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|---|---|--|
| <p><b>Form 5500</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security<br/>Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p>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).</p> <p>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p> | <p>OMB Nos. 1210-0110<br/>1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2023</p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|---|--|

**Part I Annual Report Identification Information**  
 For calendar plan year 2023 or fiscal plan year beginning 04/01/2023 and ending 03/31/2024

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

a single-employer plan  a DFE (specify) \_\_\_\_\_

**B** This return/report is:  the first return/report  the final return/report

an amended return/report  a short plan year return/report (less than 12 months)

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

**D** Check box if filing under:  Form 5558  automatic extension  the DFVC program

special extension (enter description) \_\_\_\_\_

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

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

|  |  |
|--|--|
| <p><b>1a</b> Name of plan<br/><u>SCHMITT SUSSMAN ENTERPRISES, INC - CIGNA</u></p>  | <p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>   |
| <p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br/>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br/>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br/><u>SCHMITT SUSSMAN ENTERPRISES INC</u><br/><u>PFP SERVICES</u></p> <p><u>PO BOX 1500</u> <span style="float: right;"><u>34 PRINDLE HILL ROAD</u></span><br/><u>ORANGE, CT 06477-7500</u> <span style="float: right;"><u>ORANGE, CT 06477</u></span></p> | <p><b>1c</b> Effective date of plan<br/><u>04/01/2023</u></p> <p><b>2b</b> Employer Identification Number (EIN)<br/><u>06-0895325</u></p> <p><b>2c</b> Plan Sponsor's telephone number<br/><u>203-795-6039</u></p> <p><b>2d</b> Business code (see instructions)<br/><u>524210</u></p> |

**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.

|                  |   |            |  |
|------------------|---|------------|--|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 07/24/2024 | ERIKA BAUMGARDNER  |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |   |            |  |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |   |            |  |
|                  | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

|  |  |     |
|--|--|-----|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor   | <b>3b</b> Administrator's EIN              |     |
|  | <b>3c</b> Administrator's telephone number |     |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name   | <b>4b</b> EIN                              |     |
|  | <b>4d</b> PN                               |     |
| <b>5</b> Total number of participants at the beginning of the plan year  | <b>5</b>                                   | 141 |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits .....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | <b>6a(1)</b>                               | 141 |
|  | <b>6a(2)</b>                               | 139 |
|  | <b>6b</b>                                  | 0   |
|  | <b>6c</b>                                  | 0   |
|  | <b>6d</b>                                  | 139 |
|  | <b>6e</b>                                  |     |
|  | <b>6f</b>                                  | 139 |
|  | <b>6g(1)</b>                               |     |
| <b>6g(2)</b>   |  |     |
| <b>6h</b>  |  |     |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....  | <b>7</b>                                   | 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

|   |   |
|---|---|
| <b>9a</b> Plan funding arrangement (check all that apply)               | <b>9b</b> Plan benefit arrangement (check all that apply)               |
| (1) <input checked="" type="checkbox"/> Insurance                       | (1) <input checked="" type="checkbox"/> Insurance                       |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input type="checkbox"/> Trust                                      | (3) <input type="checkbox"/> Trust                                      |
| (4) <input type="checkbox"/> General assets of the sponsor              | (4) <input type="checkbox"/> 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)

|  |   |
|--|---|
| <b>a Pension Schedules</b>   | <b>b General Schedules</b>  |
| (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  | (1) <input type="checkbox"/> <b>H</b> (Financial Information)   |
| (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)                              |
| (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary                               | (3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>  1  </u> |
| (4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____  | (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)                         |
| (5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)  | (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)                              |
|  | (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)                                 |

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

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**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.

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

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**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 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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|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p><b>2023</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

For calendar plan year 2023 or fiscal plan year beginning **04/01/2023** and ending **03/31/2024**

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>SCHMITT SUSSMAN ENTERPRISES, INC - CIGNA</b></p>                                | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>SCHMITT SUSSMAN ENTERPRISES INC</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>06-0895325</b></p> |                   |

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES (CIGNA)**

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 59-1031071 | 67369         | 3336973                               | 257   | 04/01/2023              | 03/31/2024 |

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

|   |  |
|---|--|
| <p><b>(a)</b> Total amount of commissions paid<br/><b>82422</b></p> | <p><b>(b)</b> Total amount of fees paid<br/><b>0</b></p> |
|---|--|

**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

**PATRIOT GROWTH INSURANCE SERVICES**      1460 US 9  
    SUITE 200  
    WOODBRIDGE, NJ 07095

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 82422   | 0                               |             | 3                     |

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

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

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

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

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

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

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

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

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

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

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

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

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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. |
|----------------|--|

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

**6** Contracts With Allocated Funds:

|  |           |  |
|--|-----------|--|
| <b>a</b> State the basis of premium rates ▶  |           |  |
| <b>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year.....   | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶         |           |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>   |           |  |

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

|  |              |  |
|--|--------------|--|
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration                      (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment                      (4) <input type="checkbox"/> other ▶ |              |  |
| <b>b</b> Balance at the end of the previous year .....   | <b>7b</b>    |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....  | <b>7c(1)</b> |  |
|  | <b>7c(2)</b> |  |
|  | <b>7c(3)</b> |  |
|  | <b>7c(4)</b> |  |
|  | <b>7c(5)</b> |  |
|  | <b>7c(6)</b> |  |
| (6) Total additions .....  | <b>7c(6)</b> |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....  | <b>7d</b>    |  |
| <b>e</b> Deductions:<br>(1) Disbursed from fund to pay benefits or purchase annuities during year .....  | <b>7e(1)</b> |  |
|  | <b>7e(2)</b> |  |
|  | <b>7e(3)</b> |  |
|  | <b>7e(4)</b> |  |
|  | <b>7e(5)</b> |  |
| (5) Total deductions .....   | <b>7e(5)</b> |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....  | <b>7f</b>    |  |

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

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

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

**9** Experience-rated contracts:

|  |                 |   |
|--|-----------------|---|
| <b>a</b> Premiums: (1) Amount received .....   | <b>9a(1)</b>    | 0 |
| (2) Increase (decrease) in amount due but unpaid.....  | <b>9a(2)</b>    | 0 |
| (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    | 0 |
| (4) Earned ((1) + (2) - (3)).....  | <b>9a(4)</b>    | 0 |
| <b>b</b> Benefit charges (1) Claims paid.....  | <b>9b(1)</b>    | 0 |
| (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    | 0 |
| (3) Incurred claims (add (1) and (2)).....   | <b>9b(3)</b>    | 0 |
| (4) Claims charged .....   | <b>9b(4)</b>    | 0 |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --  |                 |   |
| (A) Commissions .....  | <b>9c(1)(A)</b> | 0 |
| (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> | 0 |
| (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> | 0 |
| (D) Other expenses .....   | <b>9c(1)(D)</b> | 0 |
| (E) Taxes .....  | <b>9c(1)(E)</b> | 0 |
| (F) Charges for risks or other contingencies.....  | <b>9c(1)(F)</b> | 0 |
| (G) Other retention charges .....  | <b>9c(1)(G)</b> | 0 |
| (H) Total retention .....  | <b>9c(1)(H)</b> | 0 |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... | <b>9c(2)</b>    | 0 |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                | <b>9d(1)</b>    | 0 |
| (2) Claim reserves .....   | <b>9d(2)</b>    | 0 |
| (3) Other reserves.....  | <b>9d(3)</b>    | 0 |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....   | <b>9e</b>       | 0 |

**10** Nonexperience-rated contracts:

|   |            |        |
|---|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 688459 |
| <b>b</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 ..... | <b>10b</b> | 0      |

Specify nature of costs.

**Part IV Provision of Information**

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

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

|  |  |   |
|--|--|---|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>▶ File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2023</b><br><br><b>This Form is Open to Public Inspection.</b> |
|--|--|---|

For calendar plan year 2023 or fiscal plan year beginning **04/01/2023** and ending **03/31/2024**

|   |  |            |
|---|--|------------|
| <b>A</b> Name of plan<br><b>SCHMITT SUSSMAN ENTERPRISES, INC - CIGNA</b>                                | <b>B</b> Three-digit plan number (PN) ▶                            | <b>501</b> |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>SCHMITT SUSSMAN ENTERPRISES INC</b> | <b>D</b> Employer Identification Number (EIN)<br><b>06-0895325</b> |            |

**Part I Service Provider Information (see instructions)**

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

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

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

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

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

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

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

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

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

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

CIGNA HEALTH AND LIFE INSURANCE COM

59-1031071

| (b)<br>Service Code(s)        | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|-------------------------------|---|--|--|--|---|--|
| 12 13 31<br>38 49 50<br>56 62 | PROVIDES CLAIM<br>ADMIN SVCS  | 124095   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

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

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

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

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)                         | (c) Enter amount of indirect compensation  |
|---|--|--|
| CIGNA   | 12 13 31 38 49 50 56 62                                      | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |  | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| JPMORGAN CHASE<br>59-1031071  | 3 CHASE METRO TECH CENTER<br>5TH FLOOR<br>BROOKLYN, NY 11245 | EARNINGS CREDITS ON DAILY FUND BALANCES ASSOC WITH BANK ACCTS UTILIZED IN CLAIM ADMIN BY CIGNA. APPLICABLE TO ALL SELF FUNDED PLANS UTILIZING JPMORGAN CHASE SERVICES. \$3.70 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 3.34% |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)                         | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62                                      | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |  | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| DEUTSCHE BANK<br>59-1031071   | 60 WALL STREET<br>NEW YORK, NY 10005                         | EARNINGS CREDITS ASSOC WITH BANK ACCTS UTILIZED BY CIGNA IN ADMIN OF DISBURSING CLAIM REFUNDS. APPLICABLE TO SELF FUNDED PLANS. \$0.00 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 0.50%  |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)                         | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62                                      | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |  | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| CHLIC - COR DEPOSITS, PNC BANK<br>59-1031071                        | 1600 MARKET STREET<br>19TH FLOOR<br>PHILADELPHIA, PA 19103   | EARNINGS CREDITS ASSOC WITH BANK ACCTS UTILIZED BY CIGNA IN ADMIN OF DISBURSING CLAIM REFUNDS. APPLICABLE TO SELF FUNDED PLANS. \$0.31 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 0.92%  |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)  | (c) Enter amount of indirect compensation  |
|---|---------------------------------------|--|
| CIGNA   | 12 13 31 38 49 50 56 62               | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |                                       | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| CITIBANK NA (OMNIBUS)<br>59-1031071                                 | ONE PENNS WAY<br>NEW CASTLE, DE 19720 | EARNINGS CREDITS ON DAILY FUND BALANCES ASSOC WITH BANK ACCTS UTILIZED IN CLAIM ADMIN BY CIGNA. APPLICABLE TO ALL SELF FUNDED PLANS FOR EVERNORTH BEHAVIORAL HEALTH. \$0.01 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 3.78% |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)  | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62               | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |                                       | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| CITIBANK NA (CHLIC CORE DEPOSITS)<br>59-1031071                     | ONE PENNS WAY<br>NEW CASTLE, DE 19720 | EARNINGS CREDITS ON DAILY FUND BALANCES ASSOC WITH BANK ACCTS UTILIZED IN CLAIM ADMIN BY CIGNA. APPLICABLE TO ALL SELF FUNDED PLANS FOR EVERNORTH BEHAVIORAL HEALTH. \$0.78 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 2.51% |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)  | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62               | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |                                       | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| CITIBANK NA<br>59-1031071   | ONE PENNS WAY<br>NEW CASTLE, DE 19720 | EARNINGS CREDITS ON DAILY FUND BALANCES ASSOC WITH BANK ACCTS UTILIZED IN CLAIM ADMIN BY CIGNA. APPLICABLE TO ALL SELF FUNDED PLANS UTILIZING CITIBANK SVCS. \$2.36 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 3.78%         |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)          | (c) Enter amount of indirect compensation  |
|---|---|--|
| CIGNA   | 12 13 31 38 49 50 56 62                       | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |   | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| AMERICAN SPECIALTY HEALTH INC<br>33-0883241                         | 10221 WATERIDGE CIRCLE<br>SAN DIEGO, CA 92121 | VOLUME BASED MARKETING FEES PAID BY VENDORS IN CIGNA HEALTHY REWARDS PROGRAM OFFERING PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. INDIRECT COMP EST \$0.13 PMPY BASED ON TOTAL COMP RECD FROM HEALTHY REWARD VENDORS ACROSS CIGNA'S BOOK OF BUSINESS |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)          | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62                       | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |   | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| LCA VISION INC<br>11-2882328  | 7840 MONTGOMERY ROAD<br>CINCINNATI, OH 45236  | VOLUME BASED MARKETING FEES PAID BY VENDORS IN CIGNA HEALTHY REWARDS PROGRAM OFFERING PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. INDIRECT COMP EST \$0.13 PMPY BASED ON TOTAL COMP RECD FROM HEALTHY REWARD VENDORS ACROSS CIGNA'S BOOK OF BUSINESS |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)          | (c) Enter amount of indirect compensation  |
| CIGNA   | 12 13 31 38 49 50 56 62                       | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation |   | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |
| FITBIT<br>20-8920744  | 199 FREMONT STREET<br>SAN FRANCISCO, CA 94105 | VOLUME BASED MARKETING FEES PAID BY VENDORS IN CIGNA HEALTHY REWARDS PROGRAM OFFERING PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. INDIRECT COMP EST \$0.13 PMPY BASED ON TOTAL COMP RECD FROM HEALTHY REWARD VENDORS ACROSS CIGNA'S BOOK OF BUSINESS |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
|--|--|---|
| CIGNA  | 12 13 31 38 49 50 56 62  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation                                      | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |   |
| AMPLIFON HEARING HEALTHCARE<br>150 SOUTH 5TH STREET<br>SUITE 2300<br>MINNEAPOLIS, MN 55402<br>85-0437037 | VOLUME BASED MARKETING FEES PAID BY VENDORS IN CIGNA HEALTHY REWARDS PROGRAM OFFERING PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES. INDIRECT COMP EST \$0.13 PMPY BASED ON TOTAL COMP RECD FROM HEALTHY REWARD VENDORS ACROSS CIGNA'S BOOK OF BUSINESS |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| CIGNA  | 12 13 31 38 49 50 56 62  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation                                      | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |   |
| BANK OF AMERICA (LOCKBOX)<br>540WEST MADISON STREET<br>CHICAGO, IL 60661<br>59-1031071                   | EARNING CREDITS ASSOC WITH BANK ACCTS UTILIZED BY CIGNA IN ADMIN OF CLAIM OVERPAYMENT RECOVERIES. APPLICABLE TO ALL SELF FUNDED PLANS ADMIN BY CIGNA. \$0.00 PER PARTICIPANT WITH AVG ANNUAL RATE OF EARNINGS CREDIT AT 1.91%                        |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| CIGNA  | 12 13 31 38 49 50 56 62  | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation                                      | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.   |   |
| SAGAMORE NETWORK HOSPITALS   | NETWORK OF 22 HOSPITALS CONTRACTED TO PAY NETWORK ADMIN FEES. CIGNA RECEIVED INDIRECT COMP FROM THESE HOSPITALS OF APPROX \$0.08 PER PARTICIPANT IN ALL PLANS  |   |

**Part I Service Provider Information (continued)**

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

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
|---|--------------------------------------|---|
| CIGNA   | 12 13 31 38 49 50 56 62              | 0   |

| (d) Enter name and EIN (address) of source of indirect compensation                        | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |
|--|--|
| VISION SERVICE PLAN VSP<br>333 QUALITY DRIVE<br>RANCHO CORDOVA, CA 96670<br><br>06-1227840 | INDIRECT COMP REC'D FOR CIGNA'S EXPENSES ASSOCIATED WITH ADMIN PLANS WITH VISION BENEFITS. APPROX COMP FROM VENDOR IS \$0.94 PER PARTICIPANT                       |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
|---|--------------------------------------|---|
| CIGNA   | 12 13 31 38 49 50 56 62              | 0   |

| (d) Enter name and EIN (address) of source of indirect compensation                          | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  |
|--|---|
| OMADA HEALTH, INC<br>500 SANSOME STREET<br>#200<br>SAN FRANCISCO, CA 94111<br><br>45-2355015 | DIGITAL DIABETES PREVENTATIVE CARE (I) EXPLAINING SVCS TO EXISTING AND PROSPECTIVE CLIENTS (II) ENCOURAGING AT RISK INDIVIDUALS TO UTILIZE PREVENTATIVE CARE SVCS(III) FACILITATING ENROLLMENT OF AT RISK INDIVIDUALS IN PROGRAM EST \$0.84 PER PARTICIPANT |

| (a) Enter service provider name as it appears on line 2 | (b) Service Codes (see instructions) | (c) Enter amount of indirect compensation |
|---|--------------------------------------|---|
| CIGNA   | 12 13 31 38 49 50 56 62              | 0   |

| (d) Enter name and EIN (address) of source of indirect compensation                            | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.  |
|--|---|
| CASTLIGHT HEALTH<br>121 SPEAR STREET<br>3RD FLOOR<br>SAN FRANCISCO, CA 94105<br><br>26-1989091 | (I) DEFRAY CIGNA'S COST FOR CHANGES TO FACILITATE VENDOR'S CUSTOMER TRANSPARENCY (II) REIMBURSEMENT FOR ANNUALLY PROVIDING COE & CCD INFO (III) REIMBURSEMENT CUSTOMER ACCESS TO COST ESTIMATE INFO (IV) ACCESS TO CLIENT PAID FEES EST. \$3.65 PER PARTICI |

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

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

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

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

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

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

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

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

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

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation: