Form 5500	•	t of Employee Benefit Plan		OMB Nos. 12	10-0110 10-0089
Department of the Treasury Internal Revenue Service	and 4065 of the Employee Retireme	employee benefit plans under sections 104 nt Income Security Act of 1974 (ERISA) and the Internal Revenue Code (the Code).	2017		
Department of Labor Employee Benefits Security Administration	 Complete all entries in accordance with the instructions to the Form 5500. 			2011	
Pension Benefit Guaranty Corporation			This	Form is Open to Pu Inspection	ıblic
	ntification Information				
For calendar plan year 2017 or fiscal	plan year beginning 08/01/2017	and ending 07/31/20	018		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking t participating employer information in accor			ns.)
	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-bargain	ed plan, check here			•	
D Check box if filing under:	Form 5558	automatic extension	the	e DFVC program	
, i i i i i i i i i i i i i i i i i i i	special extension (enter description)				
Part II Basic Plan Informa	ation—enter all requested information				
1a Name of plan EGC CONSTRUCTION HEALTH PL	·		1b	Three-digit plan number (PN) ▶	501
			1c	Effective date of pla	an
City or town, state or province, co	if for a single-employer plan) pt., suite no. and street, or P.O. Box) puntry, and ZIP or foreign postal code (if foreign, see instructions)	2b	Employer Identifica Number (EIN) 61-0947016	tion
EGC CONSTRUCTION			2c	Plan Sponsor's tele number 859-442-6500	phone
30 W 4TH ST NEWPORT, KY 41071-1061	30 W 4TH S NEWPORT,	T KY 41071-1061	2d	Business code (see instructions) 236200	9

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.	02/27/2019	SARA MEINEKE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/27/2019	SARA MEINEKE
TIEILE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
neke	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2017) v. 170203

	Form 5500 (2017) Page 2		
3a	Plan administrator's name and address 🗙 Same as Plan Sponsor	3b Administrator's B	EIN
		3c Administrator's t number	elephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/re	port filed for this plan, 4b EIN	
•	enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/repo	ort:	
a c	Sponsor's name Plan Name	4d PN	
5	Total number of participants at the beginning of the plan year	5	155
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans comp 6a(2) , 6b , 6c , and 6d).	plete only lines 6a(1),	
a(1) Total number of active participants at the beginning of the plan year	<u>6a(1)</u>	155
a(2) Total number of active participants at the end of the plan year		153
b	Retired or separated participants receiving benefits	<u>6b</u>	2
С	Other retired or separated participants entitled to future benefits	<u>6c</u>	7
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	162
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<u>6e</u>	0
f	Total. Add lines 6d and 6e	6f	162
g	Number of participants with account balances as of the end of the plan year (only defined contribuction complete this item)		
h	Number of participants who terminated employment during the plan year with accrued benefits the less than 100% vested.		
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 4H

9a	Plan fun	ding	arrangement (check all that apply)	9b	Plan b	enefit	t arra	ngement (check all that apply)
	(1)	X	Insurance		(1)	X	In	surance
	(2)		Code section 412(e)(3) insurance contracts		(2)		С	ode section 412(e)(3) insurance contracts
	(3)		Trust		(3)		Т	rust
	(4)	X	General assets of the sponsor		(4)	X	G	eneral assets of the sponsor
10	Check a	ll app	plicable boxes in 10a and 10b to indicate which schedules are at	ache	d, and,	wher	e ind	licated, enter the number attached. (See instructions)
а	Pension	n Sch	nedules	b	Gene	ral Sc	ched	ules
	(1)		R (Retirement Plan Information)		(1)			H (Financial Information)
	(2)	П	MP (Multiamplayer Defined Penefit Plan and Cartain Manay		(2)			I (Financial Information – Small Plan)
	(2)		MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan		(3)	X	_4	A (Insurance Information)
			actuary		(4)	X		C (Service Provider Information)
	(3)	Π	SB (Single-Employer Defined Benefit Plan Actuarial		(5)			D (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)				
2520.	11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) If "Yes" is checked, complete lines 11b and 11c.				
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)				
Recei	the Receipt Confirmation Code for the 2017 Form M-1 annual report. If the plan was not required to file the 2017 Form M-1 annual report, enter the pt 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 pt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)				

Receipt Confirmation Code_____

SCHEDULE	A	Insuran	nce Informatio	n		OI	MB No. 1210-0110
(Form 5500))						
Department of the Treas Internal Revenue Serv			ed to be filed under secti ncome Security Act of 19				2017
Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 55	500.			
Pension Benefit Guaranty Co	orporation	 Insurance companies pursuant to 	are required to provide ERISA section 103(a)(2		tion	This Fo	rm is Open to Public Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 08/01/2017		and er	nding 07/31/	2018	
A Name of plan EGC CONSTRUCTION H	HEALTH PLAN				e-digit number (PN)	•	501
C Plan sponsor's name a EGC CONSTRUCTION	as shown on line	e 2a of Form 5500			oyer Identificat 0947016	ion Number	(EIN)
on a separ	tion Concer ate Schedule A	ning Insurance Contrac	t Coverage, Fees, as a unit in Parts II and I	and Cor II can be re	nmissions ported on a si	Provide infond	ormation for each contract ule A.
1 Coverage Information:							
(a) Name of insurance ca DENTAL CARE PLUS, INC							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n			,	contract year
	code	identification number	·	persons covered at end of policy or contract year		rom	(g) To
31-1185262	96265	064427201 & 501	12	7	08/01/2017		08/31/2018
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3-	the agents, br	okers, and	other persons in
(a) Total :	amount of com			(b) To	otal amount of	fees paid	
		2460					8669
3 Persons receiving com		ees. (Complete as many entries			: (
DENTAL CARE PLUS, INC			ROWN POINT PLACE NNATI, OH 45241		NOTIS OF THES W		
(b) Amount of sales a	nd base	Fe	es and other commissio	ons paid			
commissions pa	id	(c) Amount	DMINISTRATIVE	е		(e) Organization code	
		8669 /					5
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ions or fees w	rere naid	
SHERRILL D MORGAN &		INC. 525 W STE 3	/ 5TH ST				
(b) Amount of sales a	nd base	Fe	es and other commissio	ons paid			
commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code
	2460						3
For Paperwork Reduction	on Act Notice, s	see the Instructions for Form	5500.			Sche	Ledule A (Form 5500) 2017 v. 170203

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page 3		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end		
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	I	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Ρ	art l		Welfare Benefit Contract Informa					
			If more than one contract covers the same g the information may be combined for reporti employees, the entire group of such individu	ng purposes if such conti	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual
8	Bene	efit a	nd contract type (check all applicable boxes)					
-	a		ealth (other than dental or vision)	b X Dental	с	Vision		d Life insurance
		_	· ,					
	e	_		f Long-term disabilit		Supplemental unemp	ployment	h Prescription drug
	i	Sto	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	her (specify)					
0	F							
9			ce-rated contracts:]	00(1)			-
			iums: (1) Amount received hcrease (decrease) in amount due but unpaid		9a(1) 9a(2)			-
		. ,	ncrease (decrease) in unearned premium reso		9a(2) 9a(3)			-
		. ,	arned ((1) + (2) - (3))	•			9a(4)	
	-	• •	efit charges (1) Claims paid		9b(1)		JU(4)	
			ncrease (decrease) in claim reserves		9b(2)			
		• •	ncurred claims (add (1) and (2))	L			9b(3)	
			laims charged				9b(4)	
			nainder of premium: (1) Retention charges (or					
			(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		us of policyholder reserves at end of year: (1)				9d(1)	
		(2) (Claim reserves				9d(2)	
		· · /	Other reserves				9d(3)	
4.0			dends or retroactive rate refunds due. (Do no	t include amount entered	I in line 9c(2)	.)	9e	
10		•	erience-rated contracts:				40-	
			Il premiums or subscription charges paid to ca				10a	73828
	b		e carrier, service, or other organization incurre				106	
		rete	ntion of the contract or policy, other than repo	rted in Part I, line 2 abov	e, report amo	ount	10b	

Pa	art IV	Provision of Information			
11	Did the i	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40					

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

Specify nature of costs.

SCHEDULI (Form 550		Insuran	ce Informatio	n		OM	B No. 1210-0110
Department of the Tre	asury	This schedule is required					
Internal Revenue Se		Employee Retirement Inc	-		A).		2017
Employee Benefits Security A	Administration		ttachment to Form 55				
Pension Benefit Guaranty (Corporation	Insurance companies a pursuant to E	are required to provide t RISA section 103(a)(2)		tion		m is Open to Public Inspection
For calendar plan year 2	017 or fiscal plar	n year beginning 08/01/2017		and er	nding 07/3	31/2018	1
A Name of plan EGC CONSTRUCTION	HEALTH PLAN				e-digit number (P	N) 🕨	501
				Down		- Car Ni	
C Plan sponsor's name EGC CONSTRUCTION	as snown on line	3 28 of Form 5500		-	-0947016	cation Number (EIN)
		ning Insurance Contract					
1 Coverage Information	:						
(a) Name of insurance of UNUM LIFE INSURANCE		AMERICA					
		(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contrac		(f)	From	(g) To
01-0278678	62235	00000632681		2	08/01/201	7	08/01/2018
2 Insurance fee and cor descending order of th		ation. Enter the total fees and tota	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Tota	amount of com	missions paid		(b) T	otal amount	of fees paid	
		3379					
3 Persons receiving con	mmissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	. /	and address of the agent, broker,	or other person to who	m commiss	sions or fees	s were paid	
SHERRILL D MORGAN	& ASSOCIATES	STE 31	5TH ST 0 GTON, KY 41011				
(b) Amount of sales a	and base	Fee	es and other commission	ns paid			
commissions p		(c) Amount		(d) Purpos	е		(e) Organization code
	3379						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	sions or fees	were paid	
					_		
(b) Amount of sales a	and base	Fee	es and other commission	ns paid			
commissions p		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice	e, see the Instructions for Form 5500.

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page 3		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end		
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Specify nature of costs.

Ρ	art		Welfare Benefit Contract Informa					
			If more than one contract covers the same g the information may be combined for reporti					
			employees, the entire group of such individu	al contracts with each ca	arrier may be	treated as a unit for pu	rposes of t	his report.
8	Ben	efit ar	nd contract type (check all applicable boxes)		_	_		_
	а	He	alth (other than dental or vision)	b Dental	С	Vision		d 🗙 Life insurance
	e	Те	mporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unemp	oloyment	h Prescription drug
	i [Sto	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
	m	Ot	her (specify)	—	_	-		_
	L							
9	Expe	erienc	e-rated contracts:					
	a	Premi	iums: (1) Amount received		9a(1)			
		(2) In	ncrease (decrease) in amount due but unpaid		9a(2)			
		(3) In	crease (decrease) in unearned premium rese	erve	9a(3)		-	
		(4) E	arned ((1) + (2) - (3))				9a(4)	
	b	Bene	efit charges (1) Claims paid		9b(1)			
		(2) In	crease (decrease) in claim reserves		9b(2)		-	
		(3) In	ncurred claims (add (1) and (2))				9b(3)	
		(4) C	laims charged				9b(4)	
	С	Rem	nainder of premium: (1) Retention charges (or	n an accrual basis)				
		(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees		9c(1)(B)			
		(C) Other specific acquisition costs		9c(1)(C)			
		(D) Other expenses		9c(1)(D)			
		(E) Taxes		9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		((H) Total retention				9c(1)(H)	
		(2) C	Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)	
	d	Statu	us of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)	
		(2) C	Claim reserves				9d(2)	
		(3) C	Other reserves				9d(3)	
	е	Divid	dends or retroactive rate refunds due. (Do no	t include amount entered	l in line 9c(2)	.)	9e	
10	No	nexpe	erience-rated contracts:					
	а	Tota	I premiums or subscription charges paid to ca	arrier			10a	55197
	b	lf the	e carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	h the acquisition or		
			ntion of the contract or policy, other than repo				10b	

Pa	art IV	Provision of Information			
11	Did the	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X	No
12	If the an	swer to line 11 is "Yes," specify the information not provided.			

SCHEDULE	Α	Insuran	ce Informatio	n				
(Form 5500)		mouran		•		OM	IB No. 1210-0110	
Department of the Trea Internal Revenue Ser	isury	This schedule is required Employee Retirement In					2017	
Department of Labo Employee Benefits Security Ad		File as an a	attachment to Form 55	00.				
Pension Benefit Guaranty C		Insurance companies a pursuant to E	are required to provide t ERISA section 103(a)(2)		tion		This Form is Open to Public Inspection	
For calendar plan year 20)17 or fiscal plan	•		and en	ding 07/3	31/2018	Inspection	
A Name of plan EGC CONSTRUCTION I	HEALTH PLAN				e-digit number (P	N) 🕨	501	
C Plan sponsor's name a EGC CONSTRUCTION	as shown on line	e 2a of Form 5500		-	oyer Identific 0947016	ation Number ((EIN)	
	Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.							
1 Coverage Information:		÷ i						
(a) Name of insurance ca DEARBORN NATIONAL L		CE COMPANY			1			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a		(1)		ontract year	
(,	code	identification number	policy or contrac	(1)		From	(g) To	
36-2598882	71129	F018378	138	138 08/01/20		7	07/31/2018	
2 Insurance fee and com descending order of the		tion. Enter the total fees and tot	al commissions paid. Li	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total	amount of comn			(b) Total amount of fees paid				
		4223						
3 Persons receiving com	nmissions and fe	es. (Complete as many entries	as needed to report all	persons).				
SHERRILL D MORGAN &		STE. 3	5TH STREET	<u>m commiss</u>	ions or fees	were paid		
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid			-	
commissions paid 4223		(c) Amount		(d) Purpos	e		(e) Organization code	
					3			
	(a) Name or	nd address of the agent, broker,	or other person to who	m commiss	ions or fear	were paid		
		nd address of the agent, bloker,						
	I						1	

(b) Amount of sales and base	F			
commissions paid	(c) Amount	(d) Purpose	(e) Organization code	
For Paperwork Reduction Act Notice	adula A (Earm 5500) 2017			

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page 3		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end		
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)	I	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Ρ	art I	III	Welfare Benefit Contract Information If more than one contract covers the same of the sam			over(c) or members of t	the same of	mployee organizations(s)	
			the information may be combined for reporti employees, the entire group of such individu	ng purposes if such contr	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	e	Те	emporary disability (accident and sickness)	f 🛛 Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription drug	
	iΓ	Sto	op loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract	
	m	_	ther (specify)		L				
	Г								
9	Expe	eriend	ce-rated contracts:						
			iums: (1) Amount received		9a(1)			-	
		(2) Ir	ncrease (decrease) in amount due but unpaid		9a(2)				
		(3) Ir	ncrease (decrease) in unearned premium rese	erve	9a(3)				
		(4) E	Earned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)				
		(3) Ir	ncurred claims (add (1) and (2))				9b(3)		
		(4) C	Claims charged				9b(4)		
	С	Ren	nainder of premium: (1) Retention charges (or	n an accrual basis)					
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)			_	
			(F) Charges for risks or other contingencies		9c(1)(F)			_	
			(G) Other retention charges		9c(1)(G)				
			(H) Total retention	······	······ <u></u> ··		9c(1)(H)		
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Stat	us of policyholder reserves at end of year: (1)	Amount held to provide I	benefits after	retirement	9d(1)		
		(2) (Claim reserves				9d(2)		
		(3) (Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	l in line 9c(2)	.)	9e		
10	No	nexp	erience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a	443	313
	b	If the	e carrier, service, or other organization incurre	ed any specific costs in co	onnection wit	h the acquisition or			
			ntion of the contract or policy, other than repo				10b		

Pa	art IV	Provision of Information			
11	Did the i	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40					

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

Specify nature of costs.

SCHEDULE	A	Insuran	ce Informatio	n			
(Form 5500)						OM	B No. 1210-0110
Department of the Treasury This schedule is require			d to be filed under section for the security Act of 19				2017
Department of Labo Employee Benefits Security A		File as an a	attachment to Form 55	500.			
Pension Benefit Guaranty C	orporation	Insurance companies pursuant to l	are required to provide ERISA section 103(a)(2		tion		m is Open to Public Inspection
For calendar plan year 20)17 or fiscal plar	year beginning 08/01/2017		and er	nding 07/3	31/2018	
A Name of plan EGC CONSTRUCTION	HEALTH PLAN				e-digit number (P	N) •	501
C Plan sponsor's name EGC CONSTRUCTION	∋ 2a of Form 5500			oyer Identific 0947016	cation Number ((EIN)	
		ning Insurance Contrac					
1 Coverage Information:							
(a) Name of insurance ca HCC LIFE INSURANCE C							
	(c) NAIC	(d) Contract or	(e) Approximate n	(e) Approximate number of		Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
35-1817054	92711	EGC	15	155 08		7	07/31/2018
2 Insurance fee and con descending order of the		ation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total	amount of com	nissions paid		(b) To	otal amount	of fees paid	
		2261					
3 Persons receiving con	nmissions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,	, or other person to who	m commiss	sions or fees	s were paid	
CUSTOM DESIGN BENE	FITS LLC		CHEVIOT ROAD NNATI, OH 45247				
(b) Amount of sales a	nd base	Fe	ees and other commissions paid				
commissions paid		(c) Amount		(d) Purpos	е		(e) Organization code
2261							5
	(a) Name a	nd address of the agent, broker,	, or other person to who	m commiss	sions or fees	were paid	
(b) Amount of color of	nd base		es and other commissio	ns paid			
(b) Amount of sales and base commissions paid		(c) Amount		(d) Purpos	e		(e) Organization code

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

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

	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
			<u> </u>	

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

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

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

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

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

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

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

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

Schedule A (Form 5500) 2017

	Schedule A (Form 5500) 2017	Page 3		
Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivi- this report.	vidual contracts with each carri	er may be treated as a unit f	or purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end		
6 Cor	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier			
С	Premiums due but unpaid at the end of the year			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
_				
е	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year			
С	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)			
	\mathbf{b}			
	(6)Total additions			
Ь	Total of balance and additions (add lines 7b and 7c(6)).			
_	Deductions:			
Ŭ	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(2) Administration charge made by carrier			
	(4) Other (specify below)			
	,			
			7.(5)	
4	(5) Total deductions			
t	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	

Ρ	art		Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for reporti employees, the entire group of such individu	roup of employees of the	racts are exp	erience-rated as a unit	. Where co	ontracts cover individual	
8	Bene	efit a	nd contract type (check all applicable boxes)						
	a	He	ealth (other than dental or vision)	b Dental	c	Vision		d Life insurance	
	еĪ	Te	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unemp	oloyment	h Prescription drug	
	i D	X Ste	op loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract	
	m	_	ther (specify)	,	L				
9	Expe	eriena	ce-rated contracts:						-
-			niums: (1) Amount received		9a(1)			-	
		(2) Ir	ncrease (decrease) in amount due but unpaid		. ,			_	
		• •	ncrease (decrease) in unearned premium res						
		(4) E	Earned ((1) + (2) - (3))				9a(4)		
	b	Ben	efit charges (1) Claims paid		9b(1)				
		(2) Ir	ncrease (decrease) in claim reserves		9b(2)			_	
		(3) Ir	ncurred claims (add (1) and (2))	······			9b(3)		
			Claims charged				9b(4)		
	С	Rem	nainder of premium: (1) Retention charges (or	n an accrual basis)					
			(A) Commissions		9c(1)(A)			_	
			(B) Administrative service or other fees		9c(1)(B)				
			(C) Other specific acquisition costs		9c(1)(C)			_	
			(D) Other expenses		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies		9c(1)(F)				
			(G) Other retention charges		9c(1)(G)				
			(H) Total retention				9c(1)(H)	1	
		(2) [Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d	Stat	tus of policyholder reserves at end of year: (1)	Amount held to provide	benefits after	retirement	9d(1)		
		(2) (Claim reserves				9d(2)		
		(3) (Other reserves				9d(3)		
	е	Divi	dends or retroactive rate refunds due. (Do no	t include amount entered	d in line 9c(2)	.)	9e		_
10	No	nexp	perience-rated contracts:						
	а	Tota	al premiums or subscription charges paid to ca	arrier			10a	16590	13
	b	If the	e carrier, service, or other organization incurre	ed any specific costs in c	onnection wit	th the acquisition or			
			ntion of the contract or policy, other than repo				10b		

Pa	art IV	Provision of Information			
11	Did the i	nsurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	
40					

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

Specify nature of costs.

SCHEDULE C	Service Provider	Information	OMB No. 1210-0110	
(Form 5500)				
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under Retirement Income Security A	2017		
Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	File as an attachmen	t to Form 5500.	This Form is Open to Public Inspection.	
or calendar plan year 2017 or fiscal pla	an year beginning 08/01/2017	and ending 07/3	31/2018	
Name of plan EGC CONSTRUCTION HEALTH PLA	Ν	B Three-digit plan number (PN)	501	
Plan sponsor's name as shown on li EGC CONSTRUCTION	ne 2a of Form 5500	D Employer Identificati 61-0947016	ion Number (EIN)	
Part I Service Provider Inf	ormation (see instructions)			
or more in total compensation (i.e., n plan during the plan year. If a person	rdance with the instructions, to report the info noney or anything else of monetary value) in o n received only eligible indirect compensation include that person when completing the rem	connection with services rendered to for which the plan received the requ	the plan or the person's position with the	
received only eligible indirect comper	the name and EIN or address of each person nation. Complete as many entries as needed me and EIN or address of person who provide 3737 WEST FORK	d (see instructions). ed you disclosures on eligible indired		
82-0563218	CINCINNATI, KY 45	5247		
(b) Enter na	me and EIN or address of person who provide	ed you disclosures on eligible indired	ct compensation	
(b) Enter na	me and EIN or address of person who provide	ed you disclosures on eligible indired	ct compensation	
(b) Enter na	me and EIN or address of person who provide	ed you disclosures on eligible indired	ct compensation	
or Paperwork Reduction Act Notice	, see the Instructions for Form 5500.		Schedule C (Form 5500) 20	

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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

(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

(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

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)

SHERRILL D MORGAN & ASSOCIATES

525 WEST 5TH STREET STE. 310 COVINGTON, KY 41011

61-1008329

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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	
12	NONE	12195	Yes 🗌 No 🔀	Yes 🗌 No 🔀	0	Yes 🗌 No 🗙
			<u>```</u>			

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

CUSTOM DESIGN BENEFITS LLC

3737 WEST FORK ROAD CINCINNATI, OH 45247

(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?			
12	NONE	51846	Yes 🗌 No 🗙	Yes 🗌 No 🛛	0	Yes 🗌 No 🗙	
(a) Enter name and EIN or address (see instructions)							

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid by the plan. If none,	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	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	by the plan. If none,	(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				
	Yes No Yes Yes No Yes Yes No Yes Y								
		·	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		(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	
Yes No Yes No Yes Yes <thyes< th=""> <thyes< th=""> <thyes< th=""></thyes<></thyes<></thyes<>						Yes 🗌 No 🗍
	(a) Enter name and EIN or address (see instructions)					

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service	Relationship to	Enter direct	Did service provider	Did indirect compensation	Enter total indirect	Did the service
Code(s)	employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	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 or provides contract administrator, consulting, custodial, investment advisory, investment mana questions for (a) each source from whom the service provider received \$1,000 or more in indire provider gave you a formula used to determine the indirect compensation instead of an amount many entries as needed to report the required information for each source.	gement, broker, or recordkeepin ct compensation and (b) each s	g services, answer the following ource for whom the service
(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	formula used to determine	compensation, including any e the service provider's eligibility 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	formula used to determine	compensation, including any e the service provider's eligibility 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	formula used to determine	compensation, including any e the service provider's eligibility the indirect compensation.

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Pa	rt II Service Providers Who Fail or Refuse to I	Provide Infori	mation		
4	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	(b) Nature of	(C) Describe the information that the service provider failed or refused to		
	instructions)	Service Code(s)	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		

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e Telephone:

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:		

Explanation:

Name:	b EIN:
Position:	
Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation:

а	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:

Explanation: