

|   |   |   |
|---|---|---|
| <p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor<br/>Employee Benefits Security<br/>Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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 style="text-align: center;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p> | <p style="font-size: x-small;">OMB Nos. 1210-0110<br/>1210-0089</p> <hr/> <p style="font-size: large; text-align: center;"><b>2024</b></p> <hr/> <p style="text-align: center;"><b>This Form is Open to Public Inspection</b></p> |
|---|---|---|

**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 (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>COPPER STATE CREDIT UNION EMPLOYEE WELFARE PLAN</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>COPPER STATE CREDIT UNION</u></p> <p><u>15458 N 28TH AVE</u><br/><u>PHOENIX, AZ 85053-4062</u></p> | <p><b>1c</b> Effective date of plan<br/><u>01/01/2024</u></p> <p><b>2b</b> Employer Identification Number (EIN)<br/><u>86-6050693</u></p> <p><b>2c</b> Plan Sponsor's telephone number<br/><u>623-580-6000</u></p> <p><b>2d</b> Business code (see instructions)<br/><u>522130</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. | 07/10/2025 | AMY SINGPRADITH  |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 07/10/2025 | AMY SINGPRADITH  |
|                  | 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>                                   | 124 |
| <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>                               | 124 |
|   | <b>6a(2)</b>                               | 98  |
|   | <b>6b</b>                                  |     |
|   | <b>6c</b>                                  |     |
|   | <b>6d</b>                                  | 98  |
|   | <b>6e</b>                                  |     |
|   | <b>6f</b>                                  | 98  |
|   | <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>                                   |     |

**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 4B 4H 4F

|   |   |
|---|---|
| <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>4</u> |
| (4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____  | (4) <input 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

**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 \_\_\_\_\_

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|   |  |  |
|---|--|--|
| <p style="text-align: center;"><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p style="font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">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 style="font-size: large;"><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|  |   |  |
|--|---|--|
| <p><b>A</b> Name of plan<br/><span style="color: blue;">COPPER STATE CREDIT UNION EMPLOYEE WELFARE PLAN</span></p>                   | <p><b>B</b> Three-digit plan number (PN) ▶</p>  | <p><span style="color: blue;">501</span></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><span style="color: blue;">COPPER STATE CREDIT UNION</span></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><span style="color: blue;">86-6050693</span></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

| (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         | 00627679                              | 98  |                         |        |

**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</p> <p style="color: blue;">36462</p> | <p><b>(b)</b> Total amount of fees paid</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                      7639 E PINNACLE PEAK #100  
SCOTTSDALE, AZ 85255

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 36462   |                                 |             | 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.

|  |          |  |
|--|----------|--|
| <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:

**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>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> |  |              |  |
| (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:   |              |  |              |  |
|  | <b>7e(1)</b> |  |              |  |
|  | <b>7e(2)</b> |  |              |  |
|  | <b>7e(3)</b> |  |              |  |
|  | <b>7e(4)</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>    |                 |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |                 |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |                 |
|          | (4) Earned ((1) + (2) - (3)) .....   |                 | <b>9a(4)</b>    |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |                 |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |                 |
|          | (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b>    |
|          | (4) Claims charged .....   |                 | <b>9b(4)</b>    |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |                 |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> |                 |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |                 |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |                 |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |                 |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |                 |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |                 |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> |                 |
|          | (H) Total retention .....  |                 | <b>9c(1)(H)</b> |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   |                 | <b>9d(1)</b>    |
|          | (2) Claim reserves .....   |                 | <b>9d(2)</b>    |
|          | (3) Other reserves .....   |                 | <b>9d(3)</b>    |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  |                 | <b>9e</b>       |

**10** Nonexperience-rated contracts:

|          |  |            |        |
|----------|--|------------|--------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 312529 |
| <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> |        |

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

**2024**

**This Form is Open to Public Inspection**

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

|   |  |  |
|---|--|--|
| <b>A</b> Name of plan<br><b>COPPER STATE CREDIT UNION EMPLOYEE WELFARE PLAN</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>COPPER STATE CREDIT UNION</b> |  | <b>D</b> Employer Identification Number (EIN)<br><b>86-6050693</b> |

**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**

| <b>(b)</b> EIN    | <b>(c)</b> NAIC code | <b>(d)</b> Contract or identification number | <b>(e)</b> Approximate number of persons covered at end of policy or contract year | <b>Policy or contract year</b> |                   |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
|                   |                      |  |  | <b>(f)</b> From                | <b>(g)</b> To     |
| <b>59-1031071</b> | <b>67369</b>         | <b>0627679</b>                               | <b>114</b>   | <b>01/01/2024</b>              | <b>12/31/2024</b> |

**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.

|   |                                      |
|---|--------------------------------------|
| <b>(a)</b> Total amount of commissions paid<br><b>11552</b> | <b>(b)</b> Total amount of fees paid |
|---|--------------------------------------|

**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** **7639 E PINNACLE PEAK RD #100**  
**SCOTTSDALE, AZ 85255**

| <b>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> Purpose |                              |
| <b>11552</b>   |  |                    | <b>3</b>                     |

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

| <b>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> 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.

|  |          |  |
|--|----------|--|
| <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:

**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>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>              |              |           |  |
|  | (6) Total additions ..... |              |           |  |
| <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:   |                           |              |           |  |
|  | <b>7e(1)</b>              |              |           |  |
|  | <b>7e(2)</b>              |              |           |  |
|  | <b>7e(3)</b>              |              |           |  |
|  | <b>7e(4)</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>    |                 |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |                 |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |                 |
|          | (4) Earned ((1) + (2) - (3)) .....   |                 | <b>9a(4)</b>    |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |                 |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |                 |
|          | (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b>    |
|          | (4) Claims charged .....   |                 | <b>9b(4)</b>    |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |                 |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> |                 |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |                 |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |                 |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |                 |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |                 |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |                 |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> |                 |
|          | (H) Total retention .....  |                 | <b>9c(1)(H)</b> |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   |                 | <b>9d(1)</b>    |
|          | (2) Claim reserves .....   |                 | <b>9d(2)</b>    |
|          | (3) Other reserves .....   |                 | <b>9d(3)</b>    |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  |                 | <b>9e</b>       |

**10** Nonexperience-rated contracts:

|          |  |            |        |
|----------|--|------------|--------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 117484 |
| <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> |        |

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. ▶



(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.

|  |          |  |
|--|----------|--|
| <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:

**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>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>              |              |           |  |
|  | (6) Total additions ..... |              |           |  |
| <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:   |                           |              |           |  |
|  | <b>7e(1)</b>              |              |           |  |
|  | <b>7e(2)</b>              |              |           |  |
|  | <b>7e(3)</b>              |              |           |  |
|  | <b>7e(4)</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>    |                 |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |                 |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |                 |
|          | (4) Earned ((1) + (2) - (3)) .....   |                 | <b>9a(4)</b>    |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |                 |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |                 |
|          | (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b>    |
|          | (4) Claims charged .....   |                 | <b>9b(4)</b>    |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |                 |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> |                 |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |                 |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |                 |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |                 |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |                 |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |                 |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> |                 |
|          | (H) Total retention .....  |                 | <b>9c(1)(H)</b> |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   |                 | <b>9d(1)</b>    |
|          | (2) Claim reserves .....   |                 | <b>9d(2)</b>    |
|          | (3) Other reserves .....   |                 | <b>9d(3)</b>    |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  |                 | <b>9e</b>       |

**10** Nonexperience-rated contracts:

|          |  |            |       |
|----------|--|------------|-------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 82434 |
| <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> |       |

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. ▶



(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.

|  |          |  |
|--|----------|--|
| <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:

**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>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>               |  |           |  |
|  | (6) Total additions .....  |  |           |  |
| <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<br>(2) Administration charge made by carrier.....<br>(3) Transferred to separate account ..... | <b>7e(1)</b>               |  |           |  |
|  | <b>7e(2)</b>               |  |           |  |
|  | <b>7e(3)</b>               |  |           |  |
|  | <b>7e(4)</b>               |  |           |  |
|  | (5) Total deductions ..... |  |           |  |
| <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>    |                 |
|          | (2) Increase (decrease) in amount due but unpaid .....   | <b>9a(2)</b>    |                 |
|          | (3) Increase (decrease) in unearned premium reserve .....  | <b>9a(3)</b>    |                 |
|          | (4) Earned ((1) + (2) - (3)) .....   |                 | <b>9a(4)</b>    |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    |                 |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    |                 |
|          | (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b>    |
|          | (4) Claims charged .....   |                 | <b>9b(4)</b>    |
| <b>c</b> | Remainder of premium: (1) Retention charges (on an accrual basis) --   |                 |                 |
|          | (A) Commissions .....  | <b>9c(1)(A)</b> |                 |
|          | (B) Administrative service or other fees .....   | <b>9c(1)(B)</b> |                 |
|          | (C) Other specific acquisition costs .....   | <b>9c(1)(C)</b> |                 |
|          | (D) Other expenses .....   | <b>9c(1)(D)</b> |                 |
|          | (E) Taxes .....  | <b>9c(1)(E)</b> |                 |
|          | (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |                 |
|          | (G) Other retention charges .....  | <b>9c(1)(G)</b> |                 |
|          | (H) Total retention .....  |                 | <b>9c(1)(H)</b> |
|          | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |
| <b>d</b> | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....   |                 | <b>9d(1)</b>    |
|          | (2) Claim reserves .....   |                 | <b>9d(2)</b>    |
|          | (3) Other reserves .....   |                 | <b>9d(3)</b>    |
| <b>e</b> | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....  |                 | <b>9e</b>       |

**10** Nonexperience-rated contracts:

|          |  |            |       |
|----------|--|------------|-------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 13604 |
| <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. ....<br>Specify nature of costs. | <b>10b</b> |       |

**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. ▶



Copper State Credit Union  
Amy Singpradith  
15458 N 28th Avenue

Phoenix AZ 85053

Dear Employer:

Enclosed is the information you may need to complete and file Form 5500 with the Internal Revenue Service (IRS). Plans that are required to file the 5500 series forms must do so within a specified time period following the end of their plan year.

The Form 5500 series filing requirements are highly technical. It is your responsibility as plan sponsor to determine with your tax or legal advisor whether and when your plan is required to file a Form 5500 and any of the attendant schedules.

The information we provide for your use in preparing Schedule A and/or Schedule C of Form 5500 reflects premiums or compensation received and posted during the timeframes noted and may be adjusted in the future.

The amounts reported may not reconcile with your accounting due to timing.

Compensation for Service and / or General Agent Agreements are reflected on Schedule A and C reporting but may not have been directly paid to the producer by the Plan. Please note that even though these additional payments are associated with your plan for reporting purposes, the expenses associated with the payments may not impact your specific case level rates and premiums.

If you have any questions regarding the information provided, please contact Cigna at [SelectUnderwritingOperationsSupport@Cigna.com](mailto:SelectUnderwritingOperationsSupport@Cigna.com). For questions regarding the preparation of the Form 5500 consult your tax or legal advisor.

Sincerely,

Cigna

"Cigna Healthcare" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by The Cigna Group and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by The Cigna Group. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Sys 2/9/2025



# Cigna

## INFORMATION FOR COMPLETING SCHEDULE C ON THE IRS FORM 5500

*This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule C, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.*

**For Plan Year Beginning:** January 01, 2024 **and Ending:** December 31, 2024  
**Name of Plan:** Copper State Credit Union

### SCHEDULE C - SERVICE PROVIDER INFORMATION:

| Service Provider                        | EIN#       | Administration fees paid to the service provider * |
|---|------------|--|
| Cigna Health and Life Insurance Company | 59-1031071 | \$11,106.38  |

The following amounts were paid to your broker(s) and/or consultant(s) during the plan year:

**Commissions:** \$36,462.45  
**Service / Gen. Agent Fees:** \$0.00

**Incentive Compensation Payments based on membership in your plan/or lump sum amount:** \$0.00

**Incentive Compensation Payments are funded by the Service Provider. Contact your broker(s)/consultant(s) for details.**

\*This amount includes administrative service fees for reporting period and other fees paid by the plan, known as "Direct Compensation" as applicable.

If you have a CHLIC administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium/commissions) where applicable.

**Direct Compensation\*\* for calendar year 2024 :** \$2,840.25

\*\*Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

Direct compensation amount does not include the following compensation received, if any, by affiliated companies:

- Plan benefit payments, if any, made to eviCore
- Utilization management fees paid to eviCore
- Plan benefit payment made to Evernorth Care Solutions, Inc. or Evernorth Behavioral Health, Inc.
- Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

The amount of such compensation, if any, with respect to your plan is available upon request.

The Service Provider may have received indirect compensation and eligible indirect compensation associated with your plan. Sources of indirect compensation and eligible indirect compensation will follow if applicable.

Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:

- eviCore
- Evernorth Care Solutions, Inc.
- Evernorth Behavioral Health, Inc.
- Cigna HealthCare of Arizona, Inc. (Cigna Medical Group)



(a) Service provider name: **Cigna**

(b) Service codes:

**12 Claim Processing**

**38 Participant communications**

**50 Direct payments from the Plan**

**13 Contract Administrator**

**49 Other Services**

**56 Non-monetary compensation**

**31 Named fiduciary - (if indicated in ASO Agreement)**

**62 Float Revenue**

(c) Amount of indirect compensation: **\$0 (see formula/estimate provided below)**

(d) Name and EIN (address) of source of indirect compensation:

**Omada Complete, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015**

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Omada Diabetes and Hypertension Cigna – Indirect compensation received by Cigna from this provider for services including:

(i) explaining the availability of Omada Covered Services to CHLIC existing and prospective clients; (ii) encouraging the use of Omada Covered Services by Screened Participants that CHLIC has identified as potentially benefitting from the Omada Covered Services, and (iii) enrollment of Screened Participants in the Omada Covered Services.

Indirect Compensation Formula/Estimate:

For calendar year 2024, Cigna received indirect

compensation from this vendor of approximately \$0.18 per participant. (Determined by dividing total

compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor

(excluding Shared Administration Repricing "SAR")

Effective Date: **1/1/2024**

Cancel Date: **xx/xx/xxxx**

# Cigna

## Plan Detail Report

The following information will assist you in completing the Schedule A with respect to your Cigna insurance policy.

For Plan Year Beginning: January 01, 2024

and Ending: December 31, 2024

Name of Plan: Copper State Credit Union

Plan #: 00627679

### PREMIUMS PLAN DETAIL

| <u>BENEFIT</u> | <u>PREMIUMS</u>     | <u>ADMIN FEES*</u> | <u>TERMINATION PREMIUM</u> | <u>TERMINATION FEES</u> | <u>STATE CONTINUATION FEES</u> | <u>TOTAL PAID</u>   |
|----------------|---------------------|--------------------|----------------------------|-------------------------|--------------------------------|---------------------|
| MEDICAL        | \$312,529.18        | \$44,728.58        | \$0.00                     | \$0.00                  | \$0.00                         | \$357,257.76        |
| <b>TOTALS</b>  | <b>\$312,529.18</b> | <b>\$44,728.58</b> | <b>\$0.00</b>              | <b>\$0.00</b>           | <b>\$0.00</b>                  | <b>\$357,257.76</b> |

### COMMISSIONS PAID DETAIL

| <u>BENEFIT</u> | <u>TOTAL COMM PAID</u> | <u>BROKER ACCT#</u> | <u>BROKER NAME</u>                |
|----------------|------------------------|---------------------|-----------------------------------|
| MEDICAL        | \$36,462.45            | 536594              | PATRIOT GROWTH INSURANCE SERVICES |
| <b>TOTAL</b>   | <b>\$36,462.45</b>     |                     |                                   |

### BENEFIT ADVISOR FEE PAID DETAIL

| <u>BENEFIT</u> | <u>TOTAL FEES</u> | <u>BROKER ACCT#</u> | <u>BROKER NAME</u> |
|----------------|-------------------|---------------------|--------------------|
| <b>TOTAL</b>   |                   |                     |                    |

### SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

| <u>BENEFIT</u> | <u>TOTAL FEES</u> | <u>BROKER ACCT#</u> | <u>BROKER NAME</u> |
|----------------|-------------------|---------------------|--------------------|
| <b>TOTAL</b>   |                   |                     |                    |

### INCENTIVE COMPENSATION PAYMENTS BASED ON MEMBERSHIP IN YOUR PLAN/OR LUMP SUM AMOUNT

| <u>TOTAL PAID</u> | <u>BROKER ACCT#</u> | <u>BROKER NAME</u> |
|-------------------|---------------------|--------------------|
| <b>TOTAL</b>      |                     |                    |

### EXPOSURES DETAIL (Last Month of the Plan Period)

| <u>BENEFIT</u> | <u>EMPLOYEE</u> | <u>DEPENDENT</u> | <u>SPOUSE</u> | <u>FAMILY</u> | <u>CHILD</u> |
|----------------|-----------------|------------------|---------------|---------------|--------------|
| MEDICAL        | 98              | 0                | 16            | 22            | 12           |

\*Admin Fees Include Commissions

Sys 2/9/2025



10 Hudson Yards  
New York, NY 10001  
guardianlife.com

AMY SINGPRADITH  
COPPER STATE CREDIT UNION  
15458 N 28TH AVENUE  
PHOENIX, AZ 85053

**March 12, 2025**

Plan Number : 00512364  
Anniversary Date : 1/1/25

To help you with the preparation of your form 5500 (Annual Return / Report of Employee Benefit Plan ERISA) for filing with the Department of Labor, we are providing the following information.

You are required to transfer the information from this form to the appropriate schedule, forming Part of the 5500 form furnished by the United States Department of Labor. You will also need Guardian's Tax ID (EIN) and NAIC numbers, which are as follows :

EIN : 13-5123390

NAIC: 64246

A copy of this form should be retained for your records.

Certified to be correct

The Guardian Life Insurance Company of America.

1-800-459-9401



Name of Plan : **COPPER STATE CREDIT UNION**

Plan Number : **00512364**

Data for Period From : **1/1/24** To : **12/31/24**

The approximate number of employees covered at the end of the plan year : 135

Group Insurance coverage(s) included under this Plan :

AD&D, Life, Long Term Disability, Optional AD&D, Optional Life, Short Term Disability (Insured)

The following figure represents commissions that are to be reported on Schedule A, Line 3, Element (b):

| Contract Identification | Name and Address of Recipient of Commissions   |                  |
|-------------------------|--|------------------|
| 000RT375                | PATRIOT GROWTH INSURANCE SERVI<br>7639 E PINNACLE PEAK RD STE 10 SCOTTSDALE AZ 85255 |                  |
|                         | Group Insurance Coverage(s)<br>For Above Contract                                    | Commissions Paid |
|                         | AD&D   | 382.96           |
|                         | Life   | 2,552.89         |
|                         | Long Term Disability   | 1,771.03         |
|                         | Optional AD&D  | 176.00           |
|                         | Optional Life  | 1,757.57         |
|                         | Short Term Disability (Insured)  | 1,712.49         |
|                         | <b>Total For Contract:</b>   | <b>8,352.94</b>  |
|                         | <b>Total Commissions Paid On Plan:</b>   | <b>8,352.94</b>  |

The following figure represents fees that are to be reported on Schedule A, Line 3, Element (c):

| Contract Identification | Name of Recipient of Fees | Amount |
|-------------------------|---------------------------|--------|
|                         |                           |        |
|                         | <b>Total Fees Paid</b>    |        |

However, the compensation listed above is not charged to your case in calculating new rates.

| Recipient of One Time Reimbursement | Amount Paid             |
|-------------------------------------|-------------------------|
|                                     |                         |
|                                     | <b>Total Fees Paid:</b> |



| Group Insurance Coverage(s)<br>For Above Contract          | Gross Premium Paid |
|--|--------------------|
| AD&D   | 3,452.94           |
| Life   | 32,800.62          |
| Long Term Disability                                       | 11,806.89          |
| Optional AD&D  | 1,353.94           |
| Optional Life  | 13,519.58          |
| Short Term Disability (Insured)                            | 19,499.93          |
| <b>Totals:</b>   | <b>82,433.90</b>   |
| <b>Premium due and unpaid at<br/>the end of plan year:</b> | <b>0</b>           |

**Name of Plan:** COPPER STATE CREDIT UNION

**Plan Number:** 00512364

*The following figure represents Indirect Compensation to be reported on Schedule C, Part 1, 3, Elements (a & c)*

| <b>Contract Identification (a)</b> | <b>Name and Address of Recipient of Indirect Compensation (a)</b> | <b>Amount (c)</b> |
|------------------------------------|---|-------------------|
|                                    |   |                   |
|                                    |   |                   |
|                                    | <b>Total Indirect Compensation Paid:</b>                          |                   |

*The following is for Indirect Compensation information to be reported on Schedule C, Part 1, 3, Elements (b, d & e)*

| <b>Service Code (b)</b> | <b>Name and Address (d)</b> | <b>Indirect Compensation (e)</b> |
|-------------------------|-----------------------------|----------------------------------|
|                         |                             |                                  |

**Data for ERISA - VISION SCHEDULE A - FORM 5500**

Plan Year: January 1, 2024 Ending: December 31, 2024

Group Name: Copper State Credit Union  
Group Number: 37075V

Name of Insurance Carrier: Delta Dental of Arizona  
Employer Identification Number: 86-0274899  
NAIC Code: 053597

Number of Persons Covered at End of Contract: 239

Insurance fees and commissions paid to Agents, Brokers and Other Persons

Total amount of commissions/fees paid: \$1,358.42

Agent(s): \$1,358.42

Name of Agency Patriot Growth Insurance Services, LLC  
Agency Address 7639 E Pinnacle Peak Rd #100  
Agency Address Scottsdale, AZ 85255

Non-Experience-Rated Contract Total Premium Earned \$13,603.97