Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treesury	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	
Department of the Treasury Internal Revenue Service	sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).	2013
Department of Labor Employee Benefits Security	Complete all entries in accordance with	
Administration	the instructions to the Form 5500.	This Form is Open to Public
Pension Benefit Guaranty Corporation		Inspection
Part I Annual Report Ider	tification Information	
For calendar plan year 2013 or fiscal	plan year beginning 01/01/2013 and ending 12/31	/2013
A This return/report is for:	a multiemployer plan; a multiple-employer plan; or	
	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-bargain	ed plan, check here	
D Check box if filing under:	Form 5558; automatic extension;	the DFVC program;
	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	
Part II Basic Plan Inform	nation—enter all requested information	
1a Name of plan		1b Three-digit plan
THE TERTELING CO., INC. GROUP	BENEFIT PLAN	number (PN) > 501
		1c Effective date of plan
		04/01/1978
2a Plan sponsor's name and addres THE TERTELING CO., INC.	s; include room or suite number (employer, if for a single-employer plan)	2b Employer Identification Number (EIN) 82-0180520
THE TEXTEEING CO., INC.		2c Sponsor's telephone number
3858 N. GARDEN CENTER WAY	3858 N. GARDEN CENTER WAY	208-381-5205
STE. 300 BOISE, ID 83703	STE. 300 BOISE, ID 83703	2d Business code (see instructions) 551112

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	Filed with authorized/valid electronic signature.	07/31/2014	FLINDA TERTELING		
HERE	Signature of plan administrator	Date	Enter name of individu	al signing as plan administrator	
SIGN HERE	Filed with authorized/valid electronic signature.	07/31/2014	FLINDA TERTELING		
	Signature of employer/plan sponsor	Date	Enter name of individu	al signing as employer or plan sponsor	
SIGN HERE					
HERE	Signature of DFE	Date	Enter name of individu	al signing as DFE	
Preparer	's name (including firm name, if applicable) and address; include r	Preparer's telephone number (optional)			
For Dom	erwork Reduction Act Notice and OMB Control Numbers, see	the instantion for	- Form FF00	Form 5500 (2013)	

3a	Plan administrator's name and address Same as Plan Sponsor Name Same as Plan Sponsor Address	3b Administrate	or's EIN
TH	HE TERTELING CO., INC.		or's telephone
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN	
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	75
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	6
b	Retired or separated participants receiving benefits	6b	
С	Other retired or separated participants entitled to future benefits	6c	
d	Subtotal. Add lines 6a, 6b, and 6c	6d	7
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e .	6f	74
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 that 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	

b	If the	e plan	prov	ides v	velfare	benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
	4A	4B	4D	4E	4H	4L

9a	9a Plan funding arrangement (check all that apply)			9b Plan benefit arrangement (check all that apply)				ngement (check all that apply)
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		С	ode section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Т	rust
	(4)	X	General assets of the sponsor		(4)	X	G	eneral assets of the sponsor
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	tache	ed, and, w	vher	e inc	licated, enter the number attached. (See instructions)
a Pension Schedules b General Schedu					ules			
	(1)	Ш	R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π		I (Financial Information – Small Plan)
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X		A (Insurance Information)
			actuary		(4)	X		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (DFE/Participating Plan Information)
			Information) - signed by the plan actuary		(6)			G (Financial Transaction Schedules)

SCHEDULE	•	Incurance	e Informatio	n			
(Form 5500		Insulatio				ON	1B No. 1210-0110
Department of the Trea Internal Revenue Serv	sury	This schedule is required Employee Retirement Inc					2013
Department of Labo Employee Benefits Security Ac			tachment to Form 55		,		
Pension Benefit Guaranty Co		Insurance companies ar pursuant to El	re required to provide t RISA section 103(a)(2)		ion	This For	m is Open to Public Inspection
For calendar plan year 20	13 or fiscal plar	n year beginning 01/01/2013		and en	ding 12	/31/2013	
A Name of plan THE TERTELING CO., IN	IC. GROUP BE	NEFIT PLAN			e-digit number (P	N) 🕨	501
C Plan sponsor's name a THE TERTELING CO., IN		e 2a of Form 5500		D Emplo 82-018	-	cation Number	(EIN)
		ing Insurance Contract C Individual contracts grouped as a					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
LIFE INSURANCE COM	PANY OF AME	RICA					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of policy or contract year			Policy or contract year	
	code	identification number			(f)	(f) From (g)	
23-1503749	65498	ABL645510	672 0		01/01/20)13	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tota	l commissions paid. L	ist in line 3	the agents,	brokers, and c	ther persons in
(a) Total	amount of comr	missions paid		(b) Total amount of fees paid			
		25					-6
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all	persons).			
	. /	nd address of the agent, broker, o	or other person to who PAYSPHERE CIRCLE	m commiss	ions or fees	s were paid	
MERCER HEALTH & BE	NEFITS - SEA		AGO, IL 60674				
(b) Amount of sales a			s and other commission				-
commissions paid		(c) Amount	PPLEMENTAL COMM	(d) Purpose		(e) Organization code	
	25	-6 50		1001010			3
	(a) Name e	nd address of the agent, broker, o	or other person to who	m commise	ions or foor	were paid	
	(a) Name a	nu audress or the agent, broker, (III COMINISS		were paid	

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2013		
	v. 130118		

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(2) N2	me and address of the agent broke	r, or other person to whom commissions or fees were paid			
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid			

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

 (c) Amount
 (d) Purpose
 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		(e) Organization		
commissions paid	(c) Amount	(d) Purpose	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	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			<u> </u>

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

Page 3

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)			

Page	4
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Pa	art II	Welfare Benefit Contract Information If more than one contract covers the same grainformation may be combined for reporting put the entire group of such individual contracts of the entire group of the entir	oup of employees of the s urposes if such contracts a	are experienc	ce-rated as a unit. Whe	ere contract		s,
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	еĪ	Temporary disability (accident and sickness)	f Long-term disability	у д	Supplemental unemp	olovment	h Prescription drug	
	iΓ	Stop loss (large deductible)	j HMO contract		PPO contract	,	I Indemnity contract	
	• L			ĸ				
	m	✓ Other (specify) ►ACCIDENTAL DEATH						
9	Expe	erience-rated contracts:						
	a F	Premiums: (1) Amount received		9a(1)		0	7	
		(2) Increase (decrease) in amount due but unpaid	ł	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	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)		
	С	Remainder of premium: (1) Retention charges (or	n 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)		1		
		(H) Total retention	······	······ <u> </u>		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 b	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	ot include amount entered	in line 9c(2)	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	Х	No
12 If the	answer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Δ	Insurar	nce Information	n				
	(Form 5500)			ON	1B No. 1210-0110			
Department of the Treas Internal Revenue Serv	sury		ed to be filed under section ncome Security Act of 19				2013	
Department of Labor Employee Benefits Security Ad			attachment to Form 55		,			
Pension Benefit Guaranty Co			are required to provide the ERISA section 103(a)(2)		ion	This For	orm is Open to Public Inspection	
For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013								
A Name of plan B Three-digit THE TERTELING CO., INC. GROUP BENEFIT PLAN Plan number (PN)						N) 🕨	501	
C Plan sponsor's name a THE TERTELING CO., IN		e 2a of Form 5500		D Emplo 82-018	-	cation Number	(EIN)	
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
UNUM LIFE INSURANCE	E COMPANY O	OF AMERICA						
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year	
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To	
01-0278678	62235	342364	11	19	01/01/20	013	12/31/2013	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. Li	ist in line 3	the agents,	, brokers, and o	ther persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount	of fees paid		
		9375					2096	
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all	persons).				
	1 /	nd address of the agent, broke		m commiss	ions or fees	s were paid		
MERCER HEALTH & BE	NEFITS - SEA		5 PAYSPHERE CIRCLE CAGO, IL 60674					
(b) Amount of sales ar		Fe	ees and other commission	ns paid				
commissions par	id	(c) Amount		(d) Purpos	е		(e) Organization code	
	9375	2096 <i>F</i>	ADDITIONAL COMPENS	ATION			3	
	(a) Name a	nd address of the agent, broke	r or other person to who	m commise	ions or fear	s were paid		
		na address of the agent, broke						

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Schedule				

v. 130118

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(2) Na	me and address of the agent broke	r, or other person to whom commissions or fees were paid	
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid	

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

 (c) Amount
 (d) Purpose
 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		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	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		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

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

Page 3

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)			

10 Nonexperience-rated contracts:

Specify nature of costs

b

		Schedule A (Form 5500) 2013		Pa	ge 4			
Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	oup of employees of the saurposes if such contracts a	ire experienc	e-rated as a unit. Whe	ere contracts		
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	/ g	Supplemental unemp	loyment	h Prescription dr	ug
	iΓ	Stop loss (large deductible)	j 🗍 HMO contract	k∏	PPO contract		I Indemnity cont	ract
	m	Other (specify) ACCIDENTAL DEATH & DIS	MEMBERMENT		<u>ı</u>			
9		rience-rated contracts:	Г	a (1)			4	
		Premiums: (1) Amount received		9a(1)		154781	-	
		(2) Increase (decrease) in amount due but unpaid		9a(2)			4	
		(3) Increase (decrease) in unearned premium res		. , , ,		• (1)		45 4704
		(4) Earned ((1) + (2) - (3))				9a(4)		154781
		Benefit charges (1) Claims paid					4	
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	, ,					
		(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 🗌 d	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1				9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
			•••••••••••••••••••••••••••••••••••••••					

9e

10a

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	f the answer to line 11 is "Yes," specify the information not provided.			

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

a Total premiums or subscription charges paid to carrier

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.....

SCHEDULE	Α	Insuran	ce Informatio	n				
(Form 5500					ON	1B No. 1210-0110		
Department of the Treas Internal Revenue Serv	sury	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2013	
Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 55	600.				
Pension Benefit Guaranty Co		 Insurance companies pursuant to 	are required to provide t ERISA section 103(a)(2)		ion	This For	m is Open to Public Inspection	
For calendar plan year 2013 or fiscal plan year beginning 01/01/2013 and ending 12/31/2013								
A Name of plan B Three-digit THE TERTELING CO., INC. GROUP BENEFIT PLAN Plan number (PN)				N) 🕨	501			
	C Plan sponsor's name as shown on line 2a of Form 5500 THE TERTELING CO., INC. D Employer Identification Number (EIN) 82-0180520					(EIN)		
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
UNUM LIFE INSURANCI	E COMPANY C	OF AMERICA						
<i></i>	(c) NAIC				Policy or c	ontract year		
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To	
01-0278678	01-0278678 62235 599755 342 01/01/2013				013	12/31/2013		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	, brokers, and o	other persons in	
(a) Total a	amount of comr	missions paid		(b) To	otal amount	of fees paid		
		19840					1653	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).				
	. /	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	s were paid		
MERCER HEALTH & BE	NEFITS - SEA		CAGO, IL 60674					
(b) Amount of sales and base Fees and other commissions paid								
commissions pa	sions paid (c) Amount (d) Purpose			(e) Organization code				
19840 1653 ADDITIONAL COMPENSATION 3					3			
	(a) Name a	ind address of the agent, broker	r, or other person to who	m commiss	ions or fees	s were paid		
	I		and other commission	no noid				

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
For Paperwork Reduction Act Notice	dule A (Form 5500) 2013		
-	v. 130118		

(b) Amount of sales and base	Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

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

 (c) Amount
 (d) Purpose
 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		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	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	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
			<u> </u>		

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

Page 3

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)			

	Pag	е	4
--	-----	---	---

Part I						· · · · · · · · ·
	If more than one contract covers the same g information may be combined for reporting p	urposes if such contracts	are experien	ce-rated as a unit. Wh	ere contract	
8 Ben	the entire group of such individual contracts efit and contract type (check all applicable boxes)	-	irealeu as a l	unit for purposes of this	героп.	
г	-		م [Vision		d 🔽 Life insurance
a	Health (other than dental or vision)	b Dental	_	Vision		d X Life insurance
е	Temporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescription drug
i [Stop loss (large deductible)	j 🗌 HMO contract	k	PPO contract		I Indemnity contract
m	Other (specify)					
9 Expe	erience-rated contracts:					
•	Premiums: (1) Amount received		9a(1)		122527	1
	(2) Increase (decrease) in amount due but unpai	d				1
	(3) Increase (decrease) in unearned premium res					1
	(4) Earned ((1) + (2) - (3))				9a(4)	122527
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)	
С	Remainder of premium: (1) Retention charges (0	on an accrual basis)		T		_
	(A) Commissions		9c(1)(A)			_
	(B) Administrative service or other fees		9c(1)(B)			_
	(C) Other specific acquisition costs					_
	(D) Other expenses		9c(1)(D)			4
	(E) Taxes					4
	(F) Charges for risks or other contingencies.		9C(1)(F)			4
	(G) Other retention charges				0=(4)(1)	
	(H) Total retention		_		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These					_
d	Status of policyholder reserves at end of year: (7				9d(1) 9d(2)	
	(2) Claim reserves					
_	 (3) Other reserves. e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) 					
<u>e</u>		ot include amount entered	d in line 9c(2)] .)	9e	
_	nexperience-rated contracts:				40-	
a b	Total premiums or subscription charges paid to				10a	
b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	

Specify nature of costs

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
12 If the a	answer to line 11 is "Yes," specify the information not provided.			

		•	1 (
		Insurance Information				OM	1B No. 1210-0110
(Form 5500 Department of the Treas	-	This schedule is required to be filed under section 104 of the					2013
Internal Revenue Serv	ice	Employee Retirement In					2010
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	600.	-	This For	
Pension Benefit Guaranty Co	prporation	 Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). 				INS FOR	m is Open to Public Inspection
For calendar plan year 20	13 or fiscal pla	n year beginning 01/01/2013		and ending	g <u>12/</u> 3	1/2013	T
A Name of plan THE TERTELING CO., IN	C. GROUP BE	NEFIT PLAN		B Three-dig	-		501
				plan nur	nber (PN		
C Plan sponsor's name a	as shown on lin	ne 2a of Form 5500		D Employer	Identifica	tion Number	(EIN)
THE TERTELING CO., IN				82-018052			· · /
Dert I Informatio	on Concorr	ning Insurance Contract	Covorago Eoos a	nd Commis	scione	Dravida inform	notion for each contract
		Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
CIGNA HEALTH AND LII	FE INSURANC	E COMPANY AND AFFILIATES					
	(c) NAIC	(d) Contract or	(e) Approximate n	umber of		Policy or c	ontract year
(b) EIN	code	identification number	persons covered at end of policy or contract year (f) From			From	(g) To
59-1031071	67369	3336364	1895 01/01/20		01/01/201	3	12/31/2013
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3 the	agents, b	rokers, and c	ther persons in
(a) Total a	amount of com			(b) Total a	amount o	ount of fees paid	
		0					0
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).							
	(a) Name a	and address of the agent, broker,	or other person to who	m commissions	s or fees v	vere paid	
(b) Amount of sales ar	nd base	Fee	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
							•

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	edule A (Form 5500) 2013			
	v. 130118			

(b) Amount of sales and base commissions paid		(e) Organization		
	(c) Amount	(d) Purpose	code	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Na	ine and address of the agent, bloke	, or other person to whom commissions of lees were paid		

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

 (c) Amount
 (d) Purpose
 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		(e) Organization			
commissions paid	(c) Amount	(d) Purpose	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		(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code
			<u> </u>

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

Page 3

Part I	Investment and Annuity Contract Information			
	Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier m	ay be treated as a unit for	or purposes of
4 Curr	this report. rent value of plan's interest under this contract in the general account at year	end	4	
	ent value of plan's interest under this contract in the general accounts at year			
-	tracts With Allocated Funds:		•	
a	State the basis of premium rates			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6c	
d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) ☐ other (specify) ►	-		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, check here	1	
	tracts With Unallocated Funds (Do not include portions of these contracts ma			
		ate participation guarantee		
а				
	(3) guaranteed investment (4) other			
h	Delense of the and of the new investor		76	
<u>b</u>	Balance at the end of the previous year	7c(1)	7b	
С	Additions: (1) Contributions deposited during the year	7c(1) 7c(2)		
	(2) Dividends and credits	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	(6)Total additiona		7c(6)	
Ь	(6)Total additions Total of balance and additions (add lines 7b and 7c(6))			
	Deductions:		/ u	
•	(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)			

Page 4

F	Part	: 111	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	В	enef	it and contract type (check all applicable boxes)									
	а		Health (other than dental or vision)	b	Dental	С		Vision		d	Life insurance	
	е		Temporary disability (accident and sickness)	f	Long-term disabilit	у д		Supplemental unemp	oloyment	h	Prescription drug	
	i	X	Stop loss (large deductible)	jП	HMO contract	k	Π	PPO contract		чП	Indemnity contract	
	n	n	Other (specify)									
9	E	kperi	ience-rated contracts:									
	а	Pr	remiums: (1) Amount received			9a(1)						
		(2	2) Increase (decrease) in amount due but unpai	Jb		9a(2)						
		(3	3) Increase (decrease) in unearned premium res	erve		9a(3)						
		(4	4) Earned ((1) + (2) - (3))						9a(4)			
	k) E	Benefit charges (1) Claims paid			9b(1)						
		(2	2) Increase (decrease) in claim reserves			9b(2)						
			3) Incurred claims (add (1) and (2))						9b(3)			
		(4	4) Claims charged						9b(4)			
	C	F	Remainder of premium: (1) Retention charges (c	n an a	ccrual 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		_	_	-		9c(2)			
	c		Status of policyholder reserves at end of year: (1						9d(1)			
			2) Claim reserves						9d(2)			
		``	3) Other reserves						9d(3)			
	e	``	Dividends or retroactive rate refunds due. (Do n						9e			
1			experience-rated contracts:					<u> </u>				
•	a		Fotal premiums or subscription charges paid to c	arrier					10a			77341
	k	b li	f the carrier, service, or other organization incur etention of the contract or policy, other than rep	red any	y specific costs in c	onnection w	vith	the acquisition or	10b			

Specify nature of costs 🕨

Part IV Provision	of Information		
11 Did the insurance cor	pany fail to provide any information necessary to complete Schedule A?	Yes	X No
12 If the answer to line 1	1 is "Yes," specify the information not provided.		

SCHEDULE C	Service Provider	⁻ Information		OMB No. 1210-0110	
(Form 5500)		2013			
Department of the Treasury Internal Revenue Service	This schedule is required to be filed un Retirement Income Security				
Department of Labor Employee Benefits Security Administration	File as an attachme	nt to Form 5500.	This F	Form is Open to Public Inspection.	
Pension Benefit Guaranty Corporation For calendar plan year 2013 or fiscal pla		and ending 12/31	1/0040		
A Name of plan THE TERTELING CO., INC. GROUP E		B Three-digit plan number (PN)	1/2013	501	
C Plan sponsor's name as shown on li THE TERTELING CO., INC.	D Employer Identification Number (EIN) 82-0180520				
Part I Service Provider Info	ormation (see instructions)				
 plan during the plan year. If a person answer line 1 but are not required to 1 Information on Persons Re a Check "Yes" or "No" to indicate wheth indirect compensation for which the p b If you answered line 1a "Yes," enter 	noney or anything else of monetary value) in n received only eligible indirect compensation include that person when completing the rem receiving Only Eligible Indirect Cor her you are excluding a person from the rem plan received the required disclosures (see in r the name and EIN or address of each person insation. Complete as many entries as need	on for which the plan received the required an ander of this Part. npensation hainder of this Part because they recenstructions for definitions and condition providing the required disclosures	ived only eli	gible	
(b) Enter na	ame and EIN or address of person who provi	ded you disclosures on eligible indire	ct compensa	ation	
(b) Enter na	ame and EIN or address of person who provi	ded you disclosure on eligible indirec	t compensa	tion	
(b) Enter na	me and EIN or address of person who provid	ded you disclosures on eligible indired	ct compensa	ation	

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

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

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

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

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

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

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

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

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

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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 instruction
--

CIGNA BEHAVIORAL HEALTH, INC

41-1648670

(b)	(c)	(d)	(e)	(f)	(g)	(h)			
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or			
12 13 38 50	CONTRACTED TO ADMIN EAP	17054	Yes 🗌 No 🛛	Yes 🗌 No 🔀	0	Yes 🗌 No 🗙			
	(a) Enter name and EIN or address (see instructions)								

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct	Did service provider receive indirect	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	Did the service provider give you a formula instead of an amount or
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗍
	(a) Enter name and EIN or address (see instructions)					

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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	formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes 🗌 No 🗍

Page 3	-	2
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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

	(a) Enter name and EIN or address (see instructions)					
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 No 🗌	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(C) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes 🗌 No 🗌		Yes 🗌 No 🗌
		(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes 🗌 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
		compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any
	formula used to determine t	the service provider's eligibility le indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect c	ompensation, including any the service provider's eligibility
	for or the amount of th	ie indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect conformula used to determine to	he service provider's eligibility
	for or the amount of th	e indirect compensation.

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P	art II Service Providers Who Fail or Refuse to I	Provide Infori	mation
4	Provide, to the extent possible, the following information for each this Schedule.	ch service provide	r who failed or refused to provide the information necessary to complete
	(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 in (complete as many entries as needed)		•	structions)
а	Name:		b EIN:
С	C Position:		
d	d Address:		e Telephone:
Ex	planatio	1.	

Name:	b EIN:
Position:	
Address:	e Telephone:
	Position:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: