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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

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.)
- ☒ 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
ROCKY MOUNTAIN EXCAVATING WELFARE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 08/01/2015

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

RME LTD.LLC
ELITE SURFACE INFRASTRUCTURE
JAKE RAE
115 INVERNESS DR E STE 100
ENGLEWOOD, CO 80112-5116

115 INVERNESS DR E STE 100
ENGLEWOOD, CO 80112-5116

2b Employer Identification Number (EIN)
84-1480842

2c Plan Sponsor's telephone number
303-841-0292

2d Business code (see instructions)
238900

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 HERE	Filed with authorized/valid electronic signature.	06/15/2026	JAKE RAE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	322
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	322
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	353
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	353
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	353
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

4A

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
ROCKY MOUNTAIN EXCAVATING WELFARE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
RME LTD.LLC

D Employer Identification Number (EIN)
84-1480842

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	00651133	353	10/01/2024	09/30/2025

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
105516	482040

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

CENTERSTONE INS & FIN SVC LLC
12404 PARK CENTRAL DRIVE
SUITE 400S
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
4820			3

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

MARSH & MCLENNAN AGENCY LLC.
825 MARYVILLE CENTER DR. STE 20
CHESTERFIELD, MO 63017

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
10551600			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.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	989704
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

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

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

RME ltd, LLC. d/b/a Elite Surface I
Angela Amsinger
115 Inverness Dr East
Suite 100
Englewood CO 80112

Dear Employer:

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

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

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

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

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

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

Sincerely,

Cigna

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

Cigna

INFORMATION FOR COMPLETING SCHEDULE A ON THE IRS FORM5500

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

For Plan Year Beginning: **October 01, 2024** **and Ending:** **September 30, 2025**

Name of Plan: **RME ltd, LLC. d/b/a Elite Surface I**

SCHEDULE A - INSURANCE INFORMATION:

Information Concerning Insurance Contract Coverage, Fees and Commissions

Name of Insurance Carrier: Cigna Health and Life Insurance Company

EIN number	NAIC code	Contract or identification number	Policy or contract year: From	Policy or contract year: To
59-1031071	67369	00651133	10/1/2024	9/30/2025

Approximate number of persons covered at end of policy or contract year:

Benefit	Employee	Dependent	Spouse	Family	Child

Insurance fees, benefit advisor fees and commissions paid to agents, brokers, and other persons:

Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent / broker for specific information about their participation.

Name and address of the agents, brokers or other persons to whom commissions or fees were paid	Amount of commissions paid	Service/Gen. Agent Fees	Benefit Advisor Fees

Incentive Compensation Payments based on membership in your plan/or lump sum amount:

Producer	Amount
BENEFITS BROKER INC	$7,263.00
CENTERSTONE INS & FIN SVC LLC	$4,893.10

Incentive Compensation Payments are funded by the insurer. Contact your agent, broker or consultant for details.

Total premiums* or subscription charges paid to carrier: $989,704.08

State Continuation includes payments made by continuants in amount of $0.00 administered by CHLIC and applicable to your account.

The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. Includes charges related to Employee Assistance Plan (i.e.administration fee/insurance premium /commissions) where applicable.

*Premium may reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

Cigna

INFORMATION FOR COMPLETING SCHEDULE C ON THE IRS FORM 5500

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

For Plan Year Beginning: **October 01, 2024** **and Ending:** **September 30, 2025**

Name of Plan: **RME ltd, LLC. d/b/a Elite Surface I**

SCHEDULE C - SERVICE PROVIDER INFORMATION:

Service Provider	EIN#	Administration fees paid to the service provider *
Cigna Health and Life Insurance Company	59-1031071	$87,048.36

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

Commissions: $105,516.00

Service / Gen. Agent Fees: $4,820.40

Incentive Compensation Payments based on membership in your plan/or lump sum amount: $12,156.10

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

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

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

Direct Compensation for calendar year 2024 :** $67,189.77

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

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

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

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

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

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

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

Eligible Indirect Compensation

Service Provider Information for Reporting on Form 5500 Schedule C Part 1, Line 3

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

(b) Service codes:

12 Claim Processing **38 Participant communications** **50 Direct payments from the Plan**
13 Contract Administrator **49 Other Services** **56 Non-monetary compensation**
31 Named fiduciary - (*if indicated in ASO Agreement*) **62 Float Revenue**

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

(d) Name and EIN (address) of source of indirect compensation:
Cigna Healthy Rewards Vendors
Amplifon Hearing Healthcare Fifth Street Towers 150 South 5th Street Suite 2300 Minneapolis, MN 55402 EIN # 85-0437037
Fitbit 199 Fremont Street, San Francisco, CA 94105 EIN# 20-8920744
Lasik- LCA-Vision Inc. 7840 Montgomery Road, Cincinnati, OH 45236 EIN# 11-2882328
Active & Fit- American Specialty Health Inc. 10221 Waterridge Circle, Sand Diego CA, 92121 EIN# 33-0883241

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Volume based marketing fees paid by vendors participating in the Cigna Healthy Rewards program which offers plan participants discounts on various services. Applicable to your plan if you plan participants have a Cigna ID card and access to myCigna.com or other authorized portals.

Eligible Indirect Compensation Formula/Estimate: For calendar year 2024, $0.00 PMPY(this formula is based upon total compensation received from Healthy Rewards Vendors across Cigna companies entire insured and self-insured book of business.)

Effective Date: **1/1/2024** Cancel Date: **xx/xx/xxxx**

Sources of indirect compensation, excluding eligible indirect compensation, to be reported on Schedule C Part 1, Line 3 are as follows:

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

(b) Service codes:

12 Claim Processing **38 Participant communications** **50 Direct payments from the Plan**
13 Contract Administrator **49 Other Services** **56 Non-monetary compensation**
31 Named fiduciary - (*if indicated in ASO Agreement*) **62 Float Revenue**

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

(d) Name and EIN (address) of source of indirect compensation:
Omada Health, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Digital Diabetes Preventive Care Services Provider – Indirect compensation received by Cigna from this provider for services including:
(i) explaining the Omada services to existing and prospective clients; (ii) encouraging at risk individuals who may benefit from the Omada services to utilize Omada's preventive care services, and (iii) facilitating the enrollment of at-risk individuals in the Omada program.
Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from this vendor of approximately $1.22 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")

Effective Date: **1/1/2024** Cancel Date: **xx/xx/xxxx**

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

(b) Service codes:

12 Claim Processing
13 Contract Administrator
31 Named fiduciary - (*if indicated in ASO Agreement*)
38 Participant communications
49 Other Services
50 Direct payments from the Plan
56 Non-monetary compensation
62 Float Revenue

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

(d) Name and EIN (address) of source of indirect compensation:
Omada Complete, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Omada Diabetes and Hypertension Cigna – Indirect compensation received by Cigna from this provider for services including: (i) explaining the availability of Omada Covered Services to CHLIC existing and prospective clients; (ii) encouraging the use of Omada Covered Services by Screened Participants that CHLIC has identified as potentially benefitting from the Omada Covered Services, and (iii) enrollment of Screened Participants in the Omada Covered Services.
Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from this vendor of approximately $0.18 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")

Effective Date: **1/1/2024** Cancel Date: **xx/xx/xxxx**

Cigna

Plan Detail Report

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

For Plan Year Beginning: October 01, 2024 **and Ending: September 30, 2025**

Name of Plan: RME ltd, LLC. d/b/a Elite Surface I **Plan #: 00651133**

PREMIUMS PLAN DETAIL

BENEFIT	PREMIUMS	ADMIN FEES*	TERMINATION PREMIUM	TERMINATION FEES	STATE CONTINUATION FEES	TOTAL PAID
MEDICAL	$989,704.08	$125,374.59	$0.00	$0.00	$0.00	$1,115,078.67
TOTALS	**$989,704.08**	**$125,374.59**	**$0.00**	**$0.00**	**$0.00**	**$1,115,078.67**

COMMISSIONS PAID DETAIL

BENEFIT	TOTAL COMM PAID	BROKER ACCT#	BROKER NAME
MEDICAL	$16,848.00	304724	BENEFITS BROKER INC
MEDICAL	$88,668.00	455883	MARSH & MCLENNAN AGENCY LLC
TOTAL	**$105,516.00**		

BENEFIT ADVISOR FEE PAID DETAIL

BENEFIT	TOTAL FEES	BROKER ACCT#	BROKER NAME
TOTAL			

SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

BENEFIT	TOTAL FEES	BROKER ACCT#	BROKER NAME
MEDICAL	$4,820.40	302347	CENTERSTONE INS & FIN SVC LLC
TOTAL	**$4,820.40**		

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

	TOTAL PAID	BROKER ACCT#	BROKER NAME
	$7,263.00	304724	BENEFITS BROKER INC
	$4,893.10	302347	CENTERSTONE INS & FIN SVC LLC
TOTAL	**$12,156.10**		

EXPOSURES DETAIL (Last Month of the Plan Period)

BENEFIT	EMPLOYEE	DEPENDENT	SPOUSE	FAMILY	CHILD
MEDICAL	247	0	28	53	25

*Admin Fees Include Commissions