Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

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 6047(e), 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

2014

This Form is Open to Public Inspection

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2									
A This	return/report is for:	a multiemployer plan;		a multiple-employer plan (Filers checking this box must attach a lis participating employer information in accordance with the form inst			ons); or		
		x a single-employer plan;	a DFE (spec	DFE (specify)					
B This	return/report is:	the first return/report;	the final retu	the final return/report;					
	o.a,, opoc.	an amended return/report;	a short plan year return/report (less than 12 months).						
C If the	plan is a collectively-bargain	ned plan, check here				▶ □			
	k box if filing under:	Form 5558;	automatic ex			□ FVC program;			
D Office	K box ii iiiiiig under.	special extension (enter descriptio	ш	,	Ш = :	r - programm,			
Part	II Basic Plan Infor	mation—enter all requested information	ation						
	ne of plan	indicinal cities an requested informe	ation		1b	Three-digit plan	501		
	EMPIRE OPTICAL BENEF	IT PLAN				number (PN) ▶			
					1c	Effective date of pl 01/01/1985	an		
2a Plar	sponsor's name and addre	ss; include room or suite number (em	plover, if for a single	e-employer plan)	2b	Employer Identifica	ation		
	EMPIRE OPTICAL	(.)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Number (EIN) 91-1356329			
					2c	Plan Sponsor's tele	ephone		
127 S B	ERNARD	427 S BE	PNAPD			number 509-456-0107	7		
	NE, WA 99204		E, WA 99204		2d	Business code (see			
					20	instructions) 621111	6		
Caution	: A penalty for the late or i	ncomplete filing of this return/repo	rt will be assessed	unless reasonable cause is	s establis	shed.			
		penalties set forth in the instructions,							
statemer	nts and attachments, as well	as the electronic version of this return	n/report, and to the t	pest of my knowledge and be	lief, it is tr	rue, correct, and con	nplete.		
SIGN	= 1 14 4 1 1 1 1 1 1 1 1		07/00/0045	IAANIO ONABOONI					
HERE	Filed with authorized/valid e		07/20/2015	JANIS SIMPSON					
	Signature of plan admini	strator	Date	Enter name of individual signing as plan administrator					
SIGN	Filed with authorized/valid e	Jactronia aignatura	07/20/2015	JANIS SIMPSON					
HERE									
	Signature of employer/pl	an sponsor	Date	Enter name of individual s	igning as	employer or plan sp	onsor		
SIGN									
HERE						DEE			
Signature of DFE Date Preparer's name (including firm name, if applicable) and address (include room of the control of the co				Enter name of individual signing as DFE er) (optional) Preparer's telephone number					
	, -			(0	ptional)	•			

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor	3b Administrator's EIN			
				3c Adminis	strator's telephone r
4	If the name and/or EIN of the plan sponsor has changed since the last return. EIN and the plan number from the last return/report:	n/report filed for t	his plan, enter the name,	4b EIN	
а	Sponsor's name			4c PN	
5	Total number of participants at the beginning of the plan year			5	206
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	d (welfare plans	complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year			6a(1)	206
a(2	Total number of active participants at the end of the plan year			6a(2)	214
b	Retired or separated participants receiving benefits			6b	
С	Other retired or separated participants entitled to future benefits			6c	
d	Subtotal. Add lines 6a(2), 6b, and 6c.			6d	214
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits		6e	
f	Total. Add lines 6d and 6e			6f	214
g	Number of participants with account balances as of the end of the plan year (complete this item)			6g	
h	Number of participants that terminated employment during the plan year with less than 100% vested			6h	
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer p	lans complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature co- If the plan provides welfare benefits, enter the applicable welfare feature cod- 4A 4B 4D 4H 4Q	les from the List	of Plan Characteristics Codes	s in the instru	
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 bene (1) (2) (3) (4)	efit arrangement (check all that Insurance Code section 412(e)(3) Trust General assets of the sp	insurance co	ntracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at				(See instructions)
а	Pension Schedules	b General	Schedules		
	(1) R (Retirement Plan Information)	(1)	H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) (3) (4)	I (Financial Inform A (Insurance Inform C (Service Provide	mation) er Informatior) n)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) (6)	D (DFE/Participati G (Financial Trans	-	

Form 5500 (2014) Page **3**

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.)						
If "Yes" is checke	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.)						
11c Enter the Receipt Confirmation Code for the 2014 Form M-1 annual report. If the plan was not required to file the 2014 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 Confirma	ation Code					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

For calendar plan year 2014 or fiscal plan year beginning

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).

and ending

12/31/2014

01/01/2014

OMB No. 1210-0110

2014

This Form is Open to Public Inspection

A Name of plan INLAND EMPIRE OPTICAL BENEFIT PLAN				e-digit number (PN)	501			
				·	,	<u> </u>		
C Plan sponsor's name a INLAND EMPIRE OPTICA		2a of Form 5500		D Emplo 91-135	yer Identification Number (66329	(EIN)		
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:								
(a) Name of insurance car	rrier							
PREMERA BLUE CROSS	3							
/L\	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or co	ontract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year		(f) From	(g) To		
91-0499247	47570	1038026	19	97	01/01/2014	08/31/2014		
2 Insurance fee and commodescending order of the		tion. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, brokers, and o	ther persons in		
(a) Total a	amount of comm	nissions paid	(b) Total amount of fees paid					
		27838		6818				
3 Persons receiving com		es. (Complete as many entries						
MOLONEY & ONEILL LIF		nd address of the agent, broker	, or other person to whor W RIVERSIDE, STE 800		ions or fees were paid			
MOLONET & ONEILL LIF	-E INC		KANE, WA 99201	•				
(b) Amount of sales an	nd base	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount	(d) Purpose			(e) Organization code		
	27838	6818 P	REFERRED PRODUCE	R PROGRA	AM	3		
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees were paid			
(b) Amount of sales an	nd hase	Fe	es and other commissior	ns paid				
commissions pai		(c) Amount		(d) Purpose	e	(e) Organization code		
For Denominant Dedication	A (N ::	nd OMP Control Numbers, co	o the instructions for E					

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as a unit for purposes of		
4	Curr	ent 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 separate accounts at year e			5	
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Page 4	
mployer(s) or members of the same en perience-rated as a unit. Where contra- as a unit for purposes of this report.	
c Vision g Supplemental unemployment k PPO contract	d Life insura h Prescriptio

		If more than one contract covers the same ground information may be combined for reporting put the entire group of such individual contracts we	rposes if such co	ontracts are experi	ence	e-rated as a unit. Whe	ere contrac		
8	Ben	efit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	b Dental	c	: 🗌	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term	n disability Q	ı	Supplemental unemp	loyment	h X Prescription drug	
	i	Stop loss (large deductible)	j HMO conf	tract k	<u> </u>	PPO contract		I Indemnity contract	
	m	Other (specify)							
9	Ехр	erience-rated contracts:							
	а	Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium rese	erve	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)		
	С	Remainder of premium: (1) Retention charges (or	n an accrual bas	is)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		0 (4)(0					
		(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)				
		(H) Total retention					9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in cash, or	Cr	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to	provide benefits at	fter r	etirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amoun	t entered in line 9c	(2) .)		9e		
10	No	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to ca	arrier				10a	10)15412
	b	If the carrier, service, or other organization incurre							
		rotantian of the contract or policy, other than rone	whad in Dawl I lin	- 0 - 1		·mt	10h	1	

Part IV	Provision of Information		
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No

Specify nature of costs >

Schedule A (Form 5500) 2014

Welfare Benefit Contract Information

Part III

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

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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.

OMB No. 1210-0110

2014

Pension Benefit Guaranty Co	orporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				Inspection	
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/201	4	and end	ding 12	/31/2014	
A Name of plan INLAND EMPIRE OPTICAL BENEFIT PLAN					e-digit number (Pl	N) •	501
C Plan sponsor's name as shown on line 2a of Form 5500 INLAND EMPIRE OPTICAL					yer Identific 6329	cation Number	(EIN)
on a separat		ning Insurance Contrac Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
	(c) NAIC	(d) Contract or	(e) Approximate no	<u> </u>		Policy or co	ontract year
(b) EIN	code	identification number		persons covered at end of policy or contract year		From	(g) To
01-0278678	62235	597259	191		01/01/20)14	12/31/2014
2 Insurance fee and composite descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3 t	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		2616					
3 Persons receiving com	missions and f	ees. (Complete as many entrie	es as needed to report all	persons).			
3		and address of the agent, broke			ons or fees	were paid	
PEGGY REDDY		PO	BOX 2088 AQUAH, WA 98027			·	
(b) Amount of sales ar	nd hase	F	ees and other commission	ns paid			
commissions pa		(c) Amount	(d) Purpose			(e) Organization code	
	2616						3
	(a) Name a	and address of the agent, broke	or other person to who	m commissi	one or fees	were naid	
	(a) Name a	and address of the agent, broke	er, or other person to who	iii commissi	Ons or rees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			 -
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1					
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		

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Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent 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 separate accounts at year e			5	
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	ige 4		
e experienc		ere contracts	oloyee organizations(s), the s cover individual employees,
c g k	Vision Supplemental unemp PPO contract		d X Life insurance h ☐ Prescription drug I ☐ Indemnity contract
0-(4)			_
9a(1) 9a(2)			-
9a(3)			
		9a(4)	
9b(1)			
0h/3\			

Pa	art I	Welfare Benefit Contract Information	on					
		If more than one contract covers the same gro						
		information may be combined for reporting pur the entire group of such individual contracts wi					ts cover individual emplo	oyees,
8	Bon	nefit and contract type (check all applicable boxes)	in each camer may be nea	aleu as a ui	iit for purposes or triis	тероп.		
U	F	_	b □ p	- □	VC-1		d V 136. Sa	
	а		b Dental	c∐	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemp	oloyment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	ct
	m	X Other (specify) ▶AD&D						
9	Expe	perience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid.		9a(2)				
		(3) Increase (decrease) in unearned premium rese	rve	9a(3)				
		(4) Earned ((1) + (2) - (3))	<u></u>			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)		
	С	Remainder of premium: (1) Retention charges (on	an accrual basis)					
		(A) Commissions	<u>9</u>	9c(1)(A)				
		(B) Administrative service or other fees	l-	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	<u> </u>	9c(1)(G)		- (1)(1)		
		(H) Total retention				9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These a	amounts were paid in c	ash, or c	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)				9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do not	include amount entered in	n line 9c(2) .)	9e		
10) No	onexperience-rated contracts:				_		
	a	Total premiums or subscription charges paid to ca				10a		26158
	b	If the carrier, service, or other organization incurre				106		
		retention of the contract or policy, other than repor	τed in Part I, line 2 above,	report amo	unt	10b		

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	_

Specify nature of costs >

Schedule A (Form 5500) 2014

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

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

2014

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)				
For calendar plan year 2014 or fiscal plan year beginning 01/01/2014 and ending 12/31/2014							
A Name of plan INLAND EMPIRE OPTICA	AL BENEFIT PI	LAN			e-digit number (P	PN) ▶	501
C Plan sponsor's name a INLAND EMPIRE OPTICA		e 2a of Form 5500		D Emplo 91-138		cation Number (EIN)
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
LINCOLN NATIONAL LIF	E INSURANC	E					
/I-) [IN]	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)) From	(g) To
35-0472300	65676	10195320	2	14	09/01/2	014	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents	, brokers, and ot	her persons in
(a) Total a	amount of com			(b) To	otal amount	t of fees paid	
		1251					
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
		and address of the agent, broke			ions or fee	s were paid	
MOLONEY AND ONEILL	•	818 SPC	W RIVERSIDE, STE 800 DKANE, WA 99201)			
(In) Amount of color		Fe	ees and other commission	ns paid			
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose				(e) Organization code
	1251	, ,		` '			3
	(a) Name a	and address of the agent, broke	r. or other person to who	m commiss	ions or fee	s were paid	
	(4) 114	and address of the agent, prone	.,			o noto pata	
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
		· ·					

Schedule A (Form 5500)	2014	Page 2 - 1	
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	<u> </u>		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

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Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent 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 separate accounts at year e			5	
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	age 4		
experience		ere contracts	oyee organizations(s), the cover individual employees,
c [g [k [Vision Supplemental unemp PPO contract	coloyment h	
9a(1)			
9a(2)			
9a(3)		0.70	

Pa	art II	If more than one contract covers the same gr information may be combined for reporting positions.	oup of employees of the surposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contract		
		the entire group of such individual contracts v	with each carrier may be t	reated as a u	init for purposes of this	report.		
8	Ben	efit and contract type (check all applicable boxes)	_		_		_	
	а	Health (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	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) AD&D	_	_			_	
9	Ехре	erience-rated contracts:						
	a	Premiums: (1) Amount received		9a(1)			_	
		(2) Increase (decrease) in amount due but unpaid	1	9a(2)				
		(3) Increase (decrease) in unearned premium res	erve	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 (o	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)				
		(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)		
	е	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line 9c(2)	.)	9e		
10	No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to o	arrier			10a		9626
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, ,		•	10b		
	Sp	ecify 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	_

Schedule A (Form 5500) 2014

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

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

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					inspection		
For calendar plan year 20°	14 or fiscal pla	n year beginning 01/01/2014		and en	ding 12	2/31/2014	
A Name of plan INLAND EMPIRE OPTICA	L BENEFIT P	LAN		B Three plan	e-digit number (P	N) •	501
C Plan sponsor's name a INLAND EMPIRE OPTICA		e 2a of Form 5500		D Emplo		cation Number (l	EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
LINCOLN NATIONAL LIF	E INSURANC	E					
/h) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered at			Policy or co	ntract year
(b) EIN	code	identification number	policy or contract		(f)) From	(g) To
35-0472300	65676	10195321	20	8	09/01/20	014	12/31/2014
2 Insurance fee and complete descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	st in line 3	the agents	, brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		3610					
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all p	persons).			
	(a) Name a	and address of the agent, broker	, or other person to whom	n commissi	ons or fee	s were paid	
MOLONEY AND ONEILL			W RIVERSIDE, STE 800 KANE, WA 99201				
(b) Amount of sales ar commissions pai		(c) Amount	s and other commissions paid (d) Purpose			(e) Organization code	
commissions par	3610	(c) Amount	•	a) Pulpose	7		3
	(a) Nome	and address of the agent broken	or other person to when		ana ar faa	n wara naid	
	(a) Name a	and address of the agent, broker	, or other person to whom	II COMMINISSI	ons or rees	s were paid	
(b) Amount of sales and base Fees and other commissions paid							
commissions pai		(c) Amount		d) Purpose)		(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1						
(a) Na	(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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	<u> </u>					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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						
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as a unit for purposes of		
4 Curren		ent 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 separate accounts at year e		5		
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	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 termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Schedule A (Form 5500) 2014		Page 4		
Welfare Benefit Contract Informatif more than one contract covers the same goinformation may be combined for reporting pothe entire group of such individual contracts	roup of employees of the sar urposes if such contracts are	e experience-rate	d as a unit. Where contrac	. ,
and contract type (check all applicable boxes)	1			
lealth (other than dental or vision)	b Dental	C Visio	n	d Life insurance
emporary disability (accident and sickness)	f X Long-term disability	g Supp	olemental unemployment	h Prescription drug
top loss (large deductible)	j HMO contract	k ☐ PPO	contract	I Indemnity contract
Other (specify)				
nce-rated contracts:				
niums: (1) Amount received		9a(1)		
Increase (decrease) in amount due but unpai	d	9a(2)		
Increase (decrease) in uncorred premium re-	20010	00/2)		

		the entire group of such individual contracts v					is cover individual e	empioyees,
8	Bene	fit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	с	Vision		d Life insurance	е
	e 🗏	Temporary disability (accident and sickness)	f X Long-term disabilit	<u></u>	-	oloyment	h Prescription of	drug
	i 🗖	Stop loss (large deductible)	j HMO contract	k	1		I Indemnity cor	ntract
	m	Other (specify)			•		_	
		.						
9	Exper	rience-rated contracts:						
	a P	remiums: (1) Amount received		9a(1)				
	((2) Increase (decrease) in amount due but unpaid	J	9a(2)				
	((3) Increase (decrease) in unearned premium res	serve	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)		
	С	Remainder of premium: (1) Retention charges (o	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)				
		(H) Total retention				9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
		Status of policyholder reserves at end of year: (1				9d(1)		
		(2) Claim reserves	•			9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no				9e		
10		nexperience-rated contracts:	o		·, ······			
. 5		Total premiums or subscription charges paid to c	arrier			10a		27766
	_	If the carrier, service, or other organization incur				100		21100
		retention of the contract or policy, other than repo	, .		•	10b		
	Spe	ecify 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	

Part III

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

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

OMB No. 1210-0110

2014

pursuant to ERISA section 103(a)(2).					Inspection	
For calendar plan year 20	14 or fiscal pla	in year beginning 01/01/2014	an	d ending 12/31	1/2014	
A Name of plan INLAND EMPIRE OPTICAL BENEFIT PLAN				Three-digit plan number (PN)	•	501
C Plan sponsor's name a INLAND EMPIRE OPTICA		ne 2a of Form 5500		mployer Identification 1-1356329	on Number (EIN)
		ning Insurance Contract Individual contracts grouped as				
1 Coverage Information:						
(a) Name of insurance ca						
UNUM LIFE INSURANCI	<u> </u>			. 1	D !!	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	of	•	ontract year
(0, =	code	identification number	policy or contract year	" (f) Fi	rom	(g) To
01-0278678	62235	120280	187	01/01/2014		12/31/2014
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	tal commissions paid. List in lir	ne 3 the agents, bro	okers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid						
		1967				
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all person	ıs).		
	(a) Name	and address of the agent, broker	, or other person to whom com	missions or fees we	ere paid	
PEGGY REDDY		PO E ISSA	BOX 2088 AQUAH, WA 98027			
	ı					
(b) Amount of sales ar			es and other commissions paid			
commissions pa		(c) Amount	(d) Pui	rpose		(e) Organization code
	1967					3
	(a) Name	and address of the agent, broker	or other person to whom come	missions or fees we	ere paid	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales a	nd base	Fe	es and other commissions paid	l		
commissions pa		(c) Amount	(d) Pui	rpose		(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1						
(a) Na	(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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid				
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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						
	T					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

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Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	be treated	d as a unit for purposes of		
4 Curren		ent 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 separate accounts at year e		5		
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	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 termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	age 4	
experience	ver(s) or members of the same en ce-rated as a unit. Where contract unit for purposes of this report.	
c	Vision Supplemental unemployment PPO contract	d ☐ Life insurance h ☐ Prescription drug I ☐ Indemnity contract
)a(1))a(2)		
a(3)		

	Schedule A (Form 5500) 2014
Part III	Welfare Benefit Contract Information

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	urposes if such contrac	ts are experienc	ce-rated as a unit. Who	ere contract		
8	Bene	fit 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 X Long-term disa	bility g	Supplemental unemp	oloyment	h Prescription dr	ug
	i 🗌	Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity cont	ract
	m	Other (specify)						
<u> </u>		in a control of the c						
9		rience-rated contracts:		0.40			4	
		remiums: (1) Amount received					4	
		2) Increase (decrease) in amount due but unpaid					_	
	,	3) Increase (decrease) in unearned premium res				0.74		
	_ `	4) Earned ((1) + (2) - (3))				9a(4)		
		Benefit charges (1) Claims paid		```				
	,	2) Increase (decrease) in claim reserves				01-(0)		
		3) Incurred claims (add (1) and (2))				9b(3)		
	,	4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (o	· ·	0=(4)(A)			4	
		(A) Commissions					4	
		(B) Administrative service or other fees		- (1)(-)			4	
		(C) Other specific acquisition costs					_	
		(D) Other expenses					4	
		(E) Taxes		2 (4)(=)			_	
		(F) Charges for risks or other contingencies					_	
		(G) Other retention charges				0-/4\/11\		
		(H) Total retention	_	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These	·			9c(2)		
		Status of policyholder reserves at end of year: (1				9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount ente	red in line 9c(2)	.)	9e		
10		experience-rated contracts:						
		Total premiums or subscription charges paid to c				10a		98330
		If the carrier, service, or other organization incurr				401-		
		retention of the contract or policy, other than repo	orted in Part I, line 2 at	oove, report amo	ount	10b		
	Spe	ecify nature of costs						

Part IV	Provision of Information			
11 Did the	e 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.

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

OMB No. 1210-0110

2014

			ERISA section 103(a)(2).	momatic	511		Inspection
For calendar plan year 20	14 or fiscal pla	n year beginning 01/01/2014		and end	ling 12/3	1/2014	
A Name of plan INLAND EMPIRE OPTICA	AL BENEFIT P	LAN	E		-digit number (PN)	,	501
C Plan sponsor's name a INLAND EMPIRE OPTICA		e 2a of Form 5500	Г	91-1356	ver Identificati 6329	on Number ((EIN)
		ning Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
DELTA DENTAL OF WA	SHINGTON						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate numbersons covered at e	_		Policy or co	ontract year
(b) EIN	code	identification number	policy or contract ye		(f) F	rom	(g) To
91-0621480	47341	8066	201		01/01/2014	ı	12/31/2014
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. List	n line 3 th	he agents, br	okers, and o	ther persons in
(a) Total	(a) Total amount of commissions paid (b) Total amount of fees paid						
		7706					
3 Persons receiving com	missions and t	ees. (Complete as many entries	s as needed to report all per	sons).			
	(a) Name	and address of the agent, broker	r, or other person to whom o	ommissio	ons or fees w	ere paid	
MOLONEY & ONEILL			W RIVERSIDE, STE 800 KANE, WA 99201				
							,
(b) Amount of sales a	nd base		es and other commissions	oaid			
commissions pa		(c) Amount	(d)	Purpose			(e) Organization code
	7706						3
	(a) Name	and address of the agent, broker	r or other person to whom o	ommissio	ons or fees w	ere naid	
	(a) Ivallic i	and address of the agent, broker	, or other person to whom t	OHIIII	5113 01 1CC3 W	cro paid	
(b) Amount of sales a	nd base	Fe	es and other commissions	oaid			
commissions pa		(c) Amount	(d)	Purpose			(e) Organization code

Schedule A (Form 5500) 2014 Page 2 - 1			
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, 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) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

_		
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ıay		•

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contract	s with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent 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 separate accounts at year e			5	
_		tracts With Allocated Funds:			•	1
	а	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 corretention of the contract or policy, enter amount.	nnection with	the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, ch	eck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatio	on guarantee		
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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)	
		Total of balance and additions (add lines 7b and 7c(6)).			7d	
	е	Deductions:	70(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)			
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)	7e(3)			
		tal control (openity below)				
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

Pa	ige 4		
experienc		ere contra	nployee organizations(s), the cts cover individual employees,
c g k	Vision Supplemental unemp PPO contract	loyment	d Life insurance h Prescription drug l Indemnity contract
9a(1)		15464	7
9a(2)			
9a(3)			
		9a(4)	15464
9b(1)		13837	3

Pá	art II	Welfare Benefit Contract Inform	nation				
		If more than one contract covers the sam- information may be combined for reportin the entire group of such individual contract	g purposes if such contracts	are experienc	ce-rated as a unit. Whe	re contracts	
8	Ben	nefit and contract type (check all applicable box	res)				
	а	Health (other than dental or vision)	b X Dental	С	Vision	d	Life insurance
	е	Temporary disability (accident and sickness	s) f Long-term disabili	ty g	Supplemental unempl	oyment h	Prescription drug
	i i	Stop loss (large deductible)	j HMO contract	, J_ k□	PPO contract	., I	Indemnity contract
	L		J [] TIMO CONTIACT	ν_	11 O contract	•	Indemnity contract
	m	Other (specify)					
9	Ехре	perience-rated contracts:					
	a I	Premiums: (1) Amount received		9a(1)		154647	
		(2) Increase (decrease) in amount due but un	paid	9a(2)			
		(3) Increase (decrease) in unearned premium	reserve	9a(3)	_		
		(4) Earned ((1) + (2) - (3))				9a(4)	154647
	b	Benefit charges (1) Claims paid				138373	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add (1) and (2))				9b(3)	138373
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charge	s (on an accrual basis)				
		(A) Commissions		9c(1)(A)		7706	
		(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					
		(F) Charges for risks or other contingenci	es	9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	<u> </u>			9c(1)(H)	7706
		(2) Dividends or retroactive rate refunds. (Th	ese amounts were 📗 paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year	r: (1) Amount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (D	o not include amount entered	d in line 9c(2)	.)	9e	
10) No	Ionexperience-rated contracts:			-		
	а	Total premiums or subscription charges paid	to carrier			10a	
	b	If the carrier, service, or other organization in retention of the contract or policy, other than				10b	
		reconstruct of the contract of policy, other than	roportod iii i dit i, iiilo z abov	o, roport arric	Z		

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	_

Specify nature of costs >

Schedule A (Form 5500) 2014

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

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration Pension Benefit Guaranty Corporation

Department of Labor

Service Provider 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.

OMB No. 1210-0110

2014

This Form is Open to Public Inspection.

For calendar plan year 2014 or fiscal plan year beginning 01/01/2014	and ending 12/31/2014
A Name of plan	B Three-digit
INLAND EMPIRE OPTICAL BENEFIT PLAN	plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500	D. Faralayar Identification Number (FIN)
•	D Employer Identification Number (EIN)
INLAND EMPIRE OPTICAL	91-1356329
Part I Service Provider Information (see instructions)	<u> </u>
You must complete this Part, in accordance with the instructions, to report the information or more in total compensation (i.e., money or anything else of monetary value) in connect plan during the plan year. If a person received only eligible indirect compensation for whi answer line 1 but are not required to include that person when completing the remainder of Information on Persons Receiving Only Eligible Indirect Compensa	tion with services rendered to the plan or the person's position with the ich the plan received the required disclosures, you are required to of this Part.
a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of	
indirect compensation for which the plan received the required disclosures (see instruction	
b If you answered line 1a "Yes," enter the name and EIN or address of each person provided received only eligible indirect compensation. Complete as many entries as needed (see in the compensation). (b) Enter name and EIN or address of person who provided you	instructions).
(b) Enter name and EIN or address of person who provided you	disclosure on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	aisclosures on eligible indirect compensation
(b) Enter name and EIN or address of person who provided you	disclosures on eligible indirect compensation

Schedule C (Form 5500) 2014	Page 2- 1
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address	s of person who provided you disclosures on eligible indirect compensation

	Schedule C (Form 550	00) 2014				
-	·	,		Page 3 - 1		
answered	I "Yes" to line 1a abov	e, complete as many value) in connection v	entries as needed to list ea	r Indirect Compensation ch person receiving, directly of the plan or their position with the address (see instructions)	r indirectly, \$5,000 or more in	total compensation
MOLONEY	′ & ONEILL		a) Enter name and Enver	address (see instructions)		
91-102912	9					
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	0	Yes 🛛 No 🗌	Yes 🛛 No 🗌	16674	Yes No X
		((a) Enter name and EIN or	address (see instructions)		
HEALTHC	ARE MANAGEMENT	ADMINISTRATOR				
91-133384	0					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	0	Yes 🛛 No 🗌	Yes 🛛 No 🗌	26807	Yes No X
		((a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or		(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	(g) Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of

other than plan or plan sponsor)

Yes No

plan received the required disclosures?

Yes No

eligible indirect an amount or compensation for which you estimated amount?

Yes No

answered "Yes" to element (f). If none, enter -0-.

person known to be a party-in-interest

enter -0-.

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)		
(a) Line hame and Enver address (see instructions)						
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	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?	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, employer 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?	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 No	Yes No		Yes No 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?	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 compen or provides contract administrator, consulting, custodial, investment advisory, investment madvestions for (a) each source from whom the service provider received \$1,000 or more in incomprovider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	anagement, broker, or recordkeepin direct compensation and (b) each s	g services, answer the following ource for whom the service
(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	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation		compensation, including any
		e the service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.

Page 5	5-
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Part II Service Providers Who Fail or Refuse to Provide Information					
	4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete				
(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			

Page (6-
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Pa	rt III Ta	rmination Information on Accountants and Enralled Actuaries (see in	ctructions)		
Га	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)				
а	Name:	,	b EIN:		
С	Position:				
d	Address:		e Telephone:		
			·		
Ex	olanation:				
a	Name:		b EIN:		
С	Position:				
d	Address:		e Telephone:		
Evi	olanation:				
	Jianation.				
а	Name:		b EIN:		
C	Position:		D LIIV.		
d	Address:		e Telephone:		
-	7144.000.		· Coopnaid.		
Exp	olanation:				
а	Name:		b EIN:		
С	Position:				
d	Address:		e Telephone:		
Fvi	Explanation:				
L^	nanation.				
а	Name:		b EIN:		
C	Position:		w E117.		
d	Address:		e Telephone:		
-	. 1001000.		- 10.0pmono.		
Explanation:					