

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 09/01/2023 and ending 08/31/2024

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan... [X] a single-employer plan [] a DFE... B This return/report is: [] the first return/report [] the final return/report... C If the plan is a collectively-bargained plan... D Check box if filing under: [] Form 5558 [] automatic extension... E If this is a retroactively adopted plan...

Part II Basic Plan Information—enter all requested information

1a Name of plan THE REILY COMPANIES GROUP MEDICAL PLAN 1b Three-digit plan number (PN) 501 1c Effective date of plan 05/15/1992 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address... 2b Employer Identification Number (EIN) 72-1226188 2c Plan Sponsor's telephone number 504-799-1520 2d Business code (see instructions) 541600

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes entries for Tiffany Fagg on 05/09/2025.

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2023) v. 230707

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>																				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																				
5 Total number of participants at the beginning of the plan year	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">5</td> <td style="text-align: right;">997</td> </tr> </table>	5	997																		
5	997																				
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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">6a(1)</td> <td></td> </tr> <tr> <td style="text-align: center;">6a(2)</td> <td style="text-align: right;">903</td> </tr> <tr> <td style="text-align: center;">6b</td> <td></td> </tr> <tr> <td style="text-align: center;">6c</td> <td></td> </tr> <tr> <td style="text-align: center;">6d</td> <td style="text-align: right;">903</td> </tr> <tr> <td style="text-align: center;">6e</td> <td></td> </tr> <tr> <td style="text-align: center;">6f</td> <td style="text-align: right;">903</td> </tr> <tr> <td style="text-align: center;">6g(1)</td> <td></td> </tr> <tr> <td style="text-align: center;">6g(2)</td> <td></td> </tr> <tr> <td style="text-align: center;">6h</td> <td></td> </tr> </table>	6a(1)		6a(2)	903	6b		6c		6d	903	6e		6f	903	6g(1)		6g(2)		6h	
6a(1)																					
6a(2)	903																				
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6c																					
6d	903																				
6e																					
6f	903																				
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">7</td> <td></td> </tr> </table>	7																			
7																					

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
 4A 4D 4E

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor
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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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u> 1 </u> (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

(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

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year..... **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

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

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

a Type of contract: (1) deposit administration (2) immediate participation guarantee
 (3) guaranteed investment (4) other ▶

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits **7c(2)**
 (3) Interest credited during the year **7c(3)**
 (4) Transferred from separate account..... **7c(4)**
 (5) Other (specify below) **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier **7e(2)**
 (3) Transferred to separate account..... **7e(3)**
 (4) Other (specify below) **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3)).....		9a(4)
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2)).....		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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	1011544
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. ▶

**INSURANCE INFORMATION - WELFARE PLAN
DEPARTMENT OF LABOR FORM 5500
SCHEDULE A-PARTS I AND III
INFORMATION CERTIFIED BY CARRIER**

GROUP INSURANCE PLAN OF
The Reily Companies, LLC
PRINCIPAL ADDRESS

For Policy Year Beginning **September 1, 2023** And Ending **August 31, 2024**

1. Coverage Information:

(a) Name of Insurance carrier **UnitedHealthcare Insurance Company**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or Contract Year	
				(f) From	(g) To
36-2739571	79413	717391	903	09/01/23	08/31/24

3. Persons receiving commissions and fees.¹

(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) Organizational Code
		(c) Amount	(d) Purpose	
None	None	None	N/A	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	(c) Amount	(d) Purpose	(e) Organizational Code
None	None	None	N/A	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	(c) Amount	(d) Purpose	(e) Organizational Code
None	None	None	N/A	3

8. Benefit and contract type²

	List gross premium for each benefit and contract type	Premium rate or subscription charge
Stop Loss	\$965,024	Rates have been established in accordance with our customary rate review practices which take into consideration all risks in this category.
Spectera Vision	\$46,520	

10. Non experienced rated contracts:

(a) Total premium or subscription charges paid to carrier	\$1,011,544
(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in 3 above, report amount specify nature of costs →	NONE

The above information is hereby certified to be complete and accurate according to the Carrier's records.

Andrea Tavares
(Underwriting Signature)

Dated: 12/2/2024

1. This information furnished to the Policyholder for completion of item 3 of part I, Schedule A, of Form 5500. These are commissions charged to the policy for the policy year, but not necessarily those paid during that period.

2. These employer contracts with premiums paid exclusively out of the employer's general assets without any employee contributions generally are not paid assets and are not reportable on Schedule A.

Ref # 5500-02

**DATA FOR PLANS FOR WHICH BENEFITS ARE PROVIDED
ON OTHER THAN AN INSURED BASIS**

The information set forth below is furnished to the Contractholder to assist in the completion of U. S. Department of Labor Annual Return/Report Form 5500

Name of Contractholder: The Reily Companies, LLC

Contract Number: 717391

Data for Period Beginning September 1, 2023 and Ending August 31, 2024

Form 5500 Schedule C Part 1, Line 2 Information on Service Providers Receiving Direct or Indirect Compensation

2(a)		United Healthcare Services, Inc.		EIN: 41-1289245		
(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan *	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
12, 49	Claims Processor	\$415,441	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Refer to Footnotes

2(a)

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

2(a)

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

2(a)

(b) Service codes	(c) Relationship to employer	(d) Direct compensation paid by the plan	(e) Was any indirect Compensation received	(f) Did indirect compensation include eligible indirect compensation	(g) Enter total indirect compensation excluding 2 (f)	(h) Is a formula being provided in lieu of/in addition to 2 (g)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

*2(d) Administrative Service Fee Includes Dental

Footnotes - 2(h) Formula

Consistent with and as described in the administrative services agreement (ASA) between The Reily Companies, LLC and United Healthcare Services, Inc. (UnitedHealthcare), and in addition to direct compensation that the Plan may pay UnitedHealthcare for prescription drugs and prescription drug services, UnitedHealthcare has received certain indirect compensation for its pharmacy management services related to the plan as follows:

- Manufacturer rebate amounts retained by UnitedHealthcare. The rebate share percentages are agreed to by the Plan and are specified in the ASA. The actual rebate amounts from manufacturers can vary depending on benefit design and other factors, and most often range from \$1.35 to \$2.35 PMPM for prescription drug products dispensed under the Plan's medical benefit. UnitedHealthcare may also retain interest earned on the rebate amounts that are returned to the Plan as specified in the ASA.