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:
- [X] Form 5558
- [X] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan
PORT-A-COOL, LLC INSURANCE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2008

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)

PORT-A-COOL, LLC

711 FM 2468
CENTER, TX 75935

2b Employer Identification Number (EIN)
20-5726218

2c Plan Sponsor's telephone number
936-598-5651

2d Business code (see instructions)
335900

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.	10/02/2017	ROB KENNEDY
	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)

JIMMY FORD, P.C., CPA

AXLEY & RODE, LLP

1307 S 1ST ST
LUFKIN, TX 75901-4717

Preparer's telephone number
936-634-6621

3a Plan administrator's name and address ☐ Same as Plan Sponsor

PORT-A-COOL, LLC

711 FM 2468
CENTER, TX 75935

3b Administrator's EIN
20-5726218

3c Administrator's telephone number
936-598-5651

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:

a Sponsor's name

4b EIN

4c PN

5	Total number of participants at the beginning of the plan year	**5**	464
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)**	464
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	474
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	474
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	474
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 4E 4F 4H 4Q

9a Plan funding arrangement (check all that apply)

- **(1)** ☐ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(4)** ☒ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** ☒ Insurance
- **(2)** ☐ Code section 412(e)(3) insurance contracts
- **(3)** ☐ Trust
- **(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)** ☒ 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
PORT-A-COOL, LLC INSURANCE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PORT-A-COOL, LLC

D Employer Identification Number (EIN)
20-5726218

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
VISION SERVICE PLAN

(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
06-1227840	39616	30011696	142	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
1421	

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

WELLS FARGO INS SVCS USA INC
PO BOX 203383
DALLAS, TX 75320-3381

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1421			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** [X] 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)**			
(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**	30669
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
PORT-A-COOL, LLC INSURANCE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PORT-A-COOL, LLC

D Employer Identification Number (EIN)
20-5726218

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
BLUE CROSS BLUE SHIELD OF TEXAS

(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
36-1236610	70670	10940	474	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
42020	

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

WELLS FARGO INSURANCE
P O BOX 983
HOUSTON, TX 77001-0983

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
42020			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** [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** [ ] 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)**	1482104		
(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)**	1482104
b Benefit charges (1) Claims paid	**9b(1)**	1253864		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	1253864
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	42020		
(B) Administrative service or other fees	**9c(1)(B)**	186220		
(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)**	228240
(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**	337973
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
PORT-A-COOL, LLC INSURANCE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PORT-A-COOL, LLC

D Employer Identification Number (EIN)
20-5726218

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
THE LINCOLN NATIONAL LIFE INSURANCE CO

(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
35-0472300	65676	00001D015699	265	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
16298	592

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

WELLS FARGO INS SVCS USA INC
PO BOX 203383
DALLAS, TX 75320-3381

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
16298			3

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

WELLS FARGO INS SVCS USA INC
PO BOX 30001
TAMPA, FL 33601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	592	BROKER BONUS	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**	
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** [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)**			
(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**	162975
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
PORT-A-COOL, LLC INSURANCE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
PORT-A-COOL, LLC

D Employer Identification Number (EIN)
20-5726218

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
DEARBORN NATIONAL 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
36-2598882	71129	F014510	347	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
28154	284

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

WELLS FARGO INS SVCS USA TX
24 GREENWAY PLAZA 1100
HOUSTON, TX 77046

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
28154	284	ADDITIONAL 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	

(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** [X] Temporary disability (accident and sickness)
- **f** [X] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [X] Other (specify) ▶ ADD, ADDSUP1,C,S, DEPSUPC,S, LIFSUP

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**	196770
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 C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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 (PN) ▶	
PORT-A-COOL, LLC INSURANCE PLAN		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
PORT-A-COOL, LLC	20-5726218	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . [X] Yes [ ] No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

HEALTH CARE SERVICE CORPORATION

36-1236610

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

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

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

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

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

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

(a) Enter name and EIN or address (see instructions)

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

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received $1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

(a) Enter name and EIN or address of service provider (see instructions)	**(b)** Nature of Service Code(s)	**(c)** Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

a Name:	**b** EIN:
c Position:	
d Address:	**e** Telephone:

Explanation:

FORM 5500 SUPPLEMENTAL INFORMATION REPORT

Date: 2/20/17
Group Customer Name: PORTACOOL, LLC
Account Number: 010940
Reporting Period: 2016

HCSC:
FEIN (Federal Employer Identification Number): 36 – 1236610
NAIC Company Code: 70670

Table of Indirect Non-monetary Compensation

Provided By:	Estimated Value:*	Purpose:	Provided To:	Address: Line 1	Address: Line 2	City	State:	Zip:
HCSC	$ 28.73	Miscellaneous gifts, meals, entertainment and meetings	PORTACOOL, LLC	P.O. BOX 2167		CENTER	TX	75935 2167
HCSC	$ 38.42	Miscellaneous gifts, meals, entertainment and meetings	WELLS FARGO INS SERVICES USA INC	P. O. Box 203383		Dallas	TX	75320 3383

*The non-monetary compensation in the form of meals, entertainment, gifts and meetings provided by Health Care Service Corporation including Dental Network of America, Inc. to Group Customers and Producers in relation to Group Customer business was estimated as the sum of:

1) The 2016 calendar year expenses provided by Dental Network of America to that Group Customer or a Producer associated with that Group Customer. Producer expenses that relate to the Producer's total Group Customer business were allocated based on the weighted amount that the Group Customer's number of subscribers represented to the Producer's total Group Customer business number of subscribers. Any amounts provided by Dental Networks of America, Inc. were added to the HCSC estimate described below.

2) The 2016 calendar year expenses provided by HCSC. Expenses with unit values greater than or equal to $10 for meals, entertainment, gifts, and meetings were allocated to Group Customers and Producers based on the type of recipient and split by line of business (small group, large group, national accounts, government, etc.). For each line of business the expense amount was divided by the total number of subscribers to develop a Group Customer and Producer estimate factor. The estimate factor was then multiplied by the number of subscribers for each Group Customer to determine the estimated non-monetary compensation provided by HCSC to the Group Customer and the Producers associated with that Group Customer. In the event that more than one Producer was associated with the Group Customer during the calendar year, the Producer estimate amount was equally allocated to each Producer when the producers were active for the same number of subscriber months. For expenses where the recipient type was unknown, they were prorated between Group Customer and Producer based on the resulting allocation of expenses where the recipient type was known.

Meetings with a unit value per attendee that exceeded $500 for Group Customers were considered of high value and evaluated separately for purposes of the estimate factors. These expenses were reviewed to determine the specific Group Customer to which the expense related and added to that specific Group Customer's estimate. Meals, entertainment, and gifts with a unit value per recipient that exceeded $350 for Group Customers were considered of high value and evaluated separately for purposes of the estimate factors. These expenses were reviewed to determine the specific Group Customer to which the expense related and was added to that specific Group Customer's estimate.

PLEASE NOTE: The amounts allocated above may be more or less than the amount actually provided and, in fact, the amount of indirect non-monetary compensation actually provided to the Group Customer or Producer could be as little as $0.00.



BlueCross BlueShield of Texas

HCSC EIN # 36 – 1236610

Date: February 20, 2017

PORTACOOL, LLC
P.O. BOX 2167
CENTER , TX 759352167

ATTN: LAURIE KING

RE:	ERISA Disclosure Information Report
Reporting Period:	2016
Account Number:	010940

The 2016 ERISA Disclosure Information Report attached to this letter discusses information relating to the Form 5500 regulations promulgated under the Employee Retirement Income Security Act of 1974 (ERISA Form 5500 regulations) as well as the proposed 408(b)(2) service provider regulations.

Because both sets of regulations have a complex disclosure component, we have been and are continuing to conduct an internal assessment of information that is available to you about Health Care Service Corporation (HCSC)*, our corporate structure and the companies we use to help us deliver services to our group health customers. Historically, information has been made available to you through various avenues, such as marketing materials, websites, RFPs, contracts, reports, correspondence and various communications. As a result of our efforts, we are pleased to provide the attached detailed 2016 ERISA Disclosure Information. While some of this information has already been made available through various avenues mentioned above, additional detail may have been added in response to the ERISA regulations. In particular, we have included detailed information that we believe meets the requirements for "Eligible Indirect Compensation Disclosures" for certain services. We are providing this information because a plan sponsor's reporting requirements for Schedule C are streamlined for "Eligible Indirect Compensation (EIC)." Please note that amounts that are EIC are not included in HCSC's Form 5500 Supplemental Information Report which is also included in this packet. HCSC's Form 5500 Information Report that you have received in previous years has not changed.

You may find it appropriate to pass the attached Disclosure Information along to the person or department responsible for completing your company's tax reporting obligations.

If you have any questions about the Disclosure Information, please contact your Blue Cross and Blue Shield of Texas Account Representative.

2016 ERISA Disclosure Information Report
Provided By Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)
300 East Randolph Street; Chicago, Illinois 60601
EIN # 36 – 1236610

HCSC operates through its Blue Cross and Blue Shield plans in Illinois (BCBSIL), New Mexico (BCBSNM), Oklahoma (BCBSOK), Texas (BCBSTX), and Montana (BCBSMT), and several subsidiaries to offer a variety of health and life insurance products and related services to group customers and individuals. Information about the operations and financial relationships of HCSC and its affiliates and subsidiaries is available through many sources, such as:
Home Page -- http://www.hcsc.com/index.html
Affiliates and Subsidiaries – http://www.hcsc.com/affiliates.html
Financial Statements – http://www.hcsc.com/financial.html
Newsroom -- http://www.hcsc.com/newsroom.html
Blue Cross and Blue Shield Association – http://www.bcbs.com/
Corporate Social Responsibility -- http://www.hcsc.com/social_responsibility.html

Eligible indirect compensation ("EIC") that has been or is likely to be received by HCSC and certain of HCSC's vendors in connection with services provided by HCSC to our self-funded group customers for calendar year 2016 is listed below. Please note EIC includes amounts that are not necessarily passed on to our group customers or to members. The financial terms of the services provided by HCSC to our group customers, and additional details about the services, are described in the existing group customer's administrative services agreement(s) and insurance policies with HCSC and/or in other materials we may provide from time-to-time.

The following Disclosure Information is supplemental to, and does not take the place of, any information previously provided to our group customers. Important additional information about separate financial relationships and fees is provided in the administrative services agreement(s) and insurance policies between HCSC and our group customers. Additional information about these types of fees, the amount of these fees and the sources of these fees is available upon request.

Please Note: Not all of the following Disclosure Information will be applicable to every group customer, and not all groups are subject to Schedule C reporting. For groups not subject to Schedule C reporting, this Disclosure Information is provided for informational purposes only. For insured business, the financial arrangements below are taken into account when HCSC calculates insured group premiums, unless indicated otherwise.

Group customers should contact their Blue Cross and Blue Shield of Illinois, New Mexico, Oklahoma, or Texas Account Representative if they have questions related to a unique arrangement with us. Group customers should also consult with their own legal and other advisors.

HCSC Compensation

1. ***Separate Financial Arrangements with Providers; ADP*** -- In Illinois, HCSC's compensation for the services under its administrative services agreement(s) with certain group customers can include the difference, if any, between the net claim payments reimbursed to HCSC by the group customer and the net amounts paid to health care providers by HCSC, after giving effect to HCSC's separate financial arrangements with health care providers. Currently, these differences may arise through the use of HCSC's Average Discount Price ("ADP"). "ADP" means a percentage discount determined by HCSC, which varies from claim to claim. The ADP reflects HCSC's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with hospitals and other facilities under circumstances similar to those involved in the particular claim, reduced by an amount, not to exceed fifteen percent (15%) of such estimate, to reflect related lost investment earnings and costs (the amount of the reduction is referred to as the "planned retention"). Although the maximum planned retention can be up to 15%, the planned retention is often much lower and will vary from year to year, as more fully described below.

In Illinois, HCSC has negotiated with participating facility providers to pay the providers full billed charges of their claims upfront, and then recover from the providers the actual contractual savings at a later date. In that situation, HCSC has lost the opportunity to invest and earn interest on the amount it advances to the provider. HCSC retains a small percentage of the contractual savings for administrative expense and lost investment income, which is captured in the reduced ADP amounts credited to the group customer. This is because the value of the discount is made immediately available to the group members even though HCSC recovers the actual savings from the provider months later. The planned retention is the sum of the interest rate (prime rate determined at beginning of each quarter) times the collection lag (2/12 months for PPO; 15/12 months for non-PPO), and a flat charge of 0.45% for administration. So if the prime rate is 3%, then the retention is approximately 1.0%.

The group's liability to HCSC for certain facility claims payment is calculated, in part, based on ADP instead of the actual savings from the contract that HCSC has negotiated with the facility. The difference between the actual discounts and ADPs for any given group customer will vary, depending on the health care services received by the group's members, and can be positive or negative. An estimate of the difference can be calculated by multiplying the Estimated Provider Recoveries Percentage (published quarterly by HCSC) by the group customer's covered charges (provided by HCSC on the monthly invoices to group customers) and then subtracting the ADPs (also on the monthly invoices).

2. ***Financial Arrangements with Recovery Vendor*** -- If HCSC provides recovery-related services to its self-funded group customers, the fees are set forth in its administrative services agreement(s) with the group customer. HCSC has contracted with Equian LLC to furnish certain recovery-related services to HCSC such as the leasing of case management software, case identification/investigation service and the transfer of recovery cases to be managed by Equian LLC upon the request of HCSC.

a. Case Identification/Investigation Service. HCSC pays Equian LLC a fee of up to $7.52 for each case that Equian LLC investigates and identifies as a recovery matter.
b. Case Management. The standard administrative fee retained by HCSC is a maximum of 25% of the gross recovery and may be more specifically described in the administrative services agreement(s) with the group customer. In the event Equian LLC manages the case at the request of HCSC, Equian LLC remits the entire gross recovery to HCSC and submits an invoice (in the amount of between 20% -30% of the gross recovery) that is paid by HCSC. HCSC will retain (or absorb) any difference between the fee paid by the group customer to HCSC, and the fee paid by HCSC to Equian LLC, as compensation (or shortfall) for HCSC's services. For 2016, HCSC absorbed a shortfall.
c. Case Management Software. HCSC leases a recovery case management software system from Equian LLC for a per/member/per/year charge of $0.15 for the first 10 million lives, then $.10 for up to 15 million lives, $.08 for between 15-20 million lives, and $.05 for over 20 million lives.

3. Financial Arrangements with Pharmacies and PBMs -- Expected Rebate amounts are passed back to our self-funded and cost-plus group customers with 100% of the Expected Rebate applied as a Rebate Credit on the monthly billing statement calculated on a per employee per month basis. Based upon HCSC's previous experience with retail and mail order rebates per brand prescription for HCSC's overall commercial business in the applicable state for the prior calendar year (Prior Year's Total Brand Rebates), HCSC projects the average dollar amount of rebates per prescription for each of those group customers (Rebate Factor). One-hundred percent (100%) of the Expected Rebate is shared with the group customers and is projected based upon the Prior Year's Total Brand Rebates, the group customer's benefit design for the

upcoming plan year, the historic retail and mail order usage rates of the members, and the demographics of the members. The Expected Rebate passed back to the group customer is determined by multiplying the Rebate Factor projected for the group customer for the upcoming contract year times the projected number of prescriptions dispensed for members for the upcoming contract year, then divided by the expected number of employees, then divided by twelve (12) months. The Rebate Credits are fixed amounts, paid prospectively to the group customers without the extended delays that normally occur with billing and collection of actual rebates from pharmaceutical manufacturers. Although no true-up is done at the end of group's contract period, the re-calculation of the Expected Rebate for the renewal period takes into account the prior period's actual demographics, utilization, and aggregate rebates and interest earnings. The Rebate Credits do not continue if the group customer terminates.

The actual rebates are collected by HCSC's pharmacy benefit manager (Prime, as described in more detail below) and forwarded to HCSC. If it is determined that Prime has overpaid rebates to HCSC, then HCSC must return such overpayment to Prime (who in turn, refunds such overpayment to the manufacturer), but HCSC is not obligated to compensate Prime or any manufacturer on a time value of money basis. If it is determined that Prime has underpaid rebates to HCSC, then Prime must forward such underpayments to HCSC plus interest and late fees. On an aggregate basis for 2016, the difference between the Expected Rebate and the estimated actual rebates for 2016 is estimated to be approximately $4.20 per drug claim. HCSC will retain the actual difference, whether it is eventually higher or lower, as compensation (or shortfall) for its services. HCSC estimated this amount based on its current pricing manuals and Prime's most recent 2016 rebate projections for self-funded and cost-plus business (much of which is not yet collected).

Compensation related to the Inter-Plan Arrangements

The Inter-Plan Arrangements are established and operated pursuant to the rules and procedures issued by the Blue Cross and Blue Shield Association. HCSC is an independent licensee of the Blue Cross Blue Shield Association and developed in consultation with its member Blue Cross and/or Blue Shield Licensees. Inter-Plan Arrangements include the BlueCard Program, Negotiated National Account Arrangements, and Non-participating Provider Claims processing arrangements. Under the Inter-Plan Arrangements, members receive access to participating and non-participating provider healthcare services outside of the geographic area HCSC serves. Members may obtain care from healthcare providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the "Host Blue"). Within these situations, HCSC may be referred to as the "Home Blue."

1. *BlueCard Program*

The access fee and all other BlueCard Program-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreements Fee Schedule; however, in the event that the number of Employer's Covered Persons covered by the plan is below 50,000, or was above 50,000 but falls below 50,000 as of the Annual Measurement Date, then BlueCard Access Fees will apply per the terms of the Agreement starting on the first day of the next calendar quarter. The Annual Measurement Date is the first day of the first month of a renewal period.

If the group's BlueCard arrangement with HCSC involves the group's payment of Access Fees, they are calculated based on one or more of the following arrangements, depending on the size and distribution of your group's enrollment:

Access Fees for 2016:

Standard PPO Fee BlueCard Claims

4.64% of discounts ($2,000 maximum per claim) – less than 1,000 enrolled employees (residents and travelers)

Reduced Rate PPO Fee BlueCard Claims

2.59% of discounts ($2,000 maximum per claim) – 1,000-9,999 enrolled employees

2.40% of discounts ($2,000 maximum per claim) – 10,000+ enrolled employees

Administrative Expense Allowances (AEAs) - This is usually a flat per-claim fee paid by the Home Blue to the Host Blue. It is paid for administrative services that the Host Blue provides in processing the claim for benefits for a member of the Home Blue. Under the BlueCard Program, the AEA fee paid by the Home Blue to the Host Blue is paid for processing claim benefits received from a participating provider.

In 2016 (i) for group customers with fewer than 1,000 enrolled employees, the AEA fee is $11.00 for institutional provider claims and $5.00 for professional provider claims, and (ii) for group customers with 1,000 (or more) enrolled employees with PPO benefits, the AEA fee is $9.75 for institutional provider claims and $4.00 for professional provider claims.

Currently, the AEA fees that HCSC pays to Host Blues are not specifically passed through to our group customers as group-specific expenses, but instead HCSC factors these fees into HCSC's determination of the administrative fees that HCSC charges to group customers with BlueCard claims.

Alternative Financial Arrangements with Host Blues – HCSC may negotiate alternative financial arrangements with one or more Host Blues for fee charges on either a non-standard per claim or a per contract/per month (PCPM) basis. In such cases, the alternative financial fee arrangement would replace both the AEA and Access Fee.

2. *Negotiated National Account Arrangements* - If HCSC and the group have agreed that Host Blue shall make available custom healthcare provider network(s), then the terms and conditions set forth in HCSC's negotiated arrangement with the Host Blue shall apply. HCSC may pay an administrative and/or network access fee to the Host Blue. Any such administrative and/or network access fee will not be greater than the comparable fees that would be charged under the BlueCard Program.

3. *Non-Participating Healthcare Provider Claims* - If a member receives care from a non-participating provider of a Host Blue, an AEA will also apply. The AEA fee is $3.00 for all non-participating provider claims. HCSC currently factors these fees into HCSC's determination of the administrative fees that HCSC charges to group customers, and does not separately charge group customers these fees.

4. *Use of Estimated or Average Pricing by Host Blues* -- As described in your administrative services agreement, some Host Blues may use either estimated or average prices as the negotiated price that is made available to HCSC when plan members access the Host Blue's participating provider network. This may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount paid to the provider by the Host Blue.

   The following describes the formula used for determining an estimated or average price:

   Estimated: A percentage is used to modify the claim price for covered services for a defined category of provider (e.g., institutional, professional, etc.) of a Host Blue in a given geographic area. This percentage (either positive or negative) allows Host Blues to incorporate adjustments and actuarial projections prospectively into the final price. The percentage is determined by figuring the aggregate cost to the Host Blue over a look-back period less any initial payments made to providers divided by the total of payments initially made to providers (claims for non-covered services are not included in the calculation). The aggregate cost in the numerator includes, but is not limited to, all provider retrospective settlements, anti-fraud and abuse recoveries and provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest on provider advances, other non-claim transactions and any positive or negative balance in the variance account. The percentage is then actuarially adjusted for anticipated changes in claims expenses for the prospective period. As of December 31, 2016, the modifying percentage applied to claims from those Host Blues that use estimated pricing ranged from -8.73349% to +12.36%.

   Average: An average price is determined for a defined category of provider (e.g., institutional, professional, etc.) of a Host Blue in a given geographic area. The average is determined as follows:

   Total amount paid to such providers over a look-back period, including initial payments as well as applicable claim and non-claim related transactions, which may include but are not limited to provider retrospective settlements, anti-fraud and abuse recoveries and provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest on provider advances, other non-claim transactions, and any positive or negative balance in the variance account divided by the total amount of such providers' corresponding charges for covered services over the same look-back period (claims for non-covered services are not included in the calculation). The percentage is then actuarially adjusted for anticipated changes in claim costs for the prospective period.

   This result is an estimated or an average price that is applied to each claim for the defined category of provider of the Host Blue in the geographic area and presented as the negotiated price.

   Although use of these pricing methods may result in a difference (positive or negative) between the price a group customer pays and the amount actually paid to the provider, the price used to determine your payment is a final price. Any positive or negative differences are accounted for in a variance account held by the Host Blue. Host Blues may prospectively increase or reduce estimated or average prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from group customers. If you or group customers terminate, you will not receive a refund or charge from the variance account. Such payable or receivable funds would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices.

5. *Fee for Recovery of Overpayments* – In some cases, a Host Blue will undertake recovery efforts from its participating providers on behalf of Home Blues. These recoveries from a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse investigations, provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. In addition, the Host Blue may engage a third party vendor to assist in the identification or collection of recovery amounts. The fees of such a third party may be charged to the Employer. Recovery amounts will be applied in accordance with applicable Inter-Plan Arrangements which generally require correction on a claim-by-claim or prospective basis. Note: Effective July 1, 2012, Host Blues must not bill third-party auditor fees until the recovery adjustment has been processed.

6. *BlueCard Worldwide Program* -- The BlueCard Worldwide Program provides members with access to an international network of inpatient, outpatient and professional providers. Medical assistance and claims support services are also provided under the program by AXA Assistance USA. The 2016 fees that HCSC as a Home Blue pays to AXA Assistance USA, which are included in the HCSC administrative charge, are as follows:

Medical Assistance Services	Per Unit Price
General Inbound Calls (questions related to the BlueCard Worldwide Program and related processes)	$8.44 / Call
Phone Translation	$29.44 / Call
Fulfillment	$7.64 / Mailing
Non-Medical Referral	$10.07/Call
Medical Referral	$33.41 / Referral
Misrouted Calls	$3.37 / Call
Cashless Access	$19.21 / Call
Medical Monitoring < 3 Days	$204.88 / Case
Medical Monitoring 3 – 10 Days	$371.67 / Case
Medical Monitoring > 10 Days	$572.58 / Case
Claim Status Inquiry	$4.36 / Claim
Medical Evacuation coordination	$776.44 / Case
Medical Repatriation coordination	$690.87 / Case
Repatriation of Remains coordination	$469.26 / Case
Medical Travel – Case	$632.28/Case
Medical Travel – Travel Assistance	$49.77/Case

Claims Support Services	Per Unit Price
Claim Preparation – (Image claim, route claim, verify eligibility, conduct provider follow-ups; excluding translation and currency conversion)	$3.89 / Bill
Claim Preparation and Currency Conversion	$3.89 / Bill
Claim Preparation and Translation	$4.28 / Bill
Claim Preparation, Translation, and Currency Conversion	$4.28 / Bill
Claim Coding (Claim code to ICD standards)	$4.41 / Bill
Check Issuance (receive funds, match to file, purchase currency, issue check)	$2.33 / Payment
Misrouted Claim (e.g., domestic)	$1.58 / Claim
Void Check Request	$1.19 / Payment

Other Document Translation (e.g., medical records)	$29.40 / Page
Currency Reconciliation	At Cost
Outside Translation Costs	At Cost

Administrative Expense Allowances (AEAs) – For BlueCard Worldwide claims, Home Blues pay AEAs to a specific, designated Host Blue. For all group customers, the current BlueCard Worldwide AEA fees are $17.00 for institutional provider-submitted claims, $4.75 for professional provider-submitted claims, and $3.75 for member-submitted claims. HCSC also factors these fees into HCSC's determination of the administrative fees that HCSC charges to group customers.

7. *Medical Labs and Durable Medical Equipment (DME) Providers* – The BlueCross and Blue Shield Association has a group purchasing organization (GPO), which receives administrative fees paid by service providers within federal "safe harbor" guidelines. When claims are incurred from these service providers, the Association receives an administrative fee averaging 1.0% of revenues received for calendar year 2016.

Compensation Arrangements for Audit and Recovery Services performed by Vendors - HCSC has contracted with audit vendors to provide claim overpayment identification and recovery-related audit services to HCSC and certain self-funded group customers who have contractually agreed to participate with HCSC in the vendor audits.

1. Optum audit services are focused on the review of hospital patient account credit balances to recover claim overpayments primarily caused by provider billing errors or because necessary information was not available at the time of claim processing. Optum retains no more than 10% for reviews performed in HCSC hospitals and 13% for reviews performed in non-HCSC hospitals. The fees are a percentage of the gross recovery amount for BCBSTX, BCBSOK, BCBSNM, and BCBSMT. The BCBSIL fees are a percentage of the net benefit overpayment defined as the gross refund less discount amount that is identified and recovered. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

2. CDR Associates, an ACS company, provides audit services focused on review of hospital patient account credit balances to recover claim overpayments primarily caused by provider billing errors or because necessary information was not available at the time of claim processing. CDR retains no more than 6.7% for HCA Healthcare System providers and 9.5% for non-HCA Healthcare System providers. The fees are a percentage of the gross recovery amount for BCBSTX, BCBSOK, BCBSNM, and BCBSMT. The BCBSIL fees are a percentage of the net benefit overpayment defined as the gross refund less discount amount that is identified and recovered. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

3. Change Healthcare, an Emdeon Company, performs various types of comprehensive post-payment provider audits. These complex audits include obtaining and reviewing medical records, itemized bills, and physician orders to ensure accurate billing and coding of claims submitted to HCSC. Change Healthcare retains no more than 20% of the gross recovery amount for BCBSTX, BCBSOK, BCBSNM, and BCBSMT. The BCBSIL fees are a percentage of the net benefit overpayment defined as the gross refund less discount amount that is identified and recovered. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

4. Cotiviti Healthcare performs claim reviews via data mining for purposes of overpayment identification and recovery. Claim overpayments are primarily caused by provider billing errors or because necessary information was not available at the time of claim processing. Cotiviti Healthcare retains no more than 20% of the gross recovery amount. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

5. Accent Cost Containment Solutions performs claim reviews via data mining for purposes of overpayment identification and recovery. Claim overpayments are primarily caused by provider billing errors or because necessary information was not available at the time of claim processing. Accent Cost Containment retains no more than 16% of the gross recovery amount. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

6. Equian, LLC performs claim reviews via data mining for purposes of overpayment identification and recovery. Claim overpayments are primarily caused by provider billing errors or because necessary information was not available at the time of claim processing. Equian LLC retains no more than 13% of the gross recovery amount. HCSC receives compensation not to exceed 5% of the gross recovery amount for administration services.

Financial Arrangements with Independent Review Organization Vendors

HCSC has contracted with Advanced Medical Reviews, MCMC LLC, Lone Star Consulting Services, Inc. (dba MES), Medical Review Institute of America, and Dane Street, external independent review organizations, to provide external review services related to covered enrollees of self-funded groups. The services provided by the independent review organizations include peer reviews at the time of initial clinical review, peer reviews to support HCSC clinical appeals, and Independent External Reviews (IER) required by ACA for non-grandfathered self-funded group customer enrollees. HCSC and independent review organizations exchange supporting documents, exchange minimum necessary clinical and contract information, and output reports.

On behalf of the group customer, HCSC coordinates with the independent review organization by reviewing requests to ensure that the covered enrollee meets eligibility requirements, referring requests to one of the contracted peer review organizations, and by acting on the peer review recommendations, including reversing the Group Plan's determination if so indicated by the independent review organization. The specific independent review organization that is assigned to review a covered enrollee's request for an Independent External Review is randomly selected and the decision of the independent review organization is binding on the parties except to the extent other remedies are available under federal law.

When HCSC provides external review coordination services to the covered enrollees of a self-funded group customer for which HCSC does not have fiduciary responsibility, the fee charged to the Group Plan is set forth in the Group Plan agreements. The fee is charged per IER case and is a reasonable estimate of the cost, in total, for services provided. The estimated fee is proactively determined based on the independent review organization contracted fees, an assumption regarding the fluctuation in the mix and utilization of services, and HCSC's administrative fees.

The difference between the actual costs and the estimated fees (positive or negative) for any group customer will vary depending on the services requested by the Group Plan's covered enrollees. HCSC will retain, or absorb, any difference between the actual cost and the charged fee as compensation for services provided. HCSC retains no more than 25% of the charged fee.

Pharmacy Benefit Manager's Compensation

HCSC has contracted with Prime Therapeutics LLC (Prime) for Prime to furnish certain pharmacy benefit management and prescription drug services (PBM services), such as formulary, rebate and pharmacy networks management; claims processing; clinical management programs; utilization review; mail order and specialty pharmacy services; e-prescribing; and reporting and account support services for all operating divisions (currently BCBSIL, BCBSTX, BCBSMT, BCBSNM and BCBSOK). Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC. HCSC owns approximately 36.46% of the equity interest in

Prime. HCSC has entered into various administrative services agreements with Prime to provide these services. Some of the amounts received by Prime from HCSC, pharmacies, manufacturers or other third parties may be charged each time a claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled (transaction-based fees), and may include, but are not limited to, administrative fees charged by Prime to HCSC, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, the fees that HCSC pays to Prime are not specifically passed through to our group customers as group-specific expenses, but instead HCSC factors these fees into HCSC's determination of the administrative fees and premiums that HCSC charges to group customers with prescription drug benefit coverage administered or insured by HCSC. The amounts that Prime receives from third parties do not accrue to the benefit of group customers, unless otherwise specifically set forth in the administrative services agreement or insurance policy. The amount of compensation received by HCSC from a particular group customer for PBM services is not specifically shared with Prime. Instead, HCSC's agreements with Prime require HCSC to pay Prime various fees, of which the following were considered transaction-based fees for 2016:

1. Pharmacy Program Management Fee (Prime's recommended service code 12) – Prime receives from HCSC a program management fee (a per-claim charge) as compensation for Prime's performance of the following PBM services to HCSC:

a. Electronic claims processing
b. Access to the pharmacy claims processing system
c. Pharmacy Network development, management and oversight
d. Standard Pharmacy Program Reporting
e. PrimeMail Program
f. Prime Specialty Pharmacy Program
g. Formulary management and printing
h. P&T Committee management and oversight
i. Rebate contracting with pharmaceutical drug manufacturers
j. Call center for member and pharmacy customer service
k. Drug utilization review
l. Drug Recall notifications
m. QI Monitoring
n. RFP, Sales and Group Presentation support
o. Website and on-line tools
p. E-prescribing Program and provider connectivity (downloads of Formulary to PDA (a per-claim charge). In addition to the Pharmacy Program Management fee, HCSC also reimburses Prime for fees charged to Prime by its e-prescribing vendor(s) (per eligibility, formulary and medication history requests)
q. Paper and foreign claims processing (a per-claim charge plus postage)
r. Prior Authorization (clinical appeals and reviews) (a per-review fee).
s. Other services as mutually agreed upon

2. Separately-Priced PBM Services-- (Prime's recommended service code 12) – Prime receives from HCSC the following additional transaction-based fees:

Desktop and on-site audits of Network Pharmacies (flat fee and/or a percentage of the amount recovered not to exceed 25%). Prime may determine, through audit or otherwise, that a pharmacy has been under or overpaid under the Network Agreement. Prime forwards recoveries to HCSC net of Prime's retained recovery fee. For self-funded and cost-plus business, HCSC credits recoveries to the applicable group customer.

In addition, third parties pay Prime various fees that might be considered in connection with services provided by HCSC to our group customers, of which the following were considered transaction-based fees for 2016:

1. PrimeMail and Prime® Specialty Pharmacy Programs (Prime's recommended service code 99) – The drug fees/discounts that HCSC has negotiated through a *PBM Agreement* with Prime, will be passed-through to our group customers for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to HCSC (and ultimately to our group customers as described above). For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. HCSC pays a fee to Prime for pharmacy benefit services, which is reflected in the administrative fee charged by HCSC to our group customers. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing. The allowable amount reimbursed for prescriptions obtained at out-of-network pharmacies is determined by a group customer's benefit design, but is usually based on 75% of the cost of the prescription if it were obtained at an in-network pharmacy.

2. Float on rebate payment (Prime's recommended service code 62) – Prime contracts with pharmaceutical manufacturers for prescription drug rebates as described in the administrative services agreement. For the number of days between the day that Prime receives manufacturers' rebates and the day that Prime forwards the money to HCSC (approximately 20 days), Prime invests the money and earns float from JPMorgan Chase. Prime's float compensation equals the rebate amount multiplied by the interest rate multiplied by the amount of time the money is invested. This compensation is for Prime's rebate administration services. If the manufacturers do not forward rebates to Prime on time, Prime may charge the manufacturers a late fee, which is retained by Prime. If it is determined, through audit or otherwise, that a manufacturer has underpaid rebates to Prime (or Prime has underpaid rebates to HCSC), then Prime must forward to HCSC the underpaid rebates. If it is determined, through audit or otherwise, that a manufacturer has overpaid rebates to Prime (or Prime has overpaid rebates to HCSC), then HCSC must return such overpayment to Prime (who in turn, refunds such overpayment to the manufacturer), but HCSC is not obligated to compensate Prime or any manufacturer on a time value of money basis.

3. Pharmacy transaction fees (Prime's recommended service code 12) – Contracted pharmacies pay Prime a fee for each paid claim processed electronically, for the administration of electronic claims processing.

4. Manufacturer administrative fees (Prime's recommended service code 49) Prime also may provide administrative services, such as invoicing, data analysis and reporting, to pharmaceutical manufacturers, some of which might be construed to be in connection with services to our group customers. The top 10 manufacturers by volume based on rebates, listed in alpha order, are: Abbott Labs, Astra Zeneca, Daiichi Sankyo, GlaxoSmithKline, Johnson & Johnson, Merck & Co, Novartis, Novo Nordisk, Pfizer, and Teva Neuroscience . The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to group customer members of HCSC and other Blue Plan operating divisions.

5. Float on pharmacy and member claims payments (Prime's recommended service code 62) – For the number of days between the day that Prime receives funds from HCSC for claims payments to pharmacies and members, and the day that Prime pays the pharmacies and members, Prime invests the money and earns float from JPMorgan Chase. Prime's float compensation equals the amount of the claims multiplied by the interest rate multiplied by the amount of time it is invested. This compensation is for Prime's administrative services.

The estimated compensation that Prime received from HCSC and sources other than HCSC for 2016, captured as part of supporting the HCSC book-of-business (i.e. all self-funded and insured business), is $153,041,688. On a per claim basis, that translates to approximately $1.70 per claim.

To calculate the above per claim estimate for 2016, Prime used the following methodology:

Step 1. Sum the Prime book-of-business fees earned through September 30, 2016 for the following revenue sources:
- Pharmacy Program Management and Audit Recovery Fees
- Manufacturer Administrative Fees
- Pharmacy Transaction Fees
- Earnings from Prime business

Step 2. Using year-to-date trends, estimate the fees earned for October, November and December 2016 on a book-of-business basis for fees earned on a per claim basis (same list as above).

Step 3. Capture total interest income earned through September 30, 2016, and subtract interest attributed to Prime's financial reserves. The remaining interest earned estimates the float earned by Prime through Septem,ber 30, 2016.

Step 4. Estimate interest rates for October, November and December 2016, and use year-to-date trend to estimate float income earned in November and December.

Step 5. Sum items 1 through 4 to estimate total 2016 book-of-business earnings that are disclosable via Form 5500.

Step 6. Estimate HCSC book-of-business earnings by dividing the total in item 5 by the percentage of claims estimated for HCSC for the full 2016 plan year as a portion of Prime's book-of-business.

Step 7. To provide a per claim amount, divide the HCSC total from item 6 by the total number of claims estimated for 2016 for HCSC.