Form 5500	•	of Employee Benefit Plan		OMB Nos. 12 12	10-0110 10-0089	
Internal Revenue Service Department of Labor Employee Benefits Security Administration	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with			2015		
Pension Benefit Guaranty Corporation	the instruction	the instructions to the Form 5500.			blic	
	ntification Information					
For calendar plan year 2015 or fiscal		and ending 12/31/20				
A This return/report is for:	a multiemployer plan;	a multiple-employer plan (Filers checking the participating employer information in accor				
	X a single-employer plan;	a DFE (specify)	uance wit		15), 01	
<b>B</b> This return/report is:	the first return/report;	the final return/report;				
D This return/report is.	an amended return/report;	a short plan year return/report (less than 12 months).				
<b>C</b> If the plan is a collectively-bargain	ned plan, check here		,	Г		
· · · · ·	- -	_	_	́ Ц		
D Check box if filing under:	Form 5558;	automatic extension;	× the	e DFVC program;		
	special extension (enter description)					
	mation—enter all requested informatio	n				
1a Name of plan LUMICOR/PEGASUS NW EMPLOY	'EE WELFARE BENEFIT PLAN		1b	Three-digit plan number (PN) ▶	501	
			1c	Effective date of pla 01/01/1989	an	
<ul> <li>Plan sponsor's name (employer, if for a single-employer plan)</li> <li>Mailing address (include room, apt., suite no. and street, or P.O. Box)</li> <li>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)</li> </ul>			2b Employer Identification Number (EIN) 91-0876680			
LUMICOR, INC.			2c	Plan Sponsor's tele number 425-496-1444		
1400 MONSTER ROAD SW RENTON, WA 98057	1400 MONSTER ROAD SW RENTON, WA 98057		2d	Business code (see instructions) 325900	)	

## 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	Filed with authorized/valid electronic signature.	09/18/2018	DEBBIE SHEETS					
HERE	Signature of plan administrator	Date	Enter name of individual signing as plan administrator					
SIGN HERE								
	Signature of employer/plan sponsor	Date	Enter name of individua	al signing as employer or plan sponsor				
SIGN HERE								
	Signature of DFE	Date	Enter name of individua					
Preparer	's name (including firm name, if applicable) and address (include r	Preparer's telephone number						
For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.								

3a	Plan administrator's name and address 🛛 Same as Plan Sponsor	3b Administrator's EIN		
		3c Adminis numbe	strator's telephone r	
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN		
а	Sponsor's name	<b>4c</b> PN		
5	Total number of participants at the beginning of the plan year	5	113	
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)	113	
a(	2) Total number of active participants at the end of the plan year	6a(2)	113	
b	Retired or separated participants receiving benefits			
С	Other retired or separated participants entitled to future benefits	6c		
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	113	
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e		
f	Total. Add lines <b>6d</b> and <b>6e</b>	6f	113	
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: 4D

9a	a Plan funding arrangement (check all that apply)				<b>9b</b> Plan benefit arrangement (check all that apply)				
	(1)	X	Insurance		(1)	Insurance			
	(2)		Code section 412(e)(3) insurance contracts		(2)		Code section 412(e)(3) insurance contracts		
	(3)		Trust		(3)		Trust		
	(4)	X	General assets of the sponsor		(4)		General assets of the sponsor		
10	Check	all ap	plicable boxes in 10a and 10b to indicate which schedules are at	ttache	d, and, w	vher	re indicated, enter the number attached. (See instructions)		
а	Pensic	on Sci	hedules	b General Schedules					
	(1)		R (Retirement Plan Information)		(1)		H (Financial Information)		
	(2)	Π	MB (Multiemployer Defined Benefit Plan and Certain Money		(2)	Π	I (Financial Information – Small Plan)		
			Purchase Plan Actuarial Information) - signed by the plan		(3)	X	A (Insurance Information)		
			actuary		(4)		C (Service Provider Information)		
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)		<b>D</b> (DFE/Participating Plan Information)		
			Information) - signed by the plan actuary		(6)		G (Financial Transaction Schedules)		

Page **3** 

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)			
<b>11a</b> If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.)         If "Yes" is checked, complete lines 11b and 11c.				
<b>11b</b> Is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)			
11c Enter the F enter the R	Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report,			

SCHEDULE	Α	Insuran	ce Informatio	n			
(Form 5500	)					01	IB No. 1210-0110
	Department of the Treasury Internal Revenue ServiceThis schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).					2015	
Department of Labor Employee Benefits Security Ad		File as an a	attachment to Form 55	00.			
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>				This For	m is Open to Public Inspection
For calendar plan year 20 <sup>°</sup>	15 or fiscal plan	year beginning 01/01/2015		and er	ding 12/3	1/2015	hispottion
A Name of plan LUMICOR/PEGASUS NW	V EMPLOYEE V	VELFARE BENEFIT PLAN			e-digit number (Pl	N) 🕨	501
C Plan sponsor's name a LUMICOR, INC.	is shown on line	2a of Form 5500		-	oyer Identific 0876680	ation Number	(EIN)
		ing Insurance Contract					
1 Coverage Information:		<b>-</b> .		•		-	
(a) Name of insurance ca INION SECURITY INSUR		NY					
	(c) NAIC	C (d) Contract or	(e) Approximate num			Policy or c	ontract year
<b>(b)</b> EIN	code	identification number	persons covered at end policy or contract yea		(†)		<b>(g)</b> To
1-0170040	70408	5472833	113		01/01/201	5	09/30/2015
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
<b>(a)</b> Total a	amount of comm			<b>(b)</b> To	otal amount	of fees paid	
		1801					
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,			ions or fees	were paid	
CAPITAL BENEFIT SERVI	ICES, INC.		SE 30TH PL, SUITE 38 VUE, WA 98007	U			
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code
	1801						3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
			o and other commission				
(b) Amount of sales and base commissions paid (c) Amount			Fees and other commissions paid (d) Purpose				(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

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

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

(b) Amount of sales and base	Fees and other commissions paid					
commissions paid	(c) Amount	(d) Purpose	(e) Organization code			
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid						

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

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

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

Page 3

P	art I	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		rent value of plan's interest under this contract in the general account at year			. 4		
5		rent value of plan's interest under this contract in separate accounts at year e	nd		. 5		
6		tracts With Allocated Funds:					
	а	State the basis of premium rates					
	b	Premiums paid to carrier			. 6b		
	С	Premiums due but unpaid at the end of the year			. 6c		
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			. 6d		
		Specify nature of costs					
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity				
		(3) other (specify)					
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here			
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)			
	а	Type of contract: (1) deposit administration (2) immedia	ate participatio	on guarantee			
		(3) guaranteed investment (4) other ▶					
	b	Balance at the end of the previous year			. 7b		
	С	Additions: (1) Contributions deposited during the year	7c(1)				
		(2) Dividends and credits	. 7c(2)				
		(3) Interest credited during the year					
		(4) Transferred from separate account					
		(5) Other (specify below)	. 7c(5)				
		•					
	_	(6)Total additions			. 7c(6)		
		Total of balance and additions (add lines 7b and 7c(6)).			. 7d		
	е	Deductions:	- (1)				
		(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) 7e(4)				
		(4) Other (specify below)					
		•					
		(5) Total deductions			. 7e(5)		
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f		

Page	4
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Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pu the entire group of such individual contracts of	oup of employees of the s urposes if such contracts	are experienc	ce-rated as a unit. Wh	ere contract		
8	Bene	efit and contract type (check all applicable boxes)						
	a	Health (other than dental or vision)	<b>b</b> X Dental	с	Vision		d Life insurance	
	еΓ	Temporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	plovment	<b>h</b> Prescription dr	ua
	iΓ	Stop loss (large deductible)	i HMO contract	, s_ k[	PPO contract		I Indemnity cont	•
	• _			r_	FFO contract			laci
	m	Other (specify)						
9	Evne	erience-rated contracts:						
J		Premiums: (1) Amount received		9a(1)			4	
		(2) Increase (decrease) in amount due but unpaid					-	
		(3) Increase (decrease) in unearned premium res					1	
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid		9b(1)				
		(2) Increase (decrease) in claim reserves		9b(2)			1	
		(3) Incurred claims (add (1) and (2))				. 9b(3)		
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual basis)				_	
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)			_	
		(C) Other specific acquisition costs		9c(1)(C)			4	
		(D) Other expenses		9c(1)(D)			4	
		(E) Taxes					4	
		(F) Charges for risks or other contingencies					4	
		(G) Other retention charges				0~(1)(1)		
		(H) Total retention	_			9c(1)(H)		
	-1	(2) Dividends or retroactive rate refunds. (These						
	d	Status of policyholder reserves at end of year: (1						
		(2) Claim reserves				9d(2)		
	е	(3) Other reserves Dividends or retroactive rate refunds due. (Do no				9d(3)		
10	-	nexperience-rated contracts:		1 III IIIIe 90(2)	.)	. 9e		
10		Total premiums or subscription charges paid to c	arrier			10a		48943
	b	If the carrier, service, or other organization incurr						-03+0
		retention of the contract or policy, other than repo				10b		

Specify nature of costs 🕨

Part IV	Provision of Information			
11 Did th	ne 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		Insuran	ce Informatio	n		OM	IB No. 1210-0110
(Form 5500	,	This schedule is require	d to be filed under section	on 104 of th			
Department of the Treasury         This schedule is required to be filed under section 104 of the           Internal Revenue Service         Employee Retirement Income Security Act of 1974 (ERISA).					2015		
	Department of Labor oyee Benefits Security Administration File as an attachment to Form 5500.						
Pension Benefit Guaranty Co	prporation	<ul> <li>Insurance companies pursuant to</li> </ul>	are required to provide t ERISA section 103(a)(2)		tion	This For	m is Open to Public Inspection
	15 or fiscal plan	year beginning 01/01/2015		and er	nding 12/3	31/2015	
A Name of plan LUMICOR/PEGASUS NV	V EMPLOYEE V	VELFARE BENEFIT PLAN			e-digit number (P	N) 🕨	501
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 LUMICOR, INC.					oyer Identific 0876680	cation Number	(EIN)
		ing Insurance Contract Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca LIFEMAP ASSURANCE C							
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or contract year	
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
93-6030398	97985	WA300998	113 1		10/01/201	5	12/31/2015
2 Insurance fee and com descending order of the		tion. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	amount of comr			<b>(b)</b> T	otal amount	of fees paid	
		1717					
3 Persons receiving com	missions and fe	es. (Complete as many entries	s as needed to report all	persons).			
		nd address of the agent, broker			ions or fees	were paid	
CAPITAL BENEFIT SERVI	ICES, INC.		SE 30TH PL, SUITE 38 EVUE, WA 98007	0			
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpos	е		(e) Organization code
1717							3
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
		<b>x</b> :				i	
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns <u>paid</u>			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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

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

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

(b) Amount of sales and base	Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid					

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

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

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

Page 3

P	art I	I Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contract	s with each carrier ma	v he treated	as a unit for purposes of
		this report.				
4		rent value of plan's interest under this contract in the general account at year			. 4	
5		rent value of plan's interest under this contract in separate accounts at year e	nd			
6		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			. 6b	
	С	Premiums due but unpaid at the end of the year			. 6c	
	d	If the carrier, service, or other organization incurred any specific costs in con- retention of the contract or policy, enter amount			. 6d	
		Specify nature of costs				
	е	Type of contract:    (1)    individual policies    (2)    group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, cl	neck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	parate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participatio	on guarantee		
		(3) guaranteed investment (4) other ▶				
	b	Balance at the end of the previous year			. 7b	
	С	Additions: (1) Contributions deposited during the year	7c(1)			
		(2) Dividends and credits	. 7c(2)			
		(3) Interest credited during the year				
		(4) Transferred from separate account				
		(5) Other (specify below)	. 7c(5)			
		•				
	_	(6)Total additions			. 7c(6)	
		Total of balance and additions (add lines 7b and 7c(6)).			. 7d	
	е	Deductions:	- (1)			
		(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) 7e(4)			
		(4) Other (specify below)				
		•				
		(5) Total deductions			. 7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			. 7f	

Page 4	
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Pa	art II	Welfare Benefit Contract Informat If more than one contract covers the same gr information may be combined for reporting pr the entire group of such individual contracts of	oup of employees of the s urposes if such contracts	are experienc	e-rated as a unit. Wh	ere contract	
8	Bene	efit and contract type (check all applicable boxes)					
	a	Health (other than dental or vision)	<b>b</b> X Dental	с	Vision		d Life insurance
	еГ	Temporary disability (accident and sickness)	<b>f</b> Long-term disabilit	y g	Supplemental unem	olovment	<b>h</b> Prescription drug
	iΓ	Stop loss (large deductible)	i HMO contract	, 3_ k[	PPO contract	,	I Indemnity contract
	• L			ĸ			
	m	Other (specify)					
9	Evne	rience-rated contracts:					
Ŭ	•	Premiums: (1) Amount received		9a(1)			-
		(2) Increase (decrease) in amount due but unpaid					-
		(3) Increase (decrease) in unearned premium res					1
		(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1)			
		(2) Increase (decrease) in claim reserves		9b(2)		1	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o	,				4
		(A) Commissions		9c(1)(A)			_
		(B) Administrative service or other fees		9c(1)(B)			4
		(C) Other specific acquisition costs		9c(1)(C)			4
		(D) Other expenses		9c(1)(D) 9c(1)(E)			-
		<ul><li>(E) Taxes</li><li>(F) Charges for risks or other contingencies.</li></ul>		9c(1)(E) 9c(1)(F)			-
		(G) Other retention charges					-
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These	_	_			
		Status of policyholder reserves at end of year: (1				9d(1)	
	ŭ	(2) Claim reserves	, I			9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do n				9e	
10		nexperience-rated contracts:		()	,		
	а	Total premiums or subscription charges paid to c	arrier			10a	17174
	b	If the carrier, service, or other organization incur					
		retention of the contract or policy, other than repe	orted in Part I, line 2 abov	e, report amo	ount	10b	

Specify nature of costs

Part	Provision of Information			
<b>11</b> D	the insurance company fail to provide any information necessary to complete Schedule A?	Yes	×	No
<b>12</b> If	ne answer to line 11 is "Yes," specify the information not provided.			

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Banefits Security Administration Pension Banefit 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 college 80/700 - 80/700 - 90/700 -		OMB Nos. 1210-0110 1210-0089				
			sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code). Complete all entries in accordance with					
			the instructions to the Form 5500.					
0.131				This Form is Open to Public Inspection				
Part For cal	Annual Report Ic	lentification Information cal plan year beginning 01/01/2015	antes antes have	The set				
	s return/report is for:	a multiemployer plan;	2015 and ending 12/31/2015 a multiple-employer plan (Filers checking this box must attach a list of					
FV THE	forum/eport is tor.		participating employer information in acc	participating employer information in accordance with the form instructions); or				
D This			X a single-employer plan;       I a DFE (specify)         Ihe first return/report;       Ihe final return/report;         an amended return/report;       In a best plan upper three thr					
	s return/report is:	an amended return/report;						
C If the	e plan is a collectively-bara	ained plan, check here	a short plan year return/report (less than	, D				
	ck box if filing under:	Form 5558;	automatic extension;	8-19819 <sup>8</sup> L				
- 0110	Sk box it thing under	special extension (enter descrip		X the DFVC program;				
Part	II Basic Plan Info	ormation-enter all requested inf		a second second second				
	me of plan OR/PEGASUS NW EMPLOYEE WELFARE BENEFIT PLAN			1b Three-digit plan 501				
CONIC	NO MELLONGUA HAY EMPLI	21 EE WELFARE BENEFIL MLAN		1c Effective date of plan				
2a Pla	n shonsar's name (amel	er, if for a single-employer plan)		01/01/1989				
Ma City	iling address (include room y or town, state or province,	, apt., suite no. and street, or P.O. E country, and ZIP or foreign postal of	Box) code (if foreign, see instructions)	2b Employer Identification Number (EIN) 91-0876680				
UMICC	DR. INC.	2c Plan Sponsor's telephone number						
				number				
400 M(	ONSTER ROAD SW	1400 א	IONSTER POAD SM	number 425-496-1444				
	ONSTER ROAD SW N, WA 98057		MONSTER ROAD SW DN. WA 98057	number 425-496-1444 2d Business code (see instructions)				
				number 425-496-1444 2d Business code (see				
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## Page **2**

3a	Plan administrator's name and address 🛛 Same as Plan Sponsor	3b Ad	3b Administrator's EIN						
			Iministrator's telephone umber						
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:	e, <b>4b</b> El	4b EIN						
а	Sponsor's name	4c PN	4c PN						
5	Total number of participants at the beginning of the plan year	5	113						
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(6a(2), 6b, 6c, and 6d).								
a(′	1) Total number of active participants at the beginning of the plan year	6a(1)	113						
a(2	2) Total number of active participants at the end of the plan year	<u>6a(2)</u>	113						
b	Retired or separated participants receiving benefits	6b							
С	Other retired or separated participants entitled to future benefits								
d	Subtotal. Add lines 6a(2), 6b, and 6c.	<u>6d</u>	113						
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits								
f	Total. Add lines 6d and 6e	6f	113						
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)								
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 b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4D								
9a	Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check	all that apply)	iat apply)						
	(1) X Insurance (1) X Insurance								
	(2) Code section 412(e)(3) insurance contracts (2) Code section 412(	e)(3) insuranc	e contracts						
	(3)     Trust     (3)     Trust       (4)     X     General assets of the sponsor     (4)     General assets of	the sponsor							
10			hed (See instructions)						
			(000						
d	Pension Schedules     b     General Schedules       (1)     R (Retirement Plan Information)     (4)     (4)								
		Information -	Small Plan)						
	Purchase Plan Actuarial Information) - signed by the plan (3) A (Insurance actuary (4) C (Service D	,	ation)						
		rovider Inform	,						
		icipating Plan Transaction S	,						