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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

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
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1981

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)
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

P.O. BOX 270
OCALA, FL 34478

2b Employer Identification Number (EIN) 84-4350072

2c Plan Sponsor's telephone number 352-622-9124

2d Business code (see instructions) 621111

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	12/12/2025	SUSHIL PUSKUR, MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor

MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND
BOARD OF TRUSTEES
PO BOX 270
OCALA, FL 34478

3b Administrator's EIN: 84-4350072

3c Administrator's telephone number: 352-622-9124

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	5101
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	5076
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	5380
b	Retired or separated participants receiving benefits	**6b**	8
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5388
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F 4H 4L

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

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

b General Schedules
- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 7
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 160591408

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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

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

1 Coverage Information:

(a) Name of insurance carrier
BLUE CROSS AND BLUE SHIELD OF FLORIDA

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
59-2015694	98167	16510	2743	03/01/2024	02/28/2025

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

(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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	34322199		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	3805101		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	38127300
b Benefit charges (1) Claims paid	**9b(1)**	30145609		
(2) Increase (decrease) in claim reserves	**9b(2)**	301837		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	30447446
(4) Claims charged			**9b(4)**	31338925
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	1610691		
(E) Taxes	**9c(1)(E)**	228764		
(F) Charges for risks or other contingencies	**9c(1)(F)**	1143819		
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	2983274
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

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

1 Coverage Information:

(a) Name of insurance carrier
HEALTH OPTIONS, INC.

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
59-2403696	95089	16510	810	03/01/2024	02/28/2025

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	5195569		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	459059		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	5654628
b Benefit charges (1) Claims paid	**9b(1)**	4023290		
(2) Increase (decrease) in claim reserves	**9b(2)**	71055		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	4094345
(4) Claims charged			**9b(4)**	4356793
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	669136		
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**	169639		
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	838775
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	169612	2748	03/01/2024	02/28/2025

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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	(c) Amount	(d) Purpose	

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	(c) Amount	**(d)** Purpose	

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	384460		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	-33075		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	351385
b Benefit charges (1) Claims paid	**9b(1)**	57500		
(2) Increase (decrease) in claim reserves	**9b(2)**	-87		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	57413
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	39579		
(E) Taxes	**9c(1)(E)**	6149		
(F) Charges for risks or other contingencies	**9c(1)(F)**	27756		
(G) Other retention charges	**9c(1)(G)**	220489		
(H) Total retention			**9c(1)(H)**	293973
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	169612	577	03/01/2024	02/28/2025

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	544333		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	-69723		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	474610
b Benefit charges (1) Claims paid	**9b(1)**	204584		
(2) Increase (decrease) in claim reserves	**9b(2)**	391727		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	596311
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	83099		
(E) Taxes	**9c(1)(E)**	8306		
(F) Charges for risks or other contingencies	**9c(1)(F)**	56953		
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	148358
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

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

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
93-0242990	69019	169612	638	03/01/2024	02/28/2025

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

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

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	297728		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	-24598		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	273130
b Benefit charges (1) Claims paid	**9b(1)**	166780		
(2) Increase (decrease) in claim reserves	**9b(2)**	-1145		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	165635
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**	600		
(D) Other expenses	**9c(1)(D)**	64553		
(E) Taxes	**9c(1)(E)**	4780		
(F) Charges for risks or other contingencies	**9c(1)(F)**	19120		
(G) Other retention charges	**9c(1)(G)**	18443		
(H) Total retention			**9c(1)(H)**	107496
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	0
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

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
GUARDIAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5123390	64246	00027594	2114	03/01/2024	02/28/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
6083	51117

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

GALLAGHER BENEFIT SERVICES, INC.
2850 GOLF RD 5TH FLOOR
ROLLING MEADOWS, IL 60008

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6083	51117	ADMINISTRATIVE FEES	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	1364652
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	169612	661	03/01/2024	02/28/2025

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	32762

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

GALLAGHER BENEFIT SERVICES, INC.
PO BOX 95148
CHICAGO, IL 60694-5148

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
	32762	ADMINISTRATIVE FEES	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	6b	
c	Premiums due but unpaid at the end of the year	6c	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	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	0
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	0
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	217811
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

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

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(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

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)

PURVIS, GRAY AND COMPANY, LLP

2347 SE 17TH STREET
OCALA, FL 34471

59-0548468

(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/AUDIT	42400	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CONNER & WINTERS, LLP

15 E. 5TH STREET
TULSA, OK 74103

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	ATTORNEY	30940	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MILLIMAN INTELLISCRIPT

17335 GOLF PKWY, STE 100
BROOKFIELD, WI 53045

47-5650627

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	ACTUARIAL	19817	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II **Service Providers Who Fail or Refuse to Provide Information**

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a	Name: PURVIS, GRAY AND COMPANY, LLP	**b** EIN:	59-0548468
c	Position: AUDITOR		
d	Address: 2347 SE 17TH ST. OCALA, FL 34471	**e** Telephone:	352-732-3872

Explanation: PLAN MANAGEMENT SELECTED NEW ACCOUNTING FIRM FOLLOWING RFP.

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

D Employer Identification Number (EIN)
84-4350072

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	7066403	3399148
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	7066403	3399148
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	3374808	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	3374808	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	3691595	3399148

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	39723441	
(B) Participants	2a(1)(B)	316276	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		40039717
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		0
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		3374808
d Total income. Add all **income** amounts in column (b) and enter total	2d		43414525
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	43609427	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		43609427
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	42400	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	23817	
(8) Legal fees	2i(8)	30940	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	388	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		97545
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		43706972
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-292447
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: SIKICH CPA LLC **(2)** EIN: 54-1172176

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
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☒ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

MARION COUNTY MEDICAL SOCIETY (MCMS), INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

FINANCIAL STATEMENTS - (CASH BASIS) AND
INDEPENDENT AUDITOR'S REPORT

February 28, 2025 and February 29, 2024

MARION COUNTY MEDICAL SOCIETY (MCMS), INC. - INSURANCE TRUST FUND
GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN
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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees
Marion County Medical Society (MCMS), Inc. - Insurance Trust Fund
Group Health, Ancillary and Worksite Benefits Plan

Opinion on the 2025 Financial Statements

We have audited the accompanying financial statements of Marion County Medical Society (MCMS), Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statement of net assets available for benefits (cash basis) as of February 28, 2025, and the related statement of changes in net assets available for benefits (cash basis) for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits of the Plan (cash basis) as of February 28, 2025, and the changes in its net assets available for benefits (cash basis) for the year then ended in accordance with the cash basis of accounting.

Basis for Opinion on the 2025 Financial Statements

We conducted our audit 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 audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis of Accounting

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

Adjustments to the 2024 Financial Statements

The financial statements of the Marion County Medical Society (MCMS), Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan as of February 29, 2024 (2024 financial statements), were audited by a predecessor auditor, whose report dated April 22, 2025, expressed an unmodified opinion on those financial statements. As further discussed in Note 8, the statement of net assets available for benefits as of February 29, 2024, has been restated to reflect the removal of the reported labilities, in accordance with the cash basis of accounting. The statement of net assets available for benefits as of February 29, 2024, was also restated to present the restricted cash separate from the operating cash of the Plan. The predecessor auditors reported on the 2024 financial statements before the restatement.

As part of our audit of the 2025 financial statements, we also audited the adjustments described in Note 8 that were applied to restate the 2024 financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review, or apply any procedures to the 2024 financial statements of the Plan other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2024 financial statements as a whole.

Responsibilities of Management for the 2025 Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the cash basis of accounting described in Note 2. This includes determining that the cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible 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 within 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 2025 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 Plan's ability to continue as a going concern for a reasonable period of time.

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

Schoen CPA LLC

St. Louis, Missouri
December 12, 2025

FINANCIAL STATEMENTS

MARION COUNTY MEDICAL SOCIETY (MCMS), INC. - INSURANCE TRUST FUND
GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
(CASH BASIS)

February 28, 2025 and February 29, 2024

	2025	Restated 2024
ASSETS		
Cash, non-interest-bearing	$ 399,148	$ 3,333,193
Restricted cash, non-interst bearing, noncurrent	3,000,000	3,733,210
NET ASSETS AVAILABLE FOR BENEFITS	$ 3,399,148	$ 7,066,403

See accompanying notes to financial statements.

MARION COUNTY MEDICAL SOCIETY (MCMS), INC. - INSURANCE TRUST FUND
GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
(CASH BASIS)

For the Year Ended February 28, 2025

ADDITIONS IN NET ASSETS ATTRIBUTED TO	
Health insurance premiums received	$ 37,272,043
Ancillary insurance premiums received	2,451,398
COBRA insurance premiums received	316,276
Total additions	40,039,717
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO	
Health insurance claims	34,625,980
Ancillary and worksite insurance premiums	2,693,181
Mimimum premium administrative fees	6,290,266
Administrative expenses	97,545
Total deductions	43,706,972
NET DECREASE	(3,667,255)
NET ASSETS AVAILABLE FOR BENEFITS, BEGINNING OF YEAR	7,066,403
NET ASSETS AVAILABLE FOR BENEFITS, END OF YEAR	$ 3,399,148

See accompanying notes to financial statements.

1. DESCRIPTION OF PLAN

The following description of Marion County Medical Society (MCMS), Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan (the Plan) provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

General

The Plan was established on April 1, 1981, and is a multiple employer health and welfare plan administered by the Marion County Medical Society (MCMS), Inc. - Insurance Trust Fund (the Trust) pursuant to the Agreement and Declaration of Trust. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan has a board of trustees (the Trustees) which serves as the plan sponsor and is responsible for the management and operation of the Plan. The Board of Trustees is composed of three appointed Board members of the Society as well as members who are elected by the Participating Employers. Each county is entitled to have a member as a representative on the Board of Trustees. There were approximately 300 participating employers as of February 28, 2025 and February 29, 2024.

Various functions necessary for the operation of the Plan, including the processing of insurance premiums and minimum premium administrative fees, are performed by the Plan's Contracted Administrator, Gallagher Benefit Services, Inc. (the CA).

Eligibility and Benefits

The Plan provides health, prescription, dental, vision, disability, life insurance, accident, critical illness, and hospital indemnity benefits to the employees, and their dependents, of participating members and associate members (Participating Employers) of the Marion County Medical Society (MCMS), Inc. (the Society). All full-time employees of the Participating Employers, who regularly work a minimum of 30 hours per week, are eligible to enroll upon completion of their waiting period. The waiting period may vary by Participating Employer, but in no event can exceed 60 days of employment. Retired physicians, under certain conditions, are also permitted to remain in the Plan, and their premiums are determined by reference to the age-banded rates determined by the Plan's actuary and are not subsidized by the Plan.

1. DESCRIPTION OF PLAN (Continued)

Minimum Premium Plan Benefits

The Plan provides group medical and prescription drug benefits through Blue Cross and Blue Shield of Florida (BCBSF). The Plan has a minimum premium accounting agreement (MPAA) with BCBSF. Per the terms of the MPAA, the Plan is responsible for claims incurred, however BCBSF is responsible for any claims incurred in excess of a pre-determined "pooling point" or maximum individual claim amount. In addition to the claim payments, the Plan also pays BCBSF a monthly minimum premium charge, as defined in the MPAA, based on a per-participant rate. The claim payments and minimum premium charges are paid to BCBSF from the Plan's assets.

Fully-Insured Benefits

The Plan insures its ancillary and worksite dental, vision, life insurance, disability, accident, critical illness and hospital indemnity benefits through various insurance contracts with insurance companies. Premiums for these benefits are paid to the insurance companies from the Plan's assets.

Premium Contributions

The Plan is funded through premiums contributed by participating employers, and the rates are calculated based on an analysis performed by the Plan's actuary. These insurance premium rates are then reviewed and set annually in conjunction with contracted insurance providers.

Premiums for health, supplemental life, and critical illness coverage are age-banded and determined by the participant's age and selected coverage tier. Under this system, the amount required for each participant is computed based on the participant's age and number of family members covered. Dental, vision, basic life, accident, and hospital indemnity premiums are tier-based, reflecting the level of coverage elected. Disability insurance premiums are calculated based on the participant's age and the elected weekly or monthly benefit amount.

Participants may choose from a range of coverage options across each benefit type.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the Plan are prepared on the cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America (US GAAP). Under this method, employer premiums are recognized when received, and benefit payments, minimum premium administration fees and administrative expenses are recognized when paid. Consequently, these financial statements do not include receivables for contributions due, payables for benefits incurred but not yet paid, or other liabilities that would be recognized under the accrual basis of accounting.

Use of Estimates

The preparation of financial statements is in conformity with the cash basis of accounting and requires management to make estimates and assumptions that affect the reported benefit obligations and changes therein. Actual results could differ from those estimates. Estimates that are particularly susceptible to significant change in the near-term is the estimate of IBNR. Although it is not possible to measure the degree of variability inherent in this estimate, management believes that the amounts disclosed are adequate.

Cash

Cash held by the Trust is comprised of business checking accounts. In accordance with the MPAA with BCBSF, the Plan is required to maintain a minimum restricted cash collateral reserve. The reserve amount is actuarially determined by BCBSF on an annual basis. The intention of the Plan is to hold these funds on behalf of the individual county medical societies participating in the Plan to potentially offset future minimum premium charges to the participating employers within those counties should an acceptable and approved cash reserve surplus amount be attained. Should the Plan terminate, the amount is payable to BCBSF. As of February 28, 2025 and February 29, 2024, the restricted collateral reserve balance was $3,000,000 and $3,733,210, respectively. This amount is included in restricted cash, non-interest-bearing, noncurrent on the accompanying statements of net assets available for benefits (cash basis).

Concentrations

The Plan maintains cash balances in financial institutions that at times may exceed federally insured limits. As of February 28, 2025 and February 29, 2024, the Plan had deposits in excess of the Federal Deposit Insurance Corporation (FDIC) insurance limits in the amount $3,149,148, and $6,816,403, respectively. The Plan has not experienced any losses in such accounts and believes it is not exposed to any significant credit risks on cash.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Concentrations (Continued)

Ten participating employers contributed approximately 27% of total employer premium contributions during the year ended February 28, 2025. Ten participating employers contributed approximately 26% of total employer premium contributions during the year ended February 29, 2024. The Plan may be vulnerable to changes in contributions from this group, which could have a material adverse effect on plan funding and operations.

Payment of Benefits

Claims reimbursed to BCBSF and the premiums paid to other insurance providers are recorded when paid.

Minimum Premium Administrative Fees

The Plan pays a monthly minimum premium charge to BCBSF for health insurance administrative and claims processing services. The minimum premium administrative fee was approximately $126 per participant for the period of March 1, 2023 through February 29, 2024, then increased to approximately $132 per participant through September 30, 2024, and finally decreased to approximately $122 per participant effective October 1, 2024. The minimum premium administrative fees are recorded on the accompanying statement of changes in net assets available for benefits (cash basis).

Administrative Expenses

Professional fees and other administrative expenses paid by the Plan are included in administrative expenses on the accompany statements of changes in net assets available for benefits (cash basis). These fees primarily consist of fees paid for legal, actuary, auditing and other fees.

Benefit Obligations

Plan benefit obligations at February 28, 2025 and February 29, 2024 consist of health care claims payable and claims incurred but not reported (IBNR) and are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by BCBSF and takes into consideration prior claims experience. These amounts are paid by the Plan only if claims are submitted and approved for payment.

3. PLAN'S BENEFIT OBLIGATIONS

The Plan's benefit obligations as of February 28, 2025 and February 29, 2024 are as follows:

	2025	2024
BENEFIT OBLIGATIONS		
Health Insurance Claims Payable	$ 4,703,867	$ 5,198,408
Health insurance claims incurred but not reported	2,030,399	2,072,216
PLAN'S TOTAL BENEFIT OBLIGATIONS	$ 6,734,266	$ 7,270,624

The changes in the Plan's benefit obligations for the years ended February 28, 2025 and February 29, 2024 are as follows:

	2025	2024
BENEFIT OBLIGATIONS, BEGINNING OF YEAR	$ 7,270,624	$ 4,194,083
INCREASE DURING THE YEAR ATTRIBUTABLE TO		
Health insurance claims reported and approved for payment	34,089,622	36,409,792
Health insurance claims paid	(34,625,980)	(33,333,251)
Net increase (decrease)	(536,358)	3,076,541
BENEFIT OBLIGATIONS, END OF YEAR	$ 6,734,266	$ 7,270,624

There is no postretirement benefit obligation since retired participants pay their age-banded premium as determined by the insurance carrier which is not subsidized by the Plan.

4. PLAN TERMINATION

Although they have not expressed any intention to do so, the Trustees have the right under the Plan to modify the benefits provided to participants and dependents, to discontinue contributions at any time and to terminate the Plan subject to the provisions set forth in ERISA. In the event the Plan is terminated, Plan assets will first be allocated to any covered expenses which have been incurred prior to the date of termination, and thereafter, in a manner that is for the exclusive benefit of the participants.

5. TAX STATUS

The Trust established under the Plan to hold the Plan's assets has not applied for exemption from federal or state income taxes. The Plan is required to pay federal and state taxes on unrelated business income as defined by the Internal Revenue Code (IRC). The Plan sponsor believes the Plan does not have any taxable income for the years ended February 28, 2025 and February 29, 2024. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

6. RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS

The Plan has an administrative agreement in effect with the CA, and therefore, the CA is considered a party-in-interest with the Plan under ERISA. Certain fees are paid to the CA by the participating employers and are excluded from the financial statements of the Plan. As described in Notes 1 and 2, the Plan also has several arrangements with service providers. These transactions are also party-in-interest transactions under ERISA.

7. RISKS AND UNCERTAINTIES

The Plan is subject to various risks and uncertainties that may affect its ability to provide benefits to participants. These include changes in healthcare regulations, fluctuations in healthcare costs, demographic shifts in the covered population, and potential changes in employer contributions or plan design. Although the Plan does not currently hold any investments, it remains exposed to operational and external factors that could impact future funding requirements and benefit obligations. Plan management monitors these risks and works with advisors and service providers to mitigate potential adverse effects.

8. RESTATEMENT OF YEAR END FEBRUARY 29, 2024

The following is a reconciliation of the Plan's net assets available for benefits and benefit obligations as of February 29, 2024 per the issued financial statements to the financial statements as restated:

Statement of Net Assets Available for Benefits

	Issued	Restated
ASSETS		
Cash, non-interest-bearing	$ 7,066,403	$ 3,333,193
Restricted cash, non-interesst-bearing, noncurrent	-	3,733,210
Total assets	7,066,403	7,066,403
LIABILITIES		
Due to Barrett, Liner & Buss, LLC	655	-
Other liability	8,051	-
Premium stabilization reserve liability	3,366,102	-
Total liabilities	3,374,808	-
NET ASSETS AVAILABLE FOR BENEFITS	$ 3,691,595	$ 7,066,403

9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to net assets per the Form 5500 as of February 28, 2024:

Net assets available for benfits as reported on the restated financial statements	$ 7,066,403
Effect of prior year restatement	(3,374,808)
NET ASSETS AS REPORTED ON THE FORM 5500	$ 3,691,595

9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (Continued)

The following is a reconciliation of net decrease in net assets available for benefits per the financial statements to net loss per the Form 5500 for the year ended February 28, 2025:

Net decrease as reported in the financial statements	$ (3,667,255)
Effect of prior year restatement	3,374,808
NET LOSS AS REPORTED ON THE FORM 5500	$ (292,447)

10. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through December 12, 2025 which was the date that these financial statements were available for issuance and determined that there were no significant nonrecognized subsequent events through that date.

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
A BETTER VUE EYE PHYSICIANS LLC	26-0393015	0.27%
ABSOLUTE HEALTH INTERNAL MEDICINE & PEDIATRICS, PA	20-5100672	0.65%
ABSOLUTE MEDICAL GROUP, PA	82-0959277	0.39%
ABSOLUTE MEDICAL SERVICES, PA	59-3209230	0.04%
ACCENT PHYSICIAN SPECIALISTS, PA	59-3344396	0.77%
ACKERMAN CANCER CENTER, PA	59-2037695	2.31%
ADVANCE MEDICAL OF NAPLES, LLC	45-3131576	0.71%
ADVANCED DERMATOLOGY & SKIN SURGERY SPECIALISTS, PA	65-0667253	0.22%
ADVANCED ORTHOPEDICS INSTITUTE, PA	81-4334935	0.40%
ADVANCED UROLOGY OF SARASOTA, LLC	85-3070134	0.16%
AESTHETIC & RECONSTRUCTIVE PLASTIC SURGERY, PA	65-0347042	0.14%
AESTHETIC CENTER FOR COSMETIC RECONSTRUCTIVE SURGERY, LLC	65-0721028	0.65%
ALLERGY & ASTHMA CONSULTANTS OF CENTRAL FLORIDA	59-2578940	0.22%
ALLERGY & ASTHMA SPECIALISTS OF NORTH FLORIDA, PA	20-3722480	0.14%
ALLERGY AFFILIATES, INC.	59-1827620	0.08%
ALW ENTERPRISES PA	84-1744983	0.15%
ANDREW MARLOWE, MD, PA	65-0879521	0.27%
ANESTHESIA UNLIMITED	59-3761966	0.14%
APRIL M. THOMSON, DO, PLLC	81-3947581	0.12%
ARTHRITIS & OSTEOPOROSIS CENTER, LLC	88-3266112	0.13%
BAY RADIOLOGY ASSOCIATES PL	59-1567316	0.57%
BAYSHORE PATHOLOGY CONSULTANTS PA	46-4196957	0.36%
BEAL DERMATOLOGY, PLLC	84-4804195	0.19%
BENJAMIN TRIPP, MD, PA	65-0872918	0.17%
BETHEL BLOOD AND CANCER CENTER, PA	47-1203467	0.06%
BORYS A MASCARENHAS, MD PA	41-2094142	0.11%
BOUTIQUE BREAST IMAGING, LLC	93-3657726	0.01%
BRADENTON CARDIOLOGY	59-2440279	0.73%
BRADENTON SURGERY	65-0505185	0.39%
BRAIN & SPINE CENTER, LLC	59-3572738	0.79%
BRANDON AREA EAR, NOSE & THROAT, PA	59-2749337	0.03%
BRANDON EYE ASSOCIATES	59-3479312	1.16%
BREAST IMAGING PARTNERS LLC	85-3553454	0.33%
BRETT E. STANALAND, MD, PA	59-3283209	0.25%
BRIAN D WOLFF MD PA	20-5743208	0.09%
BROOKS MANAGEMENT, INC.	65-0461307	0.15%
BURNT STORE FAMILY MEDICINE PL	02-0609414	0.11%
CARDIOVASCULAR ANESTHESIA CONSULTANTS OF CENTRAL FL PLLC	56-2294500	1.04%
CARDIOVASCULAR INSTITUTE OF NW FLORIDA	59-2005970	2.16%
CARLOS PORTU MD., PLLC	83-1013806	0.12%
CAROLYN J. AGRESTI, MD, EAR, NOSE, & THROAT INC.	47-1787456	0.21%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
CC VISION CARE, PLLC	99-2513061	0.03%
CENTER FOR HERNIA REPAIR, LLC	26-2739384	0.18%
CENTER FOR ORTHOPAEDICS AND SPORTS MEDICINE, PA	59-2822729	0.21%
CENTRAL FLORIDA ENT ASSOCIATES PA	59-1452754	0.06%
CENTRAL FLORIDA EYE INSTITUTE, PL	42-1621290	0.48%
CENTRAL FLORIDA HEART GROUP, PA	20-0524223	0.16%
CENTRAL FLORIDA SPINE INSTITUTE, PLLC	20-5529258	0.19%
CHARLES B. STOER, PA, MD	59-3099448	0.43%
CHILDREN'S HEALTH OF OCALA, PA	59-3606013	0.11%
CHILDREN'S UROLOGY GROUP, PL	59-3236138	0.62%
CHRISTOPHER PITTMAN, MD PA	27-4035319	0.64%
COASTAL PEDIATRIC GROUP, LLC	81-1888014	0.09%
COLLIER COUNTY MEDICAL SOCIETY INC	51-0202537	0.07%
COLLIER SPORTS MEDICINE INC	56-2403150	0.45%
COMMUNITY PHYSICIANS OF NORTH PORT, P.A.	20-3387275	0.35%
COMPREHENSIVE PAIN MANAGEMENT	51-0473464	0.30%
DAVID C RITTER MD SURGICAL ONCOLOGY & GENERAL SURGERY PA	65-0943955	0.14%
DAVID GREENE, MD LLC	45-2574394	0.13%
DAVID J. APPLEBAUM MD	65-0300000	0.03%
DAVID PANTING MD	26-1773202	0.05%
DAVID SCOTT MADWAR MD PA	26-2463789	0.16%
DEMASI DIGESTIVE HEALTH PA	26-3959121	0.17%
DERMATOLOGY ASSOCIATES OF BAY COUNTY	59-1847285	0.71%
DERMATOLOGY INSTITUTE & SKIN CANCER CTR LLC	85-0782409	0.21%
DERMATOLOGY OF GAINESVILLE, LLC	82-4597536	0.26%
DERMATOLOGY SOLUTIONS GROUP, LLC	90-1007938	4.39%
DERMATOLOGY SPECIALISTS OF NAPLES	65-0265649	0.36%
DIANA J. GRAVES, DO, LLC	80-0588045	0.05%
DIANE BRZEZINSKI DO PA	59-3686839	0.14%
DIGESTIVE HEALTH ASSOCIATES, PA	45-4804019	0.15%
DOCTORS PRACTICE MANAGEMENT CORP.	27-3043076	0.06%
EAR, NOSE, THROAT & SINUS CENTER PA	59-3523581	0.10%
EDWARD H. FARRIOR, MD PA	59-3266977	0.10%
EDWARD R BERMUDEZ MD PA	59-1557202	0.02%
ELIZABETH MUDDIMAN CEFALU, MD, MPH, PLLC	47-4634833	0.01%
EMERALD COAST SPORTS MEDICINE AND ORTHOPAEDICS, PA	65-1160592	0.10%
ENDOSCOPY CENTER OF OCALA, INC.	59-3088327	2.47%
EUGENIO RODRIGUEZ MD PA	65-0734635	0.56%
EXCEL CARE ORTHOPEDICS, PLLC	82-3203199	0.09%
EXECUTIVE MEDICINE OF VERO BEACH	82-3112192	0.12%
EYE SPECIALISTS OF FLORIDA, PA	59-3576311	0.38%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
FAMILY ALLERGY & ASTHMA CONSULTANTS	20-3802248	0.42%
FAMILY PRACTICE ASSOCIATES, PA	59-3571597	0.18%
FIRST COAST DERMATOLOGY & INTERNAL MEDICINE, PA	35-2197601	0.04%
FIRST COAST FAMILY MEDICINE	20-4862099	0.31%
FLEMING ISLAND PLASTIC SURGERY, LLC	47-4973653	0.14%
FLORIDA CARDIAC CONSULTANTS, INC	65-0303477	0.71%
FLORIDA CARDIOLOGY GROUP PA	65-0431787	0.13%
FLORIDA EYE SPECIALIST INSTITUTE, PA	59-3600447	0.26%
FLORIDA GULF COAST EAR NOSE & THROAT, LLC	20-2399514	0.87%
FLORIDA PAIN CLINIC, INC.	59-2983266	0.13%
FLORIDA SKIN CANCER AND DERMATOLOGY SPECIALISTS PA	01-0709257	0.62%
FLORIDA SPORTS INJURY	45-2806834	0.48%
FLORIDA SURGICAL CLINIC, LLC	81-2708104	0.12%
FORMOSO PAIN SPECIALISTS, PA	85-1148402	0.38%
GARDNER PLASTIC SURGERY	20-4741010	0.58%
GI PROS, INC.	65-0439300	0.08%
GULF COAST ENDOSCOPY CENTER OF VENICE LLC	65-0954372	0.80%
GULF COAST HEART & VASCULAR, LLC	88-3041548	0.38%
GULF TO BAY INFECTIOUS DISEASE CONSULTANTS, PLLC	47-1915614	0.14%
GULFSHORE CONCIERGE MEDICINE	47-1701875	0.37%
GYNECOLOGY SPECIALISTS OF OCALA, PLLC	27-4598148	0.06%
HARBOR MEDICAL GROUP, LLC	81-3294700	0.18%
HEALTH MATTERS OF SARASOTA, PLLC	20-8741703	0.10%
HEART & RHYTHM ASSOCIATES, PLLC	82-5256402	0.09%
HEART ATTACK PREVENTION CENTER	20-5060385	0.13%
HERMES O. KOOP MD	26-3674659	0.13%
HOWARD TEE, MD, PLLC	82-3534142	0.11%
HUGH H. WINDOM, MD, PA	65-0600743	0.40%
HYPERTENSION KIDNEY & DIALYSIS SPECIALIST, LLC	27-4647939	0.09%
INDIAN RIVER PRIMARY CARE, PA	65-0816054	0.73%
INFECTIOUS DISEASES SPECIALTY ASSOCIATES, PLLC	82-4818791	0.18%
J MORGAN O'DONOGHUE PA	59-3680294	0.18%
J. ROBIN ATWELL, MD, PA	20-1792745	0.08%
JACKSONVILLE SKIN CANCER CENTER	20-0965184	0.09%
JAMES P BARTEK MD PL	51-0502626	0.08%
JANE LAMP MD PA	20-1999909	0.15%
JANET A. BETCHKAL, MD PA	46-4408253	0.07%
JAX SPINE & PAIN CENTERS	20-0091237	0.23%
JEREMY D. MCCONNELL, MD, PA	81-2260757	0.82%
JET MEDICAL CENTER	45-2948259	0.18%
JOHN A. PULEO MD PL	26-1098650	0.04%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
JON F. STROHMEYER, MD PA	65-0270900	0.06%
JORGE L. FLORIN MD PA	59-3453116	0.65%
JOSE GAUDIER, MD PA	01-0875404	0.16%
JOSEPH GAUTA MD PA	59-3649548	0.18%
JUSTIN ROSS WASSERMAN, MD, PL	27-4283950	0.22%
KARON R. LOCICERO, MD PA	59-2894869	0.34%
KENNETH A GIRALDO MD PA	14-1845723	0.11%
KENNETH A SAMPONG, PA	04-3726148	0.18%
KENNETH E. STARK, MD PA	20-1723835	0.09%
KENT V. HASEN, MD, PA	01-0733547	0.20%
KI HASSLER DO LLC	82-2930676	0.13%
KORUNDA MEDICAL, LLC	26-1204381	0.86%
LAKE AMERICA FAMILY PHYSICIANS	46-5282650	0.14%
LAKE ARTHRITIS CENTER, PA	59-3515993	0.08%
LAKE GASTROENTEROLOGY ASSOCIATES, LLC	27-4317031	0.55%
LAKEWOOD CARDIOVASCULAR CONSULTANTS	20-8255024	0.06%
LAWRENCE M. HURVITZ, MD, PA	59-2237040	0.09%
LCO GROUP, PA	59-2953521	0.25%
LEON MEAD MD PA	65-0122193	0.08%
LERNER COHEN HEALTHCARE, PA	74-3141022	0.60%
LEWIS J. HERZBRUN, MD PA	32-0066920	0.09%
LUNA BECK MD & ASSOCIATES, PA	20-4224678	0.15%
MACIEJ TUMIEL, MD, PA	59-3449017	0.06%
MARION PEDIATRICS, PA	59-3709114	0.15%
MARIUSZ J KLIN MD PA	02-0688777	0.09%
MARTHA A. PRICE, MD PA	59-2970608	0.09%
MATRIX PULMONARY	65-1058126	0.14%
MAZZA PLASTIC SURGERY	65-0125203	0.08%
MCMST RETIREE'S	00-0000000	0.19%
MEADOWCREST FAMILY PHYSICIANS	20-2932425	1.16%
MEDPEDS ASSOCIATES OF SARASOTA PA	65-0984667	0.27%
MID FLORIDA ENDOSCOPY & SURGERY CENTER, LLC	26-3388221	0.20%
MIDSTATE SKIN INSTITUTE, LLC	45-4674459	0.68%
MILLENNIUM CARDIOVASCULAR ASSOCIATES	92-0449791	0.22%
MINIMALLY INVASIVE VASCULAR	82-1510528	0.08%
MONICA O. WOODWARD, MD PA	59-3653792	0.18%
MORRIS R. HANAN, MD PA	59-2095930	0.15%
MURTHY HOLDINGS, INC:WELL & YOU, LLC.	27-5234510	0.22%
NAPLES CARDIAC & ENDOVASCULAR CENTER, PA	20-2547273	0.21%
NAPLES CONCIERGE CARDIOLOGY & INTERNAL MEDICINE, LLC	86-2682449	0.11%
NAPLES INDEPENDENT PHYSICIANS, LLC	26-1174832	0.07%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
NAPLES NEURO CARE, PLLC	92-0934394	0.09%
NAPLES VASCULAR SPECIALISTS, LLC	80-0926645	0.11%
NATURE COAST PRIMARY CARE, PLLC	45-5257066	0.79%
NEUROLOGICAL ASSOC OF LAKE COUNTY	59-3134797	0.01%
NEUROSPINAL ASSOCIATES	59-2831647	0.47%
NEUROSURGERY & SPINE SPECIALISTS, LLC	05-0531835	1.32%
NEUROSURGICAL ASSOCIATES - CASSIDY & GUERIN MD PA	65-0513576	0.14%
NEW VISION EYE CENTER, LLC	27-0354278	1.99%
NIBHA MEDIRATTA, MD PL	27-3534091	0.02%
NICHOLAS J. GARCIA, DO, PA	27-3730088	0.07%
NORMAN H. ANDERSON, MD PA	59-1901972	4.58%
NORTH FLORIDA KIDNEY CARE, LLC	51-0494374	0.34%
NORTHWEST FLORIDA SURGERY CENTER	59-3123289	0.59%
NOVU DERMATOLOGY & INTERNAL MEDICINE LLC	82-3048196	0.11%
NUVIEW MEDSPA	88-3046914	0.10%
OCALA DERMATOLOGY & SKIN CANCER CENTER, PA	59-3238249	0.68%
OCALA INFECTIOUS DISEASE & WOUND CENTER	20-1422124	0.52%
OCALA KIDNEY GROUP, INC.	59-2750578	2.07%
OCALA LUNG & CRITICAL CARE ASSOCIATES, INC.	65-0650144	1.14%
OCALA ORTHOPAEDIC GROUP, PA	59-2997500	0.03%
ORTHOPAEDIC CENTER OF SOUTHWEST FLORIDA	20-4098938	0.91%
ORTHOPAEDIC CENTER OF VENICE, PL	20-0943407	0.13%
ORTHOPAEDIC CENTER OF VERO BEACH, PA	65-0925136	0.52%
ORTHOPAEDIC SPECIALTY CARE, LLC	20-4857601	0.18%
OVIEDO FAMILY HEALTH CENTER PA	59-2952063	0.29%
PAIN CLINIC OF NW FLORIDA	59-3110306	0.28%
PALM BEACH COUNTY MEDICAL SOCIETY	30-0130804	0.09%
PALM BEACH PEDIATRICS, PA	59-2724116	0.82%
PALM COAST EYE CENTER	65-0987859	0.08%
PALMA SOLA NEUROLOGY ASSOCIATES	82-4780178	0.27%
PANAMA CITY NEUROSURGERY, P.A.	81-4185601	0.10%
PANAMA CITY PLASTIC SURGERY, LLC	59-3647683	0.12%
PARADISE FAMILY HEALTHCARE INC	59-3525509	0.18%
PARDO, FORSTOT, BACA & ALBOUKREK, P.A	65-0336999	0.01%
PARKINSON'S DISEASE & MOVEMENT DISORDER CENTER OF BOCA RATC	22-3659456	0.03%
PAVAN K. ANAND, MD	65-0923321	0.20%
PEDIATRIC ASSOCIATES OF OCALA, PA	59-3324260	0.22%
PEDIATRIC SERVICES & BREATHING CENTER, PA	59-3681725	0.20%
PHYSICIAN BUSINESS ALLIANCE	59-3464291	0.62%
PLASTIC SURGERY CENTER OF LAKE COUNTY, PA	59-3132127	0.16%
PLASTIC SURGERY CENTER, PA	59-1944612	0.07%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
PLASTIC SURGERY OF PALM BEACH PA	65-0208782	0.58%
POINTE WEST INFECTIOUS DISEASES, PL	94-3439188	0.64%
PONTE VEDRA PLASTIC SURGERY	59-3193989	1.68%
PREMIER DERMATOLOGY, LLC	46-3596468	0.43%
PREMIERE GI, PLLC	93-1899525	0.14%
PROVISION LASER EYE CENTER	20-0982670	0.29%
PULMONARY CONSULTANTS OF OCALA, PLLC	27-3335707	0.31%
PULMONARY PHYSICIANS, PA	59-3557176	0.08%
RADIOLOGY ASSOCIATES OF VENICE & ENGLEWOOD, PA	59-1937565	2.13%
RAINBOW PEDIATRIC CENTER, PA	86-1141885	0.21%
RAM EYE CARE & RETINA CENTER	30-0029956	0.17%
RE3 STEM CELL AND HEALING INSTITUTE, PLLC	82-0625119	0.29%
REJUVEFACE, LLC	47-0968339	0.08%
RELEVE SPORTS MEDICINE LLC	82-0712917	0.12%
RENAISSANCE PLASTIC SURGERY, PA	20-0111322	0.05%
RESTORATION ORTHOPEDICS	65-0754470	0.14%
RESTORATIVE RHEUMATOLOGY CORP	88-3707928	0.14%
RICHARD A CONROY MD PA	65-0488700	0.35%
RICHARD LAWRENCE SIEGEL, MD PA	59-2422927	0.14%
RIVERWALK AMBULATORY SURGERY CENTER LLC	26-0594903	0.62%
ROBERT H. FELMAN, MD, PA	65-0552007	0.04%
ROBERT HENDLEY, MD, LLC	81-1345718	0.09%
ROGER DANZIGER MD	65-0531220	0.07%
RUSSEL S. GLAUN MD PA	65-1039810	0.13%
SABAL DIRECT PRIMARY CARE, PA	81-2627005	0.00%
SARASOTA PHYSICIANS SURGICAL CENTER	43-2110985	0.17%
SARASOTA RETINA INSTITUTE	59-2248237	0.18%
SCHOFIELD HAND & BRIGHT ORTHOPAEDICS, PLLC	20-3582714	0.46%
SEABORN HUNT JR. MD	59-2422742	0.00%
SEABORN M. HUNT, III, MD PA	65-1075189	0.18%
SEAN GERARD DOWNING, MD, PLLC	84-2883749	0.10%
SEBASTIAN INTERNAL MEDICINE ASSOCIATES	59-3457423	0.12%
SHANE RETINA, PA	45-4893062	0.38%
SILVER LAKE PEDIATRICS, PA	59-3606003	0.20%
SIVA, MD PA	20-5459949	0.15%
SK RETINA, LLC	47-4687611	0.15%
SKIN CANCER CENTER OF CENTRAL FLORIDA, PA	59-3708058	0.42%
SKIN WELLNESS PHYSICIANS LLC	46-4477281	0.96%
SMALL WORLD PEDIATRIC, PA	30-0090138	0.11%
SOUTH FLORIDA PREMIER SURGERY, LLC	99-1493813	0.04%
SOUTH PALM ORTHOPEDICS	65-0710981	0.05%

Marion County Medical Society, Inc. - Insurance Trust Fund Group Health, Ancillary and Worksite Benefits Plan

MULTIPLE-EMPLOYER WELFARE PLAN PARTICIPATING EMPLOYER INFORMATION

EIN: 84-4350072 PLAN: #501

Name of Employer	EIN	Percentage of Total Contributions
SOUTHEAST ORTHOPEDIC SPECIALISTS, INC	59-3696338	2.52%
SPECIALIZED AESTHETICS, PA	65-0965481	0.26%
STEVEN GOODWILLER, MD PA	59-2819632	0.08%
STEVEN SCHUSTER, MD, PA	59-2845533	0.09%
SUGAR ORTHOPAEDICS, PA	27-0846679	0.20%
SUKUMARAN RAMASWAMI, MD PA	59-3638677	0.15%
SULLIVAN SINUS AND ALLERGY, LLC	86-3157476	0.25%
SUMEET BHANOT MD PA	20-4534448	0.10%
SUNCOAST ENDOSCOPY OF SARASOTA	01-0713595	0.13%
SUNCOAST ORTHOPAEDIC SURGERY & SPORTS MEDICINE	65-0927444	0.93%
SUNCOAST PSYCHIATRIC MEDICAL CLINIC	20-1809958	0.05%
SUNSHINE SPINE & PAIN SPECIALISTS, PLLC	86-3671197	0.23%
SURGICAL ASSOCIATES OF VENICE & ENGLEWOOD	59-1362995	0.21%
SUSAN BALK KRADEL, MD ASSOC	59-3598355	0.09%
SUSHIL PUSKUR, MD PA	26-3151115	0.06%
THE CARDIOVASCULAR & VEIN CENTER OF FLORIDA, PA	65-0629174	0.30%
THE HOUSE DOC, LLC	47-4344828	0.14%
THE NEUROLOGY CENTER	65-0777737	0.06%
THE WOODRUFF INSTITUTE, LLC	20-0113558	1.69%
THOMAS A DIGERONIMO MD PA	59-3399451	0.26%
TOTAL GASTROENTEROLOGY, PA	30-0518223	0.33%
TREASURE COAST CARDIOVASCULAR INSTITUTE, INC	81-1771630	0.06%
TUDOR SCRIDON, MD, PL	26-4132855	0.13%
TWIN PALM ORTHOPEDICS	20-5176873	0.39%
UNIVERSAL WELLNESS GROUP, PA	82-0857299	0.11%
VENICE DERMATOLOGY CLINIC, PA	65-1143063	0.09%
VERO BEACH NEUROLOGY & RESEARCH INSTITUTE, LLC	81-2127471	0.19%
VERO VASCULAR SURGERY, PA	65-0716495	0.16%
VERO WOMEN'S CARE, LLC	88-3810774	0.15%
VIRGINIA J GOOD, MD PA	46-3749995	0.06%
VITA ANKSH, MD PA	06-1646627	0.13%
VITREO RETINAL ASSOCIATES	59-2046817	0.59%
WATERSIDE DERMATOLOGY, PLLC	92-3850966	0.11%
WAYNE LEE MD PLASTIC SURGERY, PLLC	27-4481869	0.14%
WEITZNER, YONKER & KAINE, MD, PA	59-1842511	2.11%
WILLIAM GAYA, MD, PA	20-5517626	0.15%
WILLIAM MACK, MD PA	59-3486600	0.19%
WILLIAMS INSTITUTE OF ORTHOPEDICS, PA	11-1111111	0.22%
WRIGHT SPELLMAN PLASTIC SURGERY, PA	01-0735709	0.26%
YOU & YOUR HEALTH FAMILY CARE, INC	59-3502205	0.03%
ZUDANS MSO LLC	85-2395345	0.16%

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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

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
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1981

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)
MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

P.O. BOX 270

OCALA FL 34478

2b Employer Identification Number (EIN) 84-4350072

2c Plan Sponsor's telephone number 352-622-9124

2d Business code (see instructions) 621111

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

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

SIGN HERE	sushil puskur (Dec 12, 2025 21:50:54 GMT+5.5)		SUSHIL PUSKUR, MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

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- [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
MARION COUNTY MEDICAL SOCIETY, INC. - INSURANCE TRUST FUND GROUP HEALTH, ANCILLARY AND WORKSITE BENEFITS PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1981

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)

MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND

P.O. BOX 270

OCALA FL 34478

2b Employer Identification Number (EIN) 84-4350072

2c Plan Sponsor's telephone number 352-622-9124

2d Business code (see instructions) 621111

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

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

SIGN HERE	sushil puskur (Dec 12, 2025 21:50:54 GMT+5.5)	12/12/2025	SUSHIL PUSKUR, MD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor

MARION COUNTY MEDICAL SOCIETY INC. INSURANCE TRUST FUND
BOARD OF TRUSTEES
PO BOX 270

OCALA FL 34478

3b Administrator's EIN: 84-4350072

3c Administrator's telephone number: 352-622-9124

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	5,101
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1)**, **6a(2)**, **6b**, **6c**, and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	5,076
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	5,380
b	Retired or separated participants receiving benefits	**6b**	8
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5,388
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F 4H 4L

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
- (2) ☐ Code section 412(e)(3) insurance contracts
- (3) ☒ Trust
- (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
- (2) ☐ Code section 412(e)(3) insurance contracts
- (3) ☒ Trust
- (4) ☐ General assets of the sponsor

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

a Pension Schedules

- (1) ☐ **R** (Retirement Plan Information)
- (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (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 7
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 000160591408