

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: a multiemployer plan, a multiple-employer plan (checked), 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: PRIVIA MEDICAL GROUP HEALTH PLAN; 1b Three-digit plan number (PN): 501; 1c Effective date of plan: 01/01/2017; 2a Plan sponsor's name (employer, if for a single-employer plan): PRIVIA MANAGEMENT COMPANY, LLC PRIVIA MEDICAL GROUP; 2b Employer Identification Number (EIN): 46-2957617; 2c Plan Sponsor's telephone number: 571-366-8850; 2d Business code (see instructions): 621111

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 rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	398
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.....	6a(1)	398
	6a(2)	359
	6b	0
	6c	0
	6d	359
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

9a Plan funding arrangement (check all that apply)	9b 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 checked="" type="checkbox"/> General assets of the sponsor	(4) <input checked="" 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)

a Pension Schedules	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>1</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 160934503

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</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>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan PRIVIA MEDICAL GROUP HEALTH PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 PRIVIA MANAGEMENT COMPANY, LLC PRIVIA MEDICAL GROUP	D Employer Identification Number (EIN) 46-2957617	

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
ANTHEM HEALTH PLANS OF VIRGINIA, INC.

(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
54-0357120	71835	VA2087	359	01/01/2024	12/31/2024

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))			7d	0
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	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)		
	(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)	0
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)	0
	(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)	0
	(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		288298
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. ▶

Attachment to 2020 Form 5500
Form 5500 Multiple Employer Plan Participating Employer Information

Privia Medical Group Health Plan 46-2957617

Plan Name EIN: Privia Management Company, LLC Privia Medical Group 501

Plan Sponsor's Name PN:

Name of participating employer	EIN
MARPEL - RESTON PELVIC SURGERY ASSOCIATES	92-3210560
AFOB - ALL FEMALE OBGYN LLC	46-5448417
SQU - RICHARD SQUIRES, MD	02-0611622
MCMAN - CP & RP MCMANUS MD, LTD	54-1049773
IVY - IVY COLLABORATIVE HEALTHCARE, LLC	83-4528994
BARB - BARBARA A STEVENS MD PC	90-3691520
BFM - BATTLEFIELD FAMILY MEDICINE	54-1789568
AAA - ALLERGY AND ASTHMA ASSOCIATES	54-1616890
AACC - ALLERGY AND ASTHMA CARE CENTER	01-0757419
AAPC - ALEXANDRIA ADULT PRIMARY CARE LLC	34-2041017
ABD - ABDOW FRIENDSHIP PEDIATRICS	52-2281896
ACAA - POTOMAC ALLERGY & ASTHMA, P.C.	54-1746910
ACFM - ALBEMARLE CENTER FOR FAMILY MEDICINE	85-3771784
ADSU - ADVANCED SURGERY	52-0945442
AIM - ALBANY INTERNAL MEDICINE	58-2423695
AMA - ATLANTIC MEDICAL ASSOCIATES	54-2000795
AVSC - ALBANY VASCULAR SPECIALIST	90-0349584
BERN - RICHARD A. BERNSTEIN, MD	52-2184999
BPED - BE PEDIATRICS, LLC	46-4872965
BPEDS - BLACKSBURG PEDIATRICS	81-2816349
CAPMC - CAPSTONE MEDICAL CLINIC LLC	86-2884724
CHMMD - CLAUDIA METHVIN, MD, PLLC	41-2123551
CHUH - GASTROENTEROLOGY CONSULTANTS OF NORTHERN VA	20-2265068
CLAR - CLARII HEALTH	46-5445510
CTGP - COLEMAN PEDIATRICS	52-1075359
DFH - DOMINION FAMILY HEALTHCARE	57-1228685
DUPONT- DUPONT CIRCLE PHYSICIANS GROUP	52-1631021
FAIR - FAIR RIDGE OB/GYN ASSOCIATES	54-1997813
FAME - FAMILY MEDICINE SPECIALISTS P.C.	58-2318806
FPAT - FAMILY PRACTICE ASSOCIATES OF TIFTAREA, LLC	58-2566318
FREK - FREKKO PRIMARY CARE	20-4022387
GABLL - BULLOCH FAMILY PRACTICE, LLC	93-2053486
GAHBH - HORIZON BEHAVIORAL HEALTH	27-3385970
GATRIIP - TRINITY PRIMARY CARE, LLC	92-1894120
GHMMD - GARY H. MILLER, MD PLLC	82-0956624

GRADY - MICHAEL GRADY, MD	52-2197851
GWUC - GOWELL URGENT CARE, LLC	83-2219887
HMHB - HIGH MOUNTAIN HEALTHCARE LLC	20-8504885
INDFAM - INDIGO FAMILY HEALTH, LLC	86-2599666
JSMD - JCSTANFORD MD	85-3863444
KARL - KARL A SPECTOR MD	52-2297415
KELLY - KELLY COLLABORATIVE MEDICINE	81-3121643
LANG - DR. MONIQUE Y. LANGSTON & ASSOCIATES PA	52-2287700
LFM - LIFETIME FAMILY MEDICINE	20-4670312
LOKA - LORI M. KALER, MD	52-2030058
MACHF - CHICKAHOMINY FAMILY PRACTICE, INC.	54-1486119
MACODE - CODE MED URGENT CARE	92-3798950
MANHP - NEUROLOGY, HEADACHE & PAIN INSTITUTE	87-4164635
MANXDO - THE DOC NEXT DOOR, PLLC	88-4284919
MAPMAN - Premier Medicine of Chevy Chase, MD	88-3629168
MAREV - REVOLUTION HEALTHCARE, LLC	88-2315050
MASLEN - DR. THOMAS E. MASLEN, MD, LLC	75-2980715
MAVHW - The VA Health and Wellness	87-2690286
MAVPM - PRISMAMED SERVICES LLC	46-2097791
MCFAR - SALLY MCFARLAND MD PC	45-2043978
MFM - MIDDLEBROOK FAMILY MEDICINE	27-0355317
MIDA - MONTGOMERY INFECTIOUS DISEASE ASSOCIATES	52-0985346
MILLER - A. LARRY MILLER MD	54-1125081
NUNN - SUZANNE L NUNN MD PC	75-3114918
NVAEN - NORTHERN VIRGINIA ENDOCRINOLOGISTS INC	54-1049773
OMP - OWINGS MILLS PEDIATRICS	52-0900362
PRIPED - PRIMARY PEDIATRICS	52-0898180
ROAPH - ROANOKE PARTNERS IN HEALTH PC	27-1606402
ROCK - ROCKWELL PHYSICIANS OF SALISBURY PLLC	20-5307304
ROHE - ROCKBRIDGE HEALTH	45-3244742
SAM - STEVEN J ADASHEK MD PA	35-2213441
SAVPED - SAVANNAH PEDIATRICS PC	58-1108800
SGP - SOUTHWEST GEORGIA PEDIATRICS PC	58-1403593
SPC - SCREVEN PRIMARY CARE, LLC	85-3813504
SUES - PROSPERITY PRIMARY CARE	82-3299532
SURI - NOVA PHYSICIAN WELLNESS CENTER	27-3622833
TATE - TATE MEDICAL ASSOCIATES, LLC	45-5571029
TFM - THOMASVILLE FAMILY MEDICINE CENTER	58-1404127
VERA - VERANDA MEDICAL GROUP, LLC	58-1090380
VHNS - VIRGINIA HEAD AND NECK SURGEONS PC	04-3827664
WAC - WILLIAM A. CONDRELL, MD PC	37-1461394
WOG - WINCHESTER OBSTETRICS & GYNECOLOGY	54-1146009

