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

2022

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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)

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
INTEGRIY FOODS EMPLOYEE GROUP HEALTH PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/2017

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)
INTEGRITY FOODS INC

575 OLD HULL RD
ATHENS, GA 30601-1571

575 OLD HULL RD
ATHENS, GA 30601-1571

2b Employer Identification Number (EIN)
20-0266938

2c Plan Sponsor's telephone number
706-543-2502

2d Business code (see instructions)
311610

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.	07/19/2023	NICK JANES
	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**	105
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)**	105
a(2) Total number of active participants at the end of the plan year	**6a(2)**	113
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**	113
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	113
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 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_____

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

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
INTEGRIY FOODS EMPLOYEE GROUP HEALTH PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
INTEGRITY FOODS INC

D Employer Identification Number (EIN)
20-0266938

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
ALLIED NATIONAL, 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
46-1625757		282929	113	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.

(a) Total amount of commissions paid	(b) Total amount of fees paid
	41451

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

ALLIED NATIONAL, INC
P.O. BOX 29187
SHAWNEE MISSION, KS 66207

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	21521		

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

MARSH & MCLENNAN AGENCY LLC
8144 WALNUT HI FI 15
DALLAS, TX 75231

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	9965		

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

JOHN E HEIL

1699 WALL ST # 506
MOUNT PROSPECT, IL 60056

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	9965		

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [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** [ ] 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)**	62280		
(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)**	62280
b Benefit charges (1) Claims paid	**9b(1)**	710		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	710
(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)**	34600		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	6920		
(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)**	41520
(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)**	24880
(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. ▶

ALLIED NATIONAL
A 90 Degree Benefits Company

Date: 05-19-2023

Integrity Foods
PO BOX 81272
ATHENS, GA 30608

Re: 5500 Filing Information

Dear Plan Sponsor:

Listed below is the information you need from Allied to submit a Form 5500 or 5500-SF filing, and to distribute a Summary Annual Report (SAR), for your self-funded employee welfare benefit plan (Plan). Form 5500 must be filed within 210 days, and the SAR distributed within 270 days, of the end of the Plan Year (July 31 & September 30 for calendar year plans). Plans with less than 100 participants should be able to file the Form 5500-SF while plans with 100 or more must file the standard Form 5500.

The plan year data provided is for the period of time between the "Effective date of plan" and "Ending period of report" shown below. By default Allied generates this report assuming your 5500 filing is based on a calendar year plan (12 months beginning on January 1st). If your plan is reporting on other than a calendar year basis please contact Allied at the end of your plan year to obtain this report for your specific plan year period. This information should be provided to your tax advisor to prepare the appropriate form(s). The appropriate section numbers for form 5500SF are designated for each piece of info.

- Part IA - Your self-funded plan is "a single-employer plan" unless you have included participants in another company that causes this to be a "multiemployer plan". If participants are from companies outside your "control group" you should discuss this with your tax advisor.

- 1a: Name of Plan: Integrity Foods Employee Group Health Plan
- 1b: Three-digit plan number: 501
- 1c: Effective date of plan: 01-01-2022
- Ending period of report: 12-31-2022
- 5a: Total number of participants at the beginning of the plan year: 105
- 5b: Total number of participants at the end of the plan year: 113
- 6a: Were all of the plan's assets during the plan year invested in eligible assets? Yes
- 9b: Welfare benefit type: 4A

7a(a): Total plan assets start of plan year:	$26,973.79
7a(b): Total plan assets end of plan year:	$24,879.99 – Cash Reserves 9(d)(2)
7b(a): Total plan liabilities start of plan year:	$0.00
7b(b): Total plan liabilities end of plan year:	$0.00
Total income - total amount of all contributions for year:	$62,280.00 – 9a(1)
8d: Benefits Paid (total benefits less any stop loss payments):	$710.01 – 9b(1)
8e: Distributions (refunds):	$22,143.79
8f: Administrative Service Providers:	$34,600.00 – Admin SVC 9c(1)(B)
8g: Other expenses (Stop loss premium paid): 41,520	$6,920.00 9c(1)(D)

The information on the next page is only for Form 5500 and is not for use with 5500-SF as no fees or commissions are paid to any agents or brokers by an insurance company. For Form 5500 the next page shows your disclosed Service Providers:

ALLIED™ NATIONAL
A 90 Degree Benefits Company

Name:	Allied National, Inc. 3-A
EIN:	43-1625757
Address:	P.O. Box 29187, Shawnee Mission, KS 66207-9187
Fees Paid:	$21,521.20

Σ 41,451.20
Schedule A
2-B

Name:	Marsh & Mclennan Agency LLC
Address:	8144 Walnut Hl Fl 15, Dallas, TX 75231
Fees Paid:	$9,965.00

Name:	John E Heil
Address:	1699 Wall St # 506, Mount Prospect, IL 60056
Fees Paid:	$9,965.00

The following counts of member lives are provided as an option to use for your PCORI tax filing. See cover letter for additional information.

Patient-Centered Outcomes Research Institute (PCORI)

Covered Lives

Month	Count	Month	Count
12-2020	132	01-2022	105
01-2021	134	02-2022	110
02-2021	141	03-2022	110
03-2021	130	04-2022	112
04-2021	128	05-2022	113
05-2021	125	06-2022	114
06-2021	116	07-2022	115
07-2021	114	08-2022	117
08-2021	112	09-2022	119
09-2021	112	10-2022	122
10-2021	110	11-2022	118
11-2021	104	12-2022	113
12-2021	105		

This letter is provided only as a courtesy and should not be relied upon as legal or tax advice. Please consult your attorney or accountant regarding these and all other Plan Sponsor compliance obligations. If you need additional information or assistance, please contact our Client Services department at 800-825-7531.

Sincerely,

Client Services