224.99

Total contingent compensation paid: $243.52*

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Short Form Information

Part III - 163077
7) Benefit type
L) INDEMNITY CONTRACT

9) Non experience-rated contracts:
a) Total premiums paid to carrier $13,839.37

Standard Insurance Company hereby certifies that this information is complete and accurate.

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Self-Insured Benefit

FSA / HRA

A Schedule A will not be included in the 5500 as the benefit was self-insured. A Schedule A is only to report fully insured benefits.

We did include the appropriate benefit code for the benefit and checked general assets for funding.

Disclaimer: Wrangle, an Ascensus® company, as well as its employees and affiliates do not offer legal and accounting consultation and services. Information relayed through Wrangle-produced materials serves to provide general information only; whether expressed or implied it is not intended to constitute legal or other advice or opinions on any specific matters and is not intended to replace the advice of a qualified attorney, accountant, or other professional advisor. Wrangle applies its best effort to provide accurate and complete results and provides its service in accordance with the ERISA rules that govern Form 5500 completion. This document may contain information that is confidential. Any use, disclosure, distribution, or duplication by anyone other than an intended recipient is prohibited. Ascensus provides administrative and recordkeeping services and is not a broker-dealer or an investment advisor. Ascensus® and the Ascensus logo are registered trademarks of Ascensus, LLC © 2020 Wrangle, an Ascensus® company. All rights reserved. 7.6.20

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The Summary Annual Report…SAR

DS BL I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

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SUMMARY ANNUAL REPORT

For CCNG INC. WELFARE BENEFIT PLAN

This is a summary of the annual report of the CCNG INC. WELFARE BENEFIT PLAN, EIN 74-2413025, Plan No. 501, for period 04/01/2019 through 03/31/2020. 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).

Insurance Information

The plan has contracts with BLUECROSS BLUESHIELD OF TEXAS, and STANDARD INSURANCE COMPANY to pay Medical, Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Critical Illness, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 03/31/2020 were $749,675.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 03/31/2020, the premiums paid under such "experience-rated" contracts were $72,952 and the total of all benefit claims paid under these contracts during the plan year was $41,888.

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:

- 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 CCNG, INC. at 13453 HIGHWAY 71 WEST, BEE CAVE, TX, 78738 or by telephone at 512-524-7296.

You also have the legally protected right to examine the annual report at the main office of the plan (CCNG, INC., 13453 HIGHWAY 71 WEST, BEE CAVE, TX, 78738) 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: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection

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displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)