

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2023

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan... [X] a single-employer plan [] a DFE (specify)
B This return/report is: [] the first return/report [] the final return/report [X] an amended return/report [] a short plan year return/report...
C If the plan is a collectively-bargained plan, check here... []
D Check box if filing under: [] Form 5558 [] automatic extension [] the DFVC program [] special extension...
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here... []

Part II Basic Plan Information—enter all requested information

1a Name of plan ST. PAUL EYE CLINIC HEALTH & WELFARE SECTION 125
1b Three-digit plan number (PN) 502
1c Effective date of plan 06/01/1978
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) ST. PAUL EYE CLINIC P. A.
2080 WOODWINDS DR STE 110 WOODBURY, MN 55125-2524
2080 WOODWINDS DR STE 110 WOODBURY, MN 55125-2524
2b Employer Identification Number (EIN) 41-0949282
2c Plan Sponsor's telephone number 651-738-6800
2d Business code (see instructions) 621320

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2023) v. 230707

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	154
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	154
	6a(2)	152
	6b	
	6c	
	6d	152
	6e	
	6f	152
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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

4A 4B 4D 4F 4H

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

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) **R** (Retirement Plan Information)
- (2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) **DCG** (Individual Plan Information) – Number Attached _____
- (5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) **H** (Financial Information)
- (2) **I** (Financial Information – Small Plan)
- (3) **A** (Insurance Information) – Number Attached 2
- (4) **C** (Service Provider Information)
- (5) **D** (DFE/Participating Plan Information)
- (6) **G** (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **12/31/2023**

A Name of plan ST. PAUL EYE CLINIC HEALTH & WELFARE SECTION 125		B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 ST. PAUL EYE CLINIC P. A.		D Employer Identification Number (EIN) 41-0949282	

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

THE STANDARD

(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	164412	152	01/01/2023	12/31/2023

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 11587	(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

SUPERIOR BENEFIT ADVISORS LLC
7900 INTERNATIONAL DR
SUITE 990
BLOOMINGTON, MN 55425

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11587			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	

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year.....	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		

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

a 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 Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE 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

2023

This Form is Open to Public Inspection

For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **12/31/2023**

A Name of plan ST. PAUL EYE CLINIC HEALTH & WELFARE SECTION 125		B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 ST. PAUL EYE CLINIC P. A.		D Employer Identification Number (EIN) 41-0949282	

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 MINNESOTA AND BLUE PLUS

(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
41-0984460	55026	272063	128	01/01/2023	12/31/2023

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 71034	(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
SEVENHILLS CLEVELAND LLC

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
71034			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection.
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For calendar plan year 2023 or fiscal plan year beginning **01/01/2023** and ending **12/31/2023**

A Name of plan ST. PAUL EYE CLINIC HEALTH & WELFARE SECTION 125	B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 ST. PAUL EYE CLINIC P. A.	D Employer Identification Number (EIN) 41-0949282	

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

DDMN ASO, LLC **500 WASHINGTON AVE S**
MINNEAPOLIS, MN 55415

41-1852523

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

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

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

SEVENHILLS CLEVELAND LLC

7900 INTERNATIONAL DRIVE
#990
MINNEAPOLIS, MN 55425

41-1683746

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	AGENT/AGENCY	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	12477	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

Blue Cross and Blue Shield of Minnesota

P.O. Box 64560
St. Paul, MN 55164-0560



3/19/2024

ST PAUL EYE CLINIC PA
2080 WOODWINDS DR
STE 110
WOODBURY, MN 55125

Client Number: 272063

Dear Employer,

Attached is the health care coverage information you need to prepare your IRS Schedule A (Form 5500), if applicable. This information is provided in compliance with the Employee Retirement Income Security Act of 1974, pursuant to ERISA Section 103 (a) (2).

Blue Cross and Blue Shield of Minnesota certifies the accuracy and completeness of this information. If you have questions call your Blue Cross and Blue Shield of Minnesota Account Manager.

Sincerely,

Blue Cross and Blue Shield of Minnesota
Julie Kacon
(651) 662-8000
(800) 382-2000

**Blue Cross and Blue Shield of Minnesota and Blue Plus
Information for Schedule A**

I. Premium Received	Medical	
		\$1,903,856
II. Commissions and Other Income	Medical Drug Vision Dental Medicare	
SEVENHILLS CLEVELAND LLC		\$15,072
III. Employee Enrollment	Medical	
		128
IV. Dependent Enrollment	Medical	
		106

Note 1: This amount also includes reportable monetary and non-monetary amounts where eligibility for the payment or amount was based (in whole or in part) on business placed or retained.
Note: The above figures, at this time of this report, are accurate and correct to the best of our knowledge

ERISA Form 5500 (Schedule C) Information

Group Name:

St. Paul Eye Clinic, P.A.

Group Number(s)

DDMN 0101938

Experience Period		01-JAN-2023 Through 31-DEC-2023
Name of plan	A	DDMN ASO, LLC
Excluding a person	1a	No
Name/EIN	2a	41-1852523 Stratacor
Service Code(s)	2b	12, 13
Relationship	2c	Benefit Administrator
Direct compensation paid by the plan.	2d	\$10,605.22
Indirect compensation received	2e	No
Indirect comp. include eligible direct comp.	2f	No
Total indirect compensation	2g	\$0.00
Formula provided vs amount	2h	No
Name/address	2a	Sevenhills Cleveland LLC
	2a	7900 INTERNATIONAL DRIVE #990 MINNEAPOLIS, MN 55425
Service Code(s)	2b	22
Relationship	2c	agent/agency
Direct compensation paid by the plan.	2d	\$0.00
Indirect compensation received	2e	\$12,477.82
Indirect comp. include eligible direct comp.	2f	No
Total indirect compensation	2g	\$12,477.82
Formula provided vs amount	2h	No
Name/address	3a	Sevenhills Cleveland LLC
	3a	7900 INTERNATIONAL DRIVE #990 MINNEAPOLIS, MN 55425
Service Code(s)	3b	22
Indirect compensation received	3c	\$12,477.82
Enter name and EIN (address) of source of indirect compensation	3d	41-1852523 DDMN ASO, LLC
Describe the indirect compensation	3e	Commissions

ERISA Form 5500 (Schedule C) Information

Group Name:

St. Paul Eye Clinic, P.A.

Group Number(s)

DDMN 0101938

Please note that the direct compensation paid by the plan as reported above may also have been reported with Form 5500 Schedule A information if this form was requested by the Group.



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: ST PAUL EYE CLINIC PA

PART I

1) COVERAGE - LIFE INSURANCE

- a) CARRIER: STANDARD INSURANCE COMPANY
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 164412
e) NUMBER OF PERSIONS COVERED: 152
f) FROM: 1/1/2023
g) TO: 12/31/2023

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKER, AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$1,102.66
FEES PAID / AMOUNT: \$0.00

Table with 5 columns: A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID, B) AMOUNT OF COMMISSION PAID (COMMISSIONS, CONTINGENT COMP*), C) AMOUNT, D) PURPOSE, E) ORG. CODE. Includes entry for SUPERIOR BENEFIT ADVISORS LLC and summary rows for TOTAL COMMISSIONS PAID and TOTAL CONTINGENT COMP PAID.

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business.

LONG FORM INFORMATION

PART III - 164412
 7) BENEFIT TYPE: LIFE INSURANCE

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED	\$18,051.05	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE	\$0.00	
(4) EARNED PREMIUM ((1) +(2) - (3))		\$18,051.05
b) BENEFIT CHARGES: (1) CLAIMS PAID	\$64,000.00	
(2) INCREASE (DECREASE) CLAIM RESERVES	\$36.00	
INCURRED CLAIMS ((1) +(2))		\$64,036.00
(4) CLAIMS CHARGED		\$64,036.00
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES		
(A) COMMISSIONS	\$1,102.66	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS	\$0.00	
(D) OTHER EXPENSES	\$3,684.28	
(E) TAXES	\$288.73	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES	\$1,244.88	
(G) OTHER RETENTION CHARGES	\$0.00	
(H) TOTAL RETENTION		\$6,320.54
(2) DIVIDEND OR RETROACTIVE RATE REFUND		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		\$ 0.00
(2) CLAIM RESERVES		\$3,288.00
(3) OTHER RESERVES		\$0.00
(E) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE		\$0.00



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: ST PAUL EYE CLINIC PA

PART I

1) COVERAGE - LONG TERM DISABILITY

- a) CARRIER: STANDARD INSURANCE COMPANY
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 164412
e) NUMBER OF PERSIONS COVERED: 151
f) FROM: 1/1/2023
g) TO: 12/31/2023

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKER, AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$7,718.28
FEES PAID / AMOUNT: \$0.00

Table with 5 columns: A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID, B) AMOUNT OF COMMISSION PAID (COMMISSIONS, CONTINGENT COMP*), C) AMOUNT, D) PURPOSE, E) ORG. CODE. Includes entry for SUPERIOR BENEFIT ADVISORS LLC and summary rows for TOTAL COMMISSIONS PAID and TOTAL CONTINGENT COMP PAID.

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business.

LONG FORM INFORMATION

PART III - 164412
 7) BENEFIT TYPE: LONG TERM DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED	\$84,820.06	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE	\$0.00	
(4) EARNED PREMIUM ((1) +(2) - (3))		\$84,820.06
b) BENEFIT CHARGES: (1) CLAIMS PAID	\$88,188.83	
(2) INCREASE (DECREASE) CLAIM RESERVES	\$118,241.34	
INCURRED CLAIMS ((1) +(2))		\$206,430.17
(4) CLAIMS CHARGED		\$206,430.17
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES		
(A) COMMISSIONS	\$7,718.28	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS	\$0.00	
(D) OTHER EXPENSES	\$20,777.69	
(E) TAXES	\$1,696.42	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES	\$9,245.32	
(G) OTHER RETENTION CHARGES	\$0.00	
(H) TOTAL RETENTION		\$39,437.71
(2) DIVIDEND OR RETROACTIVE RATE REFUND		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		\$ 0.00
(2) CLAIM RESERVES		\$657,367.57
(3) OTHER RESERVES		\$0.00
(E) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE		\$0.00



LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

C) PLAN SPONSOR: ST PAUL EYE CLINIC PA

PART I

1) COVERAGE - TEMPORARY DISABILITY

- a) CARRIER: STANDARD INSURANCE COMPANY
b) EIN: 93-0242990
c) NAIC CODE: 000-69019
d) CONTRACT NUMBER: 164412
e) NUMBER OF PERSIONS COVERED: 80
f) FROM: 1/1/2023
g) TO: 12/31/2023

2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKER, AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$2,766.47
FEES PAID / AMOUNT: \$0.00

Table with 5 columns: A) NAME & ADDRESS OF AGENT OR BROKER TO WHOM COMMISSION OR FEES WERE PAID, B) AMOUNT OF COMMISSION PAID (COMMISSIONS, CONTINGENT COMP*), C) AMOUNT, D) PURPOSE, E) ORG. CODE. Includes entry for SUPERIOR BENEFIT ADVISORS LLC and summary rows for TOTAL COMMISSIONS PAID and TOTAL CONTINGENT COMP PAID.

*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business.

LONG FORM INFORMATION

PART III - 164412
 7) BENEFIT TYPE: TEMPORARY DISABILITY

EXPERIENCE RATED CONTRACTS

a) PREMIUMS: (1) AMOUNT RECEIVED	\$45,246.82	
(2) INCREASE (DECREASE) IN DUE BUT UNPAID	\$0.00	
(3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE	\$0.00	
(4) EARNED PREMIUM ((1) +(2) - (3))		\$45,246.82
b) BENEFIT CHARGES: (1) CLAIMS PAID	\$33,747.08	
(2) INCREASE (DECREASE) CLAIM RESERVES	(\$408.00)	
INCURRED CLAIMS ((1) +(2))		\$33,339.08
(4) CLAIMS CHARGED		\$33,339.08
c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES		
(A) COMMISSIONS	\$2,766.47	
(B) ADMINISTRATIVE SERVICE OR OTHER FEES	\$0.00	
(C) OTHER SPECIFIC ACQUISITION COSTS	\$0.00	
(D) OTHER EXPENSES	\$12,606.01	
(E) TAXES	\$904.96	
(F) CHARGES FOR RISK OR OTHER CONTINGENCIES	\$2,662.88	
(G) OTHER RETENTION CHARGES	\$0.00	
(H) TOTAL RETENTION		\$18,940.32
(2) DIVIDEND OR RETROACTIVE RATE REFUND		
d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR		
(1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT		\$ 0.00
(2) CLAIM RESERVES		\$4,404.00
(3) OTHER RESERVES		\$0.00
(E) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE		\$0.00

Blue Cross and Blue Shield of Minnesota

P.O. Box 64560
St. Paul, MN 55164-0560



5/6/2024

ST PAUL EYE CLINIC PA
2080 WOODWINDS DR
STE 110
WOODBURY, MN 55125

Client Number: 272063

Dear Employer,

Attached is updated health care coverage information you need to prepare your IRS Schedule A (form 5500), if applicable. We identified commission amounts were not pulling in as expected and may have impacted the data that was previously sent. This information is provided in compliance with the Employee Retirement Income Security Act of 1974, pursuant to ERISA Section 103 (a)(2). Retirement Income Security Act of 1974, pursuant to ERISA Section 103 (a) (2).

Blue Cross and Blue Shield of Minnesota certifies the accuracy and completeness of this information. If you have questions call your Blue Cross and Blue Shield of Minnesota Account Manager.

Sincerely,

Blue Cross and Blue Shield of Minnesota
Julie Kacon
(651) 662-8000
(800) 382-2000

**Blue Cross and Blue Shield of Minnesota and Blue Plus
Information for Schedule A**

I. Premium Received	Medical \$1,894,002
II. Commissions and Other Income SEVENHILLS CLEVELAND LLC	Medical \$71,034
III. Employee Enrollment	Medical 128
IV. Dependent Enrollment	Medical 106

Note¹: This amount also includes reportable monetary and non-monetary amounts where eligibility for the payment or amount was based (in whole or in part) on business placed or r
Note: The above figures, at this time of this report, are accurate and correct to the best of our knowledge

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 01/01/2023 and ending 12/31/2023

- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
 a single-employer plan a DFE (specify) ____
- B** This return/report is: the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here.
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.

Part II Basic Plan Information—enter all requested information

1a Name of plan ST. PAUL EYE CLINIC HEALTH & WELFARE SECTION 125	1b Three-digit plan number (PN) ▶ 502
	1c Effective date of plan 06/01/1978
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, and ZIP or foreign postal code (if foreign, see instructions) ST. PAUL EYE CLINIC P.A. 2080 WOODWINDS DR STE 110 WOODBURY, MN 55125-2524	2b Employer Identification Number (EIN) 41-0949282
	2c Plan Sponsor's telephone number 651-738-6800
	2d Business code (see instructions) 621320

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		6-26-24	Phillip T. Shudam
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

User ID A1274826

Pin Number 4619

Notation:

This report is amended because after the initial 2023 reporting was done, BlueCross revised their Schedule A and came back with a revised one, which had a higher commission number. That is the only difference between this amended report and what was initially submitted a few weeks ago.

Both BlueCross Schedule A's, the original and revised, are attached.