Authorization to Electronically Sign and File Health and Welfare Form 5500

I hereby authorize any employee of Wrangle, a division of Ascensus, LLC ("Service Provider") to electronically sign and transmit Health and Welfare (H&W) Form 5500s on my behalf through EFAST 2.

I further understand the following in granting authority:

I, the Plan Administrator/Plan Sponsor and signer, have the final responsibility for the H&W Form 5500, and therefore, I must review the filing carefully before I sign and agree to have it transmitted.

I must provide to Wrangle a signed and dated copy of the Form 5500. These signed copies are required per Department of Labor (DOL) rules and will be attached to the H&W Form 5500 when transmitted.

Wrangle is not liable for and does not have a duty to indemnify or hold the Plan Administrator/Plan Sponsor harmless from any penalties, damages, incidental charges or consequential damages imposed or caused as a result of the transmission of the H&W Form 5500 on my behalf. Wrangle, LLC is merely providing an option to me that will make the filing process easier should I elect this option. Wrangle, LLC or its employees shall not be deemed an administrator or other fiduciary with respect to any plan. I understand that I do have the option to obtain signing credentials and to directly submit the H&W Form 5500 to the DOL electronically.

I must sign and keep a paper copy of the completed H&W Form 5500 in my files, per ERISA.

I acknowledge that the signature as submitted through DocuSign is my adopted signature, and that I have reviewed and signed the Form 5500 as myself. Further, I accept this as my legal and binding signature.

By the signature below, I am acknowledging that I am the person responsible for the H&W Form 5500 for the entity listed below and am authorizing Wrangle to submit all Health and Welfare Form 5500s for the Form Year(s) checked below.

I may revoke or change authorization at any time by written notification to the Service Provider.

Company/Entity Name: MICHIGAN COMMUNITY SERVICES, INC.

Plan Administrator Name: Dawn Brown

Please print your name clearly, or type in from your computer. Thank you!

Plan Administrator Signature: DocuSigned by: Dawn Brown B6EC26695C37431...

Date: 5/21/2020

Note: A copy of this authorization must be kept in your records.

Failure to follow these instructions and complete this form in its entirety, including signature, will delay transmission of the 5500.

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

2018

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
MCSI WELFARE BENEFIT PLANS

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 12/01/1985

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)
MICHIGAN COMMUNITY SERVICES, INC.

PO BOX 317
SWARTZ CREEK, MI 48473

2b Employer Identification Number (EIN)
38-2443447

2c Plan Sponsor's telephone number
810-635-4407

2d Business code (see instructions)
623000

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	DocuSigned by: Dawn Brown B6EC26695C37431...	5/21/2020	Dawn Brown
	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**	140
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)**	140
a(2) Total number of active participants at the end of the plan year	**6a(2)**	91
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	91
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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 4R

9a Plan funding arrangement (check all that apply)

- (1) [X] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [X] 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) [ ] Trust
- (4) [X] 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

b General Schedules

- (1) [ ] **H** (Financial Information)
- (2) [ ] **I** (Financial Information – Small Plan)
- (3) [X] 5 **A** (Insurance Information)
- (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 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A Name of plan
MCSI WELFARE BENEFIT PLANS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MICHIGAN COMMUNITY SERVICES, INC.

D Employer Identification Number (EIN)
38-2443447

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 CARE NETWORK OF MICHIGAN

(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
38-2359234	95610	100577	93	12/01/2018	11/30/2019

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
24723	172

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
MELISSA ARMATIS
3099 BIDDLE AVENUE
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
20489			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ACTION BENEFITS COMPANY
26533 EVERGREEN ROAD, SUITE 400
SOUTHFIELD, MI 48076

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
4234			3

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

DALY-MERRITT, INC.
100 MAPLE STREET
WYANDOTTE, MI 48192

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

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)**	
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)**	
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** [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)**	522231		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	522231
b Benefit charges (1) Claims paid	**9b(1)**	517456		
(2) Increase (decrease) in claim reserves	**9b(2)**	30012		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	547468
(4) Claims charged			**9b(4)**	468821
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	24723		
(B) Administrative service or other fees	**9c(1)(B)**	72257		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	0		
(E) Taxes	**9c(1)(E)**	5692		
(F) Charges for risks or other contingencies	**9c(1)(F)**	18079		
(G) Other retention charges	**9c(1)(G)**	74986		
(H) Total retention			**9c(1)(H)**	195737
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	81774
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A Name of plan
MCSI WELFARE BENEFIT PLANS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MICHIGAN COMMUNITY SERVICES, INC.

D Employer Identification Number (EIN)
38-2443447

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 BLUE SHIELD OF MICHIGAN

(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
38-2069753	54291	100577	163	12/01/2018	11/30/2019

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
7949	8

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
MELISSA ARMATIS
3099 BIDDLE AVENUE
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
6653			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ACTION BENEFITS COMPANY
26533 EVERGREEN ROAD, SUITE 400
SOUTHFIELD, MI 48076

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
1296			3

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

DALY-MERRITT, INC. 100 MAPLE STREET
WYANDOTTE, MI 48192

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

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)**	
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)**	
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** [X] Health (other than dental or vision)
- **b** [X] 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)**	142686		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	142686
b Benefit charges (1) Claims paid	**9b(1)**	41341		
(2) Increase (decrease) in claim reserves	**9b(2)**	-810		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	40531
(4) Claims charged			**9b(4)**	40531
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	7949		
(B) Administrative service or other fees	**9c(1)(B)**	12867		
(C) Other specific acquisition costs	**9c(1)(C)**	0		
(D) Other expenses	**9c(1)(D)**	0		
(E) Taxes	**9c(1)(E)**	3535		
(F) Charges for risks or other contingencies	**9c(1)(F)**	8833		
(G) Other retention charges	**9c(1)(G)**	6487		
(H) Total retention			**9c(1)(H)**	39671
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	0
(2) Claim reserves			**9d(2)**	2010
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A Name of plan
MCSI WELFARE BENEFIT PLANS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MICHIGAN COMMUNITY SERVICES, INC.

D Employer Identification Number (EIN)
38-2443447

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
DEARBORN LIFE 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	Policy or contract year (g) To
36-2598882	71129	EAB1000083	95	12/01/2018	12/31/2018

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
639	

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

DALY MERRITT DIRECTINC
3099 BIDDLE AVENUE
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
639			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	Fees and other commissions paid (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**	
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)**	
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)**	
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** [X] Life insurance
- **e** [X] 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)**			
(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**	4755
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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A Name of plan
MCSI WELFARE BENEFIT PLANS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MICHIGAN COMMUNITY SERVICES, INC.

D Employer Identification Number (EIN)
38-2443447

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
EYEMED

(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	Policy or contract year (g) To
43-0949844	71870	10143421001	213	12/01/2018	11/30/2019

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
1304	

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
ASSUREDPARTNERS
3099 BIDDLE AVENUE
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
1304			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

INCLUDES 10143431001

(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)**	
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)**	
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** [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)**	
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**	13276
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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 12/01/2018 and ending 11/30/2019

A Name of plan
MCSI WELFARE BENEFIT PLANS

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MICHIGAN COMMUNITY SERVICES, INC.

D Employer Identification Number (EIN)
38-2443447

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
UNITED OF OMAHA LIFE 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
47-0322111	69868	GVTL0BFPK	92	01/01/2019	11/30/2019

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
4918	

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
ASSUREDPARTNERS
3099 BIDDLE AVENUE
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2709			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
DALY-MERRITT, INC.
100 MAPLE STREET
WYANDOTTE, MI 48192

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
2209			3

INCLUDES GUG0BFPK, GLTD0BFPK

(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)**	
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)**	
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** [X] Life insurance
- **e** [X] 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)**			
(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)**	
(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**	47575
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. ▶

Carriers' Schedules

DS DB I have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: MICHIGAN COMMUNITY SERVICE

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CARE NETWORK OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2359234
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	95610
(d) CONTRACT OR IDENTIFICATION NUMBER	100577
(e) APPROX. NUMBER OF PERSONS COVERED	93
(f) POLICY OR CONTRACT YEAR FROM	12/01/2018
(g) POLICY OR CONTRACT YEAR TO	11/30/2019

2. INSURANCE FEE AND COMMISSION INFORMATION — (SEE SCHEDULE A ADDENDUM)

3. PERSONS RECEIVING COMMISSIONS AND FEES — (SEE SCHEDULE A ADDENDUM)

PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION — NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (k) HMO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:	
(i) AMOUNT RECEIVED	$522,231
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$522,231
(b) BENEFIT CHARGES:	
(i) CLAIMS PAID	$517,456
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	$30,012
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$547,467
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$468,821
(c) REMAINDER OF PREMIUM	
(i) RETENTION CHARGES	
A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$72,257
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$5,692
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$18,079
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$74,987
H. TOTAL RETENTION	$171,014
(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED)	$0
(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR	
(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$81,774
(iii) OTHER RESERVES	$0
(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE	$0

10. NONEXPERIENCE-RATED CONTRACTS — NOT APPLICABLE

PART IV: PROVISION OF INFORMATION — (DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Care Network
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	MICHIGAN COMMUNITY SERVICE
Group Number:	001005770
CID:	100577
Contract Year From:	12/01/2018
Contract Year To:	11/30/2019

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	ACTION BENEFITS COMPANY 26533 EVERGREEN RD STE 400 SOUTHFIELD, MI 48076-8076
-- Amount of Sales and Base Commissions Paid	$4,233.85
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	DALY-MERRITT, INC. 100 Maple Street Wyandotte, MI 48192-8192
-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$172.43
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	MELISSA ARMATIS 3099 BIDDLE AVENUE WYANDOTTE, MI 48192-8192
-- Amount of Sales and Base Commissions Paid	$20,488.72
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan	(gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)		3

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: MICHIGAN COMMUNITY SERVICE

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CROSS BLUE SHIELD OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2069753
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	54291
(d) CONTRACT OR IDENTIFICATION NUMBER	100577
(e) APPROX. NUMBER OF PERSONS COVERED	163
(f) POLICY OR CONTRACT YEAR FROM	12/01/2018
(g) POLICY OR CONTRACT YEAR TO	11/30/2019

2. INSURANCE FEE AND COMMISSION INFORMATION — (SEE SCHEDULE A ADDENDUM)

3. PERSONS RECEIVING COMMISSIONS AND FEES — (SEE SCHEDULE A ADDENDUM)

PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION — NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (b) Dental, (k) PPO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:	
(i) AMOUNT RECEIVED	$142,686
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$142,686
(b) BENEFIT CHARGES:	
(i) CLAIMS PAID	$41,341
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	($810)
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$40,531
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$40,531
(c) REMAINDER OF PREMIUM	
(i) RETENTION CHARGES	
A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$12,867
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$3,535
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$8,833
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$6,487
H. TOTAL RETENTION	$31,723
(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED)	$0
(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR	
(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$2,010
(iii) OTHER RESERVES	$0
(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE	$0

10. NONEXPERIENCE-RATED CONTRACTS — NOT APPLICABLE

PART IV: PROVISION OF INFORMATION — (DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Cross Blue Shield Michigan
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	MICHIGAN COMMUNITY SERVICE
Group Number:	007000466
CID:	100577
Contract Year From:	12/01/2018
Contract Year To:	11/30/2019

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	ACTION BENEFITS COMPANY 26533 EVERGREEN RD STE 400 SOUTHFIELD, MI 48076-8076
-- Amount of Sales and Base Commissions Paid	$1,296.11
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	DALY-MERRITT, INC. 100 Maple Street Wyandotte, MI 48192-8192
-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$7.57
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	MELISSA ARMATIS 3099 BIDDLE AVENUE WYANDOTTE, MI 48192-8192
-- Amount of Sales and Base Commissions Paid	$6,653.35
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)	3

Dearborn Group™

701 E. 22nd Street, Suite 300 – Lombard, IL 60148

March 09, 2020

MICHIGAN COMMUNITY SERVICES, INC.
ATTN: DAWN BROWN
P O BOX 317
SWARTZ CREEK, MI 48473

Re: Policy Number EAB1000083
Information for Schedule A, Form 5500
Employee Retirement Income Security Act of 1974 (ERISA)

Dear Policyholder:

Attached is information on our insurance plan covering your employees. This will be needed by your Plan Administrator in order to complete your annual report Form 5500 if you make such a filing. In providing this information, we do not offer any opinion as to whether your group insurance program constitutes a "Welfare Benefit Plan" under ERISA.

This report has been compiled based on the information on our records. It is accurate to the best of our knowledge and belief. This report may differ from prior Schedule A's in that, as a result of a February 2005 Advisory Opinion from U.S. Department of Labor, this report also identifies any additional compensation for which this policy may have qualified through a producing entity. Additional compensation is further described on the Schedule A report and may include incentive plan payouts, overrides, and non-cash compensation. Only allocated compensation is reported; otherwise the report shows a zero (0).

Please note, even though the Additional Compensation may be associated with your policy for reporting purposes, the expenses associated with incentive payments and non-cash compensation are not allocated on the same basis in setting premium rates for your policy.

A copy of this report is being sent to each person or organization listed as receiving Sales Commission or Additional Compensation.

If you have questions or concerns about the information, or if you believe you have received this information in error, please call us at 1-800-352-3935.

We appreciate your business and are pleased to include you among our customers.

Sincerely,

Broker Administration and Commission Services

Dearborn Group™

701 E. 22nd Street, Suite 300 – Lombard, IL 60148

Insurance Information for SCHEDULE A (Form 5500)

Name of Plan: **MICHIGAN COMMUNITY SERVICES, INC.**

Name of Carrier: **Dearborn Life Insurance Company**

Tax ID: **36-2598882** NAIC Company Code: **71129**

Group Number(s) **EAB1000083** Account Number:

Report Period: **From: 12/1/2018 To: 12/31/2018**

Approximate Number of Persons covered at the end of the Reporting Period 95

Insured Welfare Plans - Premium Earned During Report Period
[This Policy is classified as a Non Experience rated Contract.]

Type of Coverage	Premium
LIFEVOL	1,886.51
LIFVOLC	63.75
LIFVOLS	187.75
LTD	1,139.91
STD	1,477.00
Total Premium:	$4,754.92

Insurance Fees and Commissions

Name and Address of each Broker, Agent or Agency Receiving Compensation	Sales Commission	Additional Compensation
DALY MERRITT DIRECTINC 3099 BIDDLE AVENUE WYANDOTTE MI 48192	639.34	0.00

Statement prepared by Dearborn Life Insurance Company Date 3/9/2020

NOTE: The above information is provided from business records of Dearborn Life Insurance Company obtained in the ordinary course of Dearborn Life Insurance Company's business to assist the plan administrator in complying with certain plan reporting requirements for Schedule A or C of Form 5500. Dearborn Life Insurance Company certifies that this information is accurate and complete to its knowledge and belief.

(1) **Sales Commissions** includes basic commission paid as a percent of premium on your policy;

(2) **Additional Compensation** could include, but is not limited to, incentive plan payouts, overrides, third party administration fees and non-cash compensation. Such as gifts, meals, entertainment and meetings. If applicable, this compensation is determined based on premium and/or persistency levels. This additional compensation is allocated to your policy based on its percentage relationship to all premium and/or standard commissions generated by the receiving entity.

Please note, even though the Additional Compensation may be associated with your policy for reporting purposes, the expenses associated with incentive payments and non-cash compensation are not allocated on the same basis in setting premium rates for your policy.

Vision Insurance Information For Form 5500

Report Start Date	Report End Date
12/1/2018	11/30/2019

Payments Received by carrier from plan or plan sponsor:

Name of Plan	Contract or ID #	Enrollment Group	Approximate number of persons covered at end of policy or contract year:	EIN	NAIC		Amount
MICHIGAN COMMUNITY SERVICES	10143421001	MICHIGAN COMMUNITY SERVICES	213	430949844	71870		$13,276.12
MICHIGAN COMMUNITY SERVICES COBR	10143431001	MICHIGAN COMMUNITY SERVICES COBRA	0	430949844	71870		$0.00
			213			Total:	$13,276.12

Commissions or fees paid by carrier to agents, brokers or other persons:

Payee Name	Address Line 1	City	State	Zip Code	Commisssion Type Code		Amount
AssuredPartners of Michigan, LLC dba Daly Mer	3099 Biddle Avenue	Wyandotte	MI	48192	COMM		$1,303.89

Self-Insured Benefit

Prescription

A Schedule A will not be included in the 5500 as the benefit was self-insured. A Schedule A is only to report fully insured benefits.

We did include the appropriate benefit code for the benefit and checked general assets for funding.

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

MICHIGAN COMMUNITY SERVICES INC
SWARTZ CREEK, MI

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BFPK
Data for Period: 01-01-2019 to 12-01-2019
Legacy Group ID: GVTL0BFPK
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Term Life - Voluntary	92

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
DALY MERRITT INC 100 MAPLE ST WYANDOTTE, MI 48192	1,652		Agent or Broker of Record	3
ASSURED PARTNERS OF MI LLC 3099 BIDDLE AVE WYANDOTTE, MI 48192	2,027		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 24,528

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: DETROIT

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

MICHIGAN COMMUNITY SERVICES INC
SWARTZ CREEK, MI

Name of Carrier:	United of Omaha Life Insurance Company - NAIC Code 69868		
EIN Number:	47-0322111		
Group Identification Number:	G000BFPK	**Data for Period:**	01-01-2019 to 12-01-2019
Legacy Group ID:	GUG 0BFPK		
Type of Contract:	NON-RETENTION		

Benefits Provided	Persons Covered
Short Term Disability Insured	55

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 14,785

Memo Items: Benefit Charges – Claims Paid 18,644
Administrative Service Fees 0

Group Office: DETROIT

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I

MICHIGAN COMMUNITY SERVICES INC
SWARTZ CREEK, MI

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000BFPK
Data for Period: 01-01-2019 to 12-01-2019
Legacy Group ID: GLTD0BFPK
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Long Term Disability Insured	55

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
DALY MERRITT INC 100 MAPLE ST WYANDOTTE, MI 48192	557		Agent or Broker of Record	3
ASSURED PARTNERS OF MI LLC 3099 BIDDLE AVE WYANDOTTE, MI 48192	682		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 8,262

Memo Items: Benefit Charges – Claims Paid 0
Administrative Service Fees 0

Group Office: DETROIT

The Summary Annual Report…SAR

DS DB I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

SUMMARY ANNUAL REPORT

For MCSI WELFARE BENEFIT PLANS

This is a summary of the annual report of the MCSI WELFARE BENEFIT PLANS, EIN 38-2443447, Plan No. 501, for period 12/01/2018 through 11/30/2019. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

MICHIGAN COMMUNITY SERVICES, INC. has committed itself to pay certain self-funded Medical claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with BLUE CARE NETWORK OF MICHIGAN, BLUE CROSS BLUE SHIELD OF MICHIGAN, DEARBORN LIFE INSURANCE COMPANY, EYEMED, and UNITED OF OMAHA LIFE INSURANCE COMPANY to pay Medical, Dental, Vision, Life Insurance, Short-term Disability, and Long-term Disability claims incurred under the terms of the plan. The total premiums paid for the plan year ending 11/30/2019 were $730,523.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 11/30/2019, the premiums paid under such "experience-rated" contracts were $664,917 and the total of all benefit claims paid under these contracts during the plan year was $509,352.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of MICHIGAN COMMUNITY SERVICES, INC. at PO BOX 317, SWARTZ CREEK, MI, 48473 or by telephone at 810-635-4407.

You also have the legally protected right to examine the annual report at the main office of the plan (MICHIGAN COMMUNITY SERVICES, INC., PO BOX 317, SWARTZ CREEK, MI, 48473) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)