

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
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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 DOT COMPLIANCE GROUP EMPLOYEE WELFARE BENEFIT PLAN
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 01/01/2023
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) DOT COMPLIANCE GROUP 2350 AIRPORT FWY STE 455 BEDFORD, TX 76022-4011
2b	Employer Identification Number (EIN) 47-4643384
2c	Plan Sponsor's telephone number 855-368-7233
2d	Business code (see instructions) 541600

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.	07/09/2026	JENNIFER TOMPKINS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/09/2026	JENNIFER TOMPKINS
	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 ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 81
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 81 6a(2) 88 6b 6c 6d 88 6e 6f 88 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan 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 4B 4Q 4E 4F 4D 4H

9a Plan funding arrangement (check all that apply) (1) ☒ 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) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

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

b General Schedules

- (1)** ☐ **H** (Financial Information)
- (2)** ☐ **I** (Financial Information – Small Plan)
- (3)** ☒ **A** (Insurance Information) – Number Attached 2
- (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
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan DOT COMPLIANCE GROUP EMPLOYEE WELFARE BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 DOT COMPLIANCE GROUP	D Employer Identification Number (EIN) 47-4643384	

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.
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1 Coverage Information:

(a) Name of insurance carrier GUARDIAN 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
13-5123390	64246	00020682	88	01/01/2025	12/31/2025

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 21044	(b) Total amount of fees paid 2789

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	
GENEROUS BENEFITS LLC 537 HOUSTON STREET COPPELL, TX 75019	

(b) Amount of sales and base commissions paid 21044	Fees and other commissions paid		(e) Organization code
	(c) Amount 2789	(d) Purpose TECHNOLOGY CREDITS	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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

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

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

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

(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. Specify nature of costs ▶	6d	

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) ▶ **CRITICAL ILLNESS, ACCIDENT, CANCER**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))		9a(4)		0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))		9b(3)		
(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	145597
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. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan	B Three-digit plan number (PN)	501
DOT COMPLIANCE GROUP EMPLOYEE WELFARE BENEFIT PLAN		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
DOT COMPLIANCE GROUP 47-4643384		

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.
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1 Coverage Information:

(a) Name of insurance carrier					
CIGNA					
(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	00657820	67	01/01/2025	12/31/2025

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
38385	22255

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
GENEROUS BENEFITS LLC 537 HOUSTON STREET COPPELL, TX 75019

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
38385			

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CENTERSTONE INSURANCE AND FINANCIAL 12377 MERIT DRIVE SUITE 825 DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
25255			

(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. Specify nature of costs ▶	6d	

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:

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	321553
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. Specify nature of costs.	10b	

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. ▶



DOT Compliance Group
Laverna Cullop
2350 Airport Freeway
Suite 455
Bedford TX 76022

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.

Sys 2/10/2026

Cigna

INFORMATION FOR COMPLETING SCHEDULE A 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 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: **January 01, 2025** **and Ending:** **December 31, 2025**
Name of Plan: **DOT Compliance Group**

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	To
59-1031071	67369	00657820	1/1/2025	12/31/2025

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

Producer Amount

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

Total premiums* or subscription charges paid to carrier: \$321,553.27

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:	January 01, 2025	and Ending:	December 31, 2025
Name of Plan:	DOT Compliance Group		

SCHEDULE C - SERVICE PROVIDER INFORMATION:

Service Provider	EIN#	Administration fees paid to the service provider *
Cigna Health and Life Insurance Company	59-1031071	\$58,846.98

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

Commissions: \$38,385.00

Service / Gen. Agent Fees: \$22,254.77

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

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

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

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

Direct Compensation for calendar year 2025 :** \$57,903.19

**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
Lasik- LCA-Vision Inc. 7840 Montgomery Road, Cincinnati, OH 45236 EIN# 11-2882328
Active & Fit- American Specialty Health Inc. 10221 Watteridge 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 2025, \$0.07 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: **1/1/2025** 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 2025, Cigna received indirect compensation from this vendor of approximately \$1.72 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2025 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")
- Effective Date: **1/1/2025** Cancel Date: **xx/xx/xxxx**
-

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claim Processing | 38 Participant communications | 50 Direct payments from the Plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO Agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation: **\$0 (see formula/estimate provided below)**
- (d) Name and EIN (address) of source of indirect compensation:
Omada Complete, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
 Omada Diabetes and Hypertension Cigna – Indirect compensation received by Cigna from this provider for services including:
 (i) explaining the availability of Omada Covered Services to CHLIC existing and prospective clients; (ii) encouraging the use of Omada Covered Services by Screened Participants that CHLIC has identified as potentially benefitting from the Omada Covered Services, and (iii) enrollment of Screened Participants in the Omada Covered Services.
 Indirect Compensation Formula/Estimate:
 For calendar year 2025, Cigna received indirect compensation from this vendor of approximately \$0.19 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2025 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")

Effective Date: **1/1/2025**

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

Cigna

Plan Detail Report

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

For Plan Year Beginning: January 01, 2025

and Ending: December 31, 2025

Name of Plan: DOT Compliance Group

Plan #: 00657820

PREMIUMS PLAN DETAIL

<u>BENEFIT</u>	<u>PREMIUMS</u>	<u>ADMIN FEES*</u>	<u>TERMINATION PREMIUM</u>	<u>TERMINATION FEES</u>	<u>STATE CONTINUATION FEES</u>	<u>TOTAL PAID</u>
MEDICAL	\$321,553.27	\$39,328.79	\$0.00	\$0.00	\$0.00	\$360,882.06
TOTALS	\$321,553.27	\$39,328.79	\$0.00	\$0.00	\$0.00	\$360,882.06

COMMISSIONS PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL COMM PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
MEDICAL	\$38,385.00	571997	GENEROUS BENEFITS LLC
TOTAL	\$38,385.00		

BENEFIT ADVISOR FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
TOTAL			

SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
MEDICAL	\$22,254.77	302347	CENTERSTONE INS & FIN SVC LLC
TOTAL	\$22,254.77		

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

<u>TOTAL PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
TOTAL		

EXPOSURES DETAIL (Last Month of the Plan Period)

<u>BENEFIT</u>	<u>EMPLOYEE</u>	<u>DEPENDENT</u>	<u>SPOUSE</u>	<u>FAMILY</u>	<u>CHILD</u>
MEDICAL	67	0	8	4	10

*Admin Fees Include Commissions

Sys 2/10/2026



10 Hudson Yards
New York, NY 10001
guardianlife.com

LAVERNA CULLOP
DOT COMPLIANCE GROUP LLC
2350 AIRPORT FREEWAY SUITE 455
BEDFORD, TX 76022

April 16, 2026

Plan Number : 00020682
Anniversary Date : 1/1/26

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

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

EIN : 13-5123390

NAIC: 64246

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

Certified to be correct

The Guardian Life Insurance Company of America.

1-800-459-9401



Name of Plan : **DOT COMPLIANCE GROUP LLC**

Plan Number : **00020682**

Data for Period From : **1/1/25** To : **12/31/25**

The approximate number of employees covered at the end of the plan year : 88

Group Insurance coverage(s) included under this Plan :

Accident, AD&D, Dental (Insured), Life, Long Term Disability, Optional AD&D, Optional Life, Short Term Disability (Insured), Vision (Insured), Voluntary Critical Illness

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

Contract Identification	Name and Address of Recipient of Commissions	
000MY755	GENEROUS BENEFITS 537 HOUSTON STREET COPPELL TX 75019	
	Group Insurance Coverage(s) For Above Contract	Commissions Paid
	Accident	1,772.84
	AD&D	30.61
	Cancer	137.35
	Dental (Insured)	6,112.29
	Life	260.13
	Long Term Disability	1,801.67
	Optional AD&D	584.96
	Optional Life	4,322.93
	Short Term Disability (Insured)	1,912.39
	Vision (Insured)	950.68
	Voluntary Critical Illness	3,048.47
	Voluntary Hospital Indemnity	110.15
	Total For Contract:	21,044.47
Total Commissions Paid On Plan:		21,044.47

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

Contract Identification	Name of Recipient of Fees	Amount
000MY755	GENEROUS BENEFITS	\$2,789.04



Contract Identification	Name of Recipient of Fees	Amount
	Total Fees Paid	\$2,789.04

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

Recipient of One Time Reimbursement	Amount Paid
Total Fees Paid:	

Group Insurance Coverage(s) For Above Contract	Gross Premium Paid
Accident	8,864.21
AD&D	170.00
Cancer	597.17
Dental (Insured)	61,122.94
Life	1,445.21
Long Term Disability	10,009.30
Optional AD&D	3,249.80
Optional Life	24,016.31
Short Term Disability (Insured)	12,749.34
Vision (Insured)	9,506.73
Voluntary Critical Illness	13,254.23
Voluntary Hospital Indemnity	611.96
Totals:	145,597.20
Premium due and unpaid at the end of plan year:	0

Name of Plan: **DOT COMPLIANCE GROUP LLC**

Plan Number: **00020682**

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

Contract Identification (a)	Name and Address of Recipient of Indirect Compensation (a)	Amount (c)
	Total Indirect Compensation Paid:	

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

Service Code (b)	Name and Address (d)	Indirect Compensation (e)