Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CAPITAL EXCAVATION CAFETERIA PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2007

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

CAPITAL EXCAVATION COMPANY

CYNTHIA COX

PO BOX 1301
AUSTIN, TX 78767-1301

2967 BUSINESS PARK DR
BUDA, TX 78610

2b Employer Identification Number (EIN) 74-2330505

2c Plan Sponsor's telephone number 512-440-1717

2d Business code (see instructions) 237310

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/26/2017	CYNTHIA COX
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

Preparer's name (including firm name, if applicable) and address (include room or suite number)

CYNTHIA COX

CAPITAL EXCAVATION COMPANY

PO BOX 1301
AUSTIN, TX 78767

Preparer's telephone number 512-440-1717

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	**4b** EIN	
a Sponsor's name	**4c** PN	
5 Total number of participants at the beginning of the plan year	**5**	440
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	440
a(2) Total number of active participants at the end of the plan year	**6a(2)**	411
b Retired or separated participants receiving benefits	**6b**	1
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	412
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	412
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[X] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[ ] Trust	**(3)**	[ ] Trust
(4)	[ ] General assets of the sponsor	**(4)**	[ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] 4 **A** (Insurance Information)
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2016 Form M-1 annual report. If the plan was not required to file the 2016 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
CAPITAL EXCAVATION CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CAPITAL EXCAVATION COMPANY

D Employer Identification Number (EIN)
74-2330505

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
CIGNA HEALTH AND LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
59-1031071	67369	3339556	412	01/01/2016	12/31/2016

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
78869	8748

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MARSH & MCLENNAN AGENCY
8144 WALNUT HILL LANE 16TH FLOOR
DALLAS, TX 75231-4388

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
18417			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
MC & H LIFE AGENCY INC.
8144 WALNUT HILL LANE 16TH FLOOR
DALLAS, TX 75231-4388

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
	8748	SERVICE/GEN. AGENT FEES	3

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

MARSH & MCLENNAN AGENCY
8144 WALNUT HILL LANE 16TH FLOOR
DALLAS, TX 75231-4388

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
60452	0	INSURANCE AGENT OR BROKER	3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [X] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	170472		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	0		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**	0		
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	170472
b Benefit charges (1) Claims paid	**9b(1)**	275359		
(2) Increase (decrease) in claim reserves	**9b(2)**	181353		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	456712
(4) Claims charged			**9b(4)**	456712
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	60452		
(B) Administrative service or other fees	**9c(1)(B)**	0		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**	140953		
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**	915		
(H) Total retention			**9c(1)(H)**	202320
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	445805
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	0

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
CAPITAL EXCAVATION CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CAPITAL EXCAVATION COMPANY

D Employer Identification Number (EIN)
74-2330505

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	KM05756199	648	01/01/2016	12/31/2016

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
11916	1323

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

MARSH & MCLENNAN
2500 PEHLE AVE STE 400
PARK 80 PLAZA 2
SADDLE, NJ 07663-5832

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	1283	SUPPLEMENTAL COMPENSATION	3

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

MARSH & MCLENNAN AGENCY LLC
2500 CITY WEST BLVD., STE 2400
HOUSTON, TX 77042-3031

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11916	40	BASE COMMISSIONS/NON-MONETARY COMPENSATION	3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	0
c	Premiums due but unpaid at the end of the year	**6c**	0
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below) ▶	**7c(5)**			
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	0		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	118000
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

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 [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
CAPITAL EXCAVATION CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CAPITAL EXCAVATION COMPANY

D Employer Identification Number (EIN)
74-2330505

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
RELIANCE STANDARD LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
36-0883760	68381	VG180106	15	01/01/2016	12/31/2016

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
807	79

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

MARSH & MCLENNAN AGENCY LLC
WALNUT GLEN TOWER
8144 WALNUT HILL LANE 16TH FLOOR
DALLAS, TX 75231

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
807	79		3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	0
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	8075
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 2016 or fiscal plan year beginning 01/01/2016 and ending 12/31/2016

A Name of plan
CAPITAL EXCAVATION CAFETERIA PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CAPITAL EXCAVATION COMPANY

D Employer Identification Number (EIN)
74-2330505

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
RELIANCE STANDARD INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
36-0883760	68381	GL 141714	341	01/01/2016	12/31/2016

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
5693	338

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

MARSH & MCLENNAN AGENCY LLC
WALNUT GLEN TOWER
8144 WALNUT HILL LANE 16TH FLOOR
DALLAS, TX 75231

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5693	338	GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	37951
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

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 [X] No

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

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Cigna.

Schedule A Insurance Information

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	CAPITAL EXCAVATION	B. Three-Digit Plan Number (PN):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information — (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or Identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From (g) Through
59-1031071	67369	3339556	412 Persons	01/01/2016 - 12/31/2016

2. Insurance fees and commissions information. Enter total fees and commissions paid.

(a) Total amount of commissions paid	78,869		(b) Total amount of fees paid	8,748	
3. Persons receiving commissions and fees. (a) Name and address of the agent, broker or other person to whom commissions or fees were paid		(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount*	(d) Purpose* *Refer to footnotes for incentive SS amounts and purpose as applicable	(e) Organization code
Experience-Rated					
MARSH & MCLENNAN AGENCY / DALLAS, TX		60,452	0		3-Insurance Agent or Broker
MC & H LIFE AGENCY INC / DALLAS, TX		0	8,748	Service/Gen Agent Fees	
Non Experience-Rated					
MARSH & MCLENNAN AGENCY / DALLAS, TX		18,417	0		

Outstanding Monies Due $ 0 — Contract or Identification Number same as 1d

PART III Welfare Benefit Contract Information:

8. Benefit and contract type

- [■] (a) Health (other than dental or vision)
- [ ] (b) Dental
- [ ] (c) Vision
- [ ] (d) Life Insurance
- [ ] (e) Temporary disability (accident and sickness)
- [ ] (f) Long-term disability
- [ ] (g) Supplemental unemployment
- [■] (h) Prescription Drug
- [ ] (i) Stop loss (large deductible)
- [ ] (j) HMO Contract
- [ ] (k) PPO contract
- [■] (l) Indemnity Contract
- [ ] (m) Other (Prepaid Dental)

9. Experience-Rated Contracts

(a) Premiums	(1) Amount received	170,472	
	(2) Increase (decrease) in amount due but unpaid		
	Premium Due as of 03/30/2017	0	
	Retrospective Premium or Bank Account Margin Due	0	
	(4) Earned, ((1) + (2) = (4))		170,472
(b) Benefit charges	(1) Claims Paid	275,359	
	(2) Increase (decrease) in claim reserves	181,353	
	(3) Incurred claims, (add (1) and (2))	456,712	
	(4) Claims charged		456,712
(c) Remainder of premium	(1) Retention charges (on an accrual basis)		
	(A) Contracted Commissions	60,452	
	(B) Administrative service or other fees	0	
	(D) Other Expenses	140,953	
	(E) Taxes (Approx)	915	
	(H) Total retention		202,320
	(2) Dividends or retroactive rate refunds (these amounts were 1) paid in cash)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to Premium Stabilization Reserve)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to other reserves)		0
	Dividends or retroactive rate refunds (these amounts were 2) credited to accumulated deficits)		0
	Deficits arising from experience in current policy reporting year		275,359
	Accumulated deficits arising from experience in current and previous policy reporting years		275,359
(d) Status of policyholder reserves at end of year	(2) Claim reserves		181,353
	(3) Other reserves (Premium Stabilization Reserve)		0
	Other reserves		0
(e) Dividends or retroactive rate refunds due. (Do not include amount entered in 9c(2).)			0
from [ ] Premium Stabilization Reserve [ ] Other Reserves			
to [ ] Credited to policy year premium [ ] Credited to offset deficit [ ] Paid in cash			

10. Non-Experience Rated Contracts	(a) Total Premiums or subscriptions charges paid to carrier	445,805
	Premium Due as of 03/30/2017	0
	(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 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. Not Applicable

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: You may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Cigna Health and Life Insurance Company
A Cigna Company
Hartford, CT 06152

Schedule A Insurance Information Footnotes

Information Required for Completion of Form 5500 Schedule A by Plan Sponsor or Administrator

A. Plan Name:	CAPITAL EXCAVATION	B. Three-Digit Plan Number (PN):	Plan will provide
C. Plan Sponsor's Name:	Plan will provide	D. Company Identification Number:	Plan will provide

PART I Information Concerning Insurance Contract Coverage, Fees and Commissions (Summary of All Insurance Contracts Included in Part III)

1. Coverage Information (a) Name of insurance carrier: Cigna Health and Life Insurance Company and affiliates ("Cigna")

(b) EIN	(c) NAIC Code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract period	Policy or contract year (f) From	(g) Through
59-1031071	67369	3339556	412 Persons	01/01/2016	12/31/2016

(Part I, line 1a) "Name of Insurance Carrier", (b) "EIN", (c) "NAIC Code" - The plan to which this report applies may be funded by contracts issued by more than one Cigna company each of which is an "insurance carrier." The issuance of multiple insurance carrier contracts is necessary to cover individuals who participate in the same plan but reside in different geographic locations. As the Cigna companies whose contracts fund the plan are grouped as a single unit by Cigna for purposes of underwriting the plan, combining the information with respect to these individual contracts in this report will provide more meaningful insurance information for the Schedule A. The individual contracts of the Cigna companies are grouped as a unit for purposes of this report. To reference individual contracts refer to the Appendix pages contained within this reporting package.

(Part I, line 1e) Schedule A subscriber/employee/participant and persons/members information is available for your contract policy year on the employer portal at www.cignaaccess.com, report titled, Subscriber and Membership Reporting.

(Part I, line 2a, 2b, 3b and/or 3c) Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

(Part I, line 2a, 2b) The following amounts were paid to your broker(s) / consultant(s) during the contract year:
Commissions: $78,869
Service/Gen.Agent Fees: $0

(Part I, line 3c) Incentive compensation payments based upon persons/members in your plan and/or lump sum amount: $8,748 (Broker, Service Provider and/or General Agents combined) attributable to your plan for the 2016 calendar year. These amounts are funded from Cigna's companies general overhead. Contact your broker/consultant for further details.

(Line 9.b.1) May include pay for performance payments to providers, vendor cost-containment, administrative and care coordination fees.

(Line 10.a) May reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

(Line 10.a) May include adjustment amounts attributable to another Cigna company whose coverage may have previously terminated.

- In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services.In addition, Cigna offers agents/ broker the opportunity to receive the benefit of Cigna's favorable pricing with vendors of various goods and services. Contact your agent/ broker for specific information about their participation.
- If the contract is a minimum premium insurance policy issued by Cigna, the "claims paid" are identified in the Bank Account Reconciliation Report for the last month of the contract year. Fees reported in Section 9 do not include fees paid to all overpayment recovery vendors based upon a percentage of recoveries.
- Certain non-claim fees paid from your benefit payment account are included as claims in your settlement but not included as claims in the ERISA Form 5500 Schedule A report (provided to ERISA plans) and the Annual Reconciliation Disclosure (provided to non-ERISA plans). As a result there may be a discrepancy between the amount of claims reflected in your settlement and on the Schedule A and Annual Reconciliation Document. A report to reconcile this discrepancy is available upon request.
- The deficit / margin is calculated including "PREMIUMS DUE BUT UNPAID".
- The contract holder is not entitled to a return of any premium or other payment made to a Cigna company unless the Cigna company has otherwise agreed in writing. The Cigna companies may use payments received for any purpose in their sole discretion.
- If the contract holder is a Public Entity located in California, you are asked to forward this report to the governing board.
- The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid and credited for any prior plan year.
- Premium also includes taxes, fees and assessments imposed under the federal Patient Protection and Affordable Care Act.
- Does not include value-based payments made to entities not contracted as participating providers.
- Premium and commission associated with insurance coverage for an Employee Assistance Plan, if applicable, is included in this report.

Official Use Only

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2016

This Form is Open to Public Inspection.

For calendar plan year 2016 or fiscal plan year beginning **01/01/2016** , and ending **12/31/2016**

A Name of plan	B Three digit plan number ▶	
C Plan sponsor's name as shown on line 2a of Form 5500 **CAPITAL EXCAVATION COMPANY**	D Employer Identification Number	

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	Policy or contract year (g) To
13-5581829	65978	KM05756199	648	01/01/2016	12/31/2016

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
11,916	1,323

00220006860000000000KM05756199

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: MARSH & MCLENNAN AGENCY LLC

Address: 2500 CITYWEST BLVD STE 2400 City: HOUSTON ST: TX ZIP: 77042-3031

Commissions Paid			Fees Paid			Organization code
Coverage	**Amount**	**Purpose**	**Coverage**	**Amount**	**Purpose**	
Dental	11,916	Base Commissions	Multiple	40	Non-Monetary Compensation	03
	11,916	**Sub-total**		40	**Sub-total**	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: MARSH & MCLENNAN

Address: 250 PEHLE AVE STE 400 PARK 80 PLAZA 2 City: SADDLE BROOK ST: NJ ZIP: 07663-5832

Commissions Paid			Fees Paid			Organization code
Coverage	**Amount**	**Purpose**	**Coverage**	**Amount**	**Purpose**	
			Dental	1,283	Supplemental Compensation	03
	0	**Sub-total**		1,283	**Sub-total**	

00220006870000000000KM057561990

Official Use Only

Part III **Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

a ☐	Health (other than dental or vision)	**b** ☒	Dental	**c** ☐	Vision	**d** ☐	Life Insurance
e ☐	Temporary disability (accident & sickness)	**f** ☐	Long-term disability	**g** ☐	Supplemental unemployment	**h** ☐	Prescription drug
i ☐	Stop Loss (large deductible)	**j** ☐	HMO contract	**k** ☐	PPO contract	**l** ☐	Indemnity contract
m ☐	Other (specify) ▶						

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts

	Coverage	Amount
	Dental	118,000
a Total premiums or subscription charges paid to carrier		118,000
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		

Specify nature of costs below ▶

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

00220006880000000000KM057561991

Metropolitan Life Insurance Company
Sales & Broker Compensation Services
501 U.S. Highway 22, 2nd Floor - West
Bridgewater, NJ 08807

MetLife®

03/08/2017

RECEIVED
MAR 16 2017
CAPITAL EXCAVATION CO.

00220
ATTENTION: JOHN PUGSLEY
CAPITAL EXCAVATION COMPANY
2967 BUSINESS PARK DRIVE
BUDA, TX 78610

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The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than $10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

June 9, 2017

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

CAPITAL EXCAVATION COMPANY
PO Box 1301
P.O. BOX 1301
Austin, TX 78767

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: Capital Excavation Company
Policy Number: GL 141714
Policy Type: GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT
Number of Covered Employees: 341
Policy Contract Year: 1/1/2016 to 12/31/2016

		PREMIUM					
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Basic AD&D	$5,920.50	0.0300	01/15	0.0300	01/07	0.0000	00/00
Basic Life	$30,589.31	0.1550	01/15	0.1550	01/07	0.0000	00/00
Dependent Life	$1,441.25	0.9999	00/00	1.2500	01/15	0.0000	00/00
Total Premium:	**$37,951.06**						

AGENT COMPENSATION

Agent Code: 12-0235
Agent Name: Marsh & McLennan Agency LLC
Agent Address: Walnut Glen Tower
8144 Walnut Hill Lane 16th Floor
Dallas, TX 75231

Total Commission: $5,692.65
Total Administrative and Other Fees: $337.65
Total Amount of Compensation: $6,030.30

RGO: DALLAS

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

June 9, 2017

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

(1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

As it appears your plan is subject to the Act, the data on the enclosed form is provided for your assistance in completing your annual report. By supplying this information it is not our intent to advise you as to your legal obligations under the act, nor do we wish to imply that this information constitutes all of the data to be included in our annual report.

If you expect to file an annual report, you would normally receive a complete copy of form 5500 and Schedule A from the Department of Labor, with all necessary instructions, prior to the filing date. Follow the instructions carefully. If you or your legal counsel have questions, please contact The Labor-Management Services Administration Office at the Department of Labor.

(2) Section 104(B) of ERISA requires a plan administrator who must file an annual report to also furnish a Summary Annual Report to each plan participant and beneficiary within 9 months of the end of your plan year and without charge.

The Summary Annual Report should include the following information:

1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
   a. The name and address of any employer having employees covered by the plan; or
   b. The name and address of any labor organization maintaining the plan; or
   c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

June 9, 2017

INSURANCE INFORMATION
FORM 5500 - SCHEDULE A

CAPITAL EXCAVATION COMPANY
PO Box 1301
3901 S. LAMAR
Austin, TX 78767

EIN: 36-0883760
NAIC: 68381
ORG. NUMBER: 3

Policyholder Name: Capital Excavation Company
Policy Number: VG 180106
Policy Type: VOLUNTARY GROUP TERM LIFE
Number of Covered Employees: 15
Policy Contract Year: 1/1/2016 to 12/31/2016

	PREMIUM						
Benefits	**Premium**	**Rate 1**	**Eff**	**Rate 2**	**Eff**	**Rate 3**	**Eff**
Basic Life	$6,247.52	0.9999	00/00	0.0000	00/00	0.0000	00/00
Dependent Life	$1,827.66	0.9999	00/00	0.0000	00/00	0.0000	00/00
Total Premium:	**$8,075.18**						

AGENT COMPENSATION

Agent Code: 12-0235
Agent Name: Marsh & McLennan Agency LLC
Agent Address: Walnut Glen Tower
8144 Walnut Hill Lane 16th Floor
Dallas, TX 75231

Total Commission: $807.46
Total Administrative and Other Fees: $78.73
Total Amount of Compensation: $886.19

RGO: DALLAS

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

June 9, 2017

TO OUR GROUP POLICYHOLDERS WITH 100 OR MORE PLAN PARTICIPANTS

RE: EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)
(1) ANNUAL REPORT OF WELFARE BENEFIT PLAN - FORM 5500
(2) SUMMARY ANNUAL REPORT

(1) Section 104 of ERISA requires that each Plan Administrator who maintains a welfare benefit Plan subject to ERISA having 100 or more participants at any time during the plan year must file an annual report with the Department of Labor. The report must be filed within 7 months of the end of the plan year. Certain failures are provided for failure to comply.

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1. The name of the plan as determined by your Plan Document and, if different, the name by which the plan is commonly known to its participants and beneficiaries; and
2. The name and business address (do not use P.O. Box number) of the Plan Sponsor (usually the employer to whom the policy was issued). However, if different, show:
   a. The name and address of any employer having employees covered by the plan; or
   b. The name and address of any labor organization maintaining the plan; or
   c. In case of a plan established or maintained by two or more employers or by one or more employers and one or more employee organizations, the name and address of the association, committee, joint board of trustees, parent, or most significant employer of a group of employees contributing to the same plan; and
3. The name, business address, (do not use P.O. Box number) and business telephone number of the Plan Administrator; and
4. A statement of assets and liabilities stated at current value; and
5. Separate or combined statements of income and expenses and changes in net assets; and
6. Such other materials as are necessary to fairly summarize the Annual Report.
7. A notice which says, for example: Plan participants and beneficiaries may obtain copies of the Annual Report filed with the Department of Labor by making a written request to the Plan Administrator. A reasonable charge will be made; or you may inspect the report without charge at the office of (give name and address, usually the Plan Administrators; or if the plan covers participants at various locations, you may be required to have a copy available at each location. If so, list the locations).

The above information with respect to the contents of the Summary Annual Report is based on our interpretation of the Act. It is not our intention to advise you as to your obligations regarding compliance under the Act. We suggest that you consult with your own legal counsel and discuss the requirements before any action is taken.

Customer Service
1-800-644-1103