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) E

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
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan

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)
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

5115 PARKCENTER AVE. SUITE 200
DUBLIN, OH 43017

2b Employer Identification Number (EIN)
37-6532551

2c Plan Sponsor's telephone number
800-766-6762

2d Business code (see instructions)

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			
	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	Filed with authorized/valid electronic signature.	10/13/2023	TODD BAKER
	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**
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)**
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** 0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**
f	Total. Add lines **6d** and **6e**.	**6f**
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:

9a Plan funding arrangement (check all that apply)
- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] 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)** [ ] 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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 1 **A** (Insurance Information)
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **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.) ..... [X] 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.) ..... [X] 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 133375610

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
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

D Employer Identification Number (EIN)
37-6532551

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
MEDICAL MUTUAL OF OHIO

(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
34-0648820	29076	0000	0	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

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	

(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**	0
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)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	0
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)**	0
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** [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)**			
(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**	0
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.**	**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	**B** Three-digit plan number (PN) ▶	
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST	37-6532551	

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

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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)

TAFT, STETTINIUS, HOLLISTER

31-0541755

(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?
29	NONE	18345	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(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 [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

(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 [ ] No [ ]	Yes [ ] No [ ]		Yes [ ] No [ ]

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:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan 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 OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST	**B** Three-digit plan number (PN) ▶ 501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST	**D** Employer Identification Number (EIN) 37-6532551

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	ADULT GERIATRICS OF WOOSTER OSMA BENEFIT PLAN		
b Name of plan sponsor	ADULT GERIATRICS OF WOOSTER	**c** EIN-PN	14-1965232-501
a Plan name	ADULT HYPERTENSION AND KIDNEY SPECIALISTS LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	ADULT HYPERTENSION AND KIDNEY SPECIALISTS LLC	**c** EIN-PN	47-4717995-501
a Plan name	ADVANCED CARE EMERGENCY MEDICINE GROUP, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	ADVANCED CARE EMERGENCY MEDICINE GROUP, LLC	**c** EIN-PN	86-1183738-501
a Plan name	AKRON OCULOPLASTICS INC OSMA BENEFIT PLAN		
b Name of plan sponsor	AKRON OCULOPLASTICS INC	**c** EIN-PN	34-1940638-501
a Plan name	ANKLE & FOOT SPECIALIST OF SYLVANIA LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	ANKLE & FOOT SPECIALIST OF SYLVANIA LLC	**c** EIN-PN	84-2096478-501
a Plan name	ANTHONY W. GRANT, D.P.M. OSMA BENEFIT PLAN		
b Name of plan sponsor	ANTHONY W. GRANT, D.P.M.	**c** EIN-PN	83-1328008-501
a Plan name	ARLINGTON FAMILY PRACTICE INC OSMA BENEFIT PLAN		
b Name of plan sponsor	ARLINGTON FAMILY PRACTICE INC	**c** EIN-PN	35-1904162-501
a Plan name	ASSOCIATES IN PODIATRY, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	ASSOCIATES IN PODIATRY, INC	**c** EIN-PN	31-1398022-501
a Plan name	BALANCE FOOT & ANKLE, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	BALANCE FOOT & ANKLE, LLC	**c** EIN-PN	81-4664040-501
a Plan name	BERNADETTE R ANDERSON, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	BERNADETTE R ANDERSON, MD	**c** EIN-PN	31-1398575-501
a Plan name	BONE & JOINT SURGEONS, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	BONE & JOINT SURGEONS, INC	**c** EIN-PN	34-2045293-501
a Plan name	BONNIE STAMATIS MD, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	BONNIE STAMATIS MD, INC	**c** EIN-PN	34-1882027-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	BORIS TEREBUH MD, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	BORIS TEREBUH MD, INC	**c** EIN-PN	34-1943144-501
a Plan name	BRETT M COLDIRON, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	BRETT M COLDIRON, MD	**c** EIN-PN	31-1356446-501
a Plan name	BRONDON FOOT AND ANKLE OSMA BENEFIT PLAN		
b Name of plan sponsor	BRONDON FOOT AND ANKLE	**c** EIN-PN	46-0747438-501
a Plan name	BUCKEYE FOOT & ANKLE, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	BUCKEYE FOOT & ANKLE, LLC	**c** EIN-PN	31-1679156-501
a Plan name	CADIZ ANIMAL CLINIC INC OSMA BENEFIT PLAN		
b Name of plan sponsor	CADIZ ANIMAL CLINIC INC	**c** EIN-PN	34-1856905-501
a Plan name	CARDIOVASCULAR CONSULTANTS OF CLEVELAND, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	CARDIOVASCULAR CONSULTANTS OF CLEVELAND, INC	**c** EIN-PN	34-1126939-501
a Plan name	CATHY DELLA MORA , PHD. OSMA BENEFIT PLAN		
b Name of plan sponsor	CATHY DELLA MORA , PHD.	**c** EIN-PN	30-9088497-501
a Plan name	CENTER FOR METABOLIC & BARIATRIC SURGERY, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	CENTER FOR METABOLIC & BARIATRIC SURGERY, LLC	**c** EIN-PN	26-1915713-501
a Plan name	CENTER FOR SIGHT, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	CENTER FOR SIGHT, INC	**c** EIN-PN	31-0996020-501
a Plan name	CENTER FOR SYMPTON RELIEF OSMA BENEFIT PLAN		
b Name of plan sponsor	CENTER FOR SYMPTON RELIEF	**c** EIN-PN	27-1778276-501
a Plan name	CHARLES D HANSHAW DO, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	CHARLES D HANSHAW DO, INC	**c** EIN-PN	31-1182034-501
a Plan name	CLEVELAND LOWER EXTREMITY SPECIALISTS OSMA BENEFIT PLAN		
b Name of plan sponsor	CLEVELAND LOWER EXTREMITY SPECIALISTS	**c** EIN-PN	82-2291725-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	COLUMBUS INPATIENT CARE, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	COLUMBUS INPATIENT CARE, INC	**c** EIN-PN	01-0651490-501
a Plan name	COLUMBUS NEPHROLOGY, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	COLUMBUS NEPHROLOGY, INC	**c** EIN-PN	31-1477544-501
a Plan name	COLUMBUS WOMEN'S WELLNESS, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	COLUMBUS WOMENS WELLNESS, LLC	**c** EIN-PN	46-5571599-501
a Plan name	COMMUNITY MEDICAL SPECIALISTS LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	COMMUNITY MEDICAL SPECIALISTS LLC	**c** EIN-PN	27-3482932-501
a Plan name	COMPLETE FOOT & ANKLE SPECIALISTS OSMA BENEFIT PLAN		
b Name of plan sponsor	COMPLETE FOOT & ANKLE SPECIALISTS	**c** EIN-PN	45-4404247-501
a Plan name	COMPREHENSIVE BEHAVIORAL HEALTH SERVICES OSMA BENEFIT PLAN		
b Name of plan sponsor	COMPREHENSIVE BEHAVIORAL HEALTH SERVICES	**c** EIN-PN	26-1950208-501
a Plan name	COMPREHENSIVE GERIATRIC CARE LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	COMPREHENSIVE GERIATRIC CARE LLC	**c** EIN-PN	14-2009046-501
a Plan name	CONSTANTINE G ECONOMUS MD LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	CONSTANTINE G ECONOMUS MD LLC	**c** EIN-PN	20-2371648-501
a Plan name	CONSULTING PATHOLOGISTS CORPORATION OSMA BENEFIT PLAN		
b Name of plan sponsor	CONSULTING PATHOLOGISTS CORPORATION	**c** EIN-PN	34-1150604-501
a Plan name	COVENANT PSYCHOLOGICAL AND CONSULTING SERVICES, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	COVENANT PSYCHOLOGICAL AND CONSULTING SERVICES, INC	**c** EIN-PN	45-5043537-501
a Plan name	CYNTHIA BENNETT PHD, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	CYNTHIA BENNETT PHD, LLC	**c** EIN-PN	82-3436485-501
a Plan name	D. MARK OELRICH, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	D. MARK OELRICH, MD	**c** EIN-PN	34-1563394-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	DAVID R LAWRENCE DO OSMA BENEFIT PLAN		
b Name of plan sponsor	DAVID R LAWRENCE DO	**c** EIN-PN	82-1173341-501
a Plan name	DAYTON NEUROLOGIC ASSOC LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	DAYTON NEUROLOGIC ASSOC LLC	**c** EIN-PN	47-3633525-501
a Plan name	DAYTON PEDIATRIC IMAGING INC OSMA BENEFIT PLAN		
b Name of plan sponsor	DAYTON PEDIATRIC IMAGING INC	**c** EIN-PN	31-1239456-501
a Plan name	DE ROZIERE VETERINARY INTERESTS, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	DE ROZIERE VETERINARY INTERESTS, LLC	**c** EIN-PN	82-3775466-501
a Plan name	DERMATOLOGY CENTER OF NORTHEAST OHIO OSMA BENEFIT PLAN		
b Name of plan sponsor	DERMATOLOGY CENTER OF NORTHEAST OHIO	**c** EIN-PN	20-1836496-501
a Plan name	DR BODMAN PODIATRY ASSOCIATES OSMA BENEFIT PLAN		
b Name of plan sponsor	DR BODMAN PODIATRY ASSOCIATES	**c** EIN-PN	34-1944827-501
a Plan name	DR MEGAN YETZER LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	DR MEGAN YETZER LLC	**c** EIN-PN	85-1663503-501
a Plan name	EAST HILLIARD VETERINARY SERVICES OSMA BENEFIT PLAN		
b Name of plan sponsor	EAST HILLIARD VETERINARY SERVICES	**c** EIN-PN	31-1214342-501
a Plan name	ELYRIA ANESTHESIA SERVICES OSMA BENEFIT PLAN		
b Name of plan sponsor	ELYRIA ANESTHESIA SERVICES	**c** EIN-PN	34-1086687-501
a Plan name	EMERGIMED, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	EMERGIMED, INC	**c** EIN-PN	34-1648098-501
a Plan name	FRIEND VETERINARY SERVICES LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	FRIEND VETERINARY SERVICES LLC	**c** EIN-PN	83-3440934-501
a Plan name	FULL SPECTRUM HEALTH CENTER, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	FULL SPECTRUM HEALTH CENTER, LLC	**c** EIN-PN	38-3663529-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	GREAT LAKES GASTROENTEROLGY, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	GREAT LAKES GASTROENTEROLGY, LLC	**c** EIN-PN	20-1466945-501
a Plan name	GREAT LAKES MEDICAL RESEARCH LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	GREAT LAKES MEDICAL RESEARCH LLC	**c** EIN-PN	46-1721240-501
a Plan name	H.R. DACHA, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	H.R. DACHA, MD	**c** EIN-PN	34-1486154-501
a Plan name	HAWTHORNE HILL OSMA BENEFIT PLAN		
b Name of plan sponsor	HAWTHORNE HILL	**c** EIN-PN	46-1429672-501
a Plan name	HEALTHY BRAIN NEUROLOGY OSMA BENEFIT PLAN		
b Name of plan sponsor	HEALTHY BRAIN NEUROLOGY	**c** EIN-PN	47-5277135-501
a Plan name	HILLIARD PEDIATRICS OSMA BENEFIT PLAN		
b Name of plan sponsor	HILLIARD PEDIATRICS	**c** EIN-PN	31-1378214-501
a Plan name	HILLTOP OB/GYN, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	HILLTOP OB/GYN, INC	**c** EIN-PN	31-1236707-501
a Plan name	HURON PODIATRY LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	HURON PODIATRY LLC	**c** EIN-PN	20-1649520-501
a Plan name	J F LYDON MD LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	J F LYDON MD LLC	**c** EIN-PN	34-2458365-501
a Plan name	JACK C LUNDERMAN JR, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	JACK C LUNDERMAN JR, MD	**c** EIN-PN	31-1260917-501
a Plan name	JAMES APESOS, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	JAMES APESOS, MD	**c** EIN-PN	34-1853081-501
a Plan name	JAMES D BRODELL MD INC. OSMA BENEFIT PLAN		
b Name of plan sponsor	JAMES D BRODELL MD INC.	**c** EIN-PN	34-1449297-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	JAMES W. THOMSON, DO OSMA BENEFIT PLAN		
b Name of plan sponsor	JAMES W. THOMSON, DO	**c** EIN-PN	47-1616936-501
a Plan name	JEFFREY S MASIN, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	JEFFREY S MASIN, MD	**c** EIN-PN	02-0559467-501
a Plan name	JOHN A WINDER, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	JOHN A WINDER, MD	**c** EIN-PN	34-1878154-501
a Plan name	JOSEPH C YU, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	JOSEPH C YU, MD	**c** EIN-PN	31-0918908-501
a Plan name	JS MEDICAL SERVCIES LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	JS AESTHETICS	**c** EIN-PN	46-4816181-501
a Plan name	KAPLANSKY FOOT & ANKLE OSMA BENEFIT PLAN		
b Name of plan sponsor	KAPLANSKY FOOT & ANKLE	**c** EIN-PN	31-0969809-501
a Plan name	KAREN R GRASSIE, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	KAREN R GRASSIE, MD	**c** EIN-PN	20-1537990-501
a Plan name	KIDNEY HEALTH GROUP, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	KIDNEY HEALTH GROUP, INC	**c** EIN-PN	47-2758921-501
a Plan name	LARRY M BUCHANAN, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	LARRY M BUCHANAN, MD	**c** EIN-PN	27-1420721-501
a Plan name	LUCKINO FOOT & ANKLE ASSOCIATES OSMA BENEFIT PLAN		
b Name of plan sponsor	LUCKINO FOOT & ANKLE ASSOCIATES	**c** EIN-PN	82-2276936-501
a Plan name	MALE REPRODUCTION MEDICINE OF SW OHIO OSMA BENEFIT PLAN		
b Name of plan sponsor	MALE REPRODUCTION MEDICINE OF SW OHIO	**c** EIN-PN	20-5132752-501
a Plan name	MARK F. SHOREMAN, MD, LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	MARK F. SHOREMAN, MD, LLC	**c** EIN-PN	81-3762297-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	MASSILLON FOOT & ANKLE CLINIC OSMA BENEFIT PLAN		
b Name of plan sponsor	MASSILLON FOOT & ANKLE CLINIC	**c** EIN-PN	34-1940614-501
a Plan name	MASTERSONS VETERINARY CLINIC INC OSMA BENEFIT PLAN		
b Name of plan sponsor	MASTERSONS VETERINARY CLINIC INC	**c** EIN-PN	31-1193315-501
a Plan name	MEDICAL EMERGENCY TREATMENT CORPORATION OSMA BENEFIT PLAN		
b Name of plan sponsor	MEDICAL EMERGENCY TREATMENT CORPORATION	**c** EIN-PN	34-1106055-501
a Plan name	MIAMI VALLEY PLASTIC SURGEONS OSMA BENEFIT PLAN		
b Name of plan sponsor	MIAMI VALLEY PLASTIC SURGEONS	**c** EIN-PN	31-1293004-501
a Plan name	MID OHIO PODIATRY INC OSMA BENEFIT PLAN		
b Name of plan sponsor	MID OHIO PODIATRY INC	**c** EIN-PN	34-1346503-501
a Plan name	MID-OHIO RADIOLOGY INC OSMA BENEFIT PLAN		
b Name of plan sponsor	MID-OHIO RADIOLOGY INC	**c** EIN-PN	31-1253448-501
a Plan name	MIDWEST PHYSICIANS ANESTHESIA SERVICES, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	MIDWEST PHYSICIANS ANESTHESIA SERVICES, INC	**c** EIN-PN	31-1039177-501
a Plan name	MIND MATTERS MEDICAL LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	MIND MATTERS MEDICAL LLC	**c** EIN-PN	85-4344018-501
a Plan name	MODERNPATH, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	MODERNPATH, INC	**c** EIN-PN	02-0737147-501
a Plan name	NEURO HEALTH AND WELLNESS OSMA BENEFIT PLAN		
b Name of plan sponsor	NEURO HEALTH AND WELLNESS	**c** EIN-PN	27-1904369-501
a Plan name	NEUROLOGY CENTER, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	NEUROLOGY CENTER, INC	**c** EIN-PN	34-1375200-501
a Plan name	NEUROLOGY DIAGNOSTICS OSMA BENEFIT PLAN		
b Name of plan sponsor	NEUROLOGY DIAGNOSTICS	**c** EIN-PN	01-0559183-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	NEW CARLISLE FAMILY PRACTICE OSMA BENEFIT PLAN		
b Name of plan sponsor	NEW CARLISLE FAMILY PRACTICE	**c** EIN-PN	36-4531765-501
a Plan name	NICHOLAS E. SHEROCK DO OSMA BENEFIT PLAN		
b Name of plan sponsor	NICHOLAS E. SHEROCK DO	**c** EIN-PN	27-3281911-501
a Plan name	NICHOLAS J SPIRTOS DO, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	NICHOLAS J SPIRTOS DO, INC	**c** EIN-PN	34-1437658-501
a Plan name	NICHOLAS JARMOSZUK MD OSMA BENEFIT PLAN		
b Name of plan sponsor	NICHOLAS JARMOSZUK MD	**c** EIN-PN	34-1287058-501
a Plan name	NICOLE RANTILLA INC OSMA BENEFIT PLAN		
b Name of plan sponsor	NICOLE RANTILLA INC	**c** EIN-PN	46-4620827-501
a Plan name	NORTH CENTRAL EYE ASSOCIATES, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	NORTH CENTRAL EYE ASSOCIATES, INC	**c** EIN-PN	34-1338184-501
a Plan name	NORTHWEST PRIMARY CARE INC OSMA BENEFIT PLAN		
b Name of plan sponsor	NORTHWEST PRIMARY CARE INC	**c** EIN-PN	34-1786340-501
a Plan name	OHIO FOOT & ANKLE OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIO PODIATRIC ASSOCIATION INC.	**c** EIN-PN	23-7239698-501
a Plan name	OHIO SLEEP MEDICINE AND NEUROSCIENCE INSTITUTE INC OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIO SLEEP MEDICINE AND NEUROSCIENCE INSTITUTE INC	**c** EIN-PN	31-0990314-501
a Plan name	OHIO VALLEY EYE PHYSICIANS & SURGEONS, PLLC OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIO VALLEY EYE PHYSICIANS & SURGEONS, PLLC	**c** EIN-PN	31-1346043-501
a Plan name	OHIO VEIN & VASCULAR, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIO VEIN & VASCULAR, INC	**c** EIN-PN	46-2564421-501
a Plan name	OHIO VETERINARY MEDICAL ASSOCIATION OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIO VETERINARY MEDICAL ASSOCIATION	**c** EIN-PN	31-4425770-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	OHIOAME OSMA BENEFIT PLAN		
b Name of plan sponsor	OHIOAME	**c** EIN-PN	46-3163796-501
a Plan name	ORACLE PAIN CLINIC INC OSMA BENEFIT PLAN		
b Name of plan sponsor	ORACLE PAIN CLINIC INC	**c** EIN-PN	46-1497689-501
a Plan name	ORTHOPEDIC SPECIALISTS & SPORTS MEDICINE INC OSMA BENEFIT PLAN		
b Name of plan sponsor	ORTHOPEDIC SPECIALISTS & SPORTS MEDICINE INC	**c** EIN-PN	31-1652701-501
a Plan name	ORTHOWEST LTD OSMA BENEFIT PLAN		
b Name of plan sponsor	ORTHOWEST LTD	**c** EIN-PN	34-1972292-501
a Plan name	PAJKA EYE CENTER, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	PAJKA EYE CENTER, INC	**c** EIN-PN	34-1146550-501
a Plan name	PATSY BUCCINO, D.O., INC OSMA BENEFIT PLAN		
b Name of plan sponsor	PATSY BUCCINO, D.O., INC	**c** EIN-PN	34-1712257-501
a Plan name	PHYSICAL MEDICINE ASSOCIATES OF NW OHIO, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	PHYSICAL MEDICINE ASSOCIATES OF NW OHIO, INC	**c** EIN-PN	31-1466212-501
a Plan name	PRADIP M VYAS, MD OSMA BENEFIT PLAN		
b Name of plan sponsor	PRADIP M VYAS, MD	**c** EIN-PN	34-1584706-501
a Plan name	PREMIER ANESTHESIA OF SANDUSKY OSMA BENEFIT PLAN		
b Name of plan sponsor	PREMIER ANESTHESIA OF SANDUSKY	**c** EIN-PN	20-0051808-501
a Plan name	PREMIER INTERNAL MEDICINE LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	PREMIER INTERNAL MEDICINE LLC	**c** EIN-PN	45-3237514-501
a Plan name	PREMIER WOMENS HEALTH OF GEAUGA LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	PREMIER WOMENS HEALTH OF GEAUGA LLC	**c** EIN-PN	83-2715411-501
a Plan name	PROFESSIONALS FOR WOMEN'S HEALTH, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	PROFESSIONALS FOR WOMENS HEALTH, INC	**c** EIN-PN	31-1370993-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	RADIOLOGY CONSULTANTS, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	RADIOLOGY CONSULTANTS, INC	**c** EIN-PN	34-0897776-501
a Plan name	REHABILITATION SPECIALIST OF SOUTHWEST OHIO OSMA BENEFIT PLAN		
b Name of plan sponsor	REHABILITATION SPECIALIST OF SOUTHWEST OHIO	**c** EIN-PN	81-2509998-501
a Plan name	RENAISSANCE RECONSTRUCTIVE & AESTHETIC SURGERY OSMA BENEFIT PLAN		
b Name of plan sponsor	RENAISSANCE RECONSTRUCTIVE & AESTHETIC SURGERY	**c** EIN-PN	31-1671524-501
a Plan name	RIVERSIDE SURGICAL ASSOCIATES, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	RIVERSIDE SURGICAL ASSOCIATES, INC	**c** EIN-PN	31-0780474-501
a Plan name	NORTHSIDE VETERINARY CLINIC OSMA BENEFIT PLAN		
b Name of plan sponsor	S&M VETERINARY SERVICES INC	**c** EIN-PN	82-5093957-501
a Plan name	SALEM RADIOLOGISTS, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	SALEM RADIOLOGISTS, INC	**c** EIN-PN	34-1039072-501
a Plan name	SCOTT A HANNAN MD LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	SCOTT A HANNAN MD LLC	**c** EIN-PN	46-1744996-501
a Plan name	SHELBY PEDIATRICS LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	SHELBY PEDIATRICS LLC	**c** EIN-PN	81-0771221-501
a Plan name	SIGNATURE DERMATOLOGY OSMA BENEFIT PLAN		
b Name of plan sponsor	SIGNATURE DERMATOLOGY	**c** EIN-PN	26-2344218-501
a Plan name	SIGNATURE PSYCHIATRY ASSOCIATES INC OSMA BENEFIT PLAN		
b Name of plan sponsor	SIGNATURE PSYCHIATRY ASSOCIATES INC	**c** EIN-PN	47-3989918-501
a Plan name	SJLE VETERNIARY LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	SJLE VETERNIARY LLC	**c** EIN-PN	82-0822072-501
a Plan name	SOUTHWEST OHIO PAIN INSTITUTE OSMA BENEFIT PLAN		
b Name of plan sponsor	SOUTHWEST OHIO PAIN INSTITUTE	**c** EIN-PN	26-2213342-501

Part II **Information on Participating Plans (to be completed by DFEs)**
(Complete as many entries as needed to report all participating plans)

a Plan name	SPECTRUM EYE CARE, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	SPECTRUM EYE CARE, INC	**c** EIN-PN	34-1289992-501
a Plan name	SUNNYSIDE VETERINARY CLINIC OSMA BENEFIT PLAN		
b Name of plan sponsor	SUNNYSIDE VETERINARY CLINIC	**c** EIN-PN	46-1162809-501
a Plan name	SURMEET BEDI MD LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	SURMEET BEDI MD LLC	**c** EIN-PN	27-0817508-501
a Plan name	TRANSFORM CONSULTING LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	TRANSFORM CONSULTING LLC	**c** EIN-PN	47-1238502-501
a Plan name	TRI STATE LUNG & SLEEP ASSOCIATES OSMA BENEFIT PLAN		
b Name of plan sponsor	TRI STATE LUNG & SLEEP ASSOCIATES	**c** EIN-PN	75-3020102-501
a Plan name	TRI-COUNTY HEMATOLOGY & ONCOLOGY ASSOCIATES, INC OSMA BENEFIT PLAN		
b Name of plan sponsor	TRI-COUNTY HEMATOLOGY & ONCOLOGY ASSOCIATES, INC	**c** EIN-PN	34-1294692-501
a Plan name	UNITED PODIATRY INC OSMA BENEFIT PLAN		
b Name of plan sponsor	UNITED PODIATRY INC	**c** EIN-PN	81-1670360-501
a Plan name	VINCENT JABOUR MD OSMA BENEFIT PLAN		
b Name of plan sponsor	VINCENT JABOUR MD	**c** EIN-PN	03-6441154-501
a Plan name	WELLER HEALTH TRANSITIONS LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	WELLER HEALTH TRANSITIONS LLC	**c** EIN-PN	47-4551726-501
a Plan name	WILLOW RIDGE VETERINARY SERVICES LLC OSMA BENEFIT PLAN		
b Name of plan sponsor	WILLOW RIDGE VETERINARY SERVICES LLC	**c** EIN-PN	45-4716012-501
a Plan name	WINDY COLE DPM OSMA BENEFIT PLAN		
b Name of plan sponsor	WINDY COLE DPM	**c** EIN-PN	25-1903311-501
a Plan name	MASON ANIMAL HOSPITAL OSMA BENEFIT PLAN		
b Name of plan sponsor	WOLF VETERINARY SERVICES LLC	**c** EIN-PN	31-1611669-501

Part II Information on Participating Plans (to be completed by DFEs)
(Complete as many entries as needed to report all participating plans)

a Plan name WOOSTER UROLOGY, LLC OSMA BENEFIT PLAN

b Name of plan sponsor WOOSTER UROLOGY, LLC | **c** EIN-PN 45-2660852-501

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

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b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

a Plan name

b Name of plan sponsor | **c** EIN-PN

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **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
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

D Employer Identification Number (EIN)
37-6532551

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	56109	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1928406	0
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	0	0
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	32	0
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	53785	0

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	2038332	0
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	505524	0
i Acquisition indebtedness	1i		
j Other liabilities	1j	73745	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	579269	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1459063	0

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)		
(B) Participants	2a(1)(B)		
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	28	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		28
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		28
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	18345	
(2) Contract administrator fees	2i(2)	0	
(3) Investment advisory and management fees	2i(3)	0	
(4) Other	2i(4)	0	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		18345
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		18345
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-18317
l Transfers of assets:			
(1) To this plan	2l(1)		0
(2) From this plan	2l(2)		1440746

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: MALONEY & NOVOTNY LLC **(2)** EIN: 34-0677006

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, or MTIA. **(2)** [ ] It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a			

		Yes	No	Amount
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k			
l Has the plan failed to provide any benefit when due under the plan?	4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? ☐ Yes ☐ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

OHIO STATE MEDICAL ASSOCIATION
HEALTH BENEFITS PLAN TRUST

FINANCIAL REPORT
(IN LIQUIDATION)

DECEMBER 31, 2022 and 2021

MALONEY + NOVOTNY LLC

OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

CONTENTS

MALONEY + NOVOTNY LLC

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Independent Auditors' Report

To the Board of Trustees of
Ohio State Medical Association Health Benefits Plan Trust
Dublin, Ohio

Opinion

We have audited the financial statements of the Ohio State Medical Association Health Benefits Plan Trust (the "Trust"), which comprise the statements of net assets as of December 31, 2022 and 2021 (in liquidation), and the related statement of changes in net assets for the year ended December 31, 2022 (in liquidation), and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets of the Trust as of December 31, 2022 and 2021 (in liquidation), and the changes in its net assets for the year ended December 31, 2022 (in liquidation) in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audits of the Financial Statements section of our report. We are required to be independent of the Trust and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of Matter - Trust Termination and Basis of Accounting

As discussed in Note 6 to the financial statements, the Board of Trustees of the Trust approved a plan of liquidation on August 18, 2021, and determined that liquidation is imminent. As a result, the Trust has used the liquidation basis in presenting the 2022 and 2021 financial statements. Our opinion is not modified with respect to this matter.

Other Matter

The accompanying financial statements are those of the Trust. These financial statements do not purport to present the net assets available for benefits and accumulated plan benefits or the changes in net assets available for benefits or changes in accumulated plan benefits of the participating plans and do not contain certain information and other disclosures necessary for a fair presentation of the financial statements of the participating plans in accordance with accounting principles generally accepted in the United States of America. Further, these financials statements do not purport to satisfy the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("ERISA") relating to the financial statements of employee benefit plans.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Trust's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditors' Responsibilities for the Audits of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but it is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Trust's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audits, significant audit findings, and certain internal control related matters that we identified during the audits.

Cleveland, Ohio
October 13, 2023

OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

STATEMENTS OF NET ASSETS (LIQUIDATION BASIS)

December 31, 2022 and 2021

	2022	2021
ASSETS		
Cash	$ -	$ 56,141
Net reinsurance receivables	-	1,928,406
Prepaids	-	53,785
Total assets	-	2,038,332
LIABILITIES		
Premiums received in advance	-	73,745
Accounts payable	-	505,524
Total liabilities	-	579,269
NET ASSETS	$ -	$1,459,063

The accompanying notes are an integral part of these financial statements.

OHIO STATE MEDICAL ASSOCIATION HEALTH BENEFITS PLAN TRUST

STATEMENT OF CHANGES IN NET ASSETS (LIQUIDATION BASIS)

Year Ended December 31, 2022

ADDITIONS	
Interest income	$ 28
DEDUCTIONS	
Distributions to participating plans for benefit claims paid, net of reinsurance recoveries	1,399,421
Distributions to participating plans for premiums paid for the provision of benefits, net of ceding allowances	41,325
Total distributions to participating plans	1,440,746
Legal expense	18,345
Total deductions	1,459,091
DECREASE IN NET ASSETS	(1,459,063)
NET ASSETS	
BEGINNING OF YEAR	1,459,063
END OF YEAR	$ -

The accompanying notes are an integral part of these financial statements.

Note 1. Description of the Trust

The following description of the Ohio State Medical Association Health Benefits Plan Trust (the "Trust") provides only general information. Participating plans should refer to the Trust agreement for a more complete description of the Trust's provisions.

General:

The Trust is intended to be a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code (the "IRC"). The purpose of the Trust is to hold Plan assets of a non-plan multiple employer welfare arrangement ("MEWA") as described in Section 1739 of the Ohio Revised Code and to pay those Plans' benefits and expenses. Employers of plans participating in this Trust (the "Plans") are members of the Ohio State Medical Association.

Contributions:

The Trust receives contributions for health and welfare coverage from participating Plans. Such funds are utilized for the payment of premiums to Medical Mutual of Ohio ("Medical Mutual") for the provision of benefits on behalf of the Plans.

Distributions:

In addition to distributions for the premium payments to Medical Mutual described above, distributions are made for the payment of benefit claims. These benefit claims are paid out of the Trust, on behalf of the participating Plans, to Medical Mutual. Medical Mutual administers payment of hospital charges, medical/surgical claims and prescription coverage.

Operating Expenses:

All administrative fees are paid by the Trust or the participating Plans at the option of the Trustees of the Trust.

Note 2. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by the Trust:

Basis of Presentation:

The accompanying financial statements for the years ended December 31, 2022 and 2021 are prepared on a liquidation basis of accounting due to the impending termination of the Trust (see Note 8). Under the liquidation basis, the Trust measures and presents its assets and liabilities at the amount of cash or other consideration that the Trust expects to collect or pay during the course of liquidation. The Trust is also required to accrue the costs and income that it expects during the liquidation.

Note 2. Summary of Significant Accounting Policies (Continued)

Net Reinsurance Receivables:

Net reinsurance receivables represent the net of amounts recoverable for claims paid (including stop loss recoveries) and amounts recoverable for administrative expenses under the quota share reinsurance agreement offset by the amounts payable for premiums ceded under the quota share and stop loss agreements.

Recognition of Contribution Revenue:

Contribution revenue is recognized in the month for which coverage is being paid. Contributions received after the coverage months are recorded as receivables and contributions received before coverage months are recorded as liabilities.

Use of Estimates:

The preparation of financial statements in conformity with the liquidation basis of accounting for the years ending December 31, 2022 and 2021 requires the trust administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Distributions for the Payment of Benefits:

Distributions for the payment of benefit claims and premiums are recorded when processed and approved for payment to Medical Mutual.

Reclassifications:

Certain amounts reported in the prior year were reclassified to conform to current year presentation.

Note 3. Cash and Investments

The Trust held its temporary cash as cash or money market funds with national financial institutions which at times exceeded federally insured amounts. The actual balance may have exceeded reported balances due to outstanding checks.

The Trust's investments are held by PNC Bank in non-insured trust funds.

Note 4. Reinsurance

The participating Plans were subject to a quota share reinsurance agreement with Medical Mutual, to cede 90% of the Plan's health business for the year ended December 31, 2022.

During 2022, the Plans were subject to a stop loss reinsurance agreement with Medical Mutual for medical and prescription drug coverage. The specific and aggregate stop loss threshold per covered person was $250,000 and 125% of policy year claims, respectively, under Medical Mutual for the year ended 2022.

Note 5. Tax Status

The Trust established to hold the participating Plans' net assets is qualified pursuant to Section 501(c)(9) of the IRC. In December 2019, the Internal Revenue Service finalized regulations under IRC Section 512(a)(3)(E)(i) which specified that net investment income earned by a VEBA is taxable as unrelated business income. These regulations became effective on January 1, 2020. Accordingly, any net investment income earned by the Trust in 2022 will be subject to federal income taxes. The Trust's management has analyzed the tax positions taken by the Trust and has concluded that, as of December 31, 2022, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Trust is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

In addition, the participating Plans and the Trust are required to operate in conformity with the IRC to maintain the tax exempt status of the Trust. The trust administrator believes that the Plans are being operated in compliance with the applicable requirements of the IRC and, therefore, believes that the related Trust is tax exempt.

Note 6. Plan and Trust Termination

On August 18, 2021, the Board of Trustees of the Plan adopted a motion to proceed with steps necessary to wind down operation of the Plan by December 31, 2021 and to relinquish its Certificate of Authority to the Ohio Department of Insurance ("ODI"). On August 19, 2021, the Plan notified ODI of its intention to cease operations.

In July 2022, the Trustees entered into an agreement with Medical Mutual, under which Medical Mutual took financial responsibility for paying all remaining, properly-payable Plan claims. After paying certain administrative costs, the Trustees identified that there was residual assets after the final payment to Medical Mutual. The final payment that was distributed to pay qualifying benefits was $400,475 for the year ended December 31, 2022.