

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

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.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2020 and ending 12/31/2020

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE, the first return/report, the final return/report, an amended return/report, a short plan year return/report.
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report.
C If the plan is a collectively-bargained plan, check here.
D Check box if filing under: Form 5558, automatic extension, special extension, the DFVC program.
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: PACIFIC ARCHITECTS AND ENGINEERS, LLC SELF-INSURED HEALTH AND WELFARE PLAN FOR SCA EMPLOYEES
1b Three-digit plan number (PN): 503
1c Effective date of plan: 10/01/1993
2a Plan sponsor's name (employer, if for a single-employer plan): PACIFIC ARCHITECTS AND ENGINEERS, LLC
2b Employer Identification Number (EIN): 98-0000105
2c Plan Sponsor's telephone number: 888-526-5416
2d Business code (see instructions): 541330

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	8449
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)	7155
	6a(2)	4797
	6b	50
	6c	109
	6d	4956
	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 4B 4D 4E 4F 4G 4H 4L 4Q

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 checked="" type="checkbox"/> Trust	(3) <input checked="" 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**
- (1) **R** (Retirement Plan Information)
 - (2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
 - (3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
 - (4) **DCG** (Individual Plan Information) – Number Attached _____
 - (5) **MEP** (Multiple-Employer Retirement Plan Information)

- b General Schedules**
- (1) **H** (Financial Information)
 - (2) **I** (Financial Information – Small Plan)
 - (3) **A** (Insurance Information) – Number Attached 1
 - (4) **C** (Service Provider Information)
 - (5) **D** (DFE/Participating Plan Information)
 - (6) **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

**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 **01/01/2020** and ending **12/31/2020**

A Name of plan PACIFIC ARCHITECTS AND ENGINEERS, LLC SELF-INSURED HEALTH AND WELFARE PLAN FOR SCA EMPLOYEES		B Three-digit plan number (PN) ▶ 503
C Plan sponsor's name as shown on line 2a of Form 5500 PACIFIC ARCHITECTS AND ENGINEERS, LLC		D Employer Identification Number (EIN) 98-0000105

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

(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	2499271	2949	01/01/2020	12/31/2020

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
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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	0
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: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	
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		1270873
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider 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.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2020** and ending **12/31/2020**

A Name of plan PACIFIC ARCHITECTS AND ENGINEERS, LLC SELF-INSURED HEALTH AND WELFARE PLAN FOR SCA EMPLOYEES	B Three-digit plan number (PN) ▶	503
C Plan sponsor's name as shown on line 2a of Form 5500 PACIFIC ARCHITECTS AND ENGINEERS, LLC	D Employer Identification Number (EIN) 98-0000105	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

CIGNA HEALTH AND LIFE INSURANCE CO.

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	CLAIMS ADMINISTRATOR	937653	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

FCE BENEFIT ADMINISTRATORS, INC.

33-0330036

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	SCA ADMINISTRATOR	619787	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BUSINESS SOLVER.COM, INC

42-1503807

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	TPA	389015	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

EXPRESS SCRIPTS, INC.

1 EXPRESS WAY
ST. LOUIS, MO 63121

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	191589	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

HARTFORD LIFE AND ACCIDENT

06-0838648

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	141466	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DELTA DENTAL OF VIRGINIA

54-0844477

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	CLAIMS ADMINISTRATOR	120196	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

TRUST MANAGEMENT SERVICES, INC.

46-3922133

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21	TRUST MANAGEMENT	37113	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ARONSON

37-1611326

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	25975	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMERICAN SPECIALITY HEALTH 33-0571188	INDIRECT COMPENSATION OF \$0.04 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CASTLIGHT HEALTH 26-1989091	INDIRECT COMPENSATION OF \$1.41 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
OMADA HEALTH INC. 45-2355015	INDIRECT COMPENSATION OF \$0.04 PER PARTICIPANT	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation VISION SERVICE PLAN 06-1227840	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$1.67 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2 CIGNA HEALTH AND LIFE INSURANCE CO.	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation BLOOMINGTON HOSPITAL 35-1720796	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.08 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2 CIGNA HEALTH AND LIFE INSURANCE CO.	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation BANK OF AMERICA 94-1687665	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.00 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 0.39%	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
AMPLIFON HEARING HEALTHCARE 85-0437037	INDIRECT COMPENSATION OF \$0.01 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
FIT FOR LIFE 38-3983812	INDIRECT COMPENSATION OF \$0.01 PER PARTICIPANT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA 13-5266470	INDIRECT COMPENSATION OF \$1.02 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation CITIBANK NA (CHLIC CORE DEPOSITS) 59-1031071	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.02 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 0.32%	
(a) Enter service provider name as it appears on line 2 CIGNA HEALTH AND LIFE INSURANCE CO.	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation CITIBANK NA (OMNIBUS) 13-5266470	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.01 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 0.32%	
(a) Enter service provider name as it appears on line 2 CIGNA HEALTH AND LIFE INSURANCE CO.	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation DEUTSCHE BANK 13-4941247	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.00 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 0.50%	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation JP MORGAN CHASE 13-4994650	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. INDIRECT COMPENSATION OF \$0.25 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 0.27%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning <u>01/01/2020</u> and ending <u>12/31/2020</u>	
A Name of plan <u>PACIFIC ARCHITECTS AND ENGINEERS, LLC SELF-INSURED HEALTH AND WELFARE PLAN FOR SCA EMPLOYEES</u>	B Three-digit plan number (PN) ▶ <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>PACIFIC ARCHITECTS AND ENGINEERS, LLC</u>	D Employer Identification Number (EIN) <u>98-0000105</u>

Part I	Asset and Liability Statement
---------------	--------------------------------------

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	1379886	552240
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	6780189	3706656
(2) Participant contributions	1b(2)	411986	0
(3) Other	1b(3)	418271	906186
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	8990332	5165082
Liabilities			
g Benefit claims payable.....	1g	3263000	1952000
h Operating payables.....	1h	180461	168889
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	3443461	2120889
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	5546871	3044193

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	16985732	
(B) Participants.....	2a(1)(B)	6492169	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		23477901
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		0
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		0
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		23477901

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	22168673	
(2) To insurance carriers for the provision of benefits	2e(2)	1270873	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		23439546
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	2477945	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	25975	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	37113	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2541033
j Total expenses. Add all expense amounts in column (b) and enter total	2j		25980579

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-2502678
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **APRIO LLP**

(2) EIN: **57-1157523**

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		10000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

**PACIFIC ARCHITECTS AND ENGINEERS, LLC
SELF-INSURED HEALTH AND WELFARE PLAN
FOR SCA EMPLOYEES**

AUDITED FINANCIAL STATEMENTS

DECEMBER 31, 2020 AND 2019

**Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan
for SCA Employees**

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Independent Auditors' Report

Board of Directors

Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan for SCA Employees
Chantilly, Virginia

We have audited the accompanying financial statements of **Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan for SCA Employees** (the Plan), which comprise the Statements of Benefit Obligations and Net Assets Available for Benefits as of December 31, 2020 and 2019, and the related Statement of Changes in Benefit Obligations and Net Assets Available for Benefits for the year ended December 31, 2020, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Independent Auditors' Report (Continued)

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of **Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan for SCA Employees** as of December 31, 2020 and 2019, and the changes in its financial status for the year ended December 31, 2020 in accordance with accounting principles generally accepted in the United States of America.

Aprilo, LLP

Rockville, Maryland
April 18, 2025

**Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan
for SCA Employees**

Statements of Benefit Obligations and Net Assets Available for Benefits

<i>December 31,</i>	2020	2019
Benefit Obligations		
Incurred but not reported claims	\$ 1,952,000	\$ 3,263,000
Total benefit obligations	1,952,000	3,263,000
Net Assets Available for Benefits		
Assets		
Cash	552,240	1,379,886
Deposit with insurance company	333,423	340,032
Employee contributions receivable	-	411,986
Employer contributions receivable	3,706,656	6,780,189
Other receivables	572,763	78,239
Total assets	5,165,082	8,990,332
Liabilities		
Accrued expenses	77,156	77,986
Due to claims administrator	91,733	102,475
Total liabilities	168,889	180,461
Net assets available for benefits	4,996,193	8,809,871
Excess of net assets available for benefits over benefit obligations	\$ 3,044,193	\$ 5,546,871

The accompanying Notes to Financial Statements are an integral part of these financial statements.

**Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan
for SCA Employees**

Statement of Changes in Benefit Obligations and Net Assets Available for Benefits

<i>For the Year Ended December 31,</i>	2020
Net Decrease in Benefit Obligations	
Increase (decrease) during the year attributable to:	
Claims and premiums incurred	\$ 23,439,546
Claims and premiums paid	(24,750,546)
Net decrease in benefit obligations	(1,311,000)
Net Decrease in Net Assets Available for Benefits	
Additions	
Contributions	
Employer	16,985,732
Participant	6,492,169
Total contributions	23,477,901
Total additions	23,477,901
Deductions	
Claims paid to participants	23,479,673
Premiums paid to insurance companies	1,270,873
Administrative expenses	2,541,033
Total deductions	27,291,579
Decrease in net assets available for benefits	(3,813,678)
Decrease in excess of net assets available for benefits over benefit obligations	(2,502,678)
Excess of net assets available for benefits over benefit obligations, beginning of year	5,546,871
Excess of net assets available for benefits over benefit obligations, end of year	\$ 3,044,193

The accompanying Notes to Financial Statements are an integral part of these financial statements.

Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan for SCA Employees

Notes to Financial Statements

1. Description of Plan

The following description of the Pacific Architects and Engineers, LLC Self-Insured Health and Welfare Plan for SCA Employees (the Plan) provides only general information. Participants should refer to the Plan document for a complete description of the Plan's provisions.

General: The Plan provides health and other benefits to eligible employees (including covered dependents) of Pacific Architects and Engineers, LLC (the Plan Sponsor) and participating affiliates, except for employees classified as seconded employees and any employees who work or are expected to work less than 30 hours a week except certain union employees and others determined to be full-time under internal policies. The Plan only covers individuals providing services under a contract subject to Service Contract Labor Standards (SCLS). The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Sponsor maintains a separate trust for purposes of holding certain assets of the Plan. Contributions are deposited to the trust to cover certain benefits for employees working on contracts covered by SCLS. All other benefits continue to be paid from the general assets of the Plan Sponsor.

Effective January 1, 2020, PAE Shared Services LLC was added as a participating affiliate.

Benefits: The Plan provides health benefits (medical, dental, and prescription drugs) and short-term disability benefits. The Plan also provides for coverage under a flexible spending program. The Plan provides continuation of certain benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA). The Plan also provides for a Health Savings Account program. These accounts are not considered Plan assets and the Plan is not obligated to pay benefits under the program; therefore, the activity in these accounts is not reflected in the accompanying financial statements.

Self-insured benefits: All Plan benefits are self-insured. The claims for self-insured benefits are processed by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the assets of the trust or from the general assets of the Plan Sponsor. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan. The Plan Sponsor utilizes a pharmacy benefit manager (PBM) with respect to the prescription drug benefits provided under the Plan. Under the agreement with the PBM, the Plan Sponsor receives rebates related to the Plan's utilization pattern of specific drugs, which it passes along to the Plan.

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Stop loss coverage: The Plan has entered into a stop-loss arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount for 2020 and 2019).

Contributions: Premium rates are set annually and are collected based on the benefit elections made by the enrolled participants. The Plan Sponsor determines what portion of the premium costs will be paid by the participant and what portion will be covered by the Plan Sponsor. The Plan Sponsor makes contributions to the Plan as needed to fund claims and pay premiums in excess of participants' contributions. Any deficiency of the Plan's net assets over benefit obligations is funded by the Plan Sponsor on a pay-as-you-go basis.

2. Significant accounting policies

Basis of accounting: The accompanying financial statements have been prepared using the accrual basis of accounting.

The Plan's benefit obligations as of December 31, 2020 and 2019 and changes in benefit obligations for the year ended December 31, 2020 have been presented on the same statements as the Plan's net assets available for benefits and changes in net assets available for benefits.

Cash: Cash and cash equivalents consist of highly liquid debt instruments with initial maturities of ninety days or less. The Plan maintains a cash balance at one commercial bank which can exceed the Federal Deposit Insurance Corporation (FDIC) insured deposit limit of \$250,000 per financial institution. At December 31, 2020 and 2019, the Plan's cash balance held at a commercial bank exceeded the FDIC limit by approximately \$302,000 and \$1,130,000, respectively. The Plan has not experienced any losses through the date when the financial statements were available to be issued.

Deposit with insurance company: As of December 31, 2020 and 2019, the Plan maintains a cash reserve on deposit with a third-party claims processor, which is used by the claims administrator to pay claims. The Plan Sponsor or the trust regularly replenishes the deposit to levels required by the claims processor.

Contributions receivable: Contributions receivable represent amounts due from the participants for premium equivalents and from the Plan Sponsor for premiums and SCLS contributions.

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Payment of benefits: Claim payments are recorded when paid by the third-party claims processors. Amounts due to the claims processors that have yet to be reimbursed by the Plan are recorded as due to claims administrators in the accompanying Statements of Benefit Obligations and Net Assets Available for Benefits.

Stop loss: Premiums for stop loss insurance are included in the period of insurance coverage in premiums paid to insurance companies in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits. Stop loss refunds of approximately \$568,000 for 2020 have been netted with claims paid in the accompanying Statement of Changes in Benefit Obligations and Net Assets Available for Benefits.

Use of estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Subsequent events: Management has evaluated subsequent events for disclosure in these financial statements through April 18, 2025, which is the date the financial statements were available to be issued.

- 3. Other receivables** At December 31, 2020, other receivables consist of rebates due under agreements with the PBM that are passed along from the Plan Sponsor. At December 31, 2019, other receivables consist of amounts held by the trustee as a reserve for future administrative expenses.
- 4. Claims incurred but not reported** Plan obligations for claims incurred but not reported are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party claims administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment.
- 5. Administrative expenses** The Plan pays administrative expenses that consist primarily of administrative fees paid to third-party claims or benefits administrators and accounting fees. These transactions qualify as exempt party-in-interest transactions. All other expenses are paid by the Plan Sponsor on behalf of the Plan.

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6. Tax status The trust established to hold the Plan’s assets has not applied for exemption from federal or state income taxes and is currently subject to income tax on its net investment income. No federal or state income taxes were payable for 2020 or 2019, therefore there is no provision for income taxes in the accompanying financial statements.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination. The Plan is subject to routine audits by taxing jurisdictions; however, there are no audits for any tax periods in progress.

7. Plan termination Although it has not expressed any intention to do so, the Board of Directors of the Plan Sponsor has the right under the Plan to modify the benefits provided to, and contributions required of, participants, to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA.

8. Reconciliation of financial statements to Form 5500 The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of December 31, 2020 and 2019 and for the year ended December 31, 2020:

	2020	2019
Net assets available for benefits per financial statements	\$ 4,996,193	\$8,809,871
Incurred but not reported claims reported as a payable	(1,952,000)	(3,263,000)
Net assets available for benefits per the Form 5500	\$ 3,044,193	\$5,546,871

	2020
Deductions per the financial statements	\$ 27,291,579
Incurred but not reported claims reported as a payable - 2019	(3,263,000)
Incurred but not reported claims reported as a payable - 2020	1,952,000
Total expenses per the Form 5500	\$ 25,980,579