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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 09/01/1972

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)
SOUTHERN METHODIST UNIVERSITY

3140 DYER ST MS261
6116 N CENTRAL EXPRESSWAY, STE 203
DALLAS, TX 75275-0261

2b Employer Identification Number (EIN)
75-0800689

2c Plan Sponsor's telephone number
214-768-2004

2d Business code (see instructions)
611000

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.	07/31/2026	MAI BUI
	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**	5524
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)**	5106
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	5070
b	Retired or separated participants receiving benefits	**6b**	159
c	Other retired or separated participants entitled to future benefits	**6c**	64
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5293
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
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 4E 4F 4B

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] 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)** [X] 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 7
- **(4)** [X] **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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
VSP

(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
06-1227840	39616	30016102	1999	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
4925	45102

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

HOLMES MURPHY AND ASSOCIATES INC
12712 PARK CENTRAL DR STE 100
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4925	45102	ADMIN FEES	

(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	

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	(c) Amount	**(d)** Purpose	

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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	

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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [X] 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)**	265305		
(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)**	265305
b Benefit charges (1) Claims paid	**9b(1)**	223406		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	223406
(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**	
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. ▶

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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
MAGELLAN HEALTH SERVICES INC.

(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
52-2135463	54199	SMUV0-001	2734	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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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	(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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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	89508
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. ▶

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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
THE STANDARD AD&D

(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
93-0242990	69019	750966	969	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

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

RELATION INSURANCE SERVICES DBA PRE
10425 S 82ND AVE 110
TULSA, OK 74133

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

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

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

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	(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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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**	92848
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. ▶

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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
THE STANDARD SUPP

(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
93-0242990	69019	750966	650	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

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

RELATION INSURANCE SERVICES DBA PRE
10425 S 82ND AVE 110
TULSA, OK 74133

(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	

(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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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**	579406
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. ▶

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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
THE STANDARD DEP LIFE

(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
93-0242990	69019	750966	486	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

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

RELATION INSURANCE SERVICES DBA PRE
10425 S 82ND AVE 110
TULSA, OK 74133

(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	

(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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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	59708
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. ▶

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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
THE STANDARD VOLUNTARY (HI,CI,AI)

(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
93-0242990	69019	750966	405	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
92192	

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY
STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
76139			3

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

IBENEFIT COMMUNICATION LLC
6230 FAIRVIW RD STE 210
SUITE 311
CHARLOTTE, NC 28210

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
16053			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. 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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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**	271470
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 [X] 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

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

A Name of plan
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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
THE STANDARD TEMPORARY DISABILITY (SHORT TERM)

(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
93-0242990	69019	750966	275	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
5491	13837

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

RELATION INSURANCE SERVICES INC
12400 COIT RD
STE 100
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	13837	CONTINGENT COMPENSATION	3

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

RELATION INSURANCE SERVICES INC
12400 COIT RD
STE 100
DALLAS, TX 75251

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5491			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. 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	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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**	80141
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. ▶

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
SOUTHERN METHODIST UNIVERSITY MEDICAL AND OTHER PLANS

B Three-digit plan number (PN) ▶ 502

C Plan sponsor's name as shown on line 2a of Form 5500
SOUTHERN METHODIST UNIVERSITY

D Employer Identification Number (EIN)
75-0800689

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

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

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)

BLUECROSS BLUESHIELD OF TEXAS

36-1236610

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	ASO ADMINISTRATOR-MEDICAL	3517568	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

HOLMES MURPHY & ASSOCIATES INC

42-0985055

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	BROKER	248849	Yes [X] No [ ]	Yes [X] No [ ]	19696	Yes [ ] No [X]

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

AVANT SPECIAL BENEFITS, LLC

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
	BROKER	0	Yes [X] No [ ]	Yes [X] No [ ]	70012	Yes [ ] No [X]

Part I Service Provider Information (continued)

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

Magellan Healthcare
14100 Magellan Plaza
Maryland Heights, MO 63043

Magellan HEALTHCARE℠

June 30, 2026

Customer ID: SMUV0-001
Customer Name: SOUTHERN METHODIST UNIVERSITY

To Whom it May Concern -

Below are the figures that you requested for filing Schedule A/ Form 5500 for calendar year 2025.

2025

Number of Employees Covered at Period's End	2,734 ees
Monthly Per Cap Rate	$ 2.78
Total Premiums Paid for EAP	$ 89,507.66*
Total Premiums Due & Unpaid at Period's End	$ 7,600.52
Administrative and Other Charges Paid	$ 0.00
Dollar Total (Paid & Unpaid 2024 EAP)	$ 97,108.18
Broker / Broker Address	Holmes Murphy 12712 Park Central Dr, Ste 100 Dallas, TX 75251
Commission Paid 0%	$ 0.00

*Premiums Paid includes $ 7,428.16 that was outstanding on 2024 Schedule A.

Magellan Healthcare Tax ID#/EIN: 52-2135463
NAICS #: 541990 Other Professional Services NAIC: Not Applicable

Please send future correspondence to:
Magellan Healthcare
Finance Department
14100 Magellan Plaza
Maryland Heights, Missouri 63043

If you have questions regarding this information, please email me at EMGantner@magellanhealth.com.

Sincerely –

Elaine Gantner
Senior Accounting Coordinator

Schedule A Form (5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 or Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation.

IF YOU HAVE QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICE.

Group ID: **30016102**
Insurance Carrier: Vision Service Plan
Insurance Carrier NAIC Code: 39616
Insurance Carrier FEIN: **061227840**
Benefit Type: Vision Care
Policy or Contract Year: **01/01/2025 - 12/31/2025**

Group Legal Name and Address:

SOUTHERN METHODIST UNIVERSITY
6425 Boaz St
Dallas TX 75205-1902

Approximate Number of Persons Covered at the End of Policy or Contract Year: **1,999**

Payments:

Total Administrative Fees Paid to Carrier:	**$ 45,101.98**
Total Payments Made to Carrier:	**$ 265,305.20**
Total Claims Paid by Carrier:	**$ 223,406.30**

Insurance Fees and Commissions Paid to Agents and Brokers:

Agent or Broker	Commissions/Fees **Paid for Policy or Contract Year**
Holmes, Murphy and Associates LLC **PO BOX 441** **DES MOINES IA 50302-0441**	**$4,925.39**

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate as of 06/19/2026 .

EXDM5500/ U-3909 / 30016102 / 1 / 20260619

Form M-1 Compliance Information

Attached to and made a part of
Form 5500
Annual Return/Report of Employee Benefit Plan

Taxpayer Name:	**Southern Methodist University**
Calendar Year:	**1/1/2025 – 12/31/2025**
EIN:	**75-0800689**
ASO Administrator/Insurance Company:	**Multiple**

Form M-1 Compliance Information

Please note that this 5500 reports information for several unrelated SMU benefits plans. None of the plans reported on this Form 5500 was subject to the Form M-1 filing requirements during the plan year above.

Attached to and made a part of
Form 5500
Annual Return/Report of Employee Benefit Plan

Taxpayer Name:	**Southern Methodist University**
Calendar Year:	**1/1/2025 – 12/31/2025**
EIN:	**75-0800689**
Insurance Company:	**Multiple**

Medical & Other 5500 – Clarifying Information

Please note that this 5500 reports information for several unrelated SMU benefit plans. Information specific to the separate plans is noted on the attached Schedules A or Schedule C, as applicable.

Attached to and made a part of
Form 5500
Annual Return/Report of Employee Benefit Plan

Taxpayer Name:	**Southern Methodist University**
Calendar Year:	**1/1/2025 – 12/31/2025**
EIN:	**75-0800689**
Insurance Company:	**The Standard**

Supplemental Life Insurance & Dependent Group Life Insurance – Schedules A

Please note that The Standard underwrites the SMU Basic Group Life, Supplemental Life, Dependent Life, and Accidental Death and Dismemberment insurance policies. Although Supplemental Life, Dependent Life, and Accidental Death and Dismemberment insurance information is reported on this 5500, the attached "Schedule A Info _The Standard" document provides combined information for all four plans (including Basic Group Life). Information specific to the Supplemental Life Insurance, Dependent Life Insurance, and Accidental Death and Dismemberment Insurance only is presented on this Form 5500 and the three distinct Schedules A, as applicable.

Premiums are segregated by plan but commissions and admin fees are not. Commissions and fees are reported under the separate Basic Group Life 5500.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

SHORT FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SOUTHERN METHODIST UNIVERSITY

PART I

1) COVERAGE - INDEMNITY CONTRACTS

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	750966
e) NUMBER OF PERSONS COVERED:	405
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: $92,191.94

FEES PAID / AMOUNT: $0.00

A) ID, NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
0000042582 DIGITAL INSURANCE LLC 300 GALLERIA PARKWAY STE 1100 ATLANTA, GA 330339	$76,138.66	$0.00	$0.00	$0.00		3
0000586933 IBENEFIT COMMUNICATION LLC 6230 FAIRVIW RD STE 210 SUITE 311 CHARLOTTE, NC 28210	$16,053.28	$0.00	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$92,191.94
TOTAL CONTINGENT COMP PAID	$0.00
TOTAL GA OVERRIDES PAID	$0.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

SHORT FORM INFORMATION

PART III - 750966

7) BENEFIT TYPE: INDEMNITY CONTRACTS

NON-EXPERIENCE RATED CONTRACT

a) TOTAL PREMIUM PAID TO CARRIER: $271,470.42

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SOUTHERN METHODIST UNIVERSITY

PART I

1) COVERAGE - LIFE INSURANCE

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	750966
e) NUMBER OF PERSONS COVERED:	2,739
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$91,399.67
FEES PAID / AMOUNT:	$0.00

A) ID, NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
0000596042 RELATION INSURANCE SERVICES INC 12400 COIT RD STE 1100 DALLAS, TX 75251	$91,399.67	$0.00	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$91,399.67
TOTAL CONTINGENT COMP PAID	$0.00
TOTAL GA OVERRIDES PAID	$0.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

PART III - 750966

7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$1,337,791.33	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$1,337,791.33
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$343,700.00	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$9,097.00	
(3) INCURRED CLAIMS ((1)+(2)):		$352,797.00
(4) CLAIMS CHARGED:		$352,797.00
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$91,399.67	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$135,482.34	
(E) TAXES:	$23,411.36	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$117,240.00	
(G) OTHER RETENTION CHARGES:	$617,461.63	
(H) TOTAL RETENTION:		$984,995.00
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$832,705.00
(3) OTHER RESERVES:		$0.00
di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SOUTHERN METHODIST UNIVERSITY

PART I

1) COVERAGE - LONG TERM DISABILITY

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	750966
e) NUMBER OF PERSONS COVERED:	2,666
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$32,455.32
FEES PAID / AMOUNT:	$0.00

A) ID, NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
0000596042 RELATION INSURANCE SERVICES INC 12400 COIT RD STE 1100 DALLAS, TX 75251	$32,455.32	$0.00	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$32,455.32
TOTAL CONTINGENT COMP PAID	$0.00
TOTAL GA OVERRIDES PAID	$0.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

PART III - 750966

7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$471,057.87	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$471,057.87
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$243,135.36	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$251,913.39	
(3) INCURRED CLAIMS ((1)+(2)):		$495,048.75
(4) CLAIMS CHARGED:		$495,048.75
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$32,455.32	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$0.00	
(D) OTHER EXPENSES:	$87,926.93	
(E) TAXES:	$8,243.52	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	$56,527.00	
(G) OTHER RETENTION CHARGES:	$0.00	
(H) TOTAL RETENTION:		$185,152.76
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$912,799.91
(3) OTHER RESERVES:		$0.00
di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION

IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500

IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: SOUTHERN METHODIST UNIVERSITY

PART I

1) COVERAGE - TEMPORARY DISABILITY

a) CARRIER:	Standard Insurance Company
b) EIN:	93-0242990
c) NAIC CODE:	000-69019
d) CONTRACT NUMBER:	750966
e) NUMBER OF PERSONS COVERED:	275
f) FROM:	1/1/2025
g) TO:	12/31/2025

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID:	$19,327.85
FEES PAID / AMOUNT:	$0.00

A) ID, NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID	B) AMOUNT OF COMMISSION PAID			FEES PAID		E) ORG. CODE
	COMM.	CONT. COMP*	GA OVR.	C) AMOUNT	D) PURPOSE	
0000596042 RELATION INSURANCE SERVICES INC 12400 COIT RD STE 1100 DALLAS, TX 75251	$5,490.89	$13,836.96	$0.00	$0.00		3

TOTAL COMMISSIONS PAID	$5,490.89
TOTAL CONTINGENT COMP PAID	$13,836.96
TOTAL GA OVERRIDES PAID	$0.00

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

PLAN INFORMATION REPORT FOR THE PERIOD OF 1/1/2025 TO 12/31/2025

LONG FORM INFORMATION

PART III - 750966

7) BENEFIT TYPE: TEMPORARY DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED:	$80,141.33	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID:	$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE:	$0.00	
(4) EARNED PREMIUM ((1)+(2) - (3)):		$80,141.33
b) BENEFIT CHARGES: (1) CLAIMS PAID:	$29,049.87	
(2) INCREASE (DECREASE) CLAIM RESERVES:	$8,731.00	
(3) INCURRED CLAIMS ((1)+(2)):		$37,780.87
(4) CLAIMS CHARGED:		$37,780.87
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:		
(A) COMMISSIONS:	$19,327.85	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES:	$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS:	$18,800.00	
(D) OTHER EXPENSES:	$16,994.87	
(E) TAXES:	$1,402.47	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES:	($8,226.96)	
(G) OTHER RETENTION CHARGES:	$0.00	
(H) TOTAL RETENTION:		$48,298.22
ci) DIVIDEND OR RETROACTIVE RATE REFUND:		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		$ 0.00
(2) CLAIM RESERVES:		$8,731.00
(3) OTHER RESERVES:		$0.00
di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:		$0.00

Standard Insurance Company HEREBY CERTIFIES THAT THIS INFORMATION IS COMPLETE AND ACCURATE

BlueCross BlueShield of Texas

FORM 5500 INFORMATION

Customer Name: Southern Methodist University ***Customer Account Number: 090138***
Financial Arrangement: ASO
Coverage Period: 01/01/2025 through 12/31/2025

1. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY OR CONTRACT PERIOD:		Medical	5293
		Dental	5035

2. EXPERIENCE RATED CONTRACTS

Premiums:	Amount billed	$50,686,022.77	
	Amount due but unpaid	$0.00	
	Total Premiums earned		$50,686,022.77
Benefit Charges:	Net Claims paid*	$54,958,318.31	
	Change in claim reserves	$0.00	
	Change in other reserves	$0.00	
	Physician Service Fees	$0.00	
	Total Claims paid		$54,958,318.31
Remainder Of Premium:	Commissions	$247,424.20	
	Service fees	$0.00	
	Drug Rebate Credits (under Pharm./Med.)	($6,216,627.72)	
	Administrative expenses	$1,696,907.98	
	Other (Interest credit)	$0.00	
	Total Retention		($4,272,295.54)
Experience or retroactive rate refunds			$0.00
Status of Policyholder Reserves at End of Year:			
	Amount held for benefits after retirement		$0.00
	Claim reserves		$0.00
	Other reserves		$0.00

3. NON EXPERIENCE RATED CONTRACTS

	Total Premiums earned	$1,813,435.30

4. COMMISSIONS AND CONSULTANT SERVICE FEES

Name Of Recipient	Amount Paid a. Base Commissions **	Amount Paid b. Other Fees/ Commissions ***	Amount Paid c. Special Programs ****
HOLMES, MURPHY AND ASSOCIATES, LLC	$248,849.02	$0.00	$19,696.00
AVANT SPECIALTY BENEFITS, LLC	$0.00	$0.00	$70,012.29

04/27/2026

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

*Based on the terms and conditions specified in the Agreement between the Contract Holder and BCBSTX.

**Base commissions paid on your contract.

***Other fees/commissions paid on your contract or policy such as consulting fees or General Agent commissions.

****Amounts based on producer's/consultant's block of business. If calculation exceeds program's defined fixed limit: the capped payment is allocated 1) between new sales and retention, based on corresponding proportions of uncapped payment (if applicable) and 2) to the account, based on account's uncapped payment as a percentage of total block uncapped payment. If block payment falls within program's fixed dollar limit and is based on a graded per employee schedule, account amount is calculated based on processing order subject to any account fixed limit. Resulting figures are combined with other special program defined payments (such as flat amount per head, percent of premium, or per account not subject to block fixed limit).

The settlement applies to the group numbers referenced on the Benefit Program Application and may include canceled group numbers if applicable.

NOTE: The above information is provided from business records of BCBSTX maintained in the ordinary course of BCBSTX's business to assist the plan administrator in complying with certain reporting requirements for Form(s) 5500. BCBSTX certifies that this information is accurate and complete to the best of its knowledge and belief.

The amounts shown in sections 4b and 4c are not typically applied as account-specific pricing adjustments to Admin Fees or Stop Loss premium.

FEIN (Federal Employer Identification Number): 36-1236610
NAIC Company Code: 70670

Employer Account Number	Parent Customer Name	Coverage Code	Claims Paid Month	Total Subscribers	Total Members	Dental	Medical-Facility	Medical-Professional	Pharmacy	Reimbursements	Value Based Care	Administration Fee	Administration Fee - Dental	Commission	Medical Rx Rebate Credit	Other Services	RX Rebate Credit	Specific Stop Loss Premium	Telehealth	Wellbeing Management	Other Services	ADPs	Total Charges
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jan-2025	2,511	5,354		$1,773,659.44	$1,186,556.35			$8,711.03	$123,462.03		$20,138.22	($6,277.50)			$152,643.69	$1,305.72	$7,658.31		$0.00	$3,267,857.29
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Feb-2025	2,494	5,340		$819,375.11	$1,090,928.44			$8,826.87	$122,635.74		$20,001.88	($6,235.00)	($0.00)		$151,610.26	$1,296.88	$7,607.06		$0.00	$2,216,047.24
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Mar-2025	2,501	5,342		$1,737,196.31	$1,267,365.42			$8,601.66	$122,978.97		$20,058.02	($6,252.50)	$0.00		$152,035.79	$1,300.52	$7,628.35		$0.00	$3,310,912.54
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Apr-2025	2,334	4,451		$1,863,364.65	$1,181,416.79		($32,753.94)	$9,044.46	$114,839.58		$18,718.68	($5,835.00)	$0.00		$141,883.86	$1,213.68	$7,123.50	($50,000.00)	$0.00	$3,249,016.26
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	May-2025	2,490	5,218		$1,454,487.05	$1,214,125.25			$9,260.27	$122,433.30		$19,969.80	($6,225.00)	$0.00		$151,367.10	$1,294.80	$7,594.50		$0.00	$2,974,307.07
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jun-2025	2,495	5,240		$1,441,644.75	$1,402,860.81		($139.39)	$9,498.24	$122,679.15		$20,009.90	($6,237.50)	$0.00		$151,671.05	$1,297.40	$7,609.75		$0.00	$3,150,894.16
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Jul-2025	2,496	5,280		$1,818,551.11	$1,555,220.67		($1,226.72)	$9,067.08	$122,733.12		$20,017.92	($6,240.00)	($0.00)		$151,731.84	$1,297.92	$7,613.10		$0.00	$3,678,766.04
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Aug-2025	2,511	5,271		$2,176,583.73	$1,478,775.42			$9,097.40	$123,466.83		$20,138.22	($6,277.50)	$0.00		$152,643.69	$1,305.72	$7,658.61		$0.00	$3,963,392.12
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Sep-2025	2,545	5,333		$1,678,746.55	$1,296,736.31		($5,529.97)	$9,086.61	$125,137.65		$20,410.90	($6,362.50)	$0.00		$154,710.55	$1,323.40	$7,762.25		$0.00	$3,282,021.75
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Oct-2025	2,519	5,281		$1,855,213.15	$1,745,255.63			$10,188.63	$123,863.07		$20,202.38	($6,297.50)	$0.00		$153,130.01	$1,309.88	$7,683.19		$0.00	$3,910,548.44
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Nov-2025	2,531	5,347		$1,315,896.96	$1,212,082.90			$10,571.63	$124,449.27		$20,298.62	($6,327.50)			$153,859.49	$1,316.12	$7,719.55		$0.00	$2,839,867.04
TX1-090138	SOUTHERN METHODIST UNIVERS	MD	Dec-2025	2,523	5,292		$2,749,579.96	$1,616,600.32			$10,456.15	$124,055.91		$20,234.46	($6,307.50)			$153,373.17	$1,311.96	$7,695.15		$0.00	$4,676,999.58
TX1-090138	SOUTHERN METHODIST UNIVERS	**MD Total**					**$20,684,298.77**	**$16,247,924.31**		**($39,650.02)**	**$112,410.03**	**$1,472,734.62**		**$240,199.00**	**($74,875.00)**	**$0.00**		**$1,820,660.50**	**$15,574.00**	**$91,353.32**	**($50,000.00)**	**$0.00**	**$40,520,629.53**
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jan-2025	2,511	5,354				$1,079,488.45								($407,620.30)					$0.00	$671,868.15
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Feb-2025	2,494	5,340				$895,368.25								($405,399.96)					$0.00	$489,968.29
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Mar-2025	2,501	5,342				$1,100,778.53								($406,482.82)					$0.00	$694,295.71
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Apr-2025	2,334	4,451				$991,982.54								($383,414.68)					$0.00	$608,567.86
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	May-2025	2,490	5,218				$1,506,342.36								($404,425.80)					$0.00	$1,101,916.56
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jun-2025	2,495	5,240				$1,215,970.84								($405,237.90)					$0.00	$810,732.94
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Jul-2025	2,496	5,280				$1,158,644.04								($405,670.72)					$0.00	$752,973.32
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Aug-2025	2,511	5,271				$1,714,421.26								($407,890.70)					$0.00	$1,306,530.56
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Sep-2025	2,545	5,333				$1,394,977.08								($413,358.90)					$0.00	$981,618.18
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Oct-2025	2,519	5,281				$1,738,025.11								($409,352.30)					$0.00	$1,328,672.81
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Nov-2025	2,531	5,347				$1,498,786.37								($411,085.02)					$0.00	$1,087,701.35
TX1-090138	SOUTHERN METHODIST UNIVERS	RX	Dec-2025	2,523	5,292				$1,561,888.29								($409,785.66)					$0.00	$1,152,102.63
TX1-090138	SOUTHERN METHODIST UNIVERS	**RX Total**							**$15,856,673.12**								**($4,869,724.76)**					**$0.00**	**$10,986,948.36**
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jan-2025	2,448	5,139	$207,322.28							$6,756.48									$0.00	$214,078.76
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Feb-2025	2,441	5,134	$216,971.71							$6,737.16									$0.00	$223,708.87
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Mar-2025	2,462	5,172	$197,999.35							$6,795.12									$0.00	$204,794.47
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Apr-2025	2,245	4,097	$221,671.70							$6,196.20									$0.00	$227,867.90
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	May-2025	2,439	5,008	$212,225.80							$6,731.64									$0.00	$218,957.44
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jun-2025	2,427	5,013	$213,558.45							$6,698.52									$0.00	$220,256.97
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Jul-2025	2,436	5,026	$228,671.74							$6,723.36									$0.00	$235,395.10
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Aug-2025	2,414	4,989	$223,387.69							$6,662.64									$0.00	$230,050.33
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Sep-2025	2,471	5,069	$182,149.76							$6,819.96									$0.00	$188,969.72
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Oct-2025	2,473	5,069	$189,730.47							$6,825.48									$0.00	$196,555.95
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Nov-2025	2,462	5,057	$173,146.34							$6,795.12									$0.00	$179,941.46
TX1-090138	SOUTHERN METHODIST UNIVERS	DN	Dec-2025	2,451	5,029	$215,935.95							$6,764.76									$0.00	$222,700.71
TX1-090138	SOUTHERN METHODIST UNIVERS	**DN Total**				**$2,482,771.24**							**$80,506.44**									**$0.00**	**$2,563,277.68**
TX1-090138	**SOUTHERN METHODIST UNIVERSITY Total**					**$2,482,771.24**	**$20,684,298.77**	**$16,247,924.31**	**$15,856,673.12**	**($39,650.02)**	**$112,410.03**	**$1,472,734.62**	**$80,506.44**	**$240,199.00**	**($74,875.00)**	**$0.00**	**($4,869,724.76)**	**$1,820,660.50**	**$15,574.00**	**$91,353.32**	**($50,000.00)**	**$0.00**	**$54,070,855.57**