

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 07/01/2023 and ending 06/30/2024

- A This return/report is for: [ ] a multiemployer plan [X] 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: [X] 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 SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION
1b Three-digit plan number (PN) 501
1c Effective date of plan 02/15/1980
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) SOUTH CAROLINA MEDICAL ASSOCIATION 132 WESTPARK BLVD COLUMBIA, SC 29210
2b Employer Identification Number (EIN) 57-0248750
2c Plan Sponsor's telephone number 803-798-6207
2d Business code (see instructions) 813000

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, Date, and Name. Rows include Michelle Bolin (plan administrator), Richele Taylor (employer/plan sponsor), and a blank row for DFE.

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

Form 5500 (2023) v. 230707

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor  TRUSTEES OF THE SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION  132 WESTPARK BLVD COLUMBIA, SC 29210		<b>3b</b> Administrator's EIN 83-4350949
		<b>3c</b> Administrator's telephone number 803-798-6207
<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>	2587
<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>6a(1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	2572
<b>6a(2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	2413
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b>	13
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	0
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....	<b>6d</b>	2426
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>	
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....	<b>6f</b>	2426
<b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>	
<b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<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>	

**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 4Q

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

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

**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   4
- (4)  **C** (Service Provider Information)
- (5)  **D** (DFE/Participating Plan Information)
- (6)  **G** (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 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 145237507

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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

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>	<b>D</b> Employer Identification Number (EIN) <b>57-0248750</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  
**SUN LIFE ASSURANCE COMPANY OF CANADA**

<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>38-1082080</b>	<b>80802</b>	<b>LIF94049</b>	<b>2379</b>	<b>01/01/2023</b>	<b>12/31/2023</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>11905</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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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  
**FULCRUM RISK SOLUTIONS** **132 WESTPARK BOULEVARD**  
**COLUMBIA, SC 29210**

<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	
<b>9317</b>			<b>3</b>

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**THE CASON GROUP** **1612 MARION STREET, SUITE 1**  
**COLUMBIA, SC 29201**

<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	
<b>2588</b>			<b>3</b>

(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>	0
<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>	
	<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>	

**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 checked="" 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>	51761
<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. ▶

**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 **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>		<b>D</b> Employer Identification Number (EIN) <b>57-0248750</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

**SUN LIFE ASSURANCE COMPANY OF CANADA**

<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>38-1082080</b>	<b>80802</b>	<b>STD94049</b>	<b>1964</b>	<b>01/01/2023</b>	<b>12/31/2023</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>62648</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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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

**FULCRUM RISK SOLUTIONS**  
**132 WESTPARK BOULEVARD**  
**COLUMBIA, SC 29210**

<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	
<b>49029</b>			<b>3</b>

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

**THE CASON GROUP**  
**1612 MARION STREET, SUITE 1**  
**COLUMBIA, SC 29201**

<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	
<b>13619</b>			<b>3</b>

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

Schedule A (Form 5500) 2023  
v. 230707

(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>	0
<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>	
	<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>	

**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>	
(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>

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	272384
<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. ▶

**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 **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>		<b>D</b> Employer Identification Number (EIN) <b>57-0248750</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  
**SUN LIFE ASSURANCE COMPANY OF CANADA**

<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>38-1082080</b>	<b>80802</b>	<b>VOL94049</b>	<b>249</b>	<b>01/01/2023</b>	<b>12/31/2023</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>36890</b>	<b>(b)</b> Total amount of fees paid <b>0</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  
**FULCRUM RISK SOLUTIONS** **132 WESTPARK BOULEVARD**  
**COLUMBIA, SC 29210**

<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	
<b>30742</b>			<b>3</b>

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**THE CASON GROUP** **1612 MARION STREET, SUITE 1**  
**COLUMBIA, SC 29201**

<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	
<b>6148</b>			<b>3</b>

(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.
----------------	--

<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:

<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"/>		

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

<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>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<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>	
	<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>	

**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) **▶ AD&D**

**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>

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	122967
<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. ▶

**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 **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>		<b>D</b> Employer Identification Number (EIN) <b>57-0248750</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  
**BCS INSURANCE COMPANY**

<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>36-6033921</b>	<b>38245</b>	<b>768</b>	<b>4200</b>	<b>01/01/2023</b>	<b>12/31/2023</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>0</b>	<b>(b)</b> Total amount of fees paid <b>0</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

<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	

**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.

<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** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

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

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

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

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

**b** Balance at the end of the previous year ..... **7b**

**c** Additions: (1) Contributions deposited during the year ..... **7c(1)**  
 (2) Dividends and credits ..... **7c(2)**  
 (3) Interest credited during the year ..... **7c(3)**  
 (4) Transferred from separate account..... **7c(4)**  
 (5) Other (specify below) ..... **7c(5)**  
 ▶

(6) Total additions ..... **7c(6)** 0

**d** Total of balance and additions (add lines **7b** and **7c(6)**) ..... **7d**

**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**  
 (2) Administration charge made by carrier ..... **7e(2)**  
 (3) Transferred to separate account..... **7e(3)**  
 (4) Other (specify below) ..... **7e(4)**  
 ▶

(5) Total deductions ..... **7e(5)** 0

**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)
- |  |  |   |  |
|--|--|---|--|
| <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 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 checked="" 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>	590367
<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</b> <b>(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>2023</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>	<b>D</b> Employer Identification Number (EIN) <b>57-0248750</b>	

**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)

OPTUM RX INC.

1 OPTUM CIRCLE  
EDEN PRAIRIE, MN 55344

33-0441200

(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?
12 50 62 99	PHARMACY BENEFIT MANAGER	9314118	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	27447	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

SOUTH CAROLINA MEDICAL ASSOCIATION

132 WESTPARK BLVD  
COLUMBIA, SC 29210

57-0248750

(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?
35 13 16 49	PLAN SPONSOR	1135870	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)

FULCRUM RISK SOLUTIONS, INC.

132 WESTPARK BLVD  
COLUMBIA, SC 29210

57-0983258

(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?
53	AFFILIATE OF PLAN SPONSOR	823009	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	25126	Yes <input type="checkbox"/> No <input checked="" 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)

PLANNED ADMINISTRATORS, INC.

POST OFFICE BOX 6927  
COLUMBIA, SC 29260

57-0718839

(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	TPA	775117	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)

AMWINS GROUP INC

4725 PIEDMONT ROW DRIVE  
CHARLOTTE, NC 28210

13-4009411

(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?
16	CONSULTING	205678	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)

BLUE CROSS BLUE SHIELD OF SC

I-20 EAST ALPINE ROAD  
COLUMBIA, SC 29219

57-0287419

(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	TPA	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	170071	Yes <input type="checkbox"/> No <input checked="" 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)

AAJ COMPUTER SERVICES

6301 NW 5TH WAY, SUITE 1700  
FORT LAUDERDALE, FL 33309

65-0762524

(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?
16	INFORMATION MANAGEMENT	155400	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)

ELLIOTT DAVIS, LLC/PLLC

2151 PICKENS ST, SUITE 200  
COLUMBIA, SC 29201

57-0381582

(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	101001	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)

FIRST HEALTH

140 STONEBRIDGE DRIVE  
COLUMBIA, SC 29210

20-1736437

(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	TPA	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	85656	Yes <input type="checkbox"/> No <input checked="" 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)

SUN LIFE ASSURANCE CO OF CANADA

2323 GRAND BOULEVARD  
KANSAS CITY, MO 64108-2670

38-1082080

(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?
12	ADMINISTRATOR	76409	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)

WINDSOR STRATEGY PARTNERS

777 ALEXANDER ROAD, SUITE 201  
PRINCETON, NJ 08540

81-0912547

(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	ACTUARY	45521	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)

NELSON MULLINS RILEY AND SCARBOROUGH

1320 MAIN STREET 17  
COLUMBIA, SC 29201

57-0215445

(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	LEGAL	42132	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)

BENEFIT COORDINATORS

PO BOX 197  
IRMO, SC 29063

57-0853863

(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	ADMINISTRATOR	40748	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)

BLUE CROSS BLUE SHIELD OF SC

I-20 EAST ALPINE ROAD  
COLUMBIA, SC 29219

57-0287419

(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	TPA	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	35690	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

MUHA CENTER FOR TELEHEALTH

2435 FOREST DRIVE  
COLUMBIA, SC 29204

(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	ADMINISTRATOR	13000	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)

GRADIENT AI CORP

ONE MARINA PARK DR, STE 305  
BOSTON, MA 02210

83-1032918

(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?
16	INFORMATION MANAGEMENT	11340	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)

PROGRESS SOFTWARE CORPORATION

15 WAYSIDE ROAD, SUITE 400  
BURLINGTON, MA 01806

04-2746201

(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?
16	INFORMATION MANAGEMENT	7236	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)

JACKSON LEWIS, P.C.

15 SOUTH MAIN STREET, SUITE 700  
GREENVILLE, SC 29601

46-3862389

(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	LEGAL	5363	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"/>



**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
BLUE CROSS BLUE SHIELD OF SC	13	170071
(d) Enter name and EIN (address) of source of indirect compensation PLANNED ADMINISTRATORS, INC. POST OFFICE BOX 6927 COLUMBIA, SC 29260 57-0718839	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. PPO AND UTILIZATION REVIEW/MANAGED CARE	
(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.

<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:

<b>SCHEDULE H</b> <b>(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>Financial Information</b>  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).  ▶ <b>File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2023 or fiscal plan year beginning <b>07/01/2023</b> and ending <b>06/30/2024</b>	
<b>A</b> Name of plan <b>SCMA VOLUNTARY MEMBERS' BENEFICIARY ASSOCIATION</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>SOUTH CAROLINA MEDICAL ASSOCIATION</b>	<b>D</b> Employer Identification Number (EIN) <b>57-0248750</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**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.

		(a) Beginning of Year	(b) End of Year
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	16217571	4987480
<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>	3814775	4570922
<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>	7443209	16443597
<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>	140794	554573

<b>1d</b> Employer-related investments:		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>	11917	7830
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	27628266	26564402
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>	2777952	2763000
<b>h</b> Operating payables .....	<b>1h</b>	755540	793178
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>	2328599	2189612
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	5862091	5745790
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	21766175	20818612

**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>		<b>(a)</b> Amount	<b>(b)</b> Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>		
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	27595220	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		27595220
<b>b Earnings on investments:</b>			
(1) Interest:			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>	716312	
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		
(2) Dividends: <b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		
(3) Rents .....	<b>2b(3)</b>		
(4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		
(5) Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts.....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts.....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities.....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<b>c</b> Other income .....	<b>2c</b>		3082
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		28314614

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	24632539	
(2) To insurance carriers for the provision of benefits.....	<b>2e(2)</b>	1075449	
(3) Other.....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		25707988
<b>f</b> Corrective distributions (see instructions).....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	<b>2i(1)</b>		
(2) Contract administrator fees.....	<b>2i(2)</b>	890096	
(3) Recordkeeping fees.....	<b>2i(3)</b>		
(4) IQPA audit fees.....	<b>2i(4)</b>		
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>		
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>		
(7) Actuarial fees .....	<b>2i(7)</b>		
(8) Legal fees .....	<b>2i(8)</b>		
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	2664093	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		3554189
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		29262177

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		-947563
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**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: **ELLIOTT DAVIS, LLC/PLLC**

(2) EIN: **57-0381582**

**d** The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1)  This form is filed for a CCT, PSA, DCG 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. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
<b>a</b> 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.) .....		X	
<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.).....		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.) .....		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.).....		X	
<b>e</b> Was this plan covered by a fidelity bond?.....	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? .....		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? .....		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?.....		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.).....	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.).....		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? .....		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan? .....		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.).....		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. ....		X	

**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.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> 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 \_\_\_\_\_.

**South Carolina Medical Association  
Members' Insurance Trust**

*Report on Financial Statements*

*For the years ended June 30, 2024 and 2023*

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# South Carolina Medical Association Members' Insurance Trust

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## Independent Auditor's Report

Board of Trustees  
South Carolina Medical Association Voluntary Employees' Beneficiary Association  
Welfare Benefit Plan and Trust d/b/a SCMA Members' Insurance Trust  
Columbia, South Carolina

### Opinion

We have audited the accompanying financial statements of South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust d/b/a SCMA Members' Insurance Trust (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 plan benefits and plan benefit obligations as of June 30, 2024 and 2023, and the related statements of changes in net assets available for plan benefits and changes in plan benefit obligations for the years then ended, and the related notes to financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the statements of net assets available for plan benefits and plan benefit obligations as of June 30, 2024 and 2023, and the changes in its net assets available for benefits and in plan benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the 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 audits. 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 accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

## **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 GAAS 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 GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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 Plans'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.

## **Supplemental Schedule Required by ERISA**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule, Schedule H, Line 4i - Schedule of Assets (Held at End of Year) as of June 30, 2024 is presented for the purpose of additional analysis and is not a required part of the financial statements but is supplemental information required by the Department of Labor's (DOL) Rules and Regulations for Reporting and Disclosure under the ERISA. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

**Supplemental Schedule Required by ERISA, Continued**

In forming our opinion on the supplemental schedule, we evaluated whether the supplemental schedule, including its form and content, is presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedule is fairly stated in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

A handwritten signature in black ink that reads "Elliott Davis, LLC". The signature is written in a cursive, flowing style.

Columbia, South Carolina  
December 20, 2024

# South Carolina Medical Association Members' Insurance Trust

## Statements of Net Assets Available for Plan Benefits

As of June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Assets</b>		
Non-interest bearing deposits	\$ 4,987,480	\$ 16,217,571
Money market fund	193,597	193,209
Certificates of deposit	16,250,000	7,250,000
Employer contributions receivable	1,819,345	1,772,529
Rebates receivable	2,751,577	2,042,246
Prepaid expenses and other assets	554,573	140,794
Property and equipment, net	7,830	11,917
Total assets	<u>26,564,402</u>	<u>27,628,266</u>
<b>Liabilities</b>		
Accounts payable and accrued expenses	663,236	606,772
Accounts payable - affiliates	129,942	148,768
Unearned employer contributions	2,189,612	2,328,599
Total liabilities	<u>2,982,790</u>	<u>3,084,139</u>
Net assets available for plan benefits	<u>\$ 23,581,612</u>	<u>\$ 24,544,127</u>

See Notes to Financial Statements

## South Carolina Medical Association Members' Insurance Trust

### Statements of Changes in Net Assets Available for Plan Benefits

For the years ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Additions:</b>		
Employer contributions	\$ 27,595,220	\$ 28,010,810
Investment income	716,312	245,200
Other income	3,082	6,146
Total additions	<u>28,314,614</u>	<u>28,262,156</u>
<b>Deductions:</b>		
Health claim payments	24,647,491	25,340,722
Commissions	823,009	887,087
Disability insurance expense	277,464	282,699
Access fees	890,096	922,240
Reinsurance fees	640,538	550,562
Life insurance premiums	157,447	165,827
Administrative fees	235,571	349,629
Leased employee expense	595,424	388,465
Depreciation expense	4,087	4,574
Other	1,006,002	846,020
Total deductions	<u>29,277,129</u>	<u>29,737,825</u>
Net change	(962,515)	(1,475,669)
<b>Net assets available for plan benefits, beginning of year</b>	<u>24,544,127</u>	<u>26,019,796</u>
<b>Net assets available for plan benefits, end of year</b>	<u>\$ 23,581,612</u>	<u>\$ 24,544,127</u>

See Notes to Financial Statements

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## South Carolina Medical Association Members' Insurance Trust

### Statements of Plan Benefit Obligations

As of June 30, 2024 and 2023

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	<u>2024</u>	<u>2023</u>
<b>Amounts currently payable for benefit obligations:</b>		
Health and prescription drug claims payable and claims incurred but not reported	<u>\$ 2,763,000</u>	<u>\$ 2,777,952</u>

See Notes to Financial Statements

## South Carolina Medical Association Members' Insurance Trust

### Statements of Changes in Plan Benefit Obligations

For the years ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Amounts currently payable for benefit obligations:</b>		
<i>Balance, beginning of year</i>	\$ 2,777,952	\$ 2,502,107
Claims incurred	24,632,539	25,616,567
Claims paid	(24,647,491)	(25,340,722)
<i>Balance, end of year</i>	<u>\$ 2,763,000</u>	<u>\$ 2,777,952</u>

See Notes to Financial Statements

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

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### Note 1. Description of the Plan

The following description of the South Carolina Medical Association Voluntary Employees' Beneficiary Association Welfare Benefit Plan and Trust d/b/a SCMA Members' Insurance Trust (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

#### General:

The Plan is a defined benefit, multiple employer welfare arrangement sponsored by the South Carolina Medical Association. The Plan is a self-insured plan, supplemented by stop-loss insurance. Plan assets are held in a voluntary employees' beneficiary association (VEBA) trust. The Plan is subject to the provisions of the Employee Retirement Security Act of 1974, as amended (ERISA).

#### Benefits:

The Plan provides health benefits (hospital, surgical, outpatient, major medical, dental, prescription drugs, and maternity) to South Carolina Medical Association (SCMA or "Sponsor") members (including their full-time employees, spouses and dependents) who elect to participate, as well as full-time employees of SCMA and its affiliates (working at least 30 hours per week) and to their covered spouses and dependents. The Plan also provides life insurance, accidental death and dismemberment, short-term disability and supplemental accident coverage through a third party. The Plan provides participants with benefits options that include Health Savings Accounts. The activity associated with Health Savings Accounts is excluded from the Plan's financial statements because the Plan is not obligated to pay the benefits and the Plan does not have title to these assets.

Medical and pharmaceutical claims of participants and dependents are processed by Planned Administrators, Inc. and OptumRx, Inc., respectively. The responsibility for payments to participants and providers is retained by the Plan.

#### Contributions:

The Plan is funded by contributions from SCMA, participating members of SCMA, and the employees of participating members. Contributions for the employees of a participating member of SCMA may, at the sole discretion of the member, be paid by the member. Contributions for employees of SCMA and spouses and their dependents are paid by SCMA. Contribution amounts for each participant are based on an actuarially determined rate schedule. The rates vary with the coverage (e.g., single or family) selected by each participant.

#### Stop-loss insurance:

Claims in excess of \$500,000 (through December 31, 2024 and 2023) per individual participant per calendar year are reinsured under a stop-loss contract with a reinsurance provider. Failure of the Plan's reinsurer to honor its obligations could result in losses to the Plan. Stop-loss insurance does not extinguish the Plan's primary liability under the policies written. Therefore, the Plan regularly evaluates the financial condition of its reinsurer and may establish allowances for uncollectible stop-loss recoveries.

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

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### Note 1. Description of the Plan, Continued

#### Stop-loss insurance, continued:

Net premiums for stop-loss insurance are included in premium payments in the statements of changes in net assets available for plan benefits. Stop-loss refunds totaling \$38,818 and \$1,221,547 have been netted with health claim payments in the statements of changes in net assets available for plan benefits for the years ended June 30, 2024 and 2023.

#### Plan termination:

The Sponsor has the right under the Plan to modify the benefits provided to participants. The Sponsor may terminate the Plan by appropriate corporate action by giving ten days prior written notice of such action to the Plan's Board of Trustees. Upon termination of the Plan, the Trustees shall hold the assets of the Plan in Trust until it is completely exhausted by paying benefits provided under the Plan as directed by the Sponsor and paying reasonable expenses of the Plan, including termination expenses.

### Note 2. Basis of Presentation and Summary of Significant Accounting Policies

#### Basis of accounting:

The accompanying financial statements are prepared in accordance with accounting principles generally accepted in the United States of America (US GAAP).

#### Use of estimates:

The preparation of financial statements in conformity with US GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, and disclosures of contingent assets and liabilities. Actual results could differ from those estimates.

#### Concentrations of credit risk:

Financial instruments, which potentially subject the Plan to significant concentrations of credit risk, consist primarily of cash and temporary cash investments. The Plan places its cash and temporary cash investments with a high-quality financial institution that is a member of the Federal Deposit Insurance Corporation. Concentrations of credit risk with respect to receivables are dispersed as the Plan's member base consists of separate entities throughout the state of South Carolina.

#### Investment valuation and income recognition:

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's management determines the Plan's valuation policies utilizing information provided by the investment advisors, custodian and insurance company. See Note 3 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Investment income includes, when applicable, the Plan's gains and losses on investments bought and sold as well as held during the year.

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

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### Note 2. Basis of Presentation and Summary of Significant Accounting Policies, Continued

#### Certificates of deposit:

Certificates of deposit are stated at amortized cost, which approximates fair value. The certificates have stated interest rates ranging from 4.93% to 5.73% and maturing at various dates through April 2025.

#### Property and equipment:

Property and equipment are stated at cost. Depreciation is calculated using the straight-line method over the estimated useful lives of the related assets.

Building and land improvements	15 years
Furniture, fixtures, and equipment	3-7 years

#### Benefit obligations:

Plan benefit obligations at June 30, 2024 and 2023 for health claims payable and claims incurred but not reported (IBNR) are reported by management based on estimates provided by the Plan's independent actuary. Management's estimates are based upon actuarial reviews of historical claims loss experience, contribution data, and industry development factors. Management reviews the adequacy of these obligations as additional claims loss experience data becomes available.

#### Employer contributions:

Employer contributions receivable balances are due from the participating employers. Employer contributions are billed monthly in advance of the applicable coverage period. The portion of employer contributions billed in advance is recorded as unearned employer contributions. Employer contributions receivable are recognized at the billed amounts. Employer contributions receivable are considered past due or delinquent when payment is not received, generally within fifteen days of the coverage period. The Plan generally does not require collateral for contracts and does not charge policyholders late fees or interest on delinquent employer contributions receivable. An allowance for uncollectible employer contributions receivable is provided based on a review of the policyholder accounts along with an analysis of historical losses and recoveries. Uncollectible employer contributions receivable are written off when deemed to be uncollectible. No allowance for uncollectible employer contributions receivable was recorded as of June 30, 2024 and 2023.

#### Rebates:

The Plan utilizes a pharmacy benefit manager (PBM) which periodically rebates funds to the Plan based on the Plan's actual utilization pattern of specific drugs. Rebates due from the Plan's PBM are recorded when earned. Rebates due have been reported as a receivable to the extent material. Pharmacy rebates totaling approximately \$4,789,000 and \$3,286,000 have been recorded as a reduction to health claim payments in the statements of changes in net assets available for plan benefits for the years ended June 30, 2024 and 2023, respectively. Pharmacy rebates receivable totaling approximately \$2,752,000 and \$2,042,000 have been recorded in the statements of net assets available for plan benefits at June 30, 2024 and 2023, respectively.

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

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### Note 2. Basis of Presentation and Summary of Significant Accounting Policies, Continued

#### Benefit payments:

Health claims and other benefits provided under the Plan are paid by claims processors and are recognized as expenses when reimbursements are paid.

#### Adoption of a new accounting standard:

In June 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, which creates a new credit impairment standard for financial assets measured at amortized cost and certain other instruments. The ASU requires these financial assets to be presented at the net amount expected to be collected, through an allowance for credit losses that are expected to occur over the remaining life of the asset, rather than incurred losses. The measurement of credit losses for newly recognized financial assets and subsequent changes in the allowance for credit losses are recorded in the statement of changes in net assets available for plan benefits as the amounts expected to be collected change. The new standard is effective for fiscal year beginning July 1, 2023. Adoption of the ASU had no material effect on the financial statements.

Other accounting standards that have been issued or proposed by FASB or other standards-setting bodies are not expected to have a material impact on the Plan's financial statements.

#### Subsequent events:

The Plan has evaluated subsequent events through December 20, 2024, the date the financial statements were available to be issued.

### Note 3. Fair Value Measurements

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

Level 1: Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2: Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
  - Quoted prices for identical or similar assets or liabilities in inactive markets.
  - Inputs other than quoted prices that are observable for the asset or liability.
  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means.
- If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3: Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

### Note 3. Fair Value Measurements, Continued

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at June 30, 2024 and 2023.

Money market fund: The Plan invests in a money market savings account with Bank of America. The Plan invests in the money market fund to provide daily liquidity. Fair value is based on the cost plus earned interest.

Certificates of deposit: The Plan invests money in various certificates of deposit with Bank of America. The certificates of deposit are stated at amortized cost, which approximates fair value.

The money market fund and certificates of deposit are all considered Level 2 investments as of June 30, 2024 and 2023.

### Note 4. Property and Equipment

Property and equipment, net, consisted of the following as of June 30:

	<u>2024</u>	<u>2023</u>
Building and land improvements	\$ 60,319	\$ 60,319
Furniture, fixtures, and equipment	<u>581,271</u>	<u>581,271</u>
	641,590	641,590
Less accumulated depreciation	<u>(633,760)</u>	<u>(629,673)</u>
	<u>\$ 7,830</u>	<u>\$ 11,917</u>

### Note 5. Related Party Transactions

Certain administrative services are performed for the Plan by SCMA. In return, the Plan incurred administrative fees of approximately \$236,000 and \$350,000 to SCMA for the years ended June 30, 2024 and 2023, respectively. The Plan also reimbursed SCMA for direct salary and employee benefit costs incurred on the Plan's behalf totaling approximately \$586,000 and \$380,000 for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024 and 2023, approximately \$71,000 and \$73,000, respectively, was due to SCMA.

The Plan also reimbursed SCMA for certain professional, administrative and other expenses incurred on behalf of the Plan totaling approximately \$28,000 and \$22,000 for the years ended June 30, 2024 and 2023, respectively.

The Plan leases office space from SCMA. The lease contains monthly rental charges through June 2023 with annual renewals thereafter. Rent expense paid to SCMA for the years ended June 30, 2024 and 2023 was approximately \$46,000 for each year.

## South Carolina Medical Association Members' Insurance Trust

### Notes to Financial Statements

June 30, 2024 and 2023

#### Note 5. Related Party Transactions, Continued

The Plan paid commissions of approximately \$823,000 and \$887,000 for the years ended June 30, 2024 and 2023, respectively, to Fulcrum Risk Solutions, Inc. (Fulcrum), an insurance agency wholly owned by SCMA, for sales of insurance coverage to participants. As of June 30, 2024 and 2023, approximately \$59,000 and \$76,000, respectively, was due to Fulcrum.

Employees leased from SCMA participate in SCMA's noncontributory, defined contribution pension plan. The Plan's policy is to fund pension costs accrued. The Plan's contribution to the pension plan is 3% of a participant's compensation up to the maximum allowed by Internal Revenue Service regulations. Contributions to the pension plan totaled approximately \$10,000 and \$9,000, respectively, for the years ended June 30, 2024 and 2023.

Other transactions with these related parties were as follows for the years ended June 30:

	<u>2024</u>	<u>2023</u>
Insurance purchased from the Plan by (included in employer contributions on the statements of changes in net assets available for Plan benefits):		
SCMA	\$ 258,672	\$ 291,364
Fulcrum Risk Solutions, Inc.	\$ 268,207	\$ 248,622

#### Note 6. Income Taxes

The VEBA trust funding certain benefits of the Plan received an exemption letter from the Internal Revenue Service (IRS) dated March 6, 1981, stating that the related trust is tax-exempt under the provisions of Section 501(c)9 of the Internal Revenue Code (IRC). However, as a result of the Plan's funding policy, from time to time the trust may become subject to income taxes. The Plan accounts for income taxes on unrelated business income, primarily investment income, in accordance with US GAAP. As a result, federal income taxes totaling approximately \$230,200 and \$75,800 and state income taxes totaling \$33,000 and \$11,000, for 2024 and 2023 respectively, have been recognized and included in other deductions on the statements of changes in net assets available for benefits.

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

US GAAP requires plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

#### Note 7. Commitments and Contingencies

The Plan, in the normal course of business, may be party to certain legal claims or lawsuits. The Plan's management does not expect the results of these claims or lawsuits to have a material adverse effect on the Plan's net assets available for plan benefits, changes in net assets available for plan benefits, or the Plan's benefit obligations.

# South Carolina Medical Association Members' Insurance Trust

## Notes to Financial Statements

June 30, 2024 and 2023

### Note 8. Risks and Uncertainties

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term could be material to the financial statements.

### Note 9. Reconciliation to Form 5500

The following is a reconciliation of the net assets available for plan benefits per the financial statements to Form 5500 as of June 30:

	<u>2024</u>	<u>2023</u>
Net assets available for plan benefits per financial statements	\$ 23,581,612	\$ 24,544,127
Health and prescription drug claims payable and claims incurred but not reported	<u>(2,763,000)</u>	<u>(2,777,952)</u>
Net assets available for plan benefits per Form 5500	<u>\$ 20,818,612</u>	<u>\$ 21,766,175</u>

The following is a reconciliation of the changes in net assets available for plan benefits per the financial statements to net loss per Form 5500 for the years ended June 30:

	<u>2024</u>	<u>2023</u>
Change in net assets available for plan benefits per the financial statements	\$ (962,515)	\$ (1,475,669)
Change in health and prescription drug claims payable and claims incurred but not reported	<u>14,952</u>	<u>(275,845)</u>
Net loss per Form 5500	<u>\$ (947,563)</u>	<u>\$ (1,751,514)</u>

**South Carolina Medical Association Members' Insurance Trust**
*Schedule H, Line 4i - Schedule of Assets (Held at End of Year) EIN 57-0248750, Plan No. 501*
*As of June 30, 2024*

(a)	(b)	(c)	(d)	(e)
Party - in- interest	Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current value
	Bank of America	Certificate of deposit, maturing July 9, 2024, interest rate of 5.70%	\$ 750,000	\$ 750,000
	Bank of America	Certificate of deposit, maturing July 10, 2024, interest rate of 5.73%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 10, 2024, interest rate of 5.73%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 16, 2024, interest rate of 5.20%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 16, 2024, interest rate of 5.20%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 23, 2024, interest rate of 5.70%	750,000	750,000
	Bank of America	Certificate of deposit, maturing August 2, 2024, interest rate of 5.17%	750,000	750,000
	Bank of America	Certificate of deposit, maturing August 6, 2024, interest rate of 5.19%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing August 7, 2024, interest rate of 5.67%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing August 7, 2024, interest rate of 5.67%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing October 22, 2024, interest rate of 5.73%	750,000	750,000
	Bank of America	Certificate of deposit, maturing October 29, 2024, interest rate of 5.70%	750,000	750,000
	Bank of America	Certificate of deposit, maturing December 3, 2024, interest rate of 5.22%	750,000	750,000
	Bank of America	Certificate of deposit, maturing December 4, 2024, interest rate of 5.22%	750,000	750,000
	Bank of America	Certificate of deposit, maturing January 13, 2025, interest rate of 5.28%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing January 17, 2025, interest rate of 4.93%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing January 17, 2025, interest rate of 4.93%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing April 17, 2025, interest rate of 5.32%	1,000,000	1,000,000
	Bank of America	Money market savings account, interest rate varies	193,597	193,597
			<u>\$ 16,443,597</u>	<u>\$ 16,443,597</u>

**South Carolina Medical Association Members' Insurance Trust**
*Schedule H, Line 4i - Schedule of Assets (Held at End of Year) EIN 57-0248750, Plan No. 501*
*As of June 30, 2024*

(a)	(b)	(c)	(d)	(e)
Party - in- interest	Identity of issue, borrower, lessor, or similar party	Description of investment including maturity date, rate of interest, collateral, par or maturity value	Cost	Current value
	Bank of America	Certificate of deposit, maturing July 9, 2024, interest rate of 5.70%	\$ 750,000	\$ 750,000
	Bank of America	Certificate of deposit, maturing July 10, 2024, interest rate of 5.73%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 10, 2024, interest rate of 5.73%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing July 16, 2024, interest rate of 5.20%	1,000,000	1,000,000
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	Bank of America	Certificate of deposit, maturing August 2, 2024, interest rate of 5.17%	750,000	750,000
	Bank of America	Certificate of deposit, maturing August 6, 2024, interest rate of 5.19%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing August 7, 2024, interest rate of 5.67%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing August 7, 2024, interest rate of 5.67%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing October 22, 2024, interest rate of 5.73%	750,000	750,000
	Bank of America	Certificate of deposit, maturing October 29, 2024, interest rate of 5.70%	750,000	750,000
	Bank of America	Certificate of deposit, maturing December 3, 2024, interest rate of 5.22%	750,000	750,000
	Bank of America	Certificate of deposit, maturing December 4, 2024, interest rate of 5.22%	750,000	750,000
	Bank of America	Certificate of deposit, maturing January 13, 2025, interest rate of 5.28%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing January 17, 2025, interest rate of 4.93%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing January 17, 2025, interest rate of 4.93%	1,000,000	1,000,000
	Bank of America	Certificate of deposit, maturing April 17, 2025, interest rate of 5.32%	1,000,000	1,000,000
	Bank of America	Money market savings account, interest rate varies	193,597	193,597
			<u>\$ 16,443,597</u>	<u>\$ 16,443,597</u>

MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION  
 South Carolina Medical Association Voluntary Members' beneficiary association, EIN 57-0248750, PN 501

(a) Name of participating employer	(b) TIN	(c) Percent of total Contributions
GREENWOOD GENETIC CENTER	57-0604070	5.5752%
PIEDMONT PATHOLOGY ASSOCIATES	57-0560638	0.5738%
MYRTLE BEACH DERMATOLOGY	20-3655134	0.1678%
BLUE RIDGE EYE CENTER	20-4191554	0.2270%
SOUTH CAROLINA SKIN CANCER CENTER	20-4788286	0.1482%
SUMTER EAR , NOSE, THROAT AND PLASTIC SURGERY	56-2198477	0.0323%
CAROLINA EYE & EAR ASSOCIATES	20-4836403	0.0842%
HELEN E HUCKS	26-1980834	0.0015%
ADVANCED WOMENS CARE FOR THE LOWCOUNTRY	20-8412489	0.3834%
Lowcountry Vein Specialists, LLC	85-1334528	0.1753%
ADULT MEDICINE SPECIALISTS	42-1594852	0.3637%
CAROLINA PULMONARY & SLEEP DISORDER	26-3922624	0.0711%
LESLIE LONG, MD, MVIP - MEDICAL CONSULTANTS	56-2053371	0.1485%
THE CHILDREN'S GROUP	27-2468236	0.3187%
JUDY C. TODD	26-0840984	0.0030%
STANLEY GREENBERG, MD	57-1026711	0.0030%
WESTGATE FAMILY PHYSICIANS	57-0677536	0.3359%
H LUCIUS LAFFITTE, JR., MD, LLC	26-3826749	0.1125%
SOUTH STRAND CARDIOLOGY	20-0308558	0.1585%
CSRA RENAL SERVICES	04-3723466	0.4760%
CAROLINA KIDNEY SPECIALISTS	20-1163281	0.0203%
GOULAS EYE	46-3050649	0.2875%
COASTAL CAROLINA UROLOGY GROUP LLC	57-1087172	0.1859%
WALTERBORO FAMILY PRACTICE	57-0536222	0.6250%
SUMTER PEDIATRICS	57-0555541	1.1379%
GREENWOOD ENT ASSOC PA	57-0534419	0.4439%
CAROLINA RADIOLOGY,LLC	57-1049603	4.5876%
WACCAMAW KIDNEY	57-0990861	0.2652%
ALLERGY & ASTHMA CONSULTANTS	57-1001465	0.5175%
SC MEDICAL ASSOCIATION	57-0248750	2.0951%
FLOYD W. PUTNEY, MD	20-1364615	0.0030%
PLASTIC & RECONSTRUCTIVE SURGERY OF SUMTER	57-1029704	0.0145%
PEE DEE NEPHROLOGY	57-0912581	1.1389%
PETER DE VITO, MD	57-0705545	0.1124%
GREENWOOD OB/GYN	57-0516688	0.3177%
NEPHROLOGY ASSOCIATES OF SPARTANBURG	20-4485213	0.5977%
BEAUFORT PEDIATRICS PA	57-1104728	0.7535%
SKIN CANCER CENTRE	57-1051529	0.3407%
UPSTATE PATHOLOGY	57-0969186	0.2887%
THE DERMATOLOGY GROUP	57-1118660	0.6634%
AIKEN EMERGENCY PHYSICIANS FAMILY MEDCENTER OF AIK	57-0652064	0.5762%
ANDERSON SKIN & CANCER CLINIC	57-0736685	1.1791%
CAROLINA ORAL & FACIAL SURGERY	57-1078939	0.2272%
CAROLINA FACIAL PLASTIC	57-1097845	0.0485%
CLINICAL PATHOLOGY CONSULTANTS	57-0514574	0.1848%

NEWBERRY OB/GYN	58-2327026	0.0474%
SEA ISLAND PEDIATRICS	57-1111584	0.1203%
PATHOLOGY ASSOCIATES OF LEXINGTON	57-0609892	0.7542%
HILTON HEAD INTERNISTS - HOHN	57-1105505	0.2416%
MT PLEASANT PEDIATRICS	57-1107504	0.3456%
SAMUEL WOOD, MD	25-6583715	0.0030%
HAND SURGERY ASSOCIATES	33-1085969	0.3092%
EAST COOPER PLASTIC SURGERY	57-1088266	0.3034%
EDGAR V. PASCHAL	24-1783286	0.0013%
Sea Island Ophthalmology, LLC	20-8081397	0.1201%
CARMEN THOMPSON	24-7395542	0.0035%
MEDICAL IMAGING CONSULTANTS	86-1091622	0.0030%
PATRICK H. DENNIS JR MD	57-0936643	0.1099%
PORT CITY PLASTIC SURGERY	27-0270404	0.0785%
MARVIN G. HEVENER, MD	26-1860997	0.0030%
TERESA MILNE	25-0080561	0.0015%
FRANK R BROWN III MD	54-6784181	0.0022%
N. SELBY RICHARDSON, III MD	24-8236470	0.0715%
CONSTANCE KERDASHA	15-3286480	0.0015%
WILLIAM A. DENNIS, MD	24-7981261	0.0040%
MAIN STREET PSYCHIATRY	57-1130973	0.0684%
PALMETTO INFECTIOUS DISEASE	16-3466548	0.7168%
SUSAN MINTER	25-9721302	0.0015%
THE CAROLINA HAND CENTER	57-1015228	0.3093%
STRAND PHYSICIAN SPECIALISTS, PA	57-0963173	3.9706%
PARKWOOD PEDIATRIC GROUP	26-3327850	0.4638%
SOUTHEAST REGIONAL VIRTUAL IMAGING	20-3929448	0.0758%
PALMETTO ANESTHESIA ASSOCIATES, LLC	57-0877232	0.7884%
LOW COUNTRY EYE ASSOCIATES	20-3414543	0.1528%
PATEL MEDICAL CLINIC	27-2249881	0.0048%
MAYES INTERNAL MEDICINE	61-1728050	0.1659%
PIEDMONT NEUROLOGY LLC	47-2919141	0.2759%
MEDIVISION	58-2316731	0.0068%
JOSEPH D THOMAS JR MD PA	57-0888034	0.1367%
PALMETTO PEDIATRICS OF THE LOWCOUNTRY	30-0065379	0.4900%
SPINE & ORTHOPAEDIC SPECIALISTS	20-1624261	0.0853%
SENIOR HEALTH ASSOCIATES	57-1104069	0.5793%
SOUTH CAROLINA INTERNAL MEDICINE	56-2124971	1.7010%
CHARLESTON NEPHROLOGY	58-2468480	0.6432%
JONATHAN L SACK, MD	20-4115414	0.2142%
CENTA MEDICAL GROUP	57-0520539	0.5583%
REHABILITATION & GERIATRIC SPECIALISTS, LLC	56-2039679	0.4736%
SC SPORTS MEDICINE & ORTHOPAEDIC CENTER, PA	57-0886946	1.4200%
CONSULTANTS IN GASTROENTEROLOGY, PA	57-0713425	3.5383%
SPARTANBURG EAR, NOSE & THROAT	57-0844100	1.5873%
CLINICAL TRIALS OF SC	46-3860079	0.0964%
PAIN SPECIALISTS OF CHARLESTON	26-3555943	1.0566%
CAROLINA MUSCULOSKELETAL INSTITUTE	57-0724225	0.4380%
ANESTHESIOLOGY OF GREENWOOD, PA	57-0964224	1.7966%
CASC ACQUISITIONS INC	81-0576467	0.3738%
NANCY NETTER, MD	46-1758502	0.0552%

AIKEN OPHTHALMOLOGY, PC	57-1003729	1.0494%
PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP	16-1639818	1.9464%
PALMETTO EYE INSTITUTE LLC	45-3959219	0.0731%
GRAND STRAND DERMATOLOGY	58-2473379	1.3478%
NEPHROLOGY ASSOCIATES	57-0919760	1.4198%
PALMETTO ANESTHESIA & PAIN	51-0490829	0.0519%
CAROLINA DERMATOLOGY CLINIC	20-2140999	0.2938%
RIVERTOWN SURGERY CENTER	59-3700931	0.6685%
PARKWAY SURGERY CENTER	62-1799370	0.6787%
AMPLOS	84-4420355	0.1784%
FLORENCE EAR, NOSE & THROAT, PC	20-0654512	0.5333%
LOWCOUNTRY LUNG & CRITICAL CARE	57-0978524	1.5908%
UPSTATE MEDICAL ASSOCIATES, PA	26-0386931	0.5654%
CAROLINA SPINE & SPORT REHAB SPEC	26-2588685	0.0690%
SADLER HUGHES APOTHECARY	57-0856179	0.0510%
JUDY CORDER	25-0768882	0.0015%
UPSTATE PLASTIC SURGERY	56-2132034	0.2336%
WELLSPRING FAMILY MEDICINE PA	06-1793145	0.3333%
CHARLESTON DERMATOLOGY PC	81-2855061	0.8838%
RIBAUT MEDICAL PARTNERS LLC	20-3764173	0.0952%
ORTHODONTIC ASSOCIATES OF GREENVILLE	26-1590419	0.3179%
AMBULATORY SURGERY CENTER OF SPTBG LLC	57-1128350	1.8969%
TRANSFORMATION SKIN & BODY SOLUTIONS	82-0978033	0.0762%
PIEDMONT PEDIATRICS	20-3318961	0.2524%
PALMETTO INTERNAL MEDICINE & PRIMARY CARE PA	27-3243242	0.0901%
SURGERY CENTER AT PELHAM, LLC	76-0745215	1.3343%
NATIONAL ALLERGY & ENT	57-1072039	0.6431%
PALMETTO PULMONARY MEDICINE PA	57-0955383	0.1934%
ZYLO THERAPEUTICS INC	83-3038824	0.2950%
FOOTHILLS COMMUNITY HEALTH CARE	26-2735317	1.3626%
UPSTATE PEDIATRIC SPEECH THERAPY	45-1634068	0.2166%
STOKES REGIONAL EYE CENTER	57-0523600	1.0549%
RETINA CONS OF CAROLINA PA	57-0991865	1.4661%
HOLLAND EYE CENTER PC	27-3004152	0.0516%
THE KRAEMER GROUP	26-0582112	0.9367%
NEPHROLOGY & INTERNAL MEDICINE OF ANDERSON, PA	57-0605223	0.0280%
SOUTH CHARLOTTE PLASTIC & AESTHETIC SURGERY	84-2168370	0.1469%
PALMETTO ADULT AND CHILDREN'S UROLOGY	57-0679250	0.4033%
CHARLESTON ENT ASSOCIATES, LLC	58-2281023	4.3262%
SOUTHERN EYE ASSOCIATES OF SC P.A.	57-0563896	1.7932%
LAUREL ENDOCRINE AND THYROID SPECIALISTS	57-0935648	0.3768%
CAROLINA UROLOGIC RESEARCH CENTER	34-1974854	0.4175%
GRIFFIN PLASTIC SURGERY	56-2169578	0.0487%
LOWCOUNTRY SURGICAL ASSOCIATES	16-1633693	0.1636%
PEDIATRIC ASSOCIATES OF KERSHAW COUNTY, PA	57-0707968	0.5340%
DEFORD REHAB CONSULTING, LLC	84-1837466	0.1047%
ENTAAC, PA	20-2212868	0.0763%
CHARLESTON PAIN AND REHABILITATION CENTER	57-0610105	0.2201%
THE SKIN CLIQUE	88-1605759	0.3326%
SEASIDE PEDIATRICS OF MOUNT PLEASANT	57-1099327	0.0583%
CAMDEN BONE AND JOINT	57-1163327	0.6459%

ESPINOZA VEIN INSTITUTE	84-4686045	0.1307%
GALLOWAY REGIONAL EYE	65-1176165	0.0880%
GENERATIONS PEDIATRICS AND INTERNAL MEDICINE	82-2821540	0.0000%
AIKEN VASCULAR SPECIALISTS	86-1794548	0.1218%
PAWLEYS ISLAND PAIN MANAGEMENT	26-1529697	0.0663%
CAROLINA PEDIATRICS	85-3846608	0.0847%
ORTHOSC	82-2962394	7.4801%
METROLINA NEUROLOGICAL ASSOCIATES	57-0753692	0.5071%
ANDERSON AREA CANCER CENTER	57-0749974	1.3558%
SOUTHERN COAST SPINE & PAIN SPECIALISTS	87-3751627	0.4459%
SEASIDE SPINE SPECIALISTS, LLC	87-3794650	0.1866%
ELITE GYNECOLOGY	84-1882736	0.0587%
SANDHILLS ENDOSCOPY CENTER	85-1392224	0.1367%
PECORA MEDICAL	27-4593807	0.0833%
DIGESTIVE DISEASE GROUP	57-0890141	1.2186%
SUNSHINE PEDIATRICS	03-0479184	0.1216%
AUGUSTA ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS	58-1327528	2.4666%
TRIDENT CARDIOLOGY ASSOCIATES, PA	57-0641594	0.7891%
FOOTHILLS ENT	46-0781707	0.3232%
DR JASJOT BHULLAR, LLC	88-3772275	0.0342%
ATREUS MED	92-1464241	0.2046%
SEASIDE DERMATOLOGY	46-4983297	0.2365%
PERRY DERMATOLOGY	83-3387536	0.1013%
AIKEN INTERNAL MEDICINE	62-0964806	0.3023%
VIRTU COSMETIC SURGERY	93-2774204	0.1044%
MG3 PRACTICE SOLUTIONS	87-1274862	0.6147%
PALMETTO CENTER OF PSYCHIATRY	27-3184553	0.0675%