Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 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

	_					inspection	
Part I		entification Information					
For caler	ndar plan year 2014 or fisca	al plan year beginning 10/01/2014		and ending 09/30/	2015		
A This	eturn/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or				
		x a single-employer plan;	a DFE (speci	fy)			
B This r	eturn/report is:	the first return/report;	the final retur	n/report;			
	·	an amended return/report;	a short plan y	ear return/report (less tha	ın 12 month	s).	
C If the	plan is a collectively-bargai	ned plan, check here				▶ □	
D Chec	k box if filing under:	X Form 5558;	automatic ext	ension;	the Di	FVC program;	
D 01100	K box ii iiiiiig dildor.	special extension (enter description		,	ш	, ,	
Part	I Rasic Plan Infor	rmation—enter all requested informa	,				
	e of plan	- enter all requested informa	ation		1b	Three-digit plan	501
	HEALTH & WELFARE BEN	NEFIT PLAN				number (PN) ▶	501
					1c	Effective date of pl 11/01/2001	an
2a Plan 3MD, IN		ess; include room or suite number (emp	oloyer, if for a single-	employer plan)	2b	Employer Identifica Number (EIN) 26-1460116	ation
17735 N	E 65TH ST, STE 130		65TH ST, STE 130		2c	2c Plan Sponsor's telephone number 425-943-5571	
REDMO	ND, WA 98052-4924	REDMON	D, WA 98052-4924		2d	2d Business code (see instructions) 541512	
Caution	A penalty for the late or	incomplete filing of this return/repor	t will be assessed	unless reasonable caus	e is establi:	shed.	
Under pe	enalties of perjury and other	penalties set forth in the instructions, last the electronic version of this return	declare that I have	examined this return/repo	rt, including	accompanying sche	
					<u> </u>		
SIGN	Filed with authorized/valid	electronic signature					
HERE	Signature of plan admin		Date	Enter name of individua	l eigning ae	nlan administrator	
	Signature of plan admin	istrator	Date	Litter Harrie of Individua	ii sigiiiiig as	pian administrator	
SIGN							
HERE	Signature of employer/p	lan snonsor	Date	Enter name of individual signing as employer or pla		employer or plan sr	nonsor
	olgitatare of employer/p	nan sponsor	Dute	Enter name of marviada	ir olgriirig ao	employer of plant of	7011301
SIGN							
HERE Signature of DFE Date Enter name of individual signing as DFE							
- J						telephone number	
WENDE WADSWORTH (option							
SWEENEY CONRAD, P.S.						425-629-1990	
	STH AVE NE, SUITE 200 JE, WA 98004						

Form 5500 (2014) Page **2**

3a	Plan administrator's name and address Same as Plan Sponsor	3b Administrator's EIN		
		3c Admir numb	nistrator's telephone er	
4	If the name and/or FINI of the plan appropriate about a fine the last return	(report filed for this plan, optor the page	4b FIN	
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:	report filed for this 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	314
6	Number of participants as of the end of the plan year unless otherwise stated 6a(2), 6b, 6c, and 6d).	I (welfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		6a(1)	309
a(2) Total number of active participants at the end of the plan year		6a(2)	353
b	Retired or separated participants receiving benefits		6b	5
С	Other retired or separated participants entitled to future benefits		. 6c	
d	Subtotal. Add lines 6a(2) , 6b , and 6c .		. 6d	358
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	. 6e	
f	Total. Add lines 6d and 6e.		. 6f	358
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	, , , , , , , , , , , , , , , , , , , ,	7	
b	If the plan provides pension benefits, enter the applicable pension feature code. If the plan provides welfare benefits, enter the applicable welfare feature code. 4A 4B 4D 4H 4E	es from the List of Plan Characteristics Code	s in the inst	
эa	Plan funding arrangement (check all that apply) (1)	9b Plan benefit arrangement (check all that (1) Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3)	insurance o	ontracts
	(3) Trust (4) X General assets of the sponsor	(3) Trust (4) X General assets of the s	noneor	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at		<u> </u>	d. (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) I (Financial Inform (3) A (Insurance Inform C (Service Provide	mation)	,
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participati	_	

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 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

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 10/01/2014	and e	ending 09/30/2015		
A Name of plan DENALI HEALTH & WELF	FARE BENEFI	T PLAN		ree-digit an number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 3MD, INC. D Employer Identification Number (E 26-1460116					er (EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.					
1 Coverage Information:						
(a) Name of insurance ca	rrier					
THE LINCOLN NATIONA	L LIFE INSUR	RANCE COMPANY				
(b) FINI	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
35-0472300	65676	1D024577	340	340 10/01/2014		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	stal commissions paid. List in line	3 the agents, brokers, and	d other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
		17867				
3 Persons receiving com			s as needed to report all persons).			
OADITAL DENEELT OFFI			r, or other person to whom commis	ssions or fees were paid		
CAPITAL BENEFIT SER	VICES INC		75 SE 30TH PL #380 LEVUE, WA 98007			
(b) Amount of sales ar	nd base _	Fe	es and other commissions paid			
commissions pa		(c) Amount	(d) Purpose		(e) Organization code	
17867					3	
	(a) Name :	and address of the agent, broke	or other person to whom commi	ssions or fees were naid		
(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 pa		(c) Amount	(d) Purpo	(d) Purpose		

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) 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	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	
-		racts With Allocated Funds:				
	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 th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n 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)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Pa	age 4			
experience	ver(s) or members of the ce-rated as a unit. Who unit for purposes of this	ere contracts		
c [g [k [Vision Supplemental unemp PPO contract	oloyment I	d [] h [] I []	Life insurance Prescription drug Indemnity contract
0-(4)				
9a(1) 9a(2)				
9a(3)				
		- (1)		

Pa	art II	Welfare Benefit Contract Informat	tion					
		If more than one contract covers the same gi						
		information may be combined for reporting potential the entire group of such individual contracts of					s cover individua	al employees,
8	Ren	efit and contract type (check all applicable boxes)		Tealed as a d	inition purposes of this	тероп.		
Ŭ	a [Health (other than dental or vision)	b X Dental	۰	Vision		d ☐ Life insura	200
	L F			c	4			
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	ployment	h Prescription	on drug
	i	Stop loss (large deductible)	j HMO contract	k [PPO contract		I Indemnity	contract
	m	Other (specify)						
	_							
9	Expe	erience-rated contracts:						
	a I	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	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 (c	, i				_	
		(A) Commissions		9c(1)(A)			_	
		(B) Administrative service or other fees					_	
		(C) Other specific acquisition costs		0 (4)(D)			_	
		(D) Other expenses		0 (4)(5)			4	
		(E) Taxes					4	
		(F) Charges for risks or other contingencies		90(1)(F)			_	
		(G) Other retention charges				0-(4)(11)		
		(H) Total retention	_			9c(1)(H)	+	
		(2) Dividends or retroactive rate refunds. (These	\					
	d	Status of policyholder reserves at end of year: (1	•					
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
4.0	<u>e</u>	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2)	.)	9e		
10		nexperience-rated contracts:				40-		47000
	a	Total premiums or subscription charges paid to c				10a		178668
	b	If the carrier, service, or other organization incurrent or policy, other than report	, ,		•	10b		

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

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 10/01/2014	and e	ending 09/30/2015		
A Name of plan DENALI HEALTH & WELF	A Name of plan DENALI HEALTH & WELFARE BENEFIT PLAN			ee-digit n number (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 3MD, INC. D Employer Identification Number (E 26-1460116					er (EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.					
1 Coverage Information:						
(a) Name of insurance ca	rrier					
THE LINCOLN NATIONA	L LIFE INSUR	RANCE COMPANY				
/L) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or	contract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To	
35-0472300	65676	10163289	354	354 10/01/2014		
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. List in line 3	3 the agents, brokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid						
		467				
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all persons).			
OADITAL DENEELT OFFI	· · ·		r, or other person to whom commis	sions or fees were paid		
CAPITAL BENEFIT SER	VICES INC		75 SE 30TH PL #380 LEVUE, WA 98007			
(b) Amount of sales ar	nd base	Fe	es and other commissions paid			
commissions pa		(c) Amount	(d) Purpos	se	(e) Organization code	
467					3	
	(a) Name :	and address of the agent, broker	or other person to whom commis	sions or fees were paid		
	(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 pa		(c) Amount	(d) Purpo	se	(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) 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.	idual contracts	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	
-		racts With Allocated Funds:				
	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 th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n 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)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Schedule A (Form 5500) 2014	Page 4	_
Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contracts the entire group of such individual contracts with each carrier may be	s are experience-rated as a unit. Where	e contracts cover individual employees,
and contract type (check all applicable boxes)		
ealth (other than dental or vision) b Dental	C Vision	d 🛛 Life insurance
emporary disability (accident and sickness) $f f$ $\overline{\ \ }$ Long-term disabil	lity $g \overline{}$ Supplemental unemplo	pyment h Prescription drug
top loss (large deductible) j HMO contract	k ☐ PPO contract	I Indemnity contract
ther (specify) ►AD&D		
ce-rated contracts:		
niums: (1) Amount received	9a(1)	
ncrease (decrease) in amount due but unpaid	9a(2)	
ncrease (decrease) in unearned premium reserve	9a(3)	
Earned ((1) + (2) - (3))		9a(4)
nefit charges (1) Claims paid	9b(1)	
ncrease (decrease) in claim reserves		
ncurred claims (add (1) and (2))		9b(3)

information may be combined for reporting purposes if such contracts ar the entire group of such individual contracts with each carrier may be tre 8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disability Stop loss (large deductible) j HMO contract m X Other (specify) ▶AD&D Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid..... (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3))..... Benefit charges (1) Claims paid..... (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions 9c(1)(A) (B) Administrative service or other fees..... 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... (F) Charges for risks or other contingencies..... 9c(1)(F) 9c(1)(H) (H) Total retention..... (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) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e 10 Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 4671 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....

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

Specify nature of costs

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 plar	n year beginning 10/01/2014	_	and end	ding 09	9/30/2015	
A Name of plan DENALI HEALTH & WELF	FARE BENEFIT	ΓPLAN		B Three plan	e-digit number (P	N) •	501
C Plan sponsor's name a 3MD, INC.	s shown on lin	e 2a of Form 5500		D Employ 26-1460		cation Number (EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	rrier						
VISION SERVICE PLAN	1		1 () 4			Dellares	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nur persons covered at			Policy or co	•
(2) =::1	code	identification number	policy or contract		(f) From	(g) To
23-7089668	53031	30010127	200	6	10/01/2	014	09/30/2015
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Lis	st in line 3 t	he agents	, brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
		1260					
3 Persons receiving com	missions and fo	ees. (Complete as many entries	s as needed to report all p	ersons).			
	(a) Name a	and address of the agent, broker	, or other person to whom	commissi	ons or fee	s were paid	
CAPITAL BENEFIT SER	VICES INC		'5 SE 30TH PL #380 LEVUE, WA 98007				
(b) Amount of sales ar	nd hase	Fe	es and other commissions	s paid			
commissions pa		(c) Amount	(0	(d) Purpose			(e) Organization code
	1260						3
	(a) Name a	and address of the agent, broker	, or other person to whom	commissi	ons or fee	s were paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	s 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			
	<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			
(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.	idual contracts	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	
-		racts With Allocated Funds:				
	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 th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n 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)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Schedule A (Form 5500) 2014		Page 4	
	same group of employees of the porting purposes if such contract	s are experience-rated as a unit. \	of the same employee organizations(s), the Where contracts cover individual employees, this report.
and contract type (check all applicable	e boxes)		
lealth (other than dental or vision)	b Dental	c X Vision	d Life insurance

	а	Health (other than dental or vision)	b Dental	c 🛚	Vision		d Life insurance	
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription dru	ıg
	i	Stop loss (large deductible)	j HMO contract	k∏	PPO contract		I Indemnity contra	act
	m	Other (specify)	, []				. 🗀,	
9	Ехр	erience-rated contracts:						
	а	Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpaid	d	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)		
	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	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to c	arrier			10a		25134
	b	If the carrier, service, or other organization incurr retention of the contract or policy, other than repo				10b		
	S	pecify 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	

8 Benefit and contract type (check all applicable boxes)

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	For calendar plan year 2014 or fiscal plan year beginning 10/01/2014 and ending 09/30/2015						
A Name of plan DENALI HEALTH & WELI	FARE BENEFIT	ΓPLAN	В	Three-digit plan numbe	er (PN)	501	
C Plan sponsor's name as shown on line 2a of Form 5500 3MD, INC. D Employer Identification Number (EI 26-1460116					(EIN)		
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca	arrier						
REGENCE BLUESHIELI)						
	(c) NAIC	(d) Contract or	(e) Approximate numb		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at en policy or contract ye		(f) From	(g) To	
91-0282080	53902	10012655	516	10/0	1/2014	09/30/2015	
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	otal commissions paid. List i	in line 3 the age	ents, brokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid							
	35881						
3 Persons receiving com	missions and fe	ees. (Complete as many entrie	s as needed to report all per	rsons).			
	(a) Name a	and address of the agent, broke	r, or other person to whom o	commissions or	fees were paid		
CAPITAL BENEFIT SER	VICES INC		75 SE 30TH PL #380 LEVUE, WA 98007				
						1	
(b) Amount of sales a			es and other commissions				
commissions pa	1	(c) Amount	(d) Purpose		(e) Organization code		
	35881					3	
	(a) Name a	and address of the agent, broke	r, or other person to whom o	commissions or	fees were paid		
(b) Amount of sales a			ees and other commissions				
commissions pa	iid	(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		
	<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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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	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	
-		racts With Allocated Funds:				
	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 th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n 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)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Page 4	
employer(s) or members of the same en xperience-rated as a unit. Where contra- d as a unit for purposes of this report.	
c ☐ Vision g ☐ Supplemental unemployment k ☐ PPO contract	d ☐ Life insurance h ☐ Prescription drug I ☐ Indemnity contract
1	
a(1)	

	art III	If more than one contract covers the same gr information may be combined for reporting po the entire group of such individual contracts of	oup of employees of the surposes if such contracts a with each carrier may be to	are experienc	ce-rated as a unit. W	here contrac		
8	Bene	fit and contract type (check all applicable boxes)	_		_		_	
	a X	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance	е
	е	Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unem	nployment	h Prescription of	drug
	i [Stop loss (large deductible)	j HMO contract	k _	PPO contract		I Indemnity cor	ntract
	m	Other (specify)						
9	Expe	rience-rated contracts:						
	a F	Premiums: (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))						
		(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	<u> </u>	9c(1)(D)			_	
		(E) Taxes		9C(1)(E)			_	
		(F) Charges for risks or other contingencies	l l	9c(1)(F) 9c(1)(G)			_	
		(G) Other retention charges		, ,, , ,		0o/1\/LI\	<u> </u>	
		(H) Total retention	_	_			,	
		(2) Dividends or retroactive rate refunds. (These		<u></u>				
		Status of policyholder reserves at end of year: (1						
		(2) Claim reserves						
		(3) Other reserves						
10		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2).	. <u>)</u>	9e		
10		nexperience-rated contracts:	parriar			400		4204000
	_	Total premiums or subscription charges paid to o				10a	_	1304629
		If the carrier, service, or other organization incurretention of the contract or policy, other than repo	, .		•	10b		
	Spe	ecify nature of costs						

Part IV	Provision of Information			
11 Did t	ne 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 10/01/2014		and en	ding 09	9/30/2015	
A Name of plan DENALI HEALTH & WELF	A Name of plan DENALI HEALTH & WELFARE BENEFIT PLAN			B Three plan	e-digit number (P	N) •	501
C Plan sponsor's name a 3MD, INC.						EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.						
1 Coverage Information:							
(a) Name of insurance ca	rrier						
THE LINCOLN NATIONAL LIFE INSURANCE COMPANY							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) LIN	code	identification number	persons covered at end of policy or contract year	(f)	From	(g) To	
35-0472300	65676	400163291	28	36	10/01/20)14	09/30/2015
2 Insurance fee and coming 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							
	3960						
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
		and address of the agent, broker	•	m commissi	ons or fees	s were paid	
CAPITAL BENEFIT SER	VICES INC	1537 BEL	75 SE 30TH PL #380 LEVUE, WA 98007				
(b) Amount of sales ar	nd base _	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose)		(e) Organization code
	3960						3
	(a) Name a	and address of the agent, broker	or other person to whor	m commissi	ons or fee	s were paid	
	(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(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		
	<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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Pa	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts	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	
-		racts With Allocated Funds:				
	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 th	ne acquisition or	6d	
		Specify nature of costs •				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, che	eck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in sep	arate accounts)	·	
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	ate participatior	n 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)	
	d	Total of balance and additions (add lines 7b and 7c(6)).			7d	
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		>				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Schedule A (Form 5500) 2014	Page 4	
	ne same employer(s) or members of the same employee organizations(sets are experience-rated as a unit. Where contracts cover individual employee treated as a unit for purposes of this report.	
and contract type (check all applicable boxes)		
ealth (other than dental or vision) b Dental	c ☐ Vision d ☒ Life insurance	
emporary disability (accident and sickness) f Long-term dis	bility g Supplemental unemployment h Prescription dru	ıg
top loss (large deductible) j HMO contract	k	act
Other (specify) AD&D		
nce-rated contracts:		
niums: (1) Amount received	9a(1)	
Increase (decrease) in amount due but unpaid	9a(2)	
Increase (decrease) in unearned premium reserve	9a(3)	
Earned ((1) + (2) - (3))	9a(4)	
nefit charges (1) Claims paid		
Increase (decrease) in claim reserves	9b(2)	
Incurred claims (add (1) and (2))	9b(3)	
Claims charged		
mainder of premium: (1) Retention charges (on an accrual basis)		
(A) Commissions	9c(1)(A)	
• •	 	

the entire group of such individual contracts with each carrier may be tree 8 Benefit and contract type (check all applicable boxes) a Health (other than dental or vision) **b** Dental Temporary disability (accident and sickness) Long-term disability Stop loss (large deductible) j HMO contract m X Other (specify) ▶AD&D Experience-rated contracts: a Premiums: (1) Amount received..... (2) Increase (decrease) in amount due but unpaid...... (3) Increase (decrease) in unearned premium reserve (4) Earned ((1) + (2) - (3))..... Benefit charges (1) Claims paid..... (2) Increase (decrease) in claim reserves..... (3) Incurred claims (add (1) and (2)) (4) Claims charged Remainder of premium: (1) Retention charges (on an accrual basis) --(A) Commissions (B) Administrative service or other fees..... 9c(1)(B) 9c(1)(C) (C) Other specific acquisition costs (D) Other expenses..... 9c(1)(D) 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies..... 9c(1)(H) (H) Total retention..... (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) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)..... 9e 10 Nonexperience-rated contracts: 10a Total premiums or subscription charges paid to carrier 26400 If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or 10b retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... 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 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.

OMB No. 1210-0110

2014

, , , , , , , , , , , , , , , , , , , ,		pursuant to	ERISA section 103(a)(2)		ion		Inspection	
For calendar plan year 20	14 or fiscal plar	n year beginning 10/01/2014		and en	ding 09/	/30/2015		
A Name of plan DENALI HEALTH & WELI	A Name of plan DENALI HEALTH & WELFARE BENEFIT PLAN				e-digit number (PN	N) •	501	
C Plan sponsor's name a 3MD, INC.								
		ing Insurance Contract Individual contracts grouped as						
1 Coverage Information:		3 p				<u>g</u>		
(a) Name of insurance ca	nrrier							
THE LINCOLN NATIONA	AL LIFE INSUR	ANCE COMPANY						
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate nu	F		Policy or	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
35-0472300	65676	10163290	35	54	10/01/20	14	09/30/2015	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.								
(a) Total amount of commissions paid (b) Total amount of fees paid								
2567								
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commissi	ions or fees	were paid		
CAPITAL BENEFIT SER	CAPITAL BENEFIT SERVICES INC 15375 SE 30TH PL #380 BELLEVUE, WA 98007							
(b) Amount of sales a			es and other commission	ns paid				
commissions pa	1	(c) Amount		(d) Purpose	9		(e) Organization code	
	2567						3	
	()))				. ,	.,		
	(a) Name a	nd address of the agent, broker	, or other person to whor	n commissi	ions or fees	were paid		
(b) Amount of sales a			es and other commission	-			(a) Organization and	
commissions pa	liu	(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					
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	line and address of the agent, broke	er, or other person to whom commissions or rees were paid					
		Fees and other commissions paid	T				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
	(0)	(5)					
(a) Na	ame 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	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid					
(4)	and and address of the agent, protect	n, et estici person to mism commissions et rece maio paid					
(h) American of a class and have		Fees and other commissions paid	(-) () (
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid					
	T		1				
(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 individual contracts with each carrier may this report.				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:				
	а	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 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	d 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	aintained 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:	70/4			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2) 7e(3)			
		(3) Transferred to separate account	7e(3) 7e(4)			
		(4) Other (specify below)	16(4)			
		•				
		(5) Total deductions.			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7 f	

Pag	ge 4				
e experience	er(s) or members of the e-rated as a unit. Whe hit for purposes of this	ere contracts			
c g k	Vision Supplemental unemp PPO contract	loyment h	Pres	nsurance cription drug nnity contract	
- (n) T					
9a(1)					
9a(2) 9a(3)					
		9a(4)			
9b(1)	<u>'</u>				
9b(2)					

		If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v	irposes if such contracts a	re experienc	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 X Long-term disability	, g [Supplemental unemp	loyment	$\mathbf{h} \ \square$ Prescription drug	
	i [Stop loss (large deductible)	j HMO contract	k 🗌	PPO contract		I Indemnity contract	t
	m	Other (specify)						
9	Expe	erience-rated contracts:						
	•	Premiums: (1) Amount received	Γ	9a(1)				
		(2) Increase (decrease) in amount due but unpaid	⊢					
		(3) Increase (decrease) in unearned premium res	_					
		(4) Earned ((1) + (2) - (3))	_			9a(4)		
	_	Benefit charges (1) Claims paid						
		(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	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	······	<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	enefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
		Dividends or retroactive rate refunds due. (Do no	ot include amount entered	in line 9c(2) .	.)	9e		
10		nexperience-rated contracts:			i			
	_	Total premiums or subscription charges paid to c				10a		25672
	b	If the carrier, service, or other organization incurr retention 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

Welfare Benefit Contract Information

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

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 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

Part I Annual Report Identification Information		
For calendar plan year 2014 or fiscal plan year beginning 10/01/2014	and ending 09/30/201	
A This return/report is for:	a multiple-employer plan (Filers checking the participating employer information in accordance)	
a single-employer plan;	a DFE (specify)	
B This return/report is:	the final return/report;	
an amended return/report;	a short plan year return/report (less than 1	2 months).
C If the plan is a collectively-bargained plan, check here.	**************************************	
D Check box if filing under:	automatic extension;	the DFVC program;
special extension (enter descri	ption)	
Part II Basic Plan Information—enter all requested info	ormation	
1a Name of plan DENALI HEALTH & WELFARE BENEFIT PLAN		1b Three-digit plan number (PN) ▶ 501
		1c Effective date of plan 11/01/2001
2a Plan sponsor's name and address; include room or suite number (3MD, INC.	(employer, if for a single-employer plan)	2b Employer Identification Number (EIN) 26-1460116
		2c Plan Sponsor's telephone number
	NE 65TH ST, STE 130 IOND, WA 98052-4924	425-943-5571
NEDWOND, WA 30002-4324	10ND, WA 30002-4324	2d Business code (see instructions) 541512
Caution: A penalty for the late or incomplete filing of this return/re	eport will be assessed unless reasonable cause is	established.
Under penalties of perjury and other penalties set forth in the instruction statements and attachments, as well as the electronic version of this re		
SIGN STORY SIGN	7/5/16 Jennifer	Spraque
Signature of plan administrator	Date Enter name of individual sig	gning as plan admilustrator
SIGN HERE	7/5/1/a Jennifer	Sprague
Signature of employer/plan sponsor	Date Enter name of individual sig	gning as employer of all n sponsor
SIGN		
HERE Signature of DFE	Date Enter name of individual sig	aning as DEF
Preparer's name (including firm name, if applicable) and address (inclu		eparer's telephone number
WENDE WADSWORTH	(ор	tional)
SWEENEY CONRAD, P.S.		425-629-1990
2606 116TH AVE NE, SUITE 200 BELLEVUE, WA 98004		

Page	2
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	the name and/or EIN of the plan sponsor has changed since the last return IN and the plan number from the last return/report: Sponsor's name	n/report filed for this plan, ent	r	dministrator's telephone number
	IN and the plan number from the last return/report:	n/report filed for this plan, ent	or the name. Ah E	
	IN and the plan number from the last return/report:	n/report filed for this plan, ent	or the name 1h	
	Sponsor's name		er the hame,	EIN
a 9			4c F	PN
5 T	otal number of participants at the beginning of the plan year		5	314
	lumber of participants as of the end of the plan year unless otherwise stated a(2), 6b, 6c, and 6d).	d (welfare plans complete on	ly lines 6a(1),	
a(1)	Total number of active participants at the beginning of the plan year		6a(1	309
a(2)	Total number of active participants at the end of the plan year		6a(2	353
	Retired or separated participants receiving benefits			5
c C	Other retired or separated participants entitled to future benefits		6c	
d s	Subtotal. Add lines 6a(2) , 6b , and 6c		6d	358
e D	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits.	6e	
f T	otal. Add lines 6d and 6e.		6f	358
	lumber of participants with account balances as of the end of the plan year omplete this item)			
le	lumber of participants that terminated employment during the plan year with			
7 E	inter the total number of employers obligated to contribute to the plan (only	multiemployer plans complet	e this item)	
b If	the plan provides pension benefits, enter the applicable pension feature could be the plan provides welfare benefits, enter the applicable welfare feature could be a 4B 4D 4H 4E		racteristics Codes in the	instructions:
	ian funding arrangement (check all that apply) Insurance	(1) Insurar	,	")
(2	H	I	ection 412(e)(3) insurar	nce contracts
(3	3) Trust	(3) Trust		
-	General assets of the sponsor		l assets of the sponsor	
10 C	theck all applicable boxes in 10a and 10b to indicate which schedules are a	ttached, and, where indicated	d, enter the number atta	cned, (See instructions)
	ension Schedules	b General Schedules		
(*	R (Retirement Plan Information)	(1) H	(Financial Information)	
(2	MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(3) <u>6</u> A	(Financial Information - (Insurance Information (Service Provider Information)
(3	SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) 📗 D	(DFE/Participating Plan (Financial Transaction	