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

2015

This Form is Open to Public Inspection

| Part I | | entification Information | | | | • | |
|---|-----------------------------------|---|--------------------------|--|--|---|---------|
| For cale | ndar plan year 2015 or fisc | cal plan year beginning 08/01/2015 | _ | and ending 07/31/2016 | | | |
| A This | return/report is for: | a multiemployer plan; | | ployer plan (Filers checking this imployer information in accordan | | | ns); or |
| | | x a single-employer plan; | a DFE (specify | y) | | | |
| B This | eturn/report is: | the first return/report; | the final return | n/report; | | | |
| | | an amended return/report; | a short plan ye | ear return/report (less than 12 m | an 12 months). | | |
| C If the | plan is a collectively-barga | ained plan, check here | | | | → | |
| D Chec | k box if filing under: | Form 5558; | automatic exter | nsion; | the | e DFVC program; | |
| | | special extension (enter description) |) | | | | |
| Part | I Basic Plan Info | ormation—enter all requested informa | ation | | | | |
| | ne of plan REES COMPANY HEALTH | I CARE PLAN | | | 1b | Three-digit plan number (PN) ▶ | 501 |
| | | | | | 1c | Effective date of pl 07/01/1987 | an |
| Mail | ing address (include room, | er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box) , country, and ZIP or foreign postal code | e (if foreign, see instr | ructions) | 2b | Employer Identifica Number (EIN) 61-0675670 | ation |
| THE DRE | EES COMPANY | | | | 2c | Plan Sponsor's tele number 859-578-4200 | |
| 211 GRANDVIEW DR FT MITCHELL, KY 41017-2759 211 GRANDVIEW DR FT MITCHELL, KY 41017-2759 | | | 9 | 2d | Business code (seinstructions) 236110 | 9 | |
| | | | | | | | |
| Caution | : A penalty for the late or | r incomplete filing of this return/repor | rt will be assessed | unless reasonable cause is e | stabli | shed. | |
| | | er penalties set forth in the instructions, lell as the electronic version of this return | | | | | |
| | | | | | | | |
| SIGN HERE | Filed with authorized/valid | l electronic signature. | 02/27/2017 | PAMELA RADER | | | |
| | Signature of plan admir | nistrator | Date | Enter name of individual sign | ing as | plan administrator | |
| SIGN | | | | | | | |
| HERE | Signature of employer/ | plan sponsor | Date | Enter name of individual sign | ing as | employer or plan sp | onsor |
| SIGN | | | | | | | |
| HERE | Signature of DFE | | Date | Enter name of individual sign | ing as | DFE | |
| Preparer | • | me, if applicable) and address (include i | | | | telephone number | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Form 5500 (2015) Page **2**

| 3a | Plan administrator's name and address Same as Plan Sponsor | | 3b Administra | ator's EIN |
|-------------|---|--|----------------------|-------------------|
| | | | 3c Administra | ator's telephone |
| 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 | 531 |
| 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) | 531 |
| a(2 | 2) Total number of active participants at the end of the plan year | | 6a(2) | 589 |
| 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 | 589 |
| е | Deceased participants whose beneficiaries are receiving or are entitled to rec | ceive benefits | 6e | |
| f | Total. Add lines 6d and 6e | | 6f | 589 |
| 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 plans complete this item) | 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. 4D 4B 4Q 4E 4A 4H | es from the List of Plan Characteristics Code | es in the instructi | |
| | Plan funding arrangement (check all that apply) (1) | Plan benefit arrangement (check all the (1) | insurance contr | |
| 10 | Check all applicable boxes in 10a and 10b to indicate which schedules are at | ttached, and, where indicated, enter the num | nber attached. (S | See instructions) |
| а | Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | b General Schedules (1) H (Financial Information 1) (2) I (Financial Information 2) (3) X 6 A (Insurance Information 4) C (Service Provide 2) | mation – Small F | Plan) |
| | (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | (5) D (DFE/Participat | _ | |

| Part III | Form M-1 Compliance Information (to be completed by welfare benefit plans) | | |
|-----------------|--|--|--|
| 2520.101-2 | 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.) | | |
| 11b Is the plan | currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) | | |
| enter the R | eceipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, eceipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure alid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) | | |

Form 5500 (2015)

Receipt Confirmation Code__

Page 3

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

2015

This Form is Open to Public Inspection

| For calendar plan year 20° | 15 or fiscal plar | n year beginning 08/01/2015 | | and en | iding 07/31/2016 | |
|---|-------------------|---|---|------------------------|---|-------------------------|
| A Name of plan THE DREES COMPANY HEALTH CARE PLAN | | | B Three | e-digit number (PN) | 501 | |
| | | | | | | |
| C Plan sponsor's name a THE DREES COMPANY | s shown on lin | e 2a of Form 5500 | | | oyer Identification Number (0675670 | EIN) |
| | | ing Insurance Contract Individual contracts grouped as | | | | |
| 1 Coverage Information: | | | | | | |
| (a) Name of insurance ca AMERICAN UNITED LIFE | | COMPANY | | | | |
| (b) EIN | (c) NAIC | (d) Contract or | (e) Approximate number of persons covered at end of | | • | ontract year I |
| (b) EIN | code | identification number | policy or contract | | (f) From | (g) To |
| 35-0145825 | 60895 | G00612708 | 286 | | 08/01/2015 | 07/31/2016 |
| 2 Insurance fee and composite descending order of the | | ation. Enter the total fees and to | tal commissions paid. Li | st in line 3 | the agents, brokers, and o | ther persons in |
| (a) Total a | amount of com | | | (b) To | otal amount of fees paid | |
| | | 11853 | 1439 | | | |
| 3 Persons receiving com | missions and fe | 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 whor | n commiss | ions or fees were paid | |
| BUSINESS BENEFITS INC | . | SUITE | RANDVIEW DRIVE 204 MITCHELL, KY 41017 | | | |
| (b) Amount of sales ar | nd base | Fe | es and other commissior | ns paid | | |
| commissions pai | | (c) Amount | | (d) Purpose | e | (e) Organization code |
| | 11853 | 1439 C | 1439 OTHER COMPENSATION 3 | | 3 | |
| | (a) Name a | and address of the agent, broker | , or other person to whor | n commiss | ions 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 | (e) Organization code |
| | | | | | | |
| For Paperwork Reductio | n Act Notice a | and OMB Control Numbers, se | e the instructions for F | orm 5500. | Scher | lule A (Form 5500) 2015 |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| (a) Na | me and address of the agent, broke | r, or other person to whom commissions or fees were paid | |
|---|-------------------------------------|--|-----------------------|
| | - | · | |
| | | | |
| | | | |
| | | | |
| | | Fees and other commissions paid | |
| (b) Amount of sales and base | | | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| | | | |
| | | | |
| (a) No | me and address of the agent broke | r or other person to whom commissions or fees were poid | |
| (a) Na | ine and address of the agent, broke | r, 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 | r, or other person to whom commissions or fees were paid | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | Fees and other commissions paid | 4.50 |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | (e) Organization code |
| confinissions paid | (C) Amount | (u) Fulpose | code |
| | | | |
| | | | |
| | | | |
| (a) Na | me and address of the agent, broke | r, or other person to whom commissions or fees were paid | |
| (2) | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| (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 | r, 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 |
| | (-) | 727 | |
| | | | |
| | | | |
| | | | |

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indiv | idual contracts w | ith each carrier may be treated | d as a unit for purposes of |
|---|-------|--|---------------------|---------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year | end | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year e | | | |
| _ | | 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 | | · DO | |
| | | 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, check | k here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in separ | ate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | ite participation g | juarantee | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | |
| | | , - | | | |
| | | | | | |
| | 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 | | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | . 7c(5) | | |
| | | • | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | <u></u> | |
| | | 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) | - (4) | | |
| | | • Chief (Specify Below) | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| Schedule A (| Form 5500) 2015 | | Page 4 | | |
|----------------------------|--|---|--------------------|-----------------------------|---------------------------|
| If more than information i | Benefit Contract Informat one contract covers the same gr may be combined for reporting po oup of such individual contracts v | roup of employees of the surposes if such contracts | are experience-rat | ed as a unit. Where contrac | |
| Benefit and contract | type (check all applicable boxes) | | | | |
| a Health (other t | than dental or vision) | b Dental | c Vis | ion | d X Life insurance |
| e Temporary dis | sability (accident and sickness) | f Long-term disabili | ty g ∏ Sup | oplemental unemployment | h Prescription drug |
| i Stop loss (larg | ue deductible) | i HMO contract | - = | O contract | I Indemnity contract |
| | y ►VOLUNTARY AD&D | , | | | |
| THE Other (specify |) VOLONIANI ADAD | | | | |
| Experience-rated con | tracts: | | | | |
| • | mount received | | 9a(1) | | |
| | crease) in amount due but unpaid | | 9a(2) | | |
| (3) Increase (de | crease) in unearned premium res | serve | 9a(3) | | |
| (4) Earned ((1) + | + (2) - (3)) | | | 9a(4) | |
| b Benefit charges | (1) Claims paid | | 9b(1) | | |
| (2) Increase (de | crease) in claim reserves | | 9b(2) | | |
| (3) Incurred clair | ms (add (1) and (2)) | | | 9b(3) | |
| (4) Claims charg | ged | | | 9b(4) | |
| C Remainder of pr | remium: (1) Retention charges (o | n an accrual basis) | r | | |
| (A) Commis | sions | | 9c(1)(A) | | |
| (B) Administ | trative service or other fees | | 9c(1)(B) | | |
| ` ' | pecific acquisition costs | | 9c(1)(C) | | |
| , , | kpenses | | 9c(1)(D) | | |
| (E) Taxes | | | 9c(1)(E) | | |

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

79019

Specify nature of costs

10 Nonexperience-rated contracts:

Part III

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

9c(1)(F)

(F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier

retention of the contract or policy, other than reported in Part I, line 2 above, report amount......

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

2015

| | | | RISA section 103(a)(2). | Inis Fo | rm is Open to Public Inspection |
|---|-------------------|---|--|---------------------------------------|------------------------------------|
| For calendar plan year 20 | 15 or fiscal plar | year beginning 08/01/2015 | and en | iding 07/31/2016 | |
| A Name of plan THE DREES COMPANY | HEALTH CARE | EPLAN | | e-digit number (PN) | 501 |
| | | | | | |
| C Plan sponsor's name a THE DREES COMPANY | s shown on line | e 2a of Form 5500 | The state of the s | oyer Identification Number 0675670 | (EIN) |
| | | ing Insurance Contract C Individual contracts grouped as a | | | |
| 1 Coverage Information: | | | | | |
| (a) Name of insurance ca | | NCE COMPANY | | | |
| | (c) NAIC | (d) Contract or | (e) Approximate number of | Policy or o | contract year |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) From | (g) To |
| 35-0472300 | 65676 | 000010118636 | 448 | 09/01/2014 | 08/31/2015 |
| 2 Insurance fee and com descending order of the | | ation. Enter the total fees and total | commissions paid. List in line 3 | the agents, brokers, and o | other persons in |
| (a) Total a | amount of comr | | (b) To | otal amount of fees paid | |
| | | 5035 | | | |
| 3 Persons receiving com | missions and fe | ees. (Complete as many entries a | is needed to report all persons). | | |
| | | nd address of the agent, broker, o | or other person to whom commiss | ions or fees were paid | |
| BUSINESS BENEFITS INC | D. | SUITE 2 | ANDVIEW DRIVE 04 CHELL, KY 41017 | | |
| (b) Amount of sales ar | nd base | Fees | and other commissions paid | | |
| commissions pa | | (c) Amount | (d) Purpose | e | (e) Organization code |
| | 5035 | | 3 | | 3 |
| | (a) Name a | nd address of the agent, broker, o | or other person to whom commiss | ions or fees were paid | |
| | | • | | | |
| (b) Amount of sales ar | nd base | Fees | and other commissions paid | | |
| commissions pa | | (c) Amount | (d) Purpose | e | (e) Organization code |
| | | | | | |
| For Panerwork Reduction | n Act Notice a | nd OMB Control Numbers, see | the instructions for Form 5500 | | • |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| (a) Na | me and address of the agent, broke | r, or other person to whom commissions or fees were paid | |
|---|-------------------------------------|--|-----------------------|
| | - | · | |
| | | | |
| | | | |
| | | | |
| | | Fees and other commissions paid | |
| (b) Amount of sales and base | | | (e) Organization |
| commissions paid | (c) Amount | (d) Purpose | code |
| | | | |
| | | | |
| | | | |
| (a) No | me and address of the agent broke | r or other person to whom commissions or food were poid | |
| (a) Na | ine and address of the agent, broke | r, 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 | r, or other person to whom commissions or fees were paid | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | Fees and other commissions paid | 4.50 |
| (b) Amount of sales and base commissions paid | (c) Amount | (d) Purpose | (e) Organization code |
| confinissions paid | (C) Amount | (u) Fulpose | code |
| | | | |
| | | | |
| | | | |
| (a) Na | me and address of the agent, broke | r, or other person to whom commissions or fees were paid | |
| (2) | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| (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 | r, 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 |
| | (-) | 727 | |
| | | | |
| | | | |
| | | | |

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indiv | idual contracts w | ith each carrier may be treated | d as a unit for purposes of |
|---|-------|--|---------------------|---------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year | end | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year e | | | |
| _ | | 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 | | · DO | |
| | | 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, check | k here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in separ | ate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | ite participation g | juarantee | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | |
| | | , - | | | |
| | | | | | |
| | 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 | | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | . 7c(5) | | |
| | | • | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | <u></u> | |
| | | 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) | - (4) | | |
| | | • Chief (Specify Below) | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| Schedule A (Form 5500) 2015 | | Page 4 | <u>. </u> | |
|---|---|---------------|--|-------------------------|
| If more than one contract covers the same information may be combined for reporting the entire group of such individual contract. | e group of employees of the sam g purposes if such contracts are | experience-ra | ited as a unit. Where contrac | |
| Benefit and contract type (check all applicable box | es) | | | |
| a Health (other than dental or vision) | b Dental | C Vis | sion | d Life insurance |
| Temporary disability (accident and sickness) |) f X Long-term disability | g ∏ Su | pplemental unemployment | h Prescription drug |
| Stop loss (large deductible) | j HMO contract | = | O contract | I Indemnity contract |
| m ☐ Other (specify) ▶ | • 🗆 | | | |
| | | | | |
| Experience-rated contracts: | | | | |
| Premiums: (1) Amount received | | 9a(1) | | |
| (2) Increase (decrease) in amount due but unp | paid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium | reserve | 9a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | | 9a(4) | |
| b Benefit charges (1) Claims paid | | 9b(1) | | |
| (2) Increase (decrease) in claim reserves | | 9b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | | 9b(3) | |
| (4) Claims charged | | | 9b(4) | |
| c Remainder of premium: (1) Retention charges | (on an accrual basis) | | | |
| (A) Commissions | 9 | c(1)(A) | | |
| (B) Administrative service or other fees | 9 | c(1)(B) | | |
| (C) Other specific acquisition costs | 90 | c(1)(C) | | |

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

106903

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Part III

(D) Other expenses.....

(E) Taxes..... (F) Charges for risks or other contingencies.....

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(D)

9c(1)(E)

9c(1)(F)

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

2015

| r ension benefit dualanty oc | прогашон | | re required to provide the information (ERISA section 103(a)(2). | This Fo | This Form is Open to Public Inspection | | |
|--|------------------|--|--|--------------------------------|---|-----------------------|--|
| For calendar plan year 20 | 15 or fiscal pla | in year beginning 08/01/2015 | and | ending 07/31 | /2016 | | |
| A Name of plan THE DREES COMPANY | HEALTH CAR | E PLAN | | ree-digit an number (PN |) • | 501 | |
| C Plan sponsor's name a THE DREES COMPANY | | | 6 | ployer Identifica 1-0675670 | | | |
| on a separat | | ning Insurance Contract (Individual contracts grouped as a | | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance ca THE GUARDIAN LIFE INS | | MPANY OF AMERICA | | | | | |
| # N = N . | (c) NAIC | (d) Contract or | (e) Approximate number of | | Policy or c | ontract year | |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) | From | (g) To | |
| 13-5123390 | 64246 | 00471695 | 341 | 08/01/2015 | | 07/31/2016 | |
| 2 Insurance fee and complete descending order of the | | nation. Enter the total fees and total | al commissions paid. List in line | 3 the agents, b | orokers, and c | other persons in | |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| 6537 2870 | | | | | | | |
| 3 Persons receiving com | missions and f | fees. (Complete as many entries | as needed to report all persons) | | | | |
| | | and address of the agent, broker, | • | ssions or fees v | were paid | | |
| CORNERSTONE BROKG. | INS. SVCS. A | | LORENCE AVE INATI, OH 45206 | | | | |
| (b) Amount of sales ar | nd base | Fee | s and other commissions paid | | | | |
| commissions pai | | (c) Amount | (d) Purpose (e) Organization | | | | |
| | | 2870 PR | RINCIPAL PAYMENT AMOUNT | | | 3 | |
| | (a) Name a | and address of the agent, broker, | or other person to whom comm | ssions or fees v | were paid | | |
| BUSINESS BENEFITS INC | . | SUITE : | ANDVIEW DRIVE 204 CHELL, KY 41017 | | | | |
| (b) Amount of sales ar | | | s and other commissions paid | | | | |
| commissions pa | id | (c) Amount | (d) Purp | ose | | (e) Organization code | |
| | 6537 | | | | | 3 | |
| For Paperwork Reductio | n Act Notice a | and OMB Control Numbers, see | the instructions for Form 550 | 00. | 0-1 | | |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indiv | idual contracts w | ith each carrier may be treated | d as a unit for purposes of |
|---|-------|--|---------------------|---------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year | end | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year e | | | |
| _ | | 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 | | · DO | |
| | | 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, check | k here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in separ | ate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | ite participation g | juarantee | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | |
| | | , - | | | |
| | | | | | |
| | 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 | | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | . 7c(5) | | |
| | | • | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | <u></u> | |
| | | 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) | - (4) | | |
| | | • Chief (Specify Below) | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| | Schedule A (Form 5500) 2015 | | Pa | ge 4 | |
|------------|---|--|---------------|---------------------------------|-------------------------|
| rt III | Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v | oup of employees of the surposes if such contracts a | are experienc | e-rated as a unit. Where contra | |
| Benefit | and contract type (check all applicable boxes) | | | | |
| а | Health (other than dental or vision) | b Dental | cX | Vision | d Life insurance |
| е 🗍 | Temporary disability (accident and sickness) | f Long-term disabilit | у д 🗍 | Supplemental unemployment | h Prescription drug |
| | Stop loss (large deductible) | j HMO contract | , <u> </u> | PPO contract | I Indemnity contract |
| | Other (specify) VOLUNTARY CRITICAL ILL | - - | | | |
| 🔼 | Other (specify) F VOLONTARY ORTHOAL ILL | NEGO | | | |
| Experie | ence-rated contracts: | | | | |
| • | emiums: (1) Amount received | | 9a(1) | | |
| (2 |) Increase (decrease) in amount due but unpaid | | 9a(2) | | |
| (3 |) Increase (decrease) in unearned premium res | erve | 9a(3) | | |
| (4 |) Earned ((1) + (2) - (3)) | | | 9a(4) | |
| b B | enefit charges (1) Claims paid | | 9b(1) | | |
| (2 | Increase (decrease) in claim reserves | | 9b(2) | | |
| | Incurred claims (add (1) and (2)) | | | | , |
| (4 | Claims charged | | | 9b(4) | , |
| C R | emainder 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) | | |

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

68851

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Part III

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves

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

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

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

9c(1)(E)

9c(1)(F)

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

For calendar plan year 2015 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

07/31/2016

08/01/2015

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

| A Name of plan THE DREES COMPANY HEALTH CARE PLAN | | | B Three | e-digit number (PN) | 501 | | |
|---|-----------------|---|---|--|--------------------------|-----------------------|--|
| | | | | · | , , | | |
| C Plan sponsor's name a THE DREES COMPANY | s shown on line | 2a of Form 5500 | | D Employer Identification Number (EIN) 61-0675670 | | | |
| | | ing Insurance Contract (Individual contracts grouped as a | | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance ca UNITED HEALTHCARE IN | | MPANY | | | | | |
| (b) EIN | (c) NAIC | (d) Contract or | (e) Approximate nu persons covered a | | Policy or | contract year | |
| (D) EIN | code | identification number | policy or contract | | (f) From | (g) To | |
| 36-2739571 | 79413 | 214257 | 1021 | | 08/01/2015 | 07/31/2016 | |
| 2 Insurance fee and composite descending order of the | | tion. Enter the total fees and total | al commissions paid. Li | st in line 3 | the agents, brokers, and | other persons in | |
| (a) Total amount of commissions paid | | | (b) To | otal amount of fees paid | | | |
| 36814 54070 | | | | | | | |
| 3 Persons receiving com | missions and fe | es. (Complete as many entries | as needed to report all | persons). | | | |
| | | nd address of the agent, broker, | | n commiss | ions or fees were paid | | |
| BUSINESS BENEFITS INC | C. | SUITE : | ANDVIEW DRIVE 204 CHELL, KY 41017 | | | | |
| (b) Amount of sales ar | nd base | Fee | s and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | е | (e) Organization code | |
| | 36814 | 54070 SE | ERVICE FEE AGREEMI | ENT | | 3 | |
| | (a) Name a | nd address of the agent, broker, | or other person to whor | n commiss | ions or fees were paid | | |
| | | | | | | | |
| (b) Amount of sales ar | nd base | | s and other commission | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | e | (e) Organization code | |
| | | | | | | | |
| For Paperwork Reductio | n Act Notice a | nd OMB Control Numbers, see | the instructions for F | orm 5500. | <u> </u> | | |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indiv | idual contracts w | ith each carrier may be treated | d as a unit for purposes of |
|---|-------|--|---------------------|---------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year | end | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year e | | | |
| _ | | 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 | | · DO | |
| | | 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, check | k here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in separ | ate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | ite participation g | juarantee | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | |
| | | , - | | | |
| | | | | | |
| | 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 | | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | . 7c(5) | | |
| | | • | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | <u></u> | |
| | | 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) | - (4) | | |
| | | • Chief (Specify Below) | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| Schedule A (Form 5500) 2015 | | Page 4 | | |
|---|----------------------------------|-----------------------|------------------------|-------------------------|
| rt III Welfare Benefit Contract Information If more than one contract covers the same information may be combined for reporting the entire group of such individual contract. | e group of employees of the sar | e experience-rated as | a unit. Where contract | |
| Benefit and contract type (check all applicable box | (es) | | | |
| a X Health (other than dental or vision) | b Dental | C Vision | | d Life insurance |
| e Temporary disability (accident and sicknes | s) f Long-term disability | g Supplem | ental unemployment | h Prescription drug |
| i Stop loss (large deductible) | j HMO contract | k PPO con | itract | I Indemnity contract |
| m ☐ Other (specify) ▶ | , <u>.</u> | | | ь, |
| | | | | |
| Experience-rated contracts: | | | | |
| Premiums: (1) Amount received | | 9a(1) | | |
| (2) Increase (decrease) in amount due but ur | paid | 9a(2) | | |
| (3) Increase (decrease) in unearned premium | ı reserve | 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) | |
| c Remainder of premium: (1) Retention charge | s (on an accrual basis) | | | |
| (A) Commissions | g | 0c(1)(A) | | |
| (B) Administrative service or other fees | g | c(1)(B) | | |
| (C) Other specific acquisition costs | 9 | c(1)(C) | | |

9c(2)

9d(1) 9d(2)

9d(3)

9e

10a

10b

4854458

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

Part III

(D) Other expenses.....

(E) Taxes.....

(F) Charges for risks or other contingencies

(H) Total retention

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

(2) Claim reserves.....

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

Total premiums or subscription charges paid to carrier If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

| Part I | / Provision of Information | | | |
|--------------|---|-----|------|--|
| 11 Di | I the insurance company fail to provide any information necessary to complete Schedule A? | Yes | X No | |

9c(1)(D)

9c(1)(E)

9c(1)(F)

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

2015

| r ension benefit dualanty oc | Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2). | | | ation | This Fo | rm is Open to Public Inspection |
|--|--|--|---|-----------------------------------|-------------|------------------------------------|
| For calendar plan year 20 | 15 or fiscal pla | n year beginning 08/01/2015 | and e | ending 07/31/20 | 016 | |
| A Name of plan THE DREES COMPANY HEALTH CARE PLAN | | E PLAN | | ee-digit In number (PN) | • | 501 |
| C Plan sponsor's name a THE DREES COMPANY | | | 6 | loyer Identification 1-0675670 | | , |
| on a separat | | ning Insurance Contract (Individual contracts grouped as a | | | | |
| 1 Coverage Information: | | | | | | |
| (a) Name of insurance ca THE GUARDIAN LIFE INS | | MPANY OF AMERICA | | | | |
| # N = N . | (c) NAIC | (d) Contract or | (e) Approximate number of | | Policy or c | ontract year |
| (b) EIN | code | identification number | persons covered at end of policy or contract year | (f) Fro | om | (g) To |
| 13-5123390 | 64246 | 00362114 | 401 | 08/01/2015 | | 07/31/2016 |
| 2 Insurance fee and composite descending order of the | | ation. Enter the total fees and total | al commissions paid. List in line | 3 the agents, brok | kers, and c | other persons in |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | |
| 25572 1690 | | | | | | |
| 3 Persons receiving com | | ees. (Complete as many entries | | | | |
| CODMEDITONE PROVO | | and address of the agent, broker, | | ssions or fees wer | re paid | |
| CORNERSTONE BROKG. | INS. SVCS. A | | LORENCE AVE NATI, OH 45206 | | | |
| (b) Amount of sales ar | nd base | Fee | s and other commissions paid | | | |
| commissions pa | | (c) Amount | (d) Purpose | | | (e) Organization code |
| 1690 SPECIAL PRODUCER COMPENSATION 3 | | | | | 3 | |
| | (a) Name a | and address of the agent, broker, | or other person to whom commis | ssions or fees wer | re paid | |
| BUSINESS BENEFITS INC | . | SUITE : | ANDVIEW DRIVE 204 CHELL, KY 41017 | | | |
| (b) Amount of sales ar | nd base | Fee | s and other commissions paid | | | |
| commissions pa | | (c) Amount | (d) Purpo | se | | (e) Organization code |
| | 25572 | | | | | 3 |
| For Paperwork Reductio | n Act Notice a | and OMB Control Numbers, see | the instructions for Form 550 | 0. | | 1.1.4/5 5500) 0045 |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indiv | idual contracts w | ith each carrier may be treated | d as a unit for purposes of |
|---|-------|--|---------------------|---------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year | end | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year e | | | |
| _ | | 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 | | · DO | |
| | | 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, check | k here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in separ | ate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | ite participation g | juarantee | |
| | | (3) ☐ guaranteed investment (4) ☐ other ▶ | | | |
| | | , - | | | |
| | | | | | |
| | 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 | | | |
| | | (4) Transferred from separate account | 7c(4) | | |
| | | (5) Other (specify below) | . 7c(5) | | |
| | | • | | | |
| | | | | | |
| | | | | | |
| | | (6)Total additions | | <u></u> | |
| | | 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) | - (4) | | |
| | | • Chief (Specify Below) | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| Schedule A (Form 5500) 2015 | | Page 4 | | |
|---|---|------------------------|---------------------|-------------------------|
| rt III Welfare Benefit Contract Inform If more than one contract covers the same information may be combined for reporting the entire group of such individual contract | e group of employees of the same g purposes if such contracts are e | xperience-rated as a ι | unit. Where contrac | |
| Benefit and contract type (check all applicable box | es) | | | |
| a Health (other than dental or vision) | b X Dental | c Vision | | d Life insurance |
| e Temporary disability (accident and sickness |) f Long-term disability | g Supplement | al unemployment | h Prescription drug |
| Stop loss (large deductible) | j HMO contract | k PPO contrac | | I Indemnity contract |
| m ☐ Other (specify) ▶ | <i>,</i> ⊔ | Ш | | — , |
| | | | | |
| Experience-rated contracts: | | | | |
| Premiums: (1) Amount received | 9 | a(1) | | |
| (2) Increase (decrease) in amount due but unp | paid9 | a(2) | | |
| (3) Increase (decrease) in unearned premium | | a(3) | | |
| (4) Earned ((1) + (2) - (3)) | | | 9a(4) | |
| b Benefit charges (1) Claims paid | 9 | b(1) | | |
| (2) Increase (decrease) in claim reserves | | b(2) | | |
| (3) Incurred claims (add (1) and (2)) | | | 9b(3) | |
| (4) Claims charged | | | 9b(4) | |
| C Remainder of premium: (1) Retention charges | s (on an accrual basis) | | | |
| (A) Commissions | 90 | (1)(A) | | |
| (B) Administrative service or other fees | | (1)(B) | | |
| (C) Other specific acquisition costs | | (1)(C) | | |
| (D) Other avances | Qc/ | (1)(D) | | |

(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 (C) Other specific acquisition costs..... (D) Other expenses..... 9c(1)(E) (E) Taxes..... 9c(1)(F) (F) Charges for risks or other contingencies (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) 9d(2) (2) Claim reserves..... 9d(3) (3) Other reserves 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 50267 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 the insurance company fail to provide any information necessary to complete Schedule A?..... Yes No 12 If the answer to line 11 is "Yes," specify the information not provided.

Part III

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

2015

This Form is Open to Public

| pursuant to ERISA section 103(a)(2). Inspection | | | | | | | |
|--|-------------------|---|---|-----------------------|---------------------------|----------------|-----------------------|
| For calendar plan year 20 | 15 or fiscal plar | year beginning 08/01/2015 | | and en | ding 07/3 | 1/2016 | |
| A Name of plan THE DREES COMPANY HEALTH CARE PLAN | | | B Three | e-digit number (PN | l) • | 501 | |
| | | | | | | | |
| C Plan sponsor's name a THE DREES COMPANY | s shown on line | e 2a of Form 5500 | | | yer Identifica 0675670 | ation Number (| EIN) |
| | | ing Insurance Contract (Individual contracts grouped as a | | | | | |
| 1 Coverage Information: | | | | | | | |
| (a) Name of insurance ca THE LINCOLN NATIONAL | | NCE COMPANY | | | | | |
| (1.) FINI | (c) NAIC | (d) Contract or | (e) Approximate nu | | | Policy or co | ontract year |
| (b) EIN | code | identification number | persons covered at policy or contract | | (f) | From | (g) To |
| 35-0472300 | 65676 | 000010118635 | 531 | | 09/01/2014 | ļ | 08/31/2015 |
| 2 Insurance fee and com- descending order of the | | ation. Enter the total fees and tota | al commissions paid. Li | st in line 3 | the agents, | brokers, and o | ther persons in |
| (a) Total amount of commissions paid (b) Total amount of fees paid | | | | | | | |
| 3121 | | | | | | | |
| 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 commiss | ions or fees | were paid | |
| BUSINESS BENEFITS INC | D. | SUITE 2 | ANDVIEW DRIVE 204 CHELL, KY 41017 | | | | |
| (b) Amount of sales ar | nd base | Fee | s and other commissior | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | е | | (e) Organization code |
| 3121 | | | | | | | 3 |
| | (a) Name a | nd address of the agent, broker, | or other person to whor | n commiss | ions or fees | were paid | |
| | | | | | | , , , | |
| (b) Amount of sales ar | nd base | Fee | s and other commissior | ns paid | | | |
| commissions pa | | (c) Amount | | (d) Purpose | Э | | (e) Organization code |
| | | | | | | | |
| | A (NI 4) | LOND O 4 IN I | | | | | • |

| Page 2 - 1 | |
|-------------------|--|
|-------------------|--|

| _ | | |
|-----|---|---|
| ยวก | Δ | |
| uq | | • |

| P | art I | Where individual contracts are provided, the entire group of such indivi | dual contracts | with each carrier may be treated | d as a unit for purposes of |
|---|-------|--|------------------|----------------------------------|-----------------------------|
| 1 | Cur | this report. Tent value of plan's interest under this contract in the general account at year of the second secon | and | 4 | |
| | | rent value of plan's interest under this contract in the general accounts at year en | | | |
| _ | | tracts 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 | | . 00 | |
| | | 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 | ating plan, che | ck here | |
| 7 | Con | tracts With Unallocated Funds (Do not include portions of these contracts ma | intained in sep | arate accounts) | |
| | а | Type of contract: (1) deposit administration (2) immedia | te participation | guarantee | |
| | | (3) guaranteed investment (4) other | | | |
| | | _ | | | |
| | | | | | |
| | 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 | | <u>`_</u> `_ | |
| | | 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) | | |
| | | (3) Transferred to separate account | 7e(4) | | |
| | | (4) Other (specify below) | , , , , , | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | _ | (5) Total deductions | | | |
| | f | Balance at the end of the current year (subtract line 7e(5) from line 7d) | | 7f | |

| | | Schedule A (Form 5500) 2015 | | | Pa | ge 4 | | | |
|----|------------|---|-------------|-----------------------|--------------|------------------------|------------|----------|--------------------|
| Pa | rt III | Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts v | oup of | s if such contracts a | re experienc | e-rated as a unit. Whe | re contrac | | |
| 8 | Benefit | and contract type (check all applicable boxes) | | | | | | | |
| | а | Health (other than dental or vision) | b | Dental | С | Vision | | d X | Life insurance |
| | e 🗍 | Temporary disability (accident and sickness) | f \square | Long-term disability | , g | Supplemental unemp | oyment | h | Prescription drug |
| | i 🗖 | Stop loss (large deductible) | iΠ | HMO contract | k 🗆 | PPO contract | | ıĒ | Indemnity contract |
| | | Other (specify) ACCIDENTAL DEATH & DIS | MEM | | | | | <u> </u> | , |
| | 🔼 | Other (specify) Proofibertific bertific bic | /IVI _ IVI | DERWEIT | | | | | |
| 9 | Experie | ence-rated contracts: | | | | | | | |
| • | | emiums: (1) Amount received | | | 9a(1) | | | | |
| | |) Increase (decrease) in amount due but unpaid | | - | 9a(2) | | | | |
| | , , |) Increase (decrease) in unearned premium res | | | 9a(3) | | | | |
| | (4 |) Earned ((1) + (2) - (3)) | | | | | 9a(4) | | |
| | b B | enefit charges (1) Claims paid | | | 9b(1) | | | | |
| | (2) |) Increase (decrease) in claim reserves | | | 9b(2) | | | | |
| | |) Incurred claims (add (1) and (2)) | | _ | | | 9b(3) | | |
| | (4) |) Claims charged | | | | | 9b(4) | | |
| | C R | emainder of premium: (1) Retention charges (o | n an a | ccrual basis) | | | | | |
| | | (A) Commissions | | | 9c(1)(A) | | | | |
| | | (B) Administrative service or other fees | | | 9c(1)(B) | | | | |
| | | (C) Other specific acquisition costs | | <u> </u> | 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) | | | | |

9c(2)

9d(1)

9d(2)

9d(3)

9e

10a

10b

64050

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

10 Nonexperience-rated contracts:

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

(H) Total retention (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....

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

Total premiums or subscription charges paid to carrier

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

(2) Claim reserves

(3) Other reserves

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