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

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

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

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
HEALTH BENEFITS

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2023

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

C2 ESSENTIALS, INC.
C2 ESSENTIALS, INC.
C2 ESSENTIALS, INC.
3975 VIRGINIA MALLORY DR STE 100
CHANTILLY, VA 20151-4033

3975 VIRGINIA MALLORY DR STE 100
CHANTILLY, VA 20151-4033

2b Employer Identification Number (EIN) 54-1869318

2c Plan Sponsor's telephone number 703-444-0096

2d Business code (see instructions) 541214

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.	08/12/2024	MIKE WATSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	584
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)**	584
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	1143
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	1143
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	1143
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

4B 4D 4E 4F 4H

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 3
- **(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 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_____

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

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
HEALTH BENEFITS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
C2 ESSENTIALS, INC.

D Employer Identification Number (EIN)
54-1869318

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
DELTA DENTAL

(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
54-0844477	55611	00000006105	1143	01/01/2023	12/31/2023

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
12718	

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

HUB INTERNTIONAL MID-ATLANTIC, INC.
1445 RESEARCH BLVD
SUITE 340
ROCKVILLE, MD 20850

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
12718	12718	COMMISSIONS	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

4	Current value of plan's interest under this contract in the general account at year end	4	430212
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	430212
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. Specify nature of costs ▶	6d	

e Type of contract: (1) [X] 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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	430212		
(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)**	430212
b Benefit charges (1) Claims paid	**9b(1)**	328075		
(2) Increase (decrease) in claim reserves	**9b(2)**	951		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	329026
(4) Claims charged			**9b(4)**	329026
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	12718		
(B) Administrative service or other fees	**9c(1)(B)**	69694		
(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)**	8604		
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	91016
(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)**	16731
(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**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
HEALTH BENEFITS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
C2 ESSENTIALS, INC.

D Employer Identification Number (EIN)
54-1869318

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
VSP VISION CARE

(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
23-7089668	53031	12144703	496	01/01/2023	12/31/2023

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
1879	12208

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

HUB INTERNATIONL MID-ATLANTIC
3290 N RIDGE RD
SUITE 300
ELLICOTT CITY, MD 21043

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1879	12208	ADMIN FEE	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	62609
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. Specify nature of costs ▶	6d	

e Type of contract: (1) [X] 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** [X] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	62609		
(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)**	62609
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)**	1879		
(B) Administrative service or other fees	**9c(1)(B)**	12208		
(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)**	14087
(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**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

A Name of plan
HEALTH BENEFITS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
C2 ESSENTIALS, INC.

D Employer Identification Number (EIN)
54-1869318

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
RELINCE STANDARD

(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
36-0883760	68381	G158961	663	01/03/2023	12/31/2023

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
27827	

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

HUB INTERNATIONL MID-ATLANTIC
3290 N RIDGE RD
SUITE 300
ELLICOTT CITY, MD 21043

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
27827			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	278278
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. Specify nature of costs ▶	6d	

e Type of contract: (1) [X] 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** [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** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	278278		
(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)**	278278
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)**	27827		
(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)**	27827
(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**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

August 5, 2024

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

C2 ESSENTIALS, INC.
3975 Virginia Mallory Drive
Suite 100
Chantilly, VA 20151

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: C2 Essentials, Inc.
Policy Number: G 158961
Policy Type: WEEKLY INCOME
Number of Covered Employees: 663
Policy Contract Year: 1/1/2023 to 12/31/2023

		PREMIUM					
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Short Term Disability	$278,278.67	0.1700	01/21	0.2800	01/21	0.0000	00/00
Total Premium:	**$278,278.67**						

COMPENSATION

Agent Code: 17-0209
Payee Name: Hub International Mid-Atlantic, Inc.
Payee Address: 3290 N. Ridge Rd
Suite 300
Ellicott City, MD 21043

Total Commission: $27,827.90
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $27,827.90

RGO: WASHINGTON DC

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

August 5, 2024

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

(1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

(2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

August 5, 2024

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

C2 ESSENTIALS, INC.
3975 Mallory Drive, Suite 100
Chantilly, VA 20151

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: C2 Essentials, Inc.
Policy Number: G 610158
Policy Type: WEEKLY INCOME
Number of Covered Employees: 11
Policy Contract Year: 1/1/2023 to 12/31/2023

		PREMIUM					
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Short Term Disability	$4,544.10	5.4000	08/13	0.0000	00/00	0.0000	00/00
Total Premium:	**$4,544.10**						

COMPENSATION

Agent Code: 17-0209
Payee Name: Hub International Mid-Atlantic, Inc.
Payee Address: 3290 N. Ridge Rd
Suite 300
Ellicott City, MD 21043

Total Commission: $454.41
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $454.41

RGO: WASHINGTON DC

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

reliancestandard
LIFE INSURANCE COMPANY
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August 5, 2024

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2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

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August 5, 2024

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

C2 ESSENTIALS, INC.
3975 Virginia Mallory Drive
Chantilly, VA 20151

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: C2 Essentials, Inc.
Policy Number: GL 142392
Policy Type: GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT
Number of Covered Employees: 666
Policy Contract Year: 1/1/2023 to 12/31/2023

		PREMIUM					
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Basic AD&D	$10,327.99	0.0200	01/21	0.0000	00/00	0.0000	00/00
Basic Life	$56,803.75	0.1100	01/21	0.0000	00/00	0.0000	00/00
Total Premium:	**$67,131.74**						

COMPENSATION

Agent Code: 17-0209
Payee Name: Hub International Mid-Atlantic, Inc.
Payee Address: 3290 N. Ridge Rd
Suite 300
Ellicott City, MD 21043

Total Commission: $6,713.18
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $6,713.18

RGO: WASHINGTON DC

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

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August 5, 2024

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2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
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August 5, 2024

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

C2 ESSENTIALS, INC.
3975 Virginia Mallory Drive
Suite 100
Chantilly, VA 20151

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: C2 Essentials, Inc.
Policy Number: LTD 116764
Policy Type: LONG TERM DISABILITY
Number of Covered Employees: 672
Policy Contract Year: 1/1/2023 to 12/31/2023

	PREMIUM						
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Long Term Disability	$223,109.05	0.2660	01/21	0.2930	01/21	0.0000	00/00
Total Premium:	**$223,109.05**						

COMPENSATION

Agent Code: 17-0209
Payee Name: Hub International Mid-Atlantic, Inc.
Payee Address: 3290 N. Ridge Rd
Suite 300
Ellicott City, MD 21043

Total Commission: $22,310.90
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $22,310.90

RGO: WASHINGTON DC

*Compensation includes, but is not limited to the following: commissions, benefit administration fees, premier/elite producer payments and administrative fees.

reliancestandard
LIFE INSURANCE COMPANY
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August 5, 2024

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

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    a. The name and address of any employer having employees covered by the plan; or
    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
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August 5, 2024

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

C2 ESSENTIALS, INC.
3975 Virginia Mallory Drive
Suite 100
Chantilly, VA 20151

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: C2 Essentials, Inc.
Policy Number: VG 180435
Policy Type: VOLUNTARY GROUP TERM LIFE
Number of Covered Employees: 70
Policy Contract Year: 1/1/2023 to 12/31/2023

		PREMIUM					
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Basic Life	$44,743.77	0.9999	00/00	0.0000	00/00	0.0000	00/00
Dependent Life	$7,875.71	0.9999	00/00	0.0000	00/00	0.0000	00/00
Total Premium:	**$52,619.48**						

COMPENSATION

Agent Code: 17-0209
Payee Name: Hub International Mid-Atlantic, Inc.
Payee Address: 3290 N. Ridge Rd
Suite 300
Ellicott City, MD 21043

Total Commission: $5,261.94
Total Administrative and Other Fees: $0.00
Total Amount of Compensation: $5,261.94

RGO: WASHINGTON DC

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reliancestandard
LIFE INSURANCE COMPANY
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August 5, 2024

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    b. The name and address of any labor organization maintaining the plan; or
    c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
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Customer Service
1-800-644-1103

Schedule A Form (5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation.

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

C2 ESSENTIALS, INC.
JACKIE ASENCIO
3975 VIRGINIA MALLORY DR STE 1
CHANTILLY VA 20151

Group ID: **12144703**
Insurance Carrier: Vision Service Plan
Insurance Carrier NAIC Code: 53031
Insurance Carrier FEIN: **237089668**
Benefit Type: Vision Care
Policy or Contract Year: **01/01/2023 - 12/31/2023**

Group Legal Name and Address:

C2 ESSENTIALS, INC.
3975 VIRGINIA MALLORY DR STE 1
CHANTILLY VA 20151

Approximate Number of Persons Covered at the End of Policy or Contract Year: **496**

Payments:

Total Administrative Fees Paid to Carrier:	**$ 12,208.93**
Total Payments Made to Carrier:	**$ 62,609.54**
Total Claims Paid by Carrier:	**$ 44,408.69**

Insurance Fees and Commissions Paid to Agents and Brokers:

Agent or Broker	Commissions/Fees **Paid for Policy or Contract Year**
HUB International Mid-Atlantic Inc **3290 N RIDGE RD STE 300** **ELLICOTT CITY MD 21043-3668**	**$1,879.05**

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 07/29/2024 .

EXDM5500/ U-3909 / 12144703 / 1 / 20240729

Delta Dental of Virginia
5415 Airport Road
Roanoke, VA 24012

C2 ESSENTIALS, INC.
-

DELTA DENTAL

Schedule A (Form 5500)
Insurance Information

FORM 5500:

No of employees at the end of the year	**584**
Number of enrollees (including dependents) at end of year	**1,143**

Schedule A (Form 5500)

Insurance Information

A Name of the Plan : Prepaid Dental Care Plan

C Plan Sponsors Name : **C2 ESSENTIALS, INC.**

Part I Information Concerning Insurance Contract Coverage, Fees and Commissions

1 Coverage Information

a Enter Name : Delta Dental of Virginia

b EIN : 540844477

c NAIC : 55611

d Contract Number : 00000006105

e Approximate number of persons covered at end of policy or contract year 1,143

Policy or Contract Year

f From : 1/1/2023

g To : 12/31/2023

2 Insurance Fee and Comission Information

a Total Amount of Comissions Paid : $12,718.25

3

(a) Name	(b) Address	(c) Comissions Paid	(d) Type
Hub International Mid-Atlantic, Inc.	1445 Research Blvd Ste 340 Rockville, MD 20850	$12,718.25	3

Part II Insured pension plans

Not Applicable

Part III Welfare Benefit Contract Information

7 Benefit and Contract Type

b Dental

DELTA DENTAL

Schedule A (Form 5500)
Insurance Information

8 Experience-rated Contracts

a	**Premiums**			
	I	Amount Received	: $430,212.20	
	II	Increase (decrease) in amount due by unpaid	: 0	
	III	Increase (decrease) in unearned premium reserve	: 0	
	IV	Earned ((I + II) - III)		: $430,212.20
b	**Benefit Charges**			
	I	Claims Paid	: $328,075.02	
	II	Increase (decrease) in claims reserves	: $950.95	
	III	Incurred claims (add I + II)	: $329,025.97	
	IV	Claims Charged		: $329,025.97
c	**Remainder of Premium**			
	I	Retention Charges (on accrual basis)		
		A Commissions	: $12,718.25	
		B Administrative Service or other fees	: $69,694.38	
		C Other specific acquisition costs	: 0	
		D Other expenses	: 0	
		E Taxes	: 0	
		F Charges for risks and other contingencies	: $8,604.24	
		G Other retention charges	: 0	
		H Total Retention		: $91,016.87
	II	Dividends or retroactive rate refunds		
d	**Status of policyholder reserves at the end of year**			
	I	Amount held to provide benefits after retirement	: 0	
	II	Claim reserves	: $16,731.83	
	III	Other Reserves	: 0	

9 Non experienced rated contracts

a	Total premiums or subscription charges paid to carrier	: N/A
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy other than reported in Part I, item 2 above, report amount.	: N/A

DELTA DENTAL

Schedule A (Form 5500)
Insurance Information

Filter Selections Applied

Top Account ID Selections: 00000006105

Top Account Name Selections: C2 ESSENTIALS, INC.

Sub Account ID Selections: All

Sub Account Name Selections: All

Sub Sub Account ID Selections: All

Sub Sub Account Name Selections: All

Benefit Plan Name Selections: All

Member Employment Status Selections: All

Department Name Selections: All

Member Employee Type Selections: All

Member Union Status Selections: All