

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110  
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

- 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.) [x] a single-employer plan [ ] a DFE (specify) \_\_\_\_
B This return/report is: [ ] the first return/report [ ] the final return/report [ ] an amended return/report [ ] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. [ ]
D Check box if filing under: [ ] Form 5558 [ ] automatic extension [ ] the DFVC program [ ] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan: HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 04/01/2021
2a Plan sponsor's name (employer, if for a single-employer plan): HORIZON CONSTRUCTION COMPANY
2b Employer Identification Number (EIN): 58-1939516
2c Plan Sponsor's telephone number: 770-255-4268
2d Business code (see instructions): 236200

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 plan administrator, employer/plan sponsor, and DFE.

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

Form 5500 (2024) v. 240311



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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><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>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><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 **04/01/2024** and ending **03/31/2025**

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT PLAN</b></p>                    | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>HORIZON CONSTRUCTION COMPANY</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>58-1939516</b></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         | 00635886                              | 107   | 04/01/2024              | 03/31/2025 |

**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>(a) Total amount of commissions paid<br/><b>3043</b></p> | <p>(b) Total amount of fees paid<br/><b>3373</b></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

**MCGRIFF INSURANCE SERVICES LLC** P O BOX 896620  
CHARLOTTE, NC 28289

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                      | (e) Organization code |
|---|---------------------------------|----------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose          |                       |
| 3043  | 330                             | BENEFIT ADVISOR FEES | 3                     |

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

**THE CASON GROUP INC** 1612 MARION STREET  
04202023TD  
COLUMBIA, SC 29201

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                        | (e) Organization code |
|---|---------------------------------|------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose            |                       |
|   | 3043                            | SERVICE/GEN AGENT FEES | 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 |                       |
|   |                                 |             |                       |

**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:<br>(1) Disbursed from fund to pay benefits or purchase annuities during year ..... | <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> | 61747 |
| <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. ▶

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>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><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 **04/01/2024** and ending **03/31/2025**

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT PLAN</b></p>                    | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>HORIZON CONSTRUCTION COMPANY</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>58-1939516</b></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 CO**

| (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         | 00635886                              | 149   | 04/01/2024              | 03/31/2025 |

**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 |
| 0                                    | 78302                         |

**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

**MCGRIFF INSURANCE SERVICES LLC** P O BOX 896620  
CHARLOTTE, NC 28289

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                      | (e) Organization code |
|---|---------------------------------|----------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose          |                       |
|   | 58391                           | BENEFIT ADVISOR FEES | 3                     |

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

**THE CASON GROUP INC** 1612 MARION ST  
COLUMBIA, SC 29201

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                        | (e) Organization code |
|---|---------------------------------|------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose            |                       |
|   | 19911                           | SERVICE/GEN AGENT FEES | 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 |                       |
|   |                                 |             |                       |

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

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

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

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

**e** Deductions:

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

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

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

|          |  |                 |        |        |
|----------|--|-----------------|--------|--------|
| <b>a</b> | Premiums: (1) Amount received .....  | <b>9a(1)</b>    | 655143 |        |
|          | (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>    |        | 655143 |
| <b>b</b> | Benefit charges (1) Claims paid .....  | <b>9b(1)</b>    | 881195 |        |
|          | (2) Increase (decrease) in claim reserves .....  | <b>9b(2)</b>    | 9211   |        |
|          | (3) Incurred claims (add (1) and (2)) .....  | <b>9b(3)</b>    |        | 890406 |
|          | (4) Claims charged .....   | <b>9b(4)</b>    |        | 890406 |
| <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> | 38868  |        |
|          | (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> | 12900  |        |
|          | (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> |        | 51768  |
|          | (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>    |        | 67936  |
|          | (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> | 329234 |  |
| <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. ▶

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>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><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 **04/01/2024** and ending **03/31/2025**

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT PLAN</b></p>                    | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>HORIZON CONSTRUCTION COMPANY</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>58-1939516</b></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  
**UNUM LIFE INSURANCE COMPANY OF AMERICA**

| (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     |
| 01-0278678 | 62235         | 440950                                | 121   | 04/01/2024              | 03/31/2025 |

**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>(a) Total amount of commissions paid<br/><b>5886</b></p> | <p>(b) Total amount of fees paid<br/><b>3823</b></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

**MCGRIFF INSURANCE SERVICES INC**      **7701 AIRPORT CENTER DRIVE**  
**SUITE 1800**  
**GREENSBORO, NC 27409**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                              | (e) Organization code |
|---|---------------------------------|------------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose                  |                       |
| 5886  | 1092                            | ADDITIONAL COMPENSATION PAID | 3                     |

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

**THE CASON GROUP LLC**      **P O BOX 11229**  
**COLUMBIA, SC 29206**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   | 2731                            | FEES PAID   | 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 |                       |
|   |                                 |             |                       |

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....  | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

**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> |  |
| (2) Dividends and credits.....   |              |  |
| (3) Interest credited during the year.....   |              |  |
| (4) Transferred from separate account .....  |              |  |
| (5) Other (specify below).....<br>▶  |              |  |
| (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> |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year .....                        |              |  |
| (2) Administration charge made by carrier.....   |              |  |
| (3) Transferred to separate account .....  |              |  |
| (4) Other (specify below).....<br>▶  |              |  |
| (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) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

**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> | 54614 |
| <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. ▶

|   |  |   |
|---|--|---|
| <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: 24pt;"><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 **04/01/2024** and ending **03/31/2025**

|  |  |  |
|--|--|--|
| <p><b>A</b> Name of plan<br/><b>HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT PLAN</b></p>                    | <p><b>B</b> Three-digit plan number (PN) ▶ <b>501</b></p>                  |  |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>HORIZON CONSTRUCTION COMPANY</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>58-1939516</b></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  
**UNUM LIFE INSURANCE CO OF AMERICA**

| (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     |
| 01-0278678 | 62235         | 440949                                | 79  | 04/01/2024              | 03/31/2025 |

**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<br><b>0</b> | (b) Total amount of fees paid<br><b>2478</b> |
|--|--|

**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  
**THE CASON GROUP LLC** P O BOX 11229  
COLUMBIA, SC 29206

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   | 1770                            | FEES PAID   | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**MCGRIFF INSURANCE SERVICES** 7701 AIRPORT CENTER DRIVE  
SUITE 1800  
GREENSBORO, NC 27409

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                              | (e) Organization code |
|---|---------------------------------|------------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose                  |                       |
|   | 708                             | ADDITIONAL COMPENSATION PAID | 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 |                       |
|   |                                 |             |                       |

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

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

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

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

**e** Deductions:

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

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

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**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> | 35399 |
| <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. ▶

|  |  |   |
|--|--|---|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>▶ File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection.</b> |
|--|--|---|

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

|  |  |            |
|--|--|------------|
| <b>A</b> Name of plan<br><b>HORIZON CONSTRUCTION COMPANY WELFARE BENEFIT 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>HORIZON CONSTRUCTION COMPANY</b> | <b>D</b> Employer Identification Number (EIN)<br><b>58-1939516</b> |            |

**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

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

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

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

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

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

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

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

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

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

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

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**(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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 13 14 15            | CLAIMS ADMIN  | 58391  | 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)

MCGRIFF INSURANCE SERVICES

P O BOX 896620  
CHARLOTTE, NC 28289

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 22 23                  | BROKER  | 1664   | 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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>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.

|  |   |  |
|--|---|--|
| <b>(a)</b> Enter service provider name as it appears on line 2             | <b>(b)</b> Service Codes<br>(see instructions)  | <b>(c)</b> Enter amount of indirect compensation |
|  |   |  |
| <b>(d)</b> Enter name and EIN (address) of source of indirect compensation | <b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |  |
|  |   |  |
| <b>(a)</b> Enter service provider name as it appears on line 2             | <b>(b)</b> Service Codes<br>(see instructions)  | <b>(c)</b> Enter amount of indirect compensation |
|  |   |  |
| <b>(d)</b> Enter name and EIN (address) of source of indirect compensation | <b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |  |
|  |   |  |
| <b>(a)</b> Enter service provider name as it appears on line 2             | <b>(b)</b> Service Codes<br>(see instructions)  | <b>(c)</b> Enter amount of indirect compensation |
|  |   |  |
| <b>(d)</b> Enter name and EIN (address) of source of indirect compensation | <b>(e)</b> 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.

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

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|   |  |   |
|---|--|---|
| <b>Form 5500</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security<br>Administration<br><br>Pension Benefit Guaranty Corporation | <b>Annual Return/Report of Employee Benefit Plan</b><br><br>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).<br><br><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b> | OMB Nos. 1210-0110<br>1210-0089<br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|---|--|---|

|               |   |  |
|---------------|---|--|
| <b>Part I</b> | <b>Annual Report Identification Information</b> | For calendar plan year 2024 or fiscal plan year beginning <u>04/01/2024</u> and ending <u>03/31/2025</u> |
|---------------|---|--|

- 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. .... ▶

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Basic Plan Information</b> —enter all requested information |
|----------------|--|

|   |  |
|---|--|
| <b>1a</b> Name of plan<br>Horizon Construction Company Welfare Benefit Plan   | <b>1b</b> Three-digit plan number (PN) ▶ <u>501</u>  |
| <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>Horizon Construction Company<br><br>415 Winkler Drive<br><br>Alpharetta GA 30004 | <b>1c</b> Effective date of plan<br><u>04/01/2021</u><br><br><b>2b</b> Employer Identification Number (EIN)<br><u>58-1939516</u><br><br><b>2c</b> Plan Sponsor's telephone number<br>(770) 255-4268<br><br><b>2d</b> Business code (see instructions)<br><u>236200</u> |

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

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

|              |                                    |                  |  |
|--------------|------------------------------------|------------------|--|
| SIGN<br>HERE | <i>Tracie Webb</i>                 | <u>9-19-2025</u> | Tracie Webb  |
|              | Signature of plan administrator    | Date             | Enter name of individual signing as plan administrator       |
| SIGN<br>HERE |                                    |                  |  |
|              | Signature of employer/plan sponsor | Date             | Enter name of individual signing as employer or plan sponsor |
| SIGN<br>HERE |                                    |                  |  |
|              | Signature of DFE                   | Date             | Enter name of individual signing as DFE                      |



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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.

---

**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><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
| <p>For calendar plan year 2024 or fiscal plan year beginning <span style="margin-left: 100px;">04/01/2024</span> and ending <span style="margin-left: 100px;">03/31/2025</span></p>   |  |  |

|   |   |            |
|---|---|------------|
| <p><b>A</b> Name of plan<br/>Horizon Construction Company Welfare Benefit Plan</p>                    | <p><b>B</b> Three-digit plan number (PN) ▶</p>                      | <p>501</p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/>Horizon Construction Company</p> | <p><b>D</b> Employer Identification Number (EIN)<br/>58-1939516</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         | 00635886                              | 107   | 04/01/2024              | 03/31/2025 |

**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) Total amount of commissions paid</b> | <b>(b) Total amount of fees paid</b> |
| 3,043                                       | 3,373                                |

**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**  
The Cason Group Inc  
1612 Marion Street  
04202023TD  
Columbia SC 29201

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                        | (e) Organization code |
|---|---------------------------------|------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose            |                       |
| 3,043   | 3,043                           | Service/Gen Agent Fees | 3                     |

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**  
McGriff Insurance Services LLC  
P O Box 896620  
Charlotte NC 28289

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                      | (e) Organization code |
|---|---------------------------------|----------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose          |                       |
| 3,043   | 330                             | Benefit Advisor Fees | 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 |                       |
|   |                                 |             |                       |

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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 ..... | <b>4</b> |  |
| 5 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 .....

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

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

|  |           |  |
|--|-----------|--|
|  | <b>6b</b> |  |
|  | <b>6c</b> |  |
|  | <b>6d</b> |  |

**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> |              |  |
| (2) Dividends and credits .....   |              |              |  |
| (3) Interest credited during the year.....  |              |              |  |
| (4) Transferred from separate account .....   |              |              |  |
| (5) Other (specify below) .....   |              |              |  |
| ▶   |              |              |  |
| (6) Total additions .....   |              | <b>7c(6)</b> |  |
| <b>d</b> Total of balance and additions (add lines 7b and 7c(6)). .....                 |              | <b>7d</b>    |  |
| <b>e</b> Deductions:  |              |              |  |
| (1) Disbursed from fund to pay benefits or purchase annuities during year .....         | <b>7e(1)</b> |              |  |
| (2) Administration charge made by carrier.....  | <b>7e(2)</b> |              |  |
| (3) Transferred to separate account .....   | <b>7e(3)</b> |              |  |
| (4) Other (specify below) .....   | <b>7e(4)</b> |              |  |
| ▶   |              |              |  |
| (5) Total deductions .....  |              | <b>7e(5)</b> |  |
| <b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d)..... |              | <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> | 61,747 |
| <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. ▶

|   |  |   |
|---|--|---|
| <b>SCHEDULE A</b><br><b>(Form 5500)</b><br>Department of the Treasury<br>Internal Revenue Service<br><hr/> Department of Labor<br>Employee Benefits Security Administration<br><hr/> Pension Benefit Guaranty Corporation | <b>Insurance Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>▶ File as an attachment to Form 5500.</b><br><br><b>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</b> | OMB No. 1210-0110<br><br><hr/> <b>2024</b><br><br><hr/> <b>This Form is Open to Public Inspection</b> |
|---|--|---|

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

|  |   |     |
|--|---|-----|
| <b>A</b> Name of plan<br>Horizon Construction Company Welfare Benefit Plan | <b>B</b> Three-digit plan number (PN) ▶ | 501 |
|--|---|-----|

|   |   |
|---|---|
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>Horizon Construction Company | <b>D</b> Employer Identification Number (EIN)<br>58-1939516 |
|---|---|

**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 Co

| (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         | 00635886                              | 149   | 04/01/2024              | 03/31/2025 |

**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) Total amount of commissions paid</b> | <b>(b) Total amount of fees paid</b> |
| 0   | 78,302                               |

**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**  
 Mcgriff Insurance Services LLC  
 P O Box 896620  
  
 Charlotte NC 28289

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                      | (e) Organization code |
|---|---------------------------------|----------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose          |                       |
|   | 58,391                          | Benefit Advisor Fees | 3                     |

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**  
 The Cason Group Inc  
 1612 Marion St  
  
 Columbia SC 29201

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                        | (e) Organization code |
|---|---------------------------------|------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose            |                       |
|   | 19,911                          | Service/Gen Agent Fees | 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 |                       |
|   |                                 |             |                       |

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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 ..... | <b>4</b> |  |
| 5 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 .....

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

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

|  |           |  |
|--|-----------|--|
|  | <b>6b</b> |  |
|  | <b>6c</b> |  |
|  | <b>6d</b> |  |

**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 .....

|  |           |  |
|--|-----------|--|
|  | <b>7b</b> |  |
|--|-----------|--|

**c** Additions: (1) Contributions deposited during the year .....

|  |              |  |
|--|--------------|--|
|  | <b>7c(1)</b> |  |
| (2) Dividends and credits.....             | <b>7c(2)</b> |  |
| (3) Interest credited during the year..... | <b>7c(3)</b> |  |
| (4) Transferred from separate account..... | <b>7c(4)</b> |  |
| (5) Other (specify below).....<br>▶        | <b>7c(5)</b> |  |
|  |              |  |

(6) Total additions .....

|  |              |  |
|--|--------------|--|
|  | <b>7c(6)</b> |  |
|--|--------------|--|

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

|  |           |  |
|--|-----------|--|
|  | <b>7d</b> |  |
|--|-----------|--|

**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year .....

|  |              |  |
|--|--------------|--|
|  | <b>7e(1)</b> |  |
| (2) Administration charge made by carrier..... | <b>7e(2)</b> |  |
| (3) Transferred to separate account.....       | <b>7e(3)</b> |  |
| (4) Other (specify below).....<br>▶            | <b>7e(4)</b> |  |
|  |              |  |

(5) Total deductions .....

|  |              |  |
|--|--------------|--|
|  | <b>7e(5)</b> |  |
|--|--------------|--|

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

|  |           |  |
|--|-----------|--|
|  | <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>    | 655,143 |  |
| (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>    | 655,143 |  |
| <b>b</b> Benefit charges (1) Claims paid.....   | <b>9b(1)</b>    | 881,195 |  |
| (2) Increase (decrease) in claim reserves.....  | <b>9b(2)</b>    | 9,211   |  |
| (3) Incurred claims (add (1) and (2)).....  | <b>9b(3)</b>    | 890,406 |  |
| (4) Claims charged.....   | <b>9b(4)</b>    | 890,406 |  |
| <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> | 38,868  |  |
| (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> | 12,900  |  |
| (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> | 51,768  |  |
| (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>    | 67,936  |  |
| (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> | 329,234 |  |
| <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. ▶

|   |  |  |
|---|--|--|
| <p align="center"><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p align="center">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p align="center">Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p align="center">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><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 04/01/2024 and ending 03/31/2025

|  |   |     |
|--|---|-----|
| <b>A</b> Name of plan<br>Horizon Construction Company Welfare Benefit Plan | <b>B</b> Three-digit plan number (PN) ▶ | 501 |
|--|---|-----|

|   |   |
|---|---|
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>Horizon Construction Company | <b>D</b> Employer Identification Number (EIN)<br>58-1939516 |
|---|---|

**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**  
Unum Life Insurance Company of America

| (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     |
| 01-0278678 | 62235         | 440950                                | 121   | 04/01/2024              | 03/31/2025 |

**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) Total amount of commissions paid</b><br>5,886 | <b>(b) Total amount of fees paid</b><br>3,823 |
|--|---|

**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**  
McGriff Insurance Services Inc  
7701 Airport Center Drive  
Suite 1800  
Greensboro NC 27409

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                              | (e) Organization code |
|---|---------------------------------|------------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose                  |                       |
| 5,886   | 1,092                           | Additional Compensation Paid | 3                     |

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**  
The Cason Group LLC  
P O Box 11229  
Columbia SC 29206

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   | 2,731                           | Fees Paid   | 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 |                       |
|   |                                 |             |                       |

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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 ..... | <b>4</b> |  |
| 5 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 .....

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

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

|  |           |  |
|--|-----------|--|
|  | <b>6b</b> |  |
|  | <b>6c</b> |  |
|  | <b>6d</b> |  |

**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 7b and 7c(6)) .....                   |   | <b>7d</b>    |  |  |
| <b>e</b> Deductions:   |   |              |  |  |
|  | (1) Disbursed from fund to pay benefits or purchase annuities during year ..... | <b>7e(1)</b> |  |  |
|  | (2) Administration charge made by carrier .....                                 | <b>7e(2)</b> |  |  |
|  | (3) Transferred to separate account .....                                       | <b>7e(3)</b> |  |  |
| (4) Other (specify below) .....  | <b>7e(4)</b>  |              |  |  |
| (5) Total deductions .....   |   | <b>7e(5)</b> |  |  |
| <b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d) ..... |   | <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) **▶**Accidental Death and Dismemberment

**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> | 54,614 |
| <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. **▶**

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>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><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 04/01/2024 and ending 03/31/2025

|  |   |     |
|--|---|-----|
| <b>A</b> Name of plan<br>Horizon Construction Company Welfare Benefit Plan | <b>B</b> Three-digit plan number (PN) ▶ | 501 |
|--|---|-----|

|   |   |
|---|---|
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>Horizon Construction Company | <b>D</b> Employer Identification Number (EIN)<br>58-1939516 |
|---|---|

**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**  
Unum Life Insurance Co of America

| (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     |
| 01-0278678 | 62235         | 440949                                | 79  | 04/01/2024              | 03/31/2025 |

**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) Total amount of commissions paid</b> | <b>(b) Total amount of fees paid</b> |
| 0   | 2,478                                |

**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**  
McGriff Insurance Services  
7701 Airport Center Drive  
Suite 1800  
Greensboro NC 27409

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                              | (e) Organization code |
|---|---------------------------------|------------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose                  |                       |
|   | 708                             | Additional Compensation Paid | 3                     |

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**  
The Cason Group LLC  
P O Box 11229  
Columbia SC 29206

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   | 1,770                           | Fees Paid   | 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 |                       |
|   |                                 |             |                       |

|                |  |
|----------------|--|
| <b>Part II</b> | <b>Investment and Annuity Contract Information</b><br>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 ..... | <b>4</b> |  |
| 5 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>b</b> Premiums paid to carrier .....   | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....   | <b>6c</b> |  |
| <b>d</b> 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 ..... | <b>6d</b> |  |

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 7b and 7c(6)) .....                   |   | <b>7d</b>    |  |  |
| <b>e</b> Deductions:   |   |              |  |  |
|  | (1) Disbursed from fund to pay benefits or purchase annuities during year ..... | <b>7e(1)</b> |  |  |
|  | (2) Administration charge made by carrier .....                                 | <b>7e(2)</b> |  |  |
|  | (3) Transferred to separate account .....                                       | <b>7e(3)</b> |  |  |
| (4) Other (specify below) .....  | <b>7e(4)</b>  |              |  |  |
| (5) Total deductions .....   |   | <b>7e(5)</b> |  |  |
| <b>f</b> Balance at the end of the current year (subtract line 7e(5) from line 7d) ..... |   | <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) **Lifestyle Life Lifestyle ADD**

**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> |  | 35,399 |
| <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. ▶

|  |  |   |
|--|--|---|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><hr/> <small>Department of Labor<br/>Employee Benefits Security Administration</small><br><hr/> <small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><hr/> <b>2024</b><br><hr/> <b>This Form is Open to Public Inspection.</b> |
|--|--|---|

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

|   |   |     |
|---|---|-----|
| <b>A</b> Name of plan<br>Horizon Construction Company Welfare Benefit Plan                    | <b>B</b> Three-digit plan number (PN) ▶                     | 501 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>Horizon Construction Company | <b>D</b> Employer Identification Number (EIN)<br>58-1939516 |     |

**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

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

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

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

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**(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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 12 13 14 15            | Claims Admin  | 58,391   | 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)

McGriff Insurance Services

P O Box 896620

Charlotte

NC 28289

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 22 23                  | Broker  | 1,664  | 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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>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<br>(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<br>(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<br>(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)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: | <b>e</b> Telephone: |
| <b>d</b> Address:  |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: | <b>e</b> Telephone: |
| <b>d</b> Address:  |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: | <b>e</b> Telephone: |
| <b>d</b> Address:  |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: | <b>e</b> Telephone: |
| <b>d</b> Address:  |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: | <b>e</b> Telephone: |
| <b>d</b> Address:  |                     |

Explanation: