

3a Plan administrator's name and address <input checked="" type="checkbox"/> 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:		4b EIN
a Sponsor's name		4d PN
c Plan Name		
5 Total number of participants at the beginning of the plan year		5 816
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) 816
a(2) Total number of active participants at the end of the plan year		6a(2) 802
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 802
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e
f Total. Add lines 6d and 6e		6f 802
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 4D		

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> 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)

<p>a Pension Schedules</p> <p>(1) <input type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p>	<p>b General Schedules</p> <p>(1) <input type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information – Small Plan)</p> <p>(3) <input checked="" type="checkbox"/> 1 A (Insurance Information)</p> <p>(4) <input checked="" type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p>
--	---

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 2022 Form M-1 annual report. If the plan was not required to file the 2022 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 _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2022</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **12/31/2022**

<p>A Name of plan STRYKER PUERTO RICO LTD</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 STRYKER PUERTO RICO HEALTH AND DENTAL PLAN</p>	<p>D Employer Identification Number (EIN) 66-0604112</p>	

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
DELTA DENTAL OF PUERTO RICO, 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
68-0652604	47085	2314	818	01/01/2022	12/31/2022

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.

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">10487</p>	<p>(b) Total amount of fees paid</p>
--	---

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

MARSH SALDANA INC **PO BOX 9023549**
SAN JUAN, PR 00902

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
10487		BROKER	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	

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	209743		
(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)		209743
b Benefit charges (1) Claims paid	9b(1)	184505		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))		9b(3)		184505
(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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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 No
- 12** If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE C
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider 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.**

OMB No. 1210-0110

2022

This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

A Name of plan <u>STRYKER PUERTO RICO LTD</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>STRYKER PUERTO RICO HEALTH AND DENTAL PLAN</u>	D Employer Identification Number (EIN) <u>66-0604112</u>	

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

MCS LIFE INSURANCE COMPANY

MCS PLAZA
255 PONCE DE LEON AVENUE
SAN JUAN, PR 00902

66-0520918

(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

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)

MARSH SALDANA INC

PO BOX 9023549
SAN JUAN, PR 00902

(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?
22	BROKER	36480	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

IKON BENEFITS GROUP

270 AVE MUNOZ RIVERA
SAN JUAN, PR 00918

(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?
22	INSURANCE SERVICES	74675	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

(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?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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:

This Data Required for Completion of
Schedule C
 Insurance Information (Form 5500)



MCS Life Insurance Company

Company Identification Number: 66-0520918
 NAIC Code: 60030

For plan year beginning January 1, 2022 and ending December 31, 2022
 Name of the plan (STRYKER PUERTO RICO LTD)

PART I

2. Coverage (a) Name of Insurance Carrier	(b) Contract number or identification	(c) Approximate number of persons covered at beginning of policy or contract year	(d) Approximate number of persons covered at end of policy or contract year	Policy / Contract Year	
				(e) From	(f) Through
MCS Life Insurance Company	79-750092	816	802	01/01/22	12/31/22

3. Fees paid to agents and brokers

(a) Contract number or identification	(b) Name, EIN number and address of the agents or brokers to whom fees were paid	(c) Amount of fees paid	(d) Fees paid	Purpose
				Commissions
79-750092	IKON BENEFITS GROUP - MARSH SALDAÑA	\$74,675.02		
		\$36,480.99		

PART II Service Provider Information

4.(a) Contract number or identification	(b) Type of Benefit	(cont'd)
79-750092	Health	(c) List gross premium for each contract N/A
		(d) Premium rate or subscription charge (manual rates as adjusted by formula) N/A

5. Service Fees	(a) Benefit charges:		
	(i) Claims paid	\$4,011,442.32	
	(b) Remainder of premium:		
	(i) Retention charges (on an accrual basis)	\$ 412,773.95	
		(Administrative Fees)	

COMMENTS:

REGISTAR > _____

NOTE TO POLICYHOLDERS: The information certified above is furnished to enable the plan administrator to complete Schedule C (Form 5500) required by the International Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by Medical Card System, Inc. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with Medical Card System, Inc.

Medical Card System, Inc. hereby certifies that the foregoing statement is complete and accurate and based on the best available estimated data that Medical Card System, Inc. as at this time.

Experience – Rated Contracts

This Data Required for Completion of
Schedule A
Insurance Information (Form 5500)



MCS Life Insurance Company

Company Identification Number: 66-0520918
NAIC Code: 60030

For plan year beginning January 1, 2022 and ending December 31, 2022
Name of the plan (STRYKER PUERTO RICO LTD)

PART I Summary of All Insurance Contracts included in Part III

2. Coverage (a) Name of Insurance Carrier	(b) Contract number or identification	(c) Approximate number of persons covered at beginning of policy or contract year	(d) Approximate number of persons covered at end of policy or contract year	Policy / Contract Year	
				(e) From	(f) Through
MCS Life Insurance Company	79-750092	816	802	01/01/22	12/31/22

3. Insurance fees and commissions paid to agents and brokers

(a) Contract number or identification	(b) Name, EIN number and address of the agents or brokers to whom commissions were paid	(c) Amount of reinsurance paid	(d) Fees paid	
			Amount	Purpose
79-750092	INTERNATIONAL REINSURANCE MANAGERS, LLC 7205 Corporate Center Drive – Suite #410 Miami, FL 33126	\$105,040.95		

4. Premiums due and unpaid at the end of the plan year contract number or identification number # 79-750092

PART III Insured Welfare Plan: Provide information for each contract on a separate Part III. If more than one contract covers the same group of employees of the same employer (s), or members of the same employee organization (s) the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

5.(a) Contract number or identification	(b) Type of Benefit	(cont'd)
79-750092	STOP LOSS	(c) List gross premium for each contract
		(d) Premium rate or subscription charge (manual rates as adjusted by formula)

6. Experience Rated Contracts

(a) Premiums:		
(i) Amount received		
(ii) Increase (decrease) in amount due but unpaid		
(iii) Increase (decrease) in unearned premium reserve		
(iv) Premium earned, (i) plus (ii) minus (iii)		
(b) Benefit charges:		
(i) Claims paid		
(ii) Increase (decrease) in claim reserves		
(iii) Incurred claims, (i) plus (ii)		
(iv) Claims charged		
I Remainder of premium:		
(i) Retention charges (on an accrual basis)		
(A) Commissions		
(B) Administrative service or other fees		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charge for risks or contingencies		
(G) Other retention charges		
(H) Total retention		
(ii) Dividends or retroactive rate refunds (such amounts were <input type="checkbox"/> paid in cash or <input type="checkbox"/> credited)		
(d) Status of policyholder reserves at the end of year:		
(i) Amount held to provide benefits after retirement		
(ii) Claim reserves		
(iii) Other reserves		
(e) Dividends or retroactive rate refunds arising from experience in previous policy reporting years		

COMMENTS:

REGISTAR > _____

NOTE TO POLICYHOLDERS: The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the International Revenue Service. Some of the terms used in the official forms are susceptible to different interpretations and all of the information requested is not readily available under the accounting methods employed by Medical Card System, Inc. Of course, nothing contained in the certified statement above diminishes or otherwise modifies your rights and privileges under the contracts with Medical Card System, Inc.

Policyholder acknowledges that the information provided by Medical Card System, Inc. is based on the best available estimated data that Medical Card System, Inc. has at this time and solely consists on the information required to be provided by Medical Card System, Inc. for this purpose. Therefore the plan administrator is responsible for verifying the accuracy of the information provided and for complimenting the Schedule with other information for which Medical Card System, Inc. has no information available.

INSURANCE CERTIFICATION

SCHEDULE A
(FORM 5500)

PART I COVERAGE

NAME OF INSURANCE CARRIER: **DELTA DENTAL OF PUERTO RICO, INC.**
SOCIAL SECURITY NO. OR ID NUMBER 68-0652604
NAIC CODE 47085

POLICY NAME: **STRYKER PUERTO RICO, LTD**
POLICY PERIOD: From: 1/1/2022 To: 12/31/2022

CONTRACT OR POLICY NUMBER: **GROUP NO.**
2314

APPROXIMATE # OF PERSONS COVERED **EMPLOYEES**
AT THE END OF POLICY OR CONTRACT YEAR: 818

POLICY OR CONTRACT YEAR 1/1/2022 12/31/2022

PART II COMMISSIONS/FEES

a) **AGENT NAME:** MARSH SALDAÑA
b) **ADDRESS:** BOX 9023549
SAN JUAN, PR 00902-3549

NONE

c) **COMMISSIONS AMOUNT:** **\$10,487.16**


PART III WELFARE BENEFITS CONTRACT

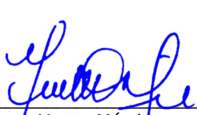
TYPE OF BENEFIT: DENTAL PLAN

LIST PAID PREMIUMS FOR EACH CONTRACT: **\$209,743.27**

LIST PAID CLAIMS FOR EACH CONTRACT: **\$184,505.84**

MONTHLY RATES
SINGLE: \$9.37
COUPLE: \$24.04
FAMILY: \$24.74

Prepared by: 
Angely Nieves

Authorized by: 
Yvette Méndez

Note to policyholders: The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Services. Some of the terms used in the official form are susceptible to different interpretations. Therefore the plan administrator is responsible for verifying the accuracy of the information provided and for complementing the Schedule with other information for which Delta Dental of PR Inc. has no information available. For further information about filing, please contact your attorney or tax consultant.