

<p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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).</p> <p style="text-align: center;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; text-align: center;"><b>2022</b></p> <hr/> <p style="text-align: center;"><b>This Form is Open to Public Inspection</b></p>
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<b>Part I</b>	<b>Annual Report Identification Information</b>
For calendar plan year 2022 or fiscal plan year beginning <u>03/01/2022</u> and ending <u>02/28/2023</u>	
<b>A</b>	This return/report is for: <input type="checkbox"/> a multiemployer plan <input checked="" type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____
<b>B</b>	This return/report is: <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report
	<input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
<b>C</b>	If the plan is a collectively-bargained plan, check here. . . . . <input type="checkbox"/>
<b>D</b>	Check box if filing under: <input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program
	<input checked="" type="checkbox"/> special extension (enter description) <u>IR-2023-159 HURRICANE IDALIA</u>
<b>E</b>	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . <input type="checkbox"/>

<b>Part II</b>	<b>Basic Plan Information</b> —enter all requested information
<b>1a</b> Name of plan <u>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</u>	<b>1b</b> Three-digit plan number (PN) ▶ <u>501</u>
	<b>1c</b> Effective date of plan <u>04/01/1981</u>
<b>2a</b> 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) <u>MARION COUNTY MEDICAL SOCIETY, INC</u>  <u>P.O. BOX 3655</u> <u>OCALA, FL 34478</u>	<b>2b</b> Employer Identification Number (EIN) <u>23-7026266</u>
	<b>2c</b> Plan Sponsor's telephone number <u>352-732-8883</u>
	<b>2d</b> Business code (see instructions) <u>621111</u>

**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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	02/14/2024	JOHN HATCH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2022)  
v. 220413

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor  MCMS INSURANCE TRUST FUND GROUP HEALTH PLAN BOARD OF TRUSTEES PO BOX 270 OCALA, FL 34478	<b>3b</b> Administrator's EIN 84-4350072  <b>3c</b> Administrator's telephone number 352-622-9124
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b> 3783
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).  <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year .....  <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....  <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....  <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....  <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b> 3756 <b>6a(2)</b> 5523 <b>6b</b> 29 <b>6c</b> 0 <b>6d</b> 5552 <b>6e</b> <b>6f</b> <b>6g</b> <b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H	
<b>9a</b> Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <b>6 A</b> (Insurance Information) (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

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

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**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.

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**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 129736206

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**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 **03/01/2022** and ending **02/28/2023**

<b>A</b> Name of plan <b>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>MARION COUNTY MEDICAL SOCIETY, INC</b>		<b>D</b> Employer Identification Number (EIN) <b>23-7026266</b>	

**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  
**BLUE CROSS AND BLUE SHIELD OF FLORIDA**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>59-2015694</b>	<b>98167</b>	<b>16510</b>	<b>3072</b>	<b>03/01/2022</b>	<b>02/28/2023</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
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**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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> 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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>		
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>		
	<b>7c(2)</b>		
	<b>7c(3)</b>		
	<b>7c(4)</b>		
	<b>7c(5)</b>		
(6) Total additions.....	<b>7c(6)</b>		
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>		
<b>e</b> Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	(2) Administration charge made by carrier.....	<b>7e(2)</b>	
	(3) Transferred to separate account.....	<b>7e(3)</b>	
(4) Other (specify below) .....	<b>7e(4)</b>		
(5) Total deductions.....	<b>7e(5)</b>		
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	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**  Stop loss (large deductible)
- j**  HMO contract
- k**  PPO contract
- l**  Indemnity contract
- m**  Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>	33069062	
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	8512540	
(3) Increase (decrease) in unearned premium reserve.....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)).....	<b>9a(4)</b>		41581602
<b>b</b> Benefit charges (1) Claims paid.....	<b>9b(1)</b>	28550555	
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	659760	
(3) Incurred claims (add (1) and (2)).....	<b>9b(3)</b>		29210315
(4) Claims charged .....	<b>9b(4)</b>		29616849
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs.....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>	1955275	
(E) Taxes .....	<b>9c(1)(E)</b>	249490	
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	1247448	
(G) Other retention charges.....	<b>9c(1)(G)</b>		
(H) Total retention.....	<b>9c(1)(H)</b>		3452213
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	<b>9c(2)</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	<b>9d(1)</b>		
(2) Claim reserves .....	<b>9d(2)</b>		
(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</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 .....	<b>10b</b>	
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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2022</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2022 or fiscal plan year beginning **03/01/2022** and ending **02/28/2023**

<p><b>A</b> Name of plan <b>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>MARION COUNTY MEDICAL SOCIETY, INC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-7026266</b></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

(a) Name of insurance carrier  
**HEALTH OPTIONS, 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
59-2403696	95089	16510	666	03/01/2022	02/28/2023

**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
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**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	

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b>	
	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.	
<b>4</b>	Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>
<b>5</b>	Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>
<b>6</b>	<b>Contracts With Allocated Funds:</b>	
<b>a</b>	State the basis of premium rates ▶	
<b>b</b>	Premiums paid to carrier .....	<b>6b</b>
<b>c</b>	Premiums due but unpaid at the end of the year .....	<b>6c</b>
<b>d</b>	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 ▶	<b>6d</b>
<b>e</b>	Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
<b>f</b>	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
<b>7</b>	<b>Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)</b>	
<b>a</b>	Type of contract: (1) <input type="checkbox"/> deposit administration                      (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment                      (4) <input type="checkbox"/> other ▶	
<b>b</b>	Balance at the end of the previous year .....	<b>7b</b>
<b>c</b>	Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>
	(2) Dividends and credits.....	<b>7c(2)</b>
	(3) Interest credited during the year.....	<b>7c(3)</b>
	(4) Transferred from separate account.....	<b>7c(4)</b>
	(5) Other (specify below) .....	<b>7c(5)</b>
	▶	
	(6) Total additions.....	<b>7c(6)</b>
<b>d</b>	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>
<b>e</b>	<b>Deductions:</b>	
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>
	(2) Administration charge made by carrier.....	<b>7e(2)</b>
	(3) Transferred to separate account.....	<b>7e(3)</b>
	(4) Other (specify below) .....	<b>7e(4)</b>
	▶	
	(5) Total deductions.....	<b>7e(5)</b>
<b>f</b>	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>
		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**  Stop loss (large deductible)
- j**  HMO contract
- k**  PPO contract
- l**  Indemnity contract
- m**  Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>	3681411	
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	803324	
(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		4484735
<b>b</b> Benefit charges (1) Claims paid .....	<b>9b(1)</b>	2756931	
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	48599	
(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		2805530
(4) Claims charged .....	<b>9b(4)</b>		2975979
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>	570890	
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	134542	
(G) Other retention charges .....	<b>9c(1)(G)</b>		
(H) Total retention .....	<b>9c(1)(H)</b>		705432
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
(2) Claim reserves .....	<b>9d(2)</b>		
(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**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. ▶



(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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	129665	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	94372	
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		224037
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	110000	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	35962	
	(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		145962
	(4) Claims charged .....	<b>9b(4)</b>		
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>	8252	
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	49458	
	(D) Other expenses .....	<b>9c(1)(D)</b>	27769	
	(E) Taxes .....	<b>9c(1)(E)</b>	3921	
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	9669	
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....	<b>9c(1)(H)</b>		99069
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
	(2) Claim reserves .....	<b>9d(2)</b>		35962
	(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2022</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2022 or fiscal plan year beginning **03/01/2022** and ending **02/28/2023**

<p><b>A</b> Name of plan <b>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>MARION COUNTY MEDICAL SOCIETY, INC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-7026266</b></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**STANDARD INSURANCE COMPANY**

(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
93-0242990	69019	169612	346	03/01/2022	02/28/2003

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;"><b>7212</b></p>	<p><b>(b)</b> Total amount of fees paid</p>
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**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

**GALLACHER BENEFIT SERVICES, INC.** **2850 GOLF RD STE 1000**  
**ROLLING MEADOWS, IL 60008**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7212			3

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>		
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>		
	<b>7c(2)</b>		
	<b>7c(3)</b>		
	<b>7c(4)</b>		
	<b>7c(5)</b>		
(6) Total additions.....	<b>7c(6)</b>		
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>		
<b>e</b> Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	(2) Administration charge made by carrier.....	<b>7e(2)</b>	
	(3) Transferred to separate account.....	<b>7e(3)</b>	
(4) Other (specify below) .....	<b>7e(4)</b>		
(5) Total deductions.....	<b>7e(5)</b>		
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	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**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>	148882	
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	106129	
(3) Increase (decrease) in unearned premium reserve.....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)).....	<b>9a(4)</b>		255011
<b>b</b> Benefit charges (1) Claims paid.....	<b>9b(1)</b>		
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	101137	
(3) Incurred claims (add (1) and (2)).....	<b>9b(3)</b>		101137
(4) Claims charged .....	<b>9b(4)</b>		101137
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>	7212	
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs.....	<b>9c(1)(C)</b>	54025	
(D) Other expenses .....	<b>9c(1)(D)</b>	35382	
(E) Taxes .....	<b>9c(1)(E)</b>	4463	
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	30601	
(G) Other retention charges.....	<b>9c(1)(G)</b>	22191	
(H) Total retention.....	<b>9c(1)(H)</b>		153874
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	<b>9c(2)</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	<b>9d(1)</b>		
(2) Claim reserves .....	<b>9d(2)</b>		101137
(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	
<b>b</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 .....	<b>10b</b>	
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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2022</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2022 or fiscal plan year beginning **03/01/2022** and ending **02/28/2023**

<p><b>A</b> Name of plan <b>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>MARION COUNTY MEDICAL SOCIETY, INC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-7026266</b></p>	

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**STANDARD INSURANCE COMPANY**

(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
93-0242990	69019	169612	476	03/01/2022	02/28/2023

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
<b>5866</b>	

**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

**GALLACHER BENEFIT SERVICES, INC.** **2850 GOLF RD STE 1000**  
**ROLLING MEADOWS, IL 60008**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5866			3

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
▶		
(6) Total additions.....	<b>7c(6)</b>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
<b>7e(4)</b>		
▶		
(5) Total deductions.....	<b>7e(5)</b>	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	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)
- |   |  |   |  |
|---|--|---|--|
| <b>a</b> <input type="checkbox"/> Health (other than dental or vision)                    | <b>b</b> <input type="checkbox"/> Dental               | <b>c</b> <input type="checkbox"/> Vision                    | <b>d</b> <input type="checkbox"/> Life insurance     |
| <b>e</b> <input checked="" type="checkbox"/> Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> Long-term disability | <b>g</b> <input type="checkbox"/> Supplemental unemployment | <b>h</b> <input type="checkbox"/> Prescription drug  |
| <b>i</b> <input type="checkbox"/> Stop loss (large deductible)                            | <b>j</b> <input type="checkbox"/> HMO contract         | <b>k</b> <input type="checkbox"/> PPO contract              | <b>l</b> <input type="checkbox"/> Indemnity contract |
| <b>m</b> <input type="checkbox"/> Other (specify) ▶                                       |  |   |  |

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>	106171	
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	77877	
(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		184048
<b>b</b> Benefit charges (1) Claims paid .....	<b>9b(1)</b>	58373	
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	19371	
(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		77744
(4) Claims charged .....	<b>9b(4)</b>		77744
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>	5866	
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	40049	
(D) Other expenses .....	<b>9c(1)(D)</b>	35668	
(E) Taxes .....	<b>9c(1)(E)</b>	3221	
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	12883	
(G) Other retention charges .....	<b>9c(1)(G)</b>	8616	
(H) Total retention .....	<b>9c(1)(H)</b>		106303
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
(2) Claim reserves .....	<b>9d(2)</b>		19371
(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		
<b>10</b> Nonexperience-rated contracts:			
<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>		
<b>b</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 .....	<b>10b</b>		
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. ▶



(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	

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end.....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	<b>7c(6)</b>	
(6) Total additions.....	<b>7c(6)</b>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
(5) Total deductions.....	<b>7e(5)</b>	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	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)
- |  |  |   |  |
|--|--|---|--|
| <b>a</b> <input type="checkbox"/> Health (other than dental or vision)         | <b>b</b> <input checked="" type="checkbox"/> Dental    | <b>c</b> <input checked="" type="checkbox"/> Vision         | <b>d</b> <input type="checkbox"/> Life insurance     |
| <b>e</b> <input type="checkbox"/> Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> Long-term disability | <b>g</b> <input type="checkbox"/> Supplemental unemployment | <b>h</b> <input type="checkbox"/> Prescription drug  |
| <b>i</b> <input type="checkbox"/> Stop loss (large deductible)                 | <b>j</b> <input type="checkbox"/> HMO contract         | <b>k</b> <input type="checkbox"/> PPO contract              | <b>l</b> <input type="checkbox"/> Indemnity contract |
| <b>m</b> <input type="checkbox"/> Other (specify) ▶                            |  |   |  |

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>		
(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
(3) Increase (decrease) in unearned premium reserve.....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)).....		<b>9a(4)</b>	
<b>b</b> Benefit charges (1) Claims paid.....	<b>9b(1)</b>		
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
(3) Incurred claims (add (1) and (2)).....		<b>9b(3)</b>	
(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs.....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>		
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
(G) Other retention charges.....	<b>9c(1)(G)</b>		
(H) Total retention.....		<b>9c(1)(H)</b>	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	
(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		<b>9e</b>	
<b>10</b> Nonexperience-rated contracts:			
<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>		614851
<b>b</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 .....	<b>10b</b>		
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. ▶

<b>SCHEDULE C (Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2022</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2022 or fiscal plan year beginning 03/01/2022 and ending 02/28/2023

<b>A</b> Name of plan <u>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>501</u>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <u>MARION COUNTY MEDICAL SOCIETY, INC</u>	<b>D</b> Employer Identification Number (EIN) <u>23-7026266</u>	

**Part I Service Provider Information (see instructions)**

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

**a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).....  Yes  No

**b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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**(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)

GALLAGHER BENEFIT SERVICES, INC.

2850 GOLF RD STE 1000  
ROLLING MEADOWS, IL 60008

36-4291971

(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?
13	CONTRACT ADMINISTRATOR	25000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MILLIMAN INTELLISCRIPIT

17335 GOLF PKWY, STE 100  
BROOKFIELD, WI 53045

47-5650627

(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?
11	ACTURIAL	27870	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PURVIS, GRAY AND COMPANY, LLP

2347 SE 17TH STREET  
OCALA, FL 34471

59-0584846

(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?
10	ACCOUNTANT/A UDIT	44100	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)

JOHN D. HATCH, P.C.

1267 BERKSHIRE LANE  
TARPON SPRING, FL 34688

75-2442789

(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	ATTORNEY	14188	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**Part I Service Provider Information (continued)**

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> 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.

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> Describe the information that the service provider failed or refused to provide

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> 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)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

**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 **03/01/2022** and ending **02/28/2023**

<b>A</b> Name of plan <b>MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN</b>	<b>B</b> Three-digit plan number (PN) ► <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>MARION COUNTY MEDICAL SOCIETY, INC</b>	<b>D</b> Employer Identification Number (EIN) <b>23-7026266</b>

**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.

<b>Assets</b>		<b>(a) Beginning of Year</b>	<b>(b) End of Year</b>
<b>a</b> Total noninterest-bearing cash.....	<b>1a</b>	8636647	7457568
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions.....	<b>1b(1)</b>		
<b>(2)</b> Participant contributions.....	<b>1b(2)</b>		
<b>(3)</b> Other.....	<b>1b(3)</b>		
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit).....	<b>1c(1)</b>	511319	514239
<b>(2)</b> U.S. Government securities.....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred.....	<b>1c(3)(A)</b>		
<b>(B)</b> All other.....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred.....	<b>1c(4)(A)</b>		
<b>(B)</b> Common.....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests.....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property).....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants).....	<b>1c(7)</b>		
<b>(8)</b> Participant loans.....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts.....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts.....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts.....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities.....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds).....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts).....	<b>1c(14)</b>		
<b>(15)</b> Other.....	<b>1c(15)</b>		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(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	9147966	7971807
<b>Liabilities</b>			
g Benefit claims payable.....	1g		
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	3374807	3374807
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	3374807	3374807
<b>Net Assets</b>			
l Net assets (subtract line 1k from line 1f).....	1l	5773159	4597000

**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.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	36058962	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)	345041	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		36404003
<b>b Earnings on investments:</b>			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	2908	
(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)		
(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)		
<b>c</b> Other income .....	2c		71
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	2d		36406982
<b>Expenses</b>			
<b>e</b> 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)	1215960	
(3) Other .....	2e(3)	30782551	
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		31998511
<b>f</b> Corrective distributions (see instructions) .....	2f		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	2g		
<b>h</b> Interest expense .....	2h		
<b>i</b> Administrative expenses: (1) Professional fees .....	2i(1)	114018	
(2) Contract administrator fees.....	2i(2)	5463324	
(3) Investment advisory and management fees .....	2i(3)		
(4) Other .....	2i(4)	7288	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		5584630
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	2j		37583141
<b>Net Income and Reconciliation</b>			
<b>k</b> Net income (loss). Subtract line 2j from line 2d.....	2k		-1176159
<b>l</b> Transfers of assets:			
(1) To this plan .....	2l(1)		
(2) From this plan.....	2l(2)		

**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)  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)  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: PURVIS, GRAY AND COMPANY, LLP

(2) EIN: 59-0548468

**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:

**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.) .....

	Yes	No	Amount
4a		X	

	Yes	No	Amount
<b>b</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	
<b>c</b> 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	
<b>d</b> 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	
<b>e</b> Was this plan covered by a fidelity bond?.....	4e	X	1000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty? .....	4f	X	
<b>g</b> 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	X	
<b>h</b> 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	X	
<b>i</b> 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	
<b>j</b> 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	X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? .....	4k	X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan? .....	4l	X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.) .....	4m	X	
<b>n</b> 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 \_\_\_\_\_.

# 2023

MCMS, Inc. - Insurance Trust Fund  
Group Health and Ancillary Plan

Financial Statements and  
Independent Auditor's Report

As of February 28, 2023 and 2022, and for  
the Year Ended February 28, 2023

**PURVIS GRAY**  
CERTIFIED PUBLIC ACCOUNTANTS

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN  
OCALA, FLORIDA**

**FINANCIAL STATEMENTS  
AND  
INDEPENDENT AUDITOR'S REPORT**

**AS OF FEBRUARY 28, 2023 AND 2022, AND FOR THE  
YEAR ENDED FEBRUARY 28, 2023**

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees and Management of  
MCMS, Inc. - Insurance Trust Fund Group Health and Ancillary Plan

### Opinion

We have audited the accompanying financial statements of MCMS, Inc. - Insurance Trust Fund Group Health and Ancillary Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits - cash basis as of February 28, 2023 and 2022, the related statement of changes in net assets available for benefits - cash basis for the year ended February 28, 2023, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits - cash basis of the Plan as of February 28, 2023 and 2022, and the changes in net assets available for benefits - cash basis for the year ended February 28, 2023, in accordance with the cash basis of accounting described in Note 2.

### Basis for Opinion

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

### Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the cash basis of accounting described in Note 2, 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 Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all Plan amendments; administering the Plan; and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due, or which may become due, to such participants.

### CERTIFIED PUBLIC ACCOUNTANTS

Gainesville | Ocala | Tallahassee | Sarasota | Orlando | Tampa

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Members of American and Florida Institutes of Certified Public Accountants

An Independent Member of the BDO Alliance USA

To the Board of Trustees and Management of  
MCMS, Inc. - Insurance Trust Fund Group Health and Ancillary Plan

## INDEPENDENT AUDITOR'S REPORT

### **Auditor's Responsibilities for the Audit 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 auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for 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 generally accepted auditing standards, 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 Plan'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.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

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

### **Basis of Accounting**

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on a cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to that matter.



February 2, 2024  
Winter Park, Florida

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**  
**CASH BASIS**  
**FEBRUARY 28, 2023 AND 2022**

	<b>2023</b>	<b>2022</b>
<b>Assets</b>		
Cash and Cash Equivalents - Held by Contracted Administrator	\$ 7,971,807	\$ 9,147,966
<b>Total Assets</b>	<b>7,971,807</b>	<b>9,147,966</b>
<b>Liabilities</b>		
Due to Barrett, Liner & Buss, LLC	654	654
Other Liability	8,051	8,051
Premium Stabilization Reserve Liability	3,366,102	3,366,102
<b>Total Liabilities</b>	<b>3,374,807</b>	<b>3,374,807</b>
<b>Net Assets Available for Benefits</b>	<b>\$ 4,597,000</b>	<b>\$ 5,773,159</b>

See accompanying notes.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**  
**CASH BASIS**  
**FOR THE YEAR ENDED FEBRUARY 28, 2023**

	<b>2023</b>
<b>Additions to Net Assets Attributed to</b>	
Health Insurance Premiums Received	\$ 34,777,392
Ancillary Insurance Premiums Received	1,281,570
COBRA Insurance Premiums Received	345,041
Interest Income	2,908
Miscellaneous Income	71
	<b>36,406,982</b>
<b>Total Additions to Net Assets</b>	
<b>Deductions from Net Assets Attributed to</b>	
Health Insurance Claims Expense	30,782,551
Ancillary Insurance Premiums Expense	1,215,960
Minimum Premium Administrative Fees	5,463,324
Professional Fees	114,018
Other Administrative Expenses	7,288
	<b>37,583,141</b>
<b>Total Deductions from Net Assets</b>	
<b>Decrease in Net Assets Available for Benefits</b>	<b>(1,176,159)</b>
<b>Net Assets Available for Benefits, Beginning of Year</b>	<b>5,773,159</b>
<b>Net Assets Available for Benefits, End of Year</b>	<b>\$ 4,597,000</b>

See accompanying notes.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**OCALA, FLORIDA**

**Note 1 - Description of the Plan**

The following description of MCMS, Inc. - Insurance Trust Fund Group Health and Ancillary Plan (f/k/a MCMS Insurance Trust Fund) (the Plan) provides only general information. Participants should refer to the Agreement and Declaration of Trust and Summary Plan Description for more complete information regarding the Plan's provisions.

**General**

The Plan, originally established on April 1, 1981, is a multiple-employer health and welfare plan administered by the Marion County Medical Society, Inc. Insurance Trust Fund (the Trust) pursuant to the Agreement and Declaration of Trust. The purpose of the Plan is to provide health, dental, disability, life insurance, and other benefits to the employees and their dependents of members and associate members (Employers) of the Marion County Medical Society, Inc. (the Society). To be eligible to participate, an Employer must: (1) be a member in good standing with the Society; (2) be currently engaged in the private practice of medicine or retired from private practice of medicine after participating in the Trust for at least ten years; (3) be accepted as a participant by the Board of Trustees (the Trustees); (4) consent to become a participant and be bound by its terms; and (5) adhere to the Employer participation rules per the respective Employer Participation and Services Agreement with the Trust.

Effective October 1, 2020, the Plan elected to convert to a Minimum Premium Plan, evidenced by a Cooperation and Support Agreement (CSA) with Blue Cross and Blue Shield of Florida (BCBSF). Under the CSA, the Plan remains fully insured under a group policy issued by BCBSF. In conjunction with the CSA, the Plan also entered into a Minimum Premium Accounting Agreement (MPAA) with BCBSF. Per the terms of the MPAA, the Plan is responsible for actual claims incurred, with BCBSF as the insurer; however, BCBSF is responsible for any claims incurred in excess of a pre-determined "pooling point" or maximum individual claim amount. The pooling point was \$300,000 through February 28, 2022, increasing to \$350,000 effective for the period from March 1, 2022 through February 28, 2023. In addition to the claims liability, the Plan also pays BCBSF a monthly minimum premium charge, as defined in the MPAA, based on a per-participant rate.

Effective March 1, 2022, the Plan was amended and restated to include certain ancillary benefits to Employers within the Society. Ancillary benefits are optional and include Dental, Vision, Basic Life, Accidental Death and Dismemberment (AD&D), Additional Life and AD&D, Short-term Disability, and Long-Term Disability insurance offerings. The Plan was also amended and restated under the name MCMS, Inc. - Insurance Trust Fund Group Health and Ancillary Plan.

Various functions necessary for the operation of the Plan, including the processing of insurance premiums and minimum premium administrative fees, are performed by the Trust's Contracted Administrator, Gallagher Benefit Services, Inc. (formerly Barrett, Liner & Buss, LLC) (the CA). The Society is the Plan sponsor with the ultimate responsibility for the operation and administration of the Plan. The Trustees of the Trust are responsible for management of the Plan assets and have been entrusted to administer the Plan. The Board of Trustees is composed of three appointed Board members of the Society plus members who are elected at large by the participating Employers. Each county is entitled to have a member as a representative on the Board of Trustees.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**OCALA, FLORIDA**

**Benefits**

The Plan provides group medical and prescription drug benefits through fully insured policies through BCBSF. Benefits available to participants are the group insurance benefits to be provided pursuant to the Plan for the employees of the Employers as defined in the insurance contracts with BCBSF. The Plan requires participating Employers to fund no less than the greater of 50% of the costs of a “minimum value” plan [as defined by the *Affordable Care Act* (the ACA)] for each eligible employee, or the carrier’s minimum Employer contribution for the cost of such a plan. In situations where an employee’s monthly cost for such “minimum coverage” exceeds 9.83% of the employee’s monthly compensation (or such other amount as may be set by federal regulation), such employee may access the ACA health insurance exchange in lieu of enrolling in the Plan. The portion of dependent coverage paid varies by Employer.

The Plan also provides ancillary dental, vision, life insurance, and disability coverage through various insurance contracts with insurance companies providing the coverage. The Plan does not assume any responsibility for the benefits provided by the insurance contracts, which are entirely and exclusively the obligation of the insurers. As such, income under these ancillary benefits arrangements represent premiums charged to Employers under the Plan, and expense represents premiums charged by the ancillary insurance carriers to the Plan.

**Premiums Paid to the Plan**

The Plan is funded through premiums paid to the Plan by participating employees, which are based on published rates provided by the Plan. Insurance premium rates are determined annually in conjunction with the contracts with the insurance providers. Health and additional life insurance premium rates are age-banded and based on coverage tier. Under this system, the required premium for each participant is computed based on the participant’s age and number of family members covered. Dental, vision, and basic life insurance premiums are based on coverage tier. Disability insurance premium rates are based on age and weekly or monthly benefit election. Participants have several coverage options to choose from for each benefit type.

**Eligibility**

All active full-time employees, as defined, who regularly work a minimum of 30 hours per week are eligible to enroll upon completion of their waiting period. The waiting period may vary by Employer, but in no event can exceed the first of the month following 60 days of employment. Employers participating in the Plan are eligible for *Consolidated Reconciliation Act of 1985* (COBRA). This results in a covered person, whose coverage is terminated due to a qualifying event, being eligible to elect continuation coverage, as required by COBRA, as amended by the *Tax Reform Act of 1986*. Retired physicians, under certain conditions, are also permitted to remain in the Plan. Retired physicians’ health insurance premiums are determined by reference to the age-banded rates, determined by the Plan actuary, and are not subsidized by the Plan.

**Termination of the Plan and Other Rights**

Although it has not expressed any intention to do so, the Trust has the right under the Plan to terminate, replace, alter, amend, or modify existing contracts of insurance whenever the Trustees deem it expedient and in the best interest of all affected parties to do so, subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Trust has the right under the Plan to modify the benefits provided to active participants, to discontinue its benefits at any time, and to terminate the Plan. In the event of termination of the Plan, remaining assets after payment of all obligations then outstanding, as determined by the Trustees, will be distributed among Employers then participating in the Plan.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**OCALA, FLORIDA**

**Note 2 - Summary of Significant Accounting Policies**

**Basis of Accounting**

The financial statements have been prepared using the cash basis of accounting and, therefore, are not intended to present net assets available for benefits and changes in net assets available for benefits in conformity with generally accepted accounting principles. The cash basis of accounting differs from generally accepted accounting principles in that premium and other income is recognized when received rather than earned, and premium expense, claims, minimum premium administrative fees, and other expenses are recognized when paid rather than when the obligation is incurred.

**Use of Estimates**

The preparation of financial statements requires the Plan CA to make estimates and assumptions that affect certain disclosures of accumulated Plan benefits. Actual results may differ from those estimates.

**Cash and Cash Equivalents - Held by Contracted Administrator**

Cash and cash equivalents - held by contracted administrator is comprised of business checking accounts and interest-bearing money market accounts held by the Plan's CA. The Plan considers highly liquid debt investments with an initial maturity of three months or less at the date of purchase to be cash equivalents. Cash equivalents were approximately \$514,000 and \$511,000 at February 28, 2023 and 2022, respectively.

Cash and cash equivalents are maintained at financial institutions which are insured by the Federal Deposit Insurance Corporation up to \$250,000 per institution. The Plan places its funds with high credit quality financial institutions and does not believe it is exposed to any significant credit risk on its cash and cash equivalents.

The Plan is required to maintain a minimum cash collateral reserve in an amount actuarially determined by BCBSF annually. The collateral reserve is required in the event any obligation of the Plan under the MPAA is not fully satisfied on a timely basis by the Plan. As of February 28, 2023 and 2022, the collateral reserve was approximately \$3,700,000 and \$3,300,000, respectively. The cash collateral reserve is included in cash and cash equivalents - held by contracted administrator on the accompanying statements of net assets available for benefits - cash basis.

**Plan Expenses**

Professional fees and other administrative expenses paid by the Plan, and included in the statements of changes in net assets available for benefits - cash basis, include accounting, professional, and other administrative fees paid to certain parties-in-interest and other unrelated parties.

**Subsequent Events**

The Plan CA has evaluated subsequent events and transactions for potential recognition or disclosure in the financial statements through February 2, 2024, the date the financial statements were available to be issued. No material events have occurred since February 28, 2023, that require recognition or disclosure in the financial statements.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**OCALA, FLORIDA**

**Note 3 - Insurance Premiums and Minimum Premium Charge**

Insurance premiums received for the year ended February 28, 2023, consisted of health and ancillary insurance premiums paid to the Plan by participating Employers based on pre-determined published rates.

The Plan pays a monthly Minimum Premium Charge (see Note 1) to BCBSF for health insurance administrative and claims processing services provided by BCBSF. These fees are recorded as minimum premium administrative fees on the accompanying statement of changes in net assets available for benefits - cash basis. The Minimum Premium Charge was \$123 per participant for the period from March 1, 2022 through February 28, 2023.

Effective March 1, 2022, the Plan pays monthly premiums to the insurance carriers providing ancillary insurance coverage, which is recognized as ancillary insurance premiums expense on the accompanying statement of changes in net assets available for benefits - cash basis.

**Note 4 - Premium Stabilization Reserve**

Prior to the Plan's conversion to a minimum premium plan on October 1, 2020, and pursuant to a previous Service Agreement with BCBSF, 50% of the excess of health insurance premiums paid over health insurance claims incurred after certain administrative expenses were accumulated by BCBSF, and referred to as a premium stabilization reserve. In circumstances in which claims incurred were in excess of premiums paid during the term of the Services Agreement, the excess was absorbed by BCBSF. Any premium surplus could either be used to offset premiums in the upcoming year, reduce future rate increases, be utilized for other expenses as deemed necessary by the Trustees of the Plan, or be distributed to participating member groups upon termination of the Services Agreement.

As a result of the Plan converting to a Minimum Premium Plan on October 1, 2020, the previous Services Agreement with BCBSF converted, and the Plan was paid the accumulated premium stabilization reserve balance from BCBSF at the time of conversion of approximately \$3,366,000. The intention of the Plan is to hold these funds on behalf of the individual County Medical Societies participating in the Plan to potentially offset future Minimum Premium Charges to the Employers within those counties should an acceptable and approved cash reserve surplus amount be attained. This reserve fund account was not utilized as of February 28, 2023 and 2022. The return of the premium stabilization reserve balance from BCBSF is recorded as a premium stabilization reserve liability on the accompanying statements of net assets available for benefits - cash basis.

**Note 5 - Tax Status**

Generally, plans that are not Voluntary Employee Beneficiary Association health and welfare plans do not receive determination letters from the Internal Revenue Service. The Plan CA believes that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, the Plan Administrator believes that the Plan is qualified and the related Trust is tax-exempt as of the date of the financial statements.

**MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**OCALA, FLORIDA**

**Note 6 - Information Regarding Accumulated Plan Benefits**

As described in Note 2, the Plan's financial statements have been prepared on the cash basis of accounting, which is considered a comprehensive basis of accounting other than generally accepted accounting principles. Under this method of accounting, expenses are recognized when paid rather than when incurred. The cash basis of accounting was selected for financial reporting by the Trustees, as it better facilitates the preparation of the Internal Revenue Service Form 5500 for this particular Plan and its related ERISA and the Department of Labor reporting requirements.

As cash basis financial statements, liability information pertaining to accumulated Plan benefits related to its health insurance offering is not required to be shown on the face of the financial statements but is required to be disclosed in the notes to the financial statements.

**Summary of Plan Benefit Obligations**

	<u>2022</u>	<u>2021</u>
Health Insurance Claims Payable	\$ 2,551,739	\$ 1,945,498
Health Insurance Claims Incurred But Not Reported	<u>1,642,344</u>	<u>1,345,263</u>
<b>Plan's Total Benefit Obligations</b>	<u>\$ 4,194,083</u>	<u>\$ 3,290,761</u>

**Reconciliation of Beginning and End Total Benefit Obligations**

	<u>2022</u>	<u>2021</u>
<b>Balance, Beginning of Year</b>	\$ 3,290,761	\$ 8,193,077
Health Insurance Claims Reported and Approved for Payment		
Including Increases or Decreases in Health Insurance Claims		
Incurred But Not Reported as of Year-End	31,685,873	27,694,382
Health Insurance Claims Paid	<u>(30,782,551)</u>	<u>(32,596,698)</u>
<b>Balance, End of Year</b>	<u>\$ 4,194,083</u>	<u>\$ 3,290,761</u>

There is no post-retirement benefit obligation since retired beneficiaries must pay their age-banded premium as determined by the insurance carrier and it is not subsidized by the Plan.

**Note 7 - Parties-In-Interest**

The Plan has an administrative agreement in effect with the CA, and thus the CA is considered a party-in-interest with the Plan under ERISA. Certain fees paid to the CA are paid by the Employers participating in the Plan and are excluded from the financial statements of the Plan. Party-in-interest fees paid by the Plan include \$44,100 to the Plan's accounting firm, \$17,048 paid to the Plan's attorney, and \$25,000 in advisory fees to the CA. Claims processing activities are managed by BCBSF and medical and ancillary insurance premiums are managed by the CA. These transactions also qualify as party-in-interest transactions.

**CERTIFIED PUBLIC ACCOUNTANTS**

Gainesville | Ocala | Tallahassee | Sarasota | Orlando | Tampa

[purvisgray.com](http://purvisgray.com)

Members of American and Florida Institutes of Certified Public Accountants

An Independent Member of the BDO Alliance USA

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
23RD STREET MANAGEMENT, INC.	45-4049688	0.11%
A BETTER VUE EYE PHYSICIANS LLC	26-0393015	0.23%
AARON'S DOCTOR OFFICE	83-2498197	0.03%
ABSOLUTE HEALTH INTERNAL MEDICINE & PEDIATRICS, PA	20-5100672	0.77%
ABSOLUTE MEDICAL GROUP. PA	82-0959277	0.53%
ACCENT PHYSICIAN SPECIALISTS, PA	59-3344396	0.89%
ACKERMAN CANCER CENTER, PA	59-2037695	1.90%
ADVANCED DERMATOLOGY & SKIN SURGERY SPECIALISTS, PA	65-0667253	0.23%
Advanced Eye Care of Bay County, PA	59-3186736	0.29%
ADVANCED ORTHOPEDICS INSTITUTE, PA	81-4334935	0.49%
ADVANCED UROLOGY OF SARASOTA, LLC	85-3070134	0.12%
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY, PA	65-0347042	0.14%
AESTHETIC CENTER FOR COSMETIC RECONSTRUCTIVE SURGERY, LLC	65-0721028	0.73%
ALFREDO D. FERNANDEZ MD PA	65-0861617	0.11%
ALLERGY & ASTHMA CONSULTANTS OF CENTRAL FLORIDA	59-2578940	0.24%
ALLERGY & ASTHMA SPECIALISTS OF NORTH FLORIDA, PA	20-3722480	0.09%
ALW ENTERPRISES PA	84-1744983	0.11%
ANDREW MARLOWE, MD, PA	65-0879521	0.22%
ANESTHESIA UNLIMITED	59-3761966	0.49%
Angel Kids, PA	20-0660471	1.11%
APRIL M. THOMSON, DO, PLLC	81-3947581	0.07%
Aristides Martinez, MD PA	20-4129382	0.01%
ARTHRITIS & OSTEOPOROSIS CENTER, LLC	59-3471782	0.07%
BACH & GODOFSKY, MD	94-3439188	0.71%
BAY RADIOLOGY ASSOCIATES PL	59-1567316	0.61%
BAYSHORE PATHOLOGY CONSULTANTS PA	46-4196957	0.34%
BEAL DERMATOLOGY, PLLC	84-4804195	0.13%
BENJAMIN TRIPP, MD, PA	65-0872918	0.21%
BETHEL BLOOD AND CANCER CENTER, PA	47-1203467	0.05%
BORYS A MASCARENHAS, MD PA	41-2094142	0.09%
BRADENTON CARDIOLOGY	59-2440279	0.61%
BRADENTON DERMATOLOGY	65-0461307	0.22%
BRADENTON EAST INTEGRATIVE MEDICINE	26-1729363	0.30%
BRADENTON SURGERY	65-0505185	0.36%
BRAIN & SPINE CENTER, LLC	59-3572738	0.76%
BRANDON AREA EAR, NOSE & THROAT, PA	59-2749337	0.03%
Brandon Eye Associates	20-5313190	1.15%
BREAST IMAGING PARTNERS LLC	85-3553454	0.32%
BRETT E. STANALAND, MD, PA	59-3283209	0.25%
BRIAN D WOLFF MD PA	20-5743208	0.09%
BRIAN E. HASS, MD, PA	65-0965481	0.08%
BURNT STORE FAMILY MEDICINE PL	02-0609414	0.12%
CARDIOVASCULAR ANESTHESIA CONSULTANTS OF CENTRAL FL PLLC	56-2294500	0.74%
CARDIOVASCULAR INSTITUTE OF NW FLORIDA	59-2005970	1.58%
CARLOS PORTU MD., PLLC	83-1013806	0.09%
CAROLYN J. AGRESTI, MD, EAR, NOSE, & THROAT INC.	47-1787456	0.22%
CENTER FOR HERNIA REPAIR, LLC	26-2739384	0.17%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, PA	59-2822729	0.22%
CENTRAL FLORIDA ENT ASSOCIATES PA	59-1452754	0.12%
CENTRAL FLORIDA EYE INSTITUTE, PL	42-1621290	0.47%
CENTRAL FLORIDA HEART GROUP, PA	20-0524223	0.15%
CENTRAL FLORIDA SPINE INSTITUTE, PLLC	20-5529258	0.18%
CHARLES B. STOER, PA, MD	59-3099448	0.41%
CHILDREN'S HEALTH OF OCALA, PA	59-3606013	0.16%
CHILDREN'S UROLOGY GROUP, PL	59-3236138	0.57%
CHRIS J. GRAINGER, MD	62-1069164	0.04%
CHRISTOPHER PITTMAN, MD PA	27-4035319	0.30%
COASTAL PEDIATRIC GROUP, LLC	81-1888014	0.13%
COLLIER COUNTY MEDICAL SOCIETY INC	51-0202537	0.06%
COLLIER SPORTS MEDICINE INC	56-2403150	0.44%
COMMUNITY PHYSICIANS OF NORTH PORT, P.A.	20-3387275	0.36%
COMPREHENSIVE PAIN MANAGEMENT	51-0473464	0.40%
CONCIERGE MEDICAL OF NAPLES LLC	47-2912066	0.06%
DAVID C RITTER MD SURGICAL ONCOLOGY & GENERAL SURGERY PA	65-0943955	0.15%
DAVID C. MISHKEL MD PA	65-0939014	0.16%
DAVID GREENE, MD LLC	45-2574394	0.13%
DAVID J. APPLEBAUM MD	65-0300000	0.15%
DAVID M. MCFADDIN, MD PA	59-3044512	0.03%
DAVID PANTING MD	26-1773202	0.07%
DAVID S BALLESTAS MD PA	59-2627966	0.13%
DAVID SCOTT MADWAR MD PA	26-2463789	0.14%
DAWN M. DAVANZO, MD, PA	45-2283330	0.08%
DEMASI DIGESTIVE HEALTH PA	26-3959121	0.14%
Dermatology Associates of Bay County	59-1847285	0.61%
DERMATOLOGY INSTITUTE & SKIN CANCER CTR LLC	85-0782409	0.18%
DERMATOLOGY OF GAINESVILLE, LLC	82-4597536	0.14%
DERMATOLOGY SOLUTIONS GROUP, LLC	90-1007938	3.70%
DERMATOLOGY SPECIALISTS OF NAPLES	65-0265649	0.29%
DIANA J. GRAVES, DO, LLC	80-0588045	0.05%
DIANE BRZEZINSKI DO PA	59-3686839	0.13%
DIGESTIVE DISEASE	20-0793285	0.20%
DIGESTIVE HEALTH ASSOCIATES, PA	45-4804019	0.09%
DOCTORS PRACTICE MANAGEMENT CORP.	27-3043076	0.05%
EAR, NOSE, THROAT & SINUS CENTER PA	59-3523581	0.10%
East Coast Medical Associates, Inc.	65-0366342	0.03%
EDWARD H. FARRIOR, MD PA	59-3266977	0.09%
ELIZABETH MUDDIMAN CEFALU, MD, MPH, PLLC	47-4634833	0.06%
EMERALD COAST ORTHOPEDICS PLLC	84-3144635	0.04%
ENDOSCOPY CENTER OF OCALA, INC.	59-3088327	2.43%
EUGENIO RODRIGUEZ MD PA	65-0734635	0.40%
EXCEL CARE ORTHOPEDICS, PLLC	83-3203199	0.11%
EXECUTIVE MEDICINE OF VERO BEACH	82-3112192	0.12%
EYE SPECIALISTS OF FLORIDA, PA	59-3576311	0.40%
FAMILY ALLERGY & ASTHMA CONSULTANTS	20-3802248	0.32%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
FAMILY PRACTICE ASSOCIATES, PA	59-3571597	0.13%
FIRST COAST DERMATOLOGY & INTERNAL MEDICINE, PA	35-2197601	0.26%
First Coast Family Medicine	20-4862099	0.18%
FLEMING ISLAND PLASTIC SURGERY, LLC	47-4973653	0.12%
FLORIDA CARDIAC CONSULTANTS, INC	65-0303477	0.71%
FLORIDA CARDIOLOGY GROUP PA	65-0431787	0.34%
FLORIDA COASTAL PLASTIC SURGERY, PA	90-0076655	0.18%
FLORIDA EYE INSTITUTE, PA	59-2511162	1.53%
FLORIDA EYE SPECIALIST INSTITUTE, PA	59-3600447	0.18%
FLORIDA GULF COAST EAR NOSE & THROAT, LLC	20-2399514	0.68%
FLORIDA PAIN CLINIC, INC.	59-2983266	0.18%
FLORIDA SKIN CANCER AND DERMATOLOGY SPECIALISTS PA	01-0709257	0.35%
FLORIDA SURGICAL CLINIC, LLC	81-2708104	0.07%
Formoso Pain Specialists, PA	85-1148402	0.03%
G. B. FISHER III, DO, PA	65-0970253	0.16%
GARDNER PLASTIC SURGERY	20-4741010	0.36%
GASTROENTEROLOGY GROUP OF NAPLES, PA	65-0320922	0.46%
GULF COAST ENDOSCOPY CENTER OF VENICE LLC	65-0954372	0.68%
Gulf Coast Heart & Vascular, LLC	88-3041548	0.11%
GULF COAST PULMONARY AND SLEEP	83-2834685	0.12%
GULF TO BAY INFECTIOUS DISEASE CONSULTANTS, PLLC	47-1915614	0.04%
GULFSHORE CONCIERGE MEDICINE	47-1701875	0.25%
Gulfshore Personalized Care, LLC	46-4558791	0.01%
GYNECOLOGY OF VENICE PL	20-0943261	0.11%
GYNECOLOGY SPECIALISTS OF OCALA, PLLC	27-4598148	0.07%
HAND & WRIST SPECIALISTS OF THE PALM BEACHES	47-2009119	0.09%
HARBOR MEDICAL GROUP, LLC	81-3294700	0.13%
HEALTH MATTERS OF SARASOTA, PLLC	20-8741703	0.09%
HEART & RHYTHM ASSOCIATES, PLLC	82-5256402	0.09%
HEART ATTACK PREVENTION CENTER	20-5060385	0.16%
HERBERT GATES III MD PA	59-3447978	0.18%
HERMES O. KOOP MD	26-3674659	0.12%
HIGH TIDE DERMATOLOGY CENTER, LLC	46-2434374	0.07%
HILLSTROM FACIAL PLASTIC SURGERY PA	01-0735709	0.30%
HOWARD TEE, MD, PLLC	82-3534142	0.10%
HUGH H. WINDOM, MD, PA	65-0600743	0.44%
Hypertension Kidney & Dialysis Specialist, LLC	27-4647939	0.10%
INDIAN RIVER PRIMARY CARE, PA	65-0816054	0.62%
INFECTIOUS DISEASES SPECIALTY ASSOCIATES, PLLC	82-4818791	0.10%
J CAPOTE PEDIATRICS PA	83-0697170	0.09%
J MORGAN O'DONOGHUE PA	59-3680294	0.16%
J. ROBIN ATWELL, MD, PA	20-1792745	0.13%
JACKSONVILLE SKIN CANCER CENTER	20-0965184	0.22%
JAMES P BARTEK MD PL	51-0502626	0.07%
JANE LAMP MD PA	20-1999909	0.13%
JANET A. BETCHKAL, MD PA	46-4408253	0.07%
JAX SPINE & PAIN CENTERS	20-0091237	2.62%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
JEFFREY S. BEARD, MD, PA	65-0778513	0.12%
JEREMY D. MCCONNELL, MD, PA	81-2260757	0.79%
JET MEDICAL CENTER	45-2948259	0.13%
JOHN A. PULEO MD PL	26-1098650	0.11%
JORGE L. FLORIN MD PA	59-3453116	0.57%
JOSE GAUDIER, MD PA	01-0875404	0.15%
JOSEPH GAUTA MD PA	59-3649548	0.08%
JUSTIN ROSS WASSERMAN, MD, PL	27-4283950	0.17%
KARON R. LOCICERO, MD PA	59-2894869	0.54%
KENNETH A GIRALDO MD PA	14-1845723	0.10%
KENNETH A SAMPONG, PA	04-3726148	0.16%
KENNETH E. STARK, MD PA	20-1723835	0.09%
KENT V. HASEN, MD, PA	01-0733547	0.19%
KI HASSLER DO LLC	82-2930676	0.10%
KORUNDA MEDICAL, LLC	26-1204381	0.66%
LAKE AMERICA FAMILY PHYSICIANS	46-5282650	0.12%
LAKE ARTHRITIS CENTER, PA	59-3515993	0.06%
LAKE DERMATOLOGY, PA	59-3308583	0.40%
LAKE GASTROENTEROLOGY ASSOCIATES, LLC	27-4317031	0.52%
LAKEWOOD CARDIOVASCULAR CONSULTANTS	20-8255024	0.09%
LAWRENCE M. HURVITZ, MD, PA	59-2237040	0.16%
LCO GROUP, PA	59-2953521	0.27%
LEON MEAD MD PA	65-0122193	0.10%
LERNER COHEN HEALTHCARE, PA	74-3141022	0.31%
LEWIS J. HERZBRUN, MD PA	32-0066920	0.09%
LUNA BECK MD & ASSOCIATES, PA	20-4224678	0.11%
MACIEJ TUMIEL, MD, PA	59-3449017	0.06%
MANOOGIAN ORTHOPEDIC CENTER PA	59-3736719	0.19%
Marc Dilorenzo, MD	59-2919611	0.00%
MARC J. HIRSH MD PA	26-0482775	0.48%
MARION PEDIATRICS, PA	59-3709114	0.10%
MARIUSZ J KLIN MD PA	02-0688777	0.08%
MARK JOHNSON, MD, PA	65-0939394	0.14%
MARTHA A. PRICE, MD PA	59-2970608	0.04%
MATRIX PULMONARY	65-1058126	0.18%
MAZZA PLASTIC SURGERY	65-0125203	0.10%
MCMS, Inc. Insurance Trust - Retiree	84-4350072	0.36%
MEADOWCREST FAMILY PHYSICIANS	20-2932425	0.84%
MEDICAL ASSOCIATES OF DELRAY PA	65-0128260	0.39%
MEDPEDS ASSOCIATES OF SARASOTA PA	65-0984667	0.33%
MICHAEL A. VENZAIO, MD	59-3457423	0.10%
MICHAEL J. FREEMAN, MD PA	59-2337462	0.63%
MICHAEL MERCANDETTI, MD, PA	27-0035769	0.12%
MID FLORIDA ENDOSCOPY & SURGERY CENTER, LLC	26-3388221	0.24%
MIDSTATE SKIN INSTITUTE, LLC	45-4674459	0.76%
Millennium Cardiovascular Associates	92-0449791	0.03%
MINIMALLY INVASIVE VASCULAR	82-1510528	0.09%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
MONICA O. WOODWARD, MD PA	59-3653792	0.19%
MORRIS R. HANAN, MD PA	59-2095930	0.09%
NAPLES CARDIAC & ENDOVASCULAR CENTER, PA	20-2547273	0.20%
Naples Concierge Cardiology & Internal Medicine, LLC	86-2682449	0.05%
NAPLES PEDIATRICS, INC	65-0797293	0.05%
NAPLES RHEUMATOLOGY PLLC	46-5146856	0.08%
NAPLES VASCULAR SPECIALISTS, LLC	80-0926645	0.17%
NATURE COAST PRIMARY CARE, PLLC	45-5257066	0.81%
Nephrology Associates	59-3568123	0.26%
Neurological Assoc of Lake County	59-3134797	0.01%
NEUROSPINAL ASSOCIATES	59-2831647	0.42%
NEUROSURGERY & SPINE SPECIALISTS, LLC	05-0531835	1.03%
NEUROSURGICAL ASSOCIATES - CASSIDY & GUERIN MD PA	65-0513576	0.22%
NEW VISION EYE CENTER, LLC	27-0354278	2.20%
Nibha Mediratta, MD PL	27-3534091	0.01%
NICHOLAS J. GARCIA, DO, PA	27-3730088	0.04%
NORMAN H. ANDERSON, MD PA	59-1901972	3.87%
NORTH FLORIDA KIDNEY CARE, LLC	51-0494374	0.21%
NORTHWEST FLORIDA SURGERY CENTER	59-3123289	0.56%
NOVU DERMATOLOGY & INTERNAL MEDICINE LLC	82-3048196	0.13%
OCALA DERMATOLOGY & SKIN CANCER CENTER, PA	59-3238249	0.64%
OCALA HEART CLINIC II, LLC	26-2131291	0.98%
OCALA INFECTIOUS DISEASE & WOUND CENTER	20-1422124	0.50%
OCALA KIDNEY GROUP, INC.	59-2750578	1.73%
OCALA LUNG & CRITICAL CARE ASSOCIATES, INC.	65-0650144	1.15%
OCALA ORTHOPAEDIC GROUP, PA	59-2997500	0.23%
OPHTHALMIC CONSULTANTS	59-2726035	0.01%
ORTHOPAEDIC CENTER OF SOUTHWEST FLORIDA	20-4098938	0.65%
ORTHOPAEDIC CENTER OF VERO BEACH, PA	65-0925136	0.45%
ORTHOPAEDIC SPECIALTY CARE, LLC	20-4857601	0.14%
OVIEDO FAMILY HEALTH CENTER PA	59-2952063	0.23%
PAIN & SPINE CENTERS OF FLORIDA, LLC	27-2618053	0.14%
Pain Clinic of NW Florida	59-3110306	0.35%
PALM BEACH COUNTY MEDICAL SOCIETY	30-0130804	0.20%
Palm Beach Pediatrics, PA	59-2724116	0.77%
PALM COAST EYE CENTER	65-0987859	0.12%
PALMA SOLA NEUROLOGY ASSOCIATES	82-4780178	0.15%
PANAMA CITY NEUROSURGERY, P.A.	81-4185601	0.08%
Panama City Plastic Surgery, LLC	59-3647683	0.10%
PARADISE FAMILY HEALTHCARE INC	59-3525509	0.19%
PARDO, FORSTOT, BACA & ALBOUKREK, P.A	65-0336999	0.78%
Parkinson's Disease & Movement Disorder Center of Boca Raton	22-3659456	0.03%
PAVAN K. ANAND, MD	65-0923321	0.16%
PEDIATRIC ASSOCIATES OF OCALA, PA	59-3324260	0.22%
PEDIATRIC SERVICES & BREATHING CENTER, PA	59-3681725	0.22%
PHILIP T. REGALA MD PL	65-0754470	0.13%
PHYSICIAN BUSINESS ALLIANCE	59-3464291	0.43%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
PLASTIC SURGERY CENTER OF LAKE COUNTY, PA	59-3132127	0.21%
Plastic Surgery Center, PA	59-1944612	0.09%
PLASTIC SURGERY OF PALM BEACH PA	65-0208782	0.91%
PONTE VEDRA PLASTIC SURGERY	59-3193989	1.24%
PRO SPORTS AND SPINE, INC	65-0968857	0.31%
PROVISION LASER EYE CENTER	20-0982690	0.35%
PULMONARY CONSULTANTS OF OCALA, PLLC	27-3335707	0.23%
PULMONARY PHYSICIANS, PA	59-3557176	0.24%
Radiology Associates of Venice & Englewood, PA	59-1937565	1.90%
RAINBOW PEDIATRIC CENTER, PA	86-1141885	0.19%
RAM EYE CARE & RETINA CENTER	30-0029956	0.17%
RE3 STEM CELL AND HEALING INSTITUTE, PLLC	82-0625119	0.18%
REJUVEFACE, LLC	47-0968339	0.08%
RELEVE SPORTS MEDICINE LLC	82-0712917	0.07%
Renaissance Plastic Surgery, PA	20-0111322	0.05%
Restorative Rheumatology Corp	88-3707928	0.06%
RETINA CARE CONSULTANTS, PA	45-4893062	0.26%
RICHARD A CONROY MD PA	65-0488700	0.28%
Richard Lawrence Siegel, MD PA	59-2422927	0.23%
RIVERWALK AMBULATORY SURGERY CENTER LLC	26-0594903	0.69%
ROBERT H. FELMAN, MD, PA	65-0552007	0.09%
ROBERT HENDLEY, MD, LLC	81-1345718	0.10%
Roberta S. Rose, DO PA	31-1287458	0.00%
ROGER DANZIGER MD	65-0531220	0.09%
RUSSEL S. GLAUN MD PA	65-1039810	0.11%
Sabal Direct Primary Care	81-2627005	0.00%
SARASOTA ARTHRITIS CENTER	59-1842511	0.86%
SARASOTA IMMEDIATE CARE, INC.	38-3744482	0.02%
SARASOTA PHYSICIANS SURGICAL CENTER	43-2110985	0.17%
SARASOTA RETINA INSTITUTE	59-2248237	0.33%
SCHOFIELD HAND & BRIGHT ORTHOPAEDICS, PLLC	20-3582714	0.43%
SCOTT L WIESEN MD, LLC	27-3370927	0.14%
Seaborn Hunt Jr. MD	59-2422742	0.00%
SEABORN M. HUNT, III, MD PA	65-1075189	0.27%
SEAN DOWNING, MD	84-2883749	0.09%
SILVER LAKE PEDIATRICS, PA	59-3606003	0.21%
SIVA, MD PA	20-5459949	0.18%
SK RETINA, LLC	47-4687611	0.09%
SKIN CANCER CENTER OF CENTRAL FLORIDA, PA	59-3708058	0.27%
SKIN WELLNESS PHYSICIANS LLC	46-4477281	0.62%
SMALL WORLD PEDIATRIC, PA	30-0090138	0.09%
SMIRNOFF NEUROLOGY, PA	83-0486801	0.06%
SOUTH PALM MEDICAL ASSOCIATES	65-1005367	0.16%
SOUTH PALM ORTHOPEDICS	65-0710981	0.68%
SOUTHEAST ORTHOPEDIC SPECIALISTS, INC	59-3696338	2.07%
SPARTAN ANESTHESIA ASSOCIATES, PA	65-1018177	0.24%
Specialized Aesthetics, PA	65-0965481	0.16%

**MCMS - Insurance Trust Fund Group Health Plan & Ancillary Plan**  
**EIN 23-7026266**  
**MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION**

Name of Employer	EIN	Percentage of Total Contributions
STEPHEN A. BOOKBINDER, MD PA	59-2760716	0.17%
STEVEN GOODWILLER, MD PA	59-2819632	0.07%
Steven Knezevich, MD PA	59-3072246	0.12%
STEVEN SCHUSTER, MD, PA	59-2845533	0.09%
SUGAR ORTHOPAEDICS, PA	27-0846679	0.28%
SUKUMARAN RAMASWAMI, MD PA	59-3638677	0.14%
SUMEET BHANOT MD PA	20-4534448	0.09%
SUNCOAST ENDOSCOPY OF SARASOTA	01-0713595	0.15%
SUNCOAST PSYCHIATRIC MEDICAL CLINIC	20-1809958	0.10%
Susan Balk Kradel, MD Assoc	59-3598355	0.09%
SUSHIL PUSKUR, MD PA	26-3151115	0.06%
SWICFT MEDICAL PARTNERS	20-1827306	0.62%
THE CARDIOVASCULAR & VEIN CENTER OF FLORIDA, PA	65-0629174	0.38%
THE HOUSE DOC, LLC	47-4344828	0.15%
THOMAS A DIGERONIMO MD PA	59-3399451	0.16%
Thomas L. Bowers, IV DMD, MD PA	59-3703943	0.01%
THOMAS MEDRICK SWEENEY II, MD, PHD, PLLC	83-4538346	0.05%
TOTAL GASTROENTEROLOGY, PA	30-0518223	0.24%
TREASURE COAST CARDIOVASCULAR INSTITUTE, INC	81-1771630	0.11%
TUDOR SCRIDON, MD, PL	26-4132855	0.12%
TWIN PALM ORTHOPEDICS	20-5176873	0.38%
UNIVERSAL WELLNESS GROUP, PA	82-0857299	0.08%
VENICE DERMATOLOGY CLINIC, PA	65-1143063	0.09%
VERO BEACH NEUROLOGY & RESEARCH INSTITUTE, LLC	81-2127471	0.11%
VERO RENAL ASSOCIATES, PA	34-2002685	0.22%
VERO VASCULAR SURGERY, PA	65-0716495	0.10%
Vero Women's Care, LLC	88-3810774	0.02%
VIRGINIA J GOOD, MD PA	46-3749995	0.07%
VITA ANKSH, MD PA	06-1646627	0.10%
VITREO RETINAL ASSOCIATES	59-2046817	0.48%
WAYNE LEE MD PLASTIC SURGERY, PLLC	27-4481869	0.16%
WELL & YOU, LLC.	27-5234510	0.03%
WILLIAM GAYA, MD, PA	46-3749995	0.11%
WILLIAM MACK, MD PA	59-3486600	0.17%
WOMEN'S & CHILDREN'S PHYSICIANS OF NAPLES LLP	59-2046817	0.08%
YOU & YOUR HEALTH FAMILY CARE, INC	27-4481869	0.04%

**Federal Statements**

FYE: 2/28/2023 **MCMS, Inc. - Insurance Trust Fund Group Health and  
Plan: 501**

**General Footnote**

Description

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EXTENSION WAS FILED UNDER FORM 5558. FILING UNDER IR-2023-159 HURRICANE IDALIA LATE FILING RELIEF.

PLAN NAME IS MCMS, INC. - INSURANCE TRUST FUND GROUP HEALTH AND ANCILLARY PLAN. IT WAS FORMALLY KNOWN AS MCMS INSURANCE TRUST FUND GROUP HEALTH PLAN.