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 07/01/2024 and ending 06/30/2025

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
SHARED SERVICES HEALTH PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 11/01/2008

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)
SHARED SERVICES CONSORTIUM, LLC

C/O BENECON
201 E. OREGON ROAD SUITE 100
LITITZ, PA 17543

2b Employer Identification Number (EIN) 25-1882792

2c Plan Sponsor's telephone number 717-723-4600

2d Business code (see instructions) 541990

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.	04/07/2026	JEFF SCACCIA
	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 [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	2854
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)**	2730
a(2) Total number of active participants at the end of the plan year	**6a(2)**	2727
b Retired or separated participants receiving benefits	**6b**	121
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2848
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 4E

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(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 1
- **(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 171862428

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 07/01/2024 and ending 06/30/2025

A Name of plan
SHARED SERVICES HEALTH PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SHARED SERVICES CONSORTIUM, LLC

D Employer Identification Number (EIN)
25-1882792

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
AVALON 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
76-0801682	12358	00506848	2855	07/01/2024	06/30/2025

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	0

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	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	5385915
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 07/01/2024 and ending 06/30/2025

A Name of plan
SHARED SERVICES HEALTH PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SHARED SERVICES CONSORTIUM, LLC

D Employer Identification Number (EIN)
25-1882792

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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(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)

THE BENECON GROUP

23-1315351

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	605606	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

GEISINGER INDEMNITY INSURANCE CO.

23-2815174

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	201028	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PATRIOT (EXUDE, INC.)

87-2917800

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	73535	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

UPMC

25-1844144

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	62870	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HENDERSON BROTHERS

25-0543730

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	59047	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PRIME THERAPEUTICS

26-0076803

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	21101	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

RXBENEFITS

63-1157085

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	19406	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INDEPENDENCE ADMINISTRATORS

23-2184623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	19126	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

REVIVEHEALTH, INC.

86-1279290

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	19005	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

INNOVU

2403 SIDNEY ST SUITE 225
PITTSBURGH, PA 15203

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	18972	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TOMPKINS INSURANCE AGENCY

83-0389955

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	17699	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TRUESCRIPTS

46-4334244

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	14253	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

MERITAIN HEALTH, AN AETNA COMPANY

16-1264154

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	13762	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SUSQUEHANNA INSURANCE

23-2838726

(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?
50	NONE	9590	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BSI CORPORATE BENEFITS LLC

51-0467698

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	9486	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

Part I Service Provider Information (continued)

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

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

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

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE 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 07/01/2024 and ending 06/30/2025

A Name of plan
SHARED SERVICES HEALTH PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
SHARED SERVICES CONSORTIUM, LLC

D Employer Identification Number (EIN)
25-1882792

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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	2790755	1090049
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	14750190	19881154
(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	17540945	20971203
Liabilities			
g Benefit claims payable	1g	1244391	721716
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j	462386	424195
k Total liabilities (add all amounts in lines 1g through1j)	1k	1706777	1145911
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	15834168	19825292

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)	40783803	
(B) Participants	2a(1)(B)	9446390	
(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)		50230193
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	454393	
(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)		454393
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		6864114
d Total income. Add all **income** amounts in column (b) and enter total	2d		57548700
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	41625687	
(2) To insurance carriers for the provision of benefits	2e(2)	11605854	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		53231541
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)	118701	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	178739	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	28595	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		326035
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		53557576
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		3991124
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: BAKER TILLY US, LLP **(2)** EIN: 30-1413443

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		18000000
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**		X	

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 _____.

Shared Services Health Plan

Financial Statements

June 30, 2025 and 2024

Shared Services Health Plan

Table of Contents
June 30, 2025 and 2024

Independent Auditors' Report

To the Board of Trustees of
Shared Services Health Plan

Opinion

We have audited the financial statements of Shared Services Health Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits—modified cash basis as of June 30, 2025 and 2024, and the related statements of changes in net assets available for benefits—modified cash basis for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits—modified cash basis of the Plan as of June 30, 2025 and 2024, and the changes in its net assets available for benefits—modified cash basis for the years ended June 30, 2025 and 2024, in accordance with the modified cash basis of accounting described in Note 2.

Basis for Opinion

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

Emphasis of Matter - 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 modified 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 this matter.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the modified cash basis of accounting described in Note 2, and for determining that the modified 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.

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.

Baker Tilly Advisory Group, LP and Baker Tilly US, LLP, trading as Baker Tilly, are members of the global network of Baker Tilly International Ltd., the members of which are separate and independent legal entities. Baker Tilly US, LLP is a licensed CPA firm that provides assurance services to its clients. Baker Tilly Advisory Group, LP and its subsidiary entities provide tax and consulting services to their clients and are not licensed CPA firms.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' 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.

Allentown, Pennsylvania
April 14, 2026

Shared Services Health Plan

Statements of Net Assets Available for Benefits—Modified Cash Basis
June 30, 2025 and 2024

	2025	2024
Assets		
Investments:		
Money market accounts	$ 18,546,043	$ 13,969,436
Interest-bearing cash	1,335,111	780,754
Total investments	19,881,154	14,750,190
Receivables:		
Excess loss insurance receivable	1,090,049	2,790,755
Total assets	20,971,203	17,540,945
Liabilities		
Deferred revenue	424,195	462,386
Due to insurance carriers	721,716	1,244,391
Total liabilities	1,145,911	1,706,777
Net assets available for benefits	$ 19,825,292	$ 15,834,168

See notes to financial statements

Shared Services Health Plan

Statements of Changes in Net Assets Available for Benefits—Modified Cash Basis
Years Ended June 30, 2025 and 2024

	2025	2024
Additions		
Contributions:		
Employers	$ 40,783,803	$ 36,721,232
Employees	9,177,451	8,714,689
COBRA	125,490	147,527
Retirees	143,449	457,357
Total contributions	50,230,193	46,040,805
Excess loss insurance reimbursements	6,864,114	10,838,523
Interest income	454,393	475,328
Total additions	57,548,700	57,354,656
Deductions		
Claims expense	41,625,687	46,679,837
Excess loss insurance premiums paid	11,605,854	11,135,092
ASO fees (rebates)	(486,905)	894,931
Plan management fees	605,606	621,326
Other administration expenses	207,334	194,951
Total deductions	53,557,576	59,526,137
Net increase (decrease)	3,991,124	(2,171,481)
Net Assets Available for Benefits		
Beginning of year	15,834,168	18,005,649
End of year	$ 19,825,292	$ 15,834,168

See notes to financial statements

1. Description of the Plan

The following description of the Shared Services Health Plan (the Plan) provides only general information. Participants should refer to the plan agreement applicable to the respective employer for more complete information.

General

The sponsor of the Plan is Shared Services Consortium, LLC (SSC), a Pennsylvania limited liability company owned by the not-for-profit colleges and universities that participate in the Plan. SSC was established to provide savings opportunities for not-for-profit colleges and universities. This Plan is one means of achieving this mission. The Plan was established on November 1, 2008. Effective as follows, the Plan has provided health benefits to eligible employees, dependents, certain retirees and former employees electing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provisions of the following participating Pennsylvania not-for-profit colleges and universities (participating employers):

- Albright College - effective June 1, 2015; terminated June 30, 2025
- Alvernia University - effective July 1, 2018
- Elizabethtown College - effective January 1, 2012
- Franklin & Marshall College - effective November 1, 2008
- Juniata College - effective August 1, 2015
- La Roche University - effective December 1, 2020
- Rosemont College - effective November 1, 2008
- Susquehanna University - effective November 1, 2008
- Ursinus College – effective November 1, 2024
- Wilkes University - effective June 1, 2020
- Wilson College - effective July 1, 2019

The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Effective November 1, 2025, Holy Family University joined the Plan as a participating employer.

Benefits

Benefits provided by the Plan vary based on the elections of each participating employer as follows:

Albright College

Health insurance and prescription drug benefits are provided to all regular, full-time employees working 30 hours per week and their dependents, in addition to contracted faculty members on approved leave or approved for phased retirement with a reduced class load. Employees in full-time executive and faculty positions can enter the Plan the first day of the month following the first day that all eligibility requirements are met and, thereafter, at the annual open enrollment period. Administrative and support employees can enter the Plan the first day of the month following 45 days of employment and after all eligibility requirements are met and, thereafter, at the annual open enrollment period. A Preferred Provider Organization (PPO) Plan was offered through May 31, 2024. Effective June 1, 2024, two additional PPO Plans were offered.

Alvernia University

Health insurance and prescription drug benefits are provided to all regular, full-time employees working 30 hours per week and their dependents. In most cases, employees can enter the Plan on the first day of the month coinciding with or following their date of hire and, thereafter, at the annual open enrollment period. Health plan options include two different PPO plans, as well as a PPO plan with a tiered network option.

Elizabethtown College

Health insurance and prescription drug benefits are provided to all 52-week employees working 1,560 hours over 52 weeks and their dependents; and all 11-month employees working 1,625 hours over the academic year and their dependents; all 10-month employees working 1,787 hours over the academic year and their dependents; all 9-month employee working 1,462 hours over the academic year and their dependents. Also, retirees 60 years of age or more with at least 12 years of service and their dependents are covered. Upon reaching Medicare eligibility, Medicare will be primary payer, and the group health plan will be secondary. Employees can enter the Plan on the first day of employment and, thereafter, at the annual open enrollment period. Effective January 1, 2024, spouses are eligible for medical coverage only if the spouse is unemployed or the spouse is employed but is not eligible for medical coverage through the spouse's employer (or no coverage is available) or the spouse is not eligible for Medicare. Employees can choose between (1) the PPO Core $1,000 option, (2) the PPO Tiered Network $1,000 option, (3) a PPO Qualified High-Deductible Health Plan (QHDHP) $2,000 option, or (4) the PPO QHDHP Tiered Network $2,000 Option.

Franklin & Marshall College

Health insurance and prescription drug benefits are provided to all regular full-time employees authorized and scheduled to work at least 30 hours per week on an approved 9, 10, 11 or 12 months per year appointment. Paired faculty members on an approved joint appointment are eligible if working at least 1,040 hours annually. Centennial Conference employees and Lancaster City Alliance employees are eligible if they work on the Franklin & Marshall campus, are paid through the Franklin & Marshall payroll system, and are authorized and scheduled to work at least 30 hours per week on an approved 9, 10, 11 or 12 month per year appointment. Employees covered under a severance agreement are eligible for benefits. Retirees who retired prior to January 1, 2013, are eligible if they are 60 years of age or more with at least 10 consecutive years of full-time service with Franklin & Marshall College after age 50. Also, those covered under a Phased Retirement Program or Pre-Retirement Leave of Absence Agreement on or before December 31, 2012, and those covered under a Voluntary Early Retirement Program Agreement prior to January 1, 2013, are eligible for coverage. In addition, the spouse and dependent children of an eligible retiree are eligible for coverage. Upon reaching Medicare eligibility, Medicare will be primary payer and the group health plan through Franklin & Marshall College will be secondary for retirees and their spouse and/or dependent children. Employees are eligible on the date of hire. Health plan options include (1) a Tiered Network High-Deductible Health Plan paired with an HRA (not available to retirees) and (2) a Tiered Network PPO Health Plan $450 option. Effective July 1, 2024, a third option, the Tiered Network PPO QHDHP, was added.

Juniata College

Health insurance and prescription drug benefits are provided to all regular, full-time employees who average 30 hours of service per week, including those with contracted employment break periods, or continued benefits under the terms of a severance agreement and their dependents. The Plan excludes spouses who decline group coverage from their employer. In most cases, employees can enter the Plan on the first day of the month following or coinciding with their date of hire and, thereafter, at the annual open enrollment period. Eligible retirees are those who are (1) age 55, (2) have a minimum of ten years employment and (3) were hired prior to January 1, 1997. The spouse and dependent children who are enrolled on the Plan at the time of retirement are eligible. A PPO plan and a QHDHP are offered with another HDHP added effective January 1, 2025.

La Roche University

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least 30 hours per week and their eligible dependents. Employees can enter the Plan on the first day of the month coinciding with or following their date of hire and, thereafter, at the annual open enrollment period. Health plan options include (1) an MCA EPO 600, (2) MCA PPO 600, (3) MCA PPO 600 OOA, (4) MCA HSA EPO 3,300 (5) MCA HSA PPO 3,300 and (6) HSA PPO 3,300 OOA.

Rosemont College

Health insurance and prescription drug benefits are provided to all regular, full-time and part-time employees who work at least 20 hours per week and their dependents. Ten-month employees are considered active, full-time employees throughout the two-month period that they are not on the regular payroll. Employees are eligible upon date of hire and begin coverage on the first day of the month following the date of hire. Health plan options include the (1) PPO 350 and (2) HDHP PPO paired with an HRA.

Susquehanna University

Health insurance and prescription drug benefits are provided to regular full-time and benefits-eligible employees (appointed to a position that is to last for at least nine months and work a minimum of 21 hours per week during the academic year), and all faculty members who have received their tenured appointment regardless of the number of hours worked, and their dependents. Spouses are eligible for medical coverage only if the spouse is unemployed or the spouse is employed but is not eligible for medical coverage through the spouse's employer (or no coverage is available). In most cases, employees can enter the Plan on the first of the month following the first day that all eligibility requirements have been met and, thereafter, at the annual open enrollment period. Health plan options include (1) a PPO option and (2) an HMO option.

Ursinus College

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least thirty (30) hours per week and their spouses, domestic partners and dependents. Employees are eligible upon date of hire and begin coverage on the first day of the month following or coinciding with the first day that all eligibility requirements are met. Health plan options include a Bronze QHDHP, Silver QHDHP and a Gold $1,000 plan.

Wilkes University

Health insurance and prescription drug benefits are provided to all regular full-time employees working at least 30 hours per week and their dependents. Employees are eligible upon date of hire and begin coverage on the first day of the month following or coinciding with the date of hire. Covered retirees include specific retirees listed in the summary plan description. When eligible for Medicare, Medicare will become primary payor and the Plan will reimburse as secondary. Spouses and dependent children of retirees are not eligible. Health plan options include the (1) PPO option and (2) QHDHP option.

Wilson College

Health insurance and prescription drug benefits are provided to all regular, full-time employees working at least 30 hours per week and their dependents. The Plan includes a monthly surcharge for spouses and domestic partners who decline group coverage from their employer. Employees are eligible after they have been employed for 30 days and begin coverage on the first day of the month following or coinciding with the first day that eligibility requirements have been met. The waiting period is waived for former employees of Wilson College that are rehired within 13 months of their termination date. Health plan options include (1) a PPO Plan and (2) a QHDHP option.

The Plan also provides continuation of certain benefits upon termination of employment through COBRA as defined in the plan agreement applicable for the respective employer.

Health claims are processed through different insurance providers for each participating employer.

Contributions

The contribution rates for each participating employer are determined at the beginning of each plan year based on actuarially determined claim projections and expected expenses for excess loss insurance premiums and administrative expenses. Contributions are calculated monthly based on the contribution rates and actual enrollment. Additional contributions may be required from participating employers based on actual results. Once all transactions for a policy year are settled, surplus amounts, if any, are determined for each participating employer. Surplus amounts from a finalized policy year can then be utilized by the participating employer to reduce the current policy period's required contributions. Participating employers utilized $5,820,003 and $8,305,479 in surplus for the years ended June 30, 2025 and 2024, respectively.

The Plan is contributory. As required, employees and retirees contribute a flat rate towards their coverage, which varies depending upon the level of coverage selected and, in some instances, based on the employee's annual base salary. The employee contribution requirement is determined by each participating employer and subject to periodic increases.

The costs of the postretirement benefit plan are shared by the Plan's participating employers who offer such benefits and their retirees.

Risk Sharing

On March 10, 2005, SSC received permission from the Commonwealth of Pennsylvania Insurance Department to operate as exempt under Section 208 of the Insurance Department Act (Act of 1921, May 17 P.L. 789, as amended) and consequently established the Plan, which includes a risk-sharing provision between participating employers for which no certificate of authority from the Commonwealth of Pennsylvania Insurance Department has been obtained or is required to be obtained.

For each policy year, a portion of the participating employers' contributions is earmarked for the payment of claims versus other plan expenses and is referred to as the claim fund. At the end of the policy year, actual claims paid for each participating employer, net of specific excess loss insurance reimbursements, are compared to the respective contributions to determine a surplus or deficit. Each participating employer has pledged a certain percentage of a policy period's surplus to offset the deficit of other participating employers, should such a deficit arise.

During the years ended June 30, 2025 and 2024, all participating employers ended the plan year with a surplus and no cross share was utilized.

Excess Loss Insurance

The Plan has acquired excess loss insurance through an insurer to cede the risk for individual claims exceeding a specified amount over the policy year. The specific excess loss insurance deductibles range from $70,000 to $100,000 for the years ended June 30, 2025 and 2024, respectively. The policy also contains an aggregate provision by which the Plan cedes all losses in participating employers' claim funds which remain after all agreed-upon specific excess loss insurance provisions and risk sharing pledges have been exhausted. All excess loss insurance reimbursements for the years ended June 30, 2025 and 2024 pertained to specific excess loss insurance provisions. Aggregate attachment points were not reached for any participating employer for the excess loss insurance periods ended June 30, 2025 and 2024.

2. Summary of Significant Accounting Policies

Basis of Accounting

The Plan follows the practice of presenting its financial statements in accordance with the modified cash basis of accounting, which is a comprehensive basis of accounting other than accounting principles generally accepted in the United States of America (U.S. GAAP). Under the modified cash basis of accounting, only revenues collected, costs and expenses paid and assets and liabilities arising as a result of cash transactions occurring during the June 30, 2025 and 2024 plan years, as well as: (1) excess loss insurance reimbursements related to claims paid during the June 30, 2025 and 2024 plan years, (2) June income, expense and claim payments received or paid after the June 30, 2025 and 2024 plan year ends and (3) deferred revenue related to the prepayment of premiums for the June 30, 2026 and 2025 plan years, are recognized. In addition, receivables are written off when they are deemed to be uncollectible based upon review of the accounts by management, whereas U.S. GAAP requires that an allowance be used to recognize bad debts.

Use of Estimates

The preparation of financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of incurred but not reported claims payable, contingent assets, liabilities and benefit obligations. Actual results could differ from these estimates.

Benefit Obligations

In accordance with the modified cash basis of accounting, the effects of the liability for benefit obligations, including claims incurred, but not reported, and postretirement benefit obligations are not reflected in the Plan's financial statements as they would be following U.S. GAAP. Information on the Plan's benefit obligations are as follows:

Claims Incurred, but not Reported

The Plan determines its expected benefit obligation for claims incurred, but not reported based on estimates of the ultimate liability for claims at the end of each accounting period. Such estimates consider loss development factors based on past claims experience for the participating employers as well as industry data. The Plan continually reviews methods for making such estimates. Due to the short-term nature of the obligation, time value of money was not used to discount future payments. Actual losses may vary from such estimates and variances could have a material effect on the disclosed obligation. However, plan management believes disclosed obligations are adequate.

Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to Franklin & Marshall, Elizabethtown and Juniata Colleges' employee service rendered to June 30, 2025 and 2024, respectively. Postretirement benefits include future benefits expected to be paid under the Plan to or for (a) currently retired employees and their beneficiaries and dependents and (b) active employees and their beneficiaries and dependents after retirement from service with the participating employer.

Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date. The other participating schools do not provide any material postretirement benefits under this Plan.

The actuarial present value of the expected postretirement benefit obligation is determined by actuaries and is the amount that results from applying actuarial assumptions (as disclosed in the actuarial reports) to historical claims cost-data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements, such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment. The postretirement benefit obligation is unfunded and is paid with contributions received during the period in which the actual claims are incurred by the Plan.

The Plan's benefit obligations are as follows at June 30:

	2025	2024
Claims incurred, but not reported	$ 4,090,000	$ 4,060,000
Postretirement benefit obligations:		
Fully eligible active participants	247,000	610,000
Other active participants	21,000	46,000
Retirees and beneficiaries	20,636,000	22,889,000
	20,904,000	23,545,000
Total	$ 24,994,000	$ 27,605,000

Interest-Bearing Cash

For the purpose of the Statements of Net Assets Available for Benefits—Modified Cash Basis, interest-bearing cash is defined as a demand deposit in a checking account at a financial institution.

Investment Income Recognition

Interest income is recorded when received, in accordance with the modified cash basis of accounting.

Payment of Benefits

Premiums paid by the Plan are recorded as excess loss insurance premiums paid in the accompanying Statements of Changes in Net Assets Available for Benefits—Modified Cash Basis.

Claims payments are recorded in accordance with the modified cash basis of accounting as described in Note 2. In July 2025 and 2024, claim payments of $721,716 and $1,244,391 were paid by the Plan to the insurance providers which related to the plan years July 1, 2024 to June 30, 2025 and July 1, 2023 to June 30, 2024, respectively. These amounts are recorded as a liability in the Statements of Net Assets Available for Benefits—Modified Cash Basis as of June 30, 2025 and 2024.

Administrative and Other Expenses

Expenses are paid by the Plan and consist of Administrative Services Only (ASO) fees paid to various claims administrators, plan management fees paid to their third-party administrator and other administrative expenses.

Excess Loss Insurance Receivables

Excess loss insurance receivables are expected reimbursements for claims paid by the Plan in excess of agreed-upon excess loss thresholds from the insurance carrier. The Plan continually reviews the excess loss insurance receivables to determine if any amounts are no longer deemed collectible. No bad debt expense was recorded for the years ended June 30, 2025 or 2024.

Deferred Revenue

Deferred revenue represents administrative fees and claims fund deposits for July 2025 and 2024, received by the Plan from the participating employers during the years ended June 30, 2025 and 2024, respectively.

Subsequent Events

Plan management has evaluated subsequent events through April 14, 2026. This date is the date the financial statements were available to be issued.

3. Concentrations of Credit Risk

Financial instruments that potentially subject the Plan to concentrations of credit risk consist principally of interest-bearing cash, money market accounts and excess loss insurance receivables. The Plan maintains its interest-bearing cash and money market accounts with one financial institution where the account balances generally exceed Federal Deposit Insurance Corporation insured limits. The Plan cedes portions of its claim risk exposure to one excess loss insurance carrier. Plan management monitors the financial condition of its banking and excess loss insurance carrier relationships.

4. Tax Status

The Trust established under the Plan to hold the Plan's net assets is qualified pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the Trust's net interest income is exempt from income taxes. The Trust has obtained a favorable tax determination letter from the Internal Revenue Service (IRS) on May 7, 2011, in which the IRS stated that the Trust, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended and the Trust has added new members since receiving the determination letter. However, the plan administrator believes that the Trust is currently designed and being operated in compliance with the applicable requirements of the IRC. Plan management is required to evaluate tax positions taken by the Plan.

Plan management evaluated the Plan's tax positions and concluded that the Plan had maintained its tax exempt status and had taken no uncertain tax positions that require recognition or disclosure in the financial statements. Therefore, no provision or liability for income taxes has been included in the financial statements.

5. Plan Termination

Although it has not expressed any intention to do so, the plan sponsor and participating employers have the right under the Plan to modify the benefits provided to and contributions required of participants, to discontinue contributions at any time, and to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, the participating employers must pay the claims incurred and expenses of the Plan due up to the date of termination, plus extended benefits, if any, provided under the Plan.

6. Related-Party Transactions and Party in Interest Transactions

The Plan paid certain expenses related to plan operations and investment activity to various service providers. These transactions are party in interest transactions under ERISA. No officer or employee receives compensation from the Plan.

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 07/01/2024 and ending 06/30/2025

A This return/report is for: ☐ a multiemployer plan ☒ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

B This return/report is: ☐ a single-employer plan ☐ a DFE (specify) _____
☐ the first return/report ☐ the final return/report
☐ an amended return/report ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here ▶ ☐

D Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program
☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶ ☐

Part II Basic Plan Information - enter all requested information

1a Name of plan
SHARED SERVICES HEALTH PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 11/01/2008

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)
SHARED SERVICES CONSORTIUM, LLC

C/O BENECON
201 E. OREGON ROAD SUITE 100
LITITZ PA 17543

2b Employer Identification Number (EIN) 25-1882792

2c Plan Sponsor's telephone number 717 723 4600

2d Business code (see instructions) 541990

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

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

SIGN HERE	Signature of plan administrator	Date 4/17/26	JEFF SCACCIA 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

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

Form 5500 (2024)
v. 240311

418401 11-25-24

08510407 144198 142249HP 2024.05060 SHARED SERVICES CONSORTIU 142249H1

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	2,854
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)**	2,730
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	2,727
b	Retired or separated participants receiving benefits	**6b**	121
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	2,848
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)**	
(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 4E

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 1
- (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 000171862428

Multiple Employer Plan Participating Employer Information
Shared Services Health Plan, EIN 25-1882792, PN 501

(a) Name of Participating Employer	(b) EIN	(c) Percent of Total Contributions
Albright College	23-1352615	6%
Alvernia University	23-1522643	8%
Elizabethtown College	23-1352632	13%
Franklin & Marshall College	25-1352635	23%
Juniata College	23-1352652	11%
LaRoche University	25-1882792	3%
Rosemont College	23-1365966	3%
Susquehanna University	23-1353385	13%
Ursinus College	23-1177930	3%
Wilkes University	24-0795506	14%
Wilson College	23-1352692	3%