Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2015** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2015 or fiscal plan year beginning 01/01/2015 and ending 12/31/2015

A This return/report is for:
- [ ] a multiemployer plan;
- [X] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or
- [ ] a single-employer plan;
- [ ] a DFE (specify) ____

B This return/report is:
- [X] 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:
- [X] Form 5558;
- [ ] automatic extension;
- [ ] the DFVC program;
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
AUTOMEP OPEN MULTIPLE EMPLOYER 401(K) PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan 01/01/2015

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

100 TERRA BELLA DR
YOUNGSTOWN, OH 44505

2b Employer Identification Number (EIN) 34-1781113

2c Plan Sponsor's telephone number 800-451-2865

2d Business code (see instructions) 524290

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.	10/14/2016	PAMELA L BOBERSKY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2016	PAMELA L BOBERSKY
	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

Preparer's name (including firm name, if applicable) and address (include room or suite number)

Preparer's telephone number

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 has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b** EIN	
a Sponsor's name	**4c** PN	
5 Total number of participants at the beginning of the plan year	**5**	8
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)**	8
a(2) Total number of active participants at the end of the plan year	**6a(2)**	15
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	2
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	17
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	0
f Total. Add lines **6d** and **6e**.	**6f**	17
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	16
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	0
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:
2E 2G 2J 2K 2S 2T 3D

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

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [ ] Insurance	**(1)** [ ] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	**(2)** [ ] Code section 412(e)(3) insurance contracts
(3) [X] Trust	**(3)** [X] Trust
(4) [ ] General assets of the sponsor	**(4)** [ ] General assets of the sponsor

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

a Pension Schedules

(1) [ ] **R** (Retirement Plan Information)

(2) [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

(1) [ ] **H** (Financial Information)

(2) [ ] **I** (Financial Information – Small Plan)

(3) [ ] ___ **A** (Insurance Information)

(4) [ ] **C** (Service Provider Information)

(5) [ ] **D** (DFE/Participating Plan Information)

(6) [ ] **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 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_____

Multiple Employer Plan Participating Employer Information

For the plan year beginning 01/01/2015 and ending 12/31/2015

Name of plan	PN:
AutoMEP Open Multiple Employer 401(k) Plan	002
Sponsor Name:	**EIN:**
AMI Benefit Plan Administrators Inc	34-1781113

Sponsor Name	EIN	Percent of Total Contributions
MedAvail Technologies, Inc.	36-4794085	100.00 %
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