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

2018

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must attach a list of 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)

Part II Basic Plan Information—enter all requested information

1a Name of plan
MAGUIRE AUTOMOTIVE LLC WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/01/2018

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)
MAGUIRE AUTOMOTIVE LLC WELFARE PLAN

504 S MEADOW ST
ITHACA, NY 14850-5317

504 S MEADOW ST
ITHACA, NY 14850-5317

2b Employer Identification Number (EIN)
26-0547998

2c Plan Sponsor's telephone number
607-282-8000

2d Business code (see instructions)
441110

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.	12/18/2019	FRANCIS LOIACONO
	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
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	244
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)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	281
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	281
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	281
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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 Characteristics Codes in the instructions:

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

4A

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] 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)** [ ] 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

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **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 2018 Form M-1 annual report. If the plan was not required to file the 2018 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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan
MAGUIRE AUTOMOTIVE LLC WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MAGUIRE AUTOMOTIVE LLC WELFARE PLAN

D Employer Identification Number (EIN)
26-0547998

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
EXCELLUS BLUE CROSS BLUE SHIELD

(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
15-0329043	55107	00113315	281	06/01/2018	05/31/2019

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
46584	

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

ENV INSURANCE AGENCY
7789 OSWEGO ROAD
LIVERPOOL, NY 13090

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
46584			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		
	(c) Amount	(d) Purpose	(e) Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [X] 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)**	325921		
(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)**	325921
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**	
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. ▶

Excellus
165 Court Street
Rochester, NY 14647
A nonprofit independent licensee of the Blue Cross Blue Shield Association

12/17/2019

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,

Dear Group Representative:

Enclosed is information related to your group's health plan. If your plan complies with ERISA and files IRS Form 5500, this information pertains to the Schedule A and/or Schedule C attachment.

Instructions on how to complete Form 5500, along with guidance on who must file, can be found online at www.dol.gov (Forms, 5500 Series). Assistance is also available by calling the EFAST2 Help Line at 1-866-463-3278.

Please contact your health plan sales consultant for any questions regarding the enclosed information.

Sincerely,



Arthur J. Hameline IV
Manager | Finance Operations
Enclosure

182378351 000002 00001 00002 00 000006

Excellus
165 Court Street
Rochester, NY 14647
A nonprofit independent licensee of the Blue Cross Blue Shield Association

Data Information for IRS Form 5500, Schedule A 5500 Insurance Information

Group Name **Funding Arrangement** Stop Loss

Group Address ,

Reporting Period 6/1/2018 - 5/31/2019

Part I - Information Concerning Insurance Contract Coverage, Fees, and Commissions

1. Coverage Information

1.(a) Name of Insurance Carrier EXCELLUS BLUE CROSS BLUE SHIELD

1.(b)	1.(c)	1.(d)	1.(e)	1.(f)	1.(g)
EIN	NAIC Code	Contract Number	Contracts at end of Plan Year	Policy or Contract Year From	Policy or Contract Year To
15-0329043	55107	00113315	281	6/1/2018	5/31/2019

2. Insurance Fee and Commission Information

2.(a) Total amount of commissions paid $46,584.96

3. Persons Receiving Commissions and Fees

3.(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	3.(b) Commission Paid	3.(c) Organization Code
ENV Insurance Agency, LLC, 7789 Oswego Road, Liverpool, NY, 13090	$46,584.96	3
Commission Total:	$46,584.96	

Part III - Welfare Benefit Contract Information

8. Benefit and Contract Type STOP LOSS

Plan Type Stop Loss

Group Number	Subgroup Number	Contracts at End of Plan Year	10.(a) Premium Amount Received	Claims Paid	Commissions (Socialized Brokerage)	Administrative Service or Other Fees	Total Retention	Other Reserves
00113315	0001	14	$18,013.14	N/A	N/A	N/A	N/A	N/A
00113315	0002	14	$16,538.38	N/A	N/A	N/A	N/A	N/A
00113315	0003	7	$10,112.64	N/A	N/A	N/A	N/A	N/A
00113315	0004	25	$30,864.62	N/A	N/A	N/A	N/A	N/A
00113315	0005	11	$13,062.16	N/A	N/A	N/A	N/A	N/A
00113315	0006	0	$210.68	N/A	N/A	N/A	N/A	N/A
00113315	0008	3	$4,213.60	N/A	N/A	N/A	N/A	N/A
00113315	0009	3	$3,370.88	N/A	N/A	N/A	N/A	N/A
00113315	0010	7	$8,637.88	N/A	N/A	N/A	N/A	N/A
00113315	0011	3	$3,792.24	N/A	N/A	N/A	N/A	N/A
00113315	0012	5	$6,004.38	N/A	N/A	N/A	N/A	N/A

Note: This is not the actual IRS Form 5500 Schedule A. This is an informational data sheet only.
MRP 6826

			10.(a)					
Group Number	Subgroup Number	Contracts at End of Plan Year	Premium Amount Received	Claims Paid	Commissions (Socialized Brokerage)	Administrative Service or Other Fees	Total Retention	Other Reserves
00113315	0015	7	$10,744.68	N/A	N/A	N/A	N/A	N/A
00113315	0016	1	$1,369.42	N/A	N/A	N/A	N/A	N/A
00113315	0017	6	$6,636.42	N/A	N/A	N/A	N/A	N/A
00113315	0018	2	$2,528.16	N/A	N/A	N/A	N/A	N/A
00113315	0020	1	$1,896.12	N/A	N/A	N/A	N/A	N/A
00113315	0022	2	$3,581.56	N/A	N/A	N/A	N/A	N/A
00113315	0025	14	$16,643.72	N/A	N/A	N/A	N/A	N/A
00113315	0026	2	$2,317.48	N/A	N/A	N/A	N/A	N/A
00113315	0027	3	$3,897.58	N/A	N/A	N/A	N/A	N/A
00113315	0028	2	$2,528.16	N/A	N/A	N/A	N/A	N/A
00113315	0029	8	$8,005.84	N/A	N/A	N/A	N/A	N/A
00113315	0030	7	$8,637.88	N/A	N/A	N/A	N/A	N/A
00113315	0031	4	$5,793.70	N/A	N/A	N/A	N/A	N/A
00113315	0032	5	$7,584.48	N/A	N/A	N/A	N/A	N/A
00113315	0033	1	$1,264.08	N/A	N/A	N/A	N/A	N/A
00113315	0034	8	$8,321.86	N/A	N/A	N/A	N/A	N/A
00113315	0036	6	$8,532.54	N/A	N/A	N/A	N/A	N/A
00113315	0037	5	$6,320.40	N/A	N/A	N/A	N/A	N/A
00113315	0038	17	$18,750.52	N/A	N/A	N/A	N/A	N/A
00113315	0039	46	$54,355.44	N/A	N/A	N/A	N/A	N/A
00113315	0040	23	$24,122.86	N/A	N/A	N/A	N/A	N/A
00113315	0041	2	$526.70	N/A	N/A	N/A	N/A	N/A
00113315	0042	15	$5,372.34	N/A	N/A	N/A	N/A	N/A
00113315	C015	1	$105.34	N/A	N/A	N/A	N/A	N/A
00113315	C034	1	$1,264.08	N/A	N/A	N/A	N/A	N/A
	Totals:	281	$325,921.96	N/A	N/A	N/A	N/A	N/A