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

2017

This Form is Open to Public Inspection

Part I	Annual Report Id	entification Informatio	n					
For calenda	For calendar plan year 2017 or fiscal plan year beginning 08/01/2017 and ending 07/31/2018							
A This retu	urn/report is for:	a multiemployer plan		a multiple-employer plan (Filers checking this participating employer information in accorda			ns.)	
		x a single-employer plan		a DFE (specify)				
B This retu	urn/report is:	the first return/report		the final return/report				
		an amended return/report	rt	a short plan year return/report (less than 12 r	nonths))		
C If the pla	an is a collectively-barga	nined plan, check here				• [
D Check b	ox if filing under:	X Form 5558		automatic extension	the	e DFVC program		
	special extension (enter description)							
Part II	Basic Plan Inforn	nation—enter all requested	information	1				
1a Name of plan GENSCO, INC. HEALTH CARE BENEFITS PLAN				1b	Three-digit plan number (PN) ▶	501		
					1c	Effective date of pla 06/01/1986	an	
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)					2b	2b Employer Identification Number (EIN) 91-0539873		
GENSCO, II	NC.				2c	Plan Sponsor's tele number 253-926-2032	phone	
4402 20TH STREET EAST TACOMA, WA 98424 4402 20TH STREET EAST TACOMA, WA 98424			2d	Business code (see instructions) 423700)			

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. Signature of plan administrator	04/01/2019 Date	MARCIE BUTTERFIELD Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature. Signature of employer/plan sponsor	04/01/2019 Date	MARCIE BUTTERFIELD Enter name of individual signing as employer or plan sponsor
SIGN HERE	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

		- 0		
3a	Form 5500 (2017) Plan administrator's name and address X Same as Plan Sponsor	Page 2	3b Administrator	s EIN
			3c Administrator' number	s telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed since enter the plan sponsor's name, EIN, the plan name and the plan number from the		4b EIN	
a c	Sponsor's name Plan Name		4d PN	
5	Total number of participants at the beginning of the plan year		5	568
6	Number of participants as of the end of the plan year unless otherwise stated (w 6a(2), 6b, 6c, and 6d).	elfare plans complete only lines 6a(1),		
a(1) Total number of active participants at the beginning of the plan year		<mark>6a(1)</mark>	568
a(2) Total number of active participants at the end of the plan year		6a(2)	619
	Retired or separated participants receiving benefits			2
	Other retired or separated participants entitled to future benefits		6c	621
a e	Subtotal. Add lines 6a(2) , 6b , and 6c Deceased participants whose beneficiaries are receiving or are entitled to receiv		6d	621
f	Total. Add lines 6d and 6e .		6f	621
g	Number of participants with account balances as of the end of the plan year (onl complete this item)		6g	
h	Number of participants who terminated employment during the plan year with ac less than 100% vested		6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiple to the plan (only multiple to the plan (only multiple to the plan to the pl		·· 7	
b	If the plan provides pension benefits, enter the applicable pension feature codes If the plan provides welfare benefits, enter the applicable welfare feature codes f 4A 4B 4D 4E 4H Plan funding arrangement (check all that apply)		es in the instructions:	
Ju	(1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust (4) X General assets of the sponsor	(1) X Insurance Code section 412(e)(3) Trust X General assets of the s	insurance contracts	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attac	hed, and, where indicated, enter the num	ber attached. (See	nstructions)
а	Pension Schedules (1) R (Retirement Plan Information)	b General Schedules (1) H (Financial Infor	mation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Infor (3) X 3 A (Insurance Info	mation – Small Plan) rmation)	

(4) (5)

(6)

C (Service Provider Information)

D (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

actuary

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

(3)

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.)							
If "Ye	If "Yes" is checked, complete lines 11b and 11c.						
11b Is the	e plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)						
11c Enter 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 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.)							
Rece	eipt Confirmation Code						

Form 5500 (2017)

Page 3

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

2017

This Form is Open to Public Inspection

		pursuant to	ETTIOA 30011011 103(a)(2)	•			Inspection			
For calendar plan year 20	17 or fiscal plar	year beginning 08/01/2017		and en	iding 07/31/201	8				
A Name of plan GENSCO, INC. HEALTH	CARE BENEF	ITS PLAN			e-digit number (PN)	•	501			
C Plan sponsor's name a GENSCO, INC.	s shown on line	e 2a of Form 5500			oyer Identification 0539873	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:										
(a) Name of insurance ca										
	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year			
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	1	(g) To			
06-0838648	70815	707336G	714	ļ	01/01/2018		12/31/2018			
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. Li	ist in line 3	the agents, broke	rs, and o	ther persons in			
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fee	s paid				
		0					0			
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all	persons).						
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid						
commissions pa		(c) Amount	(d) Purpose			(e) Organization code				
	(a) Name a	nd address of the agent, broker	, or other person to whor	m commiss	ions or fees were	paid				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid						
commissions pa		(c) Amount	(d) Purpose		ose		(e) Organization code			

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	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 cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	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	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)).		İ	7d	
		Deductions:	Γ			
	•	(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(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

P	art	Welfare Benefit Contract Informa If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such conti	acts are ex	perience-rated as a	a unit. Where co	entracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	v a	Supplemental u	inemployment	h Prescription drug
	; [Stop loss (large deductible)	j HMO contract	, s k	=	mompley mone	I Indemnity contract
	' <u> </u>		I HIVIO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
_							
9		erience-rated contracts:	1	- 41			
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium res		9a(3)		0-(4)	
	h	(4) Earned ((1) + (2) - (3))				9a(4)	
	b	Benefit charges (1) Claims paid		9b(1) 9b(2)			
		(2) Increase (decrease) in claim reserves				0b/2\	
		(3) Incurred claims (add (1) and (2))					
	_	(4) Claims charged				90(4)	
	С			9c(1)(A)			
		(A) Commissions(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.)		
	d	Status of policyholder reserves at end of year: (1			1		
	-	(2) Claim reserves	•			· · · · · · ·	
		(3) Other reserves				2 1/2)	
	е	Dividends or retroactive rate refunds due. (Do no					
10	No	nexperience-rated contracts:		•	•	1	
	а	Total premiums or subscription charges paid to c	arrier			10a	6749
	b	If the carrier, service, or other organization incurr	ed anv specific costs in c	onnection w	vith the acquisition	or	
		retention of the contract or policy, other than repo					
	Spe	cify nature of costs.					
Р	art	V Provision of Information					
11	Dic	I the insurance company fail to provide any inform	ation necessary to compl	ete Schedu	le A?	Yes	X No
		ne answer to line 11 is "Yes," specify the informati		2.0 2 011000			
1 4		ie answer to line i i is i les, specify the informati	on 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

2017

This Form is Open to Public Inspection

		paredant to	ETTIOA SCCIIOTI TOS(a)(z)				Inspection
For calendar plan year 20	17 or fiscal plar	year beginning 08/01/2017		and en	iding 07/31/2	018	
A Name of plan GENSCO, INC. HEALTH	CARE BENEF	TS PLAN			e-digit number (PN))	501
C Plan sponsor's name a GENSCO, INC.	s shown on line	e 2a of Form 5500		-	oyer Identificatio 0539873	n Number	(EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca		,					
(1) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or	contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) Fro	om	(g) To
91-0742147	68608	01-015119-00	642	2	01/01/2017		12/31/2017
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, bro	kers, and	other persons in
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fe	ees paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees we	re paid	
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose		(e) Organization code	
	(a) Name a	nd address of the agent, broker	, or other person to who	m commiss	ions or fees we	re paid	
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1		
(a) No.			aminaiana ar fana wara naid		
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid		
4.1.		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid		
(-)		,			
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization	
commissions paid	(c) Amount	((d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
	<u> </u>				
(b) Amount of sales and base		Fees and other commissions p		(e) Organization	
commissions paid	(c) Amount	(1	d) Purpose	code	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
		Fees and other commissions p	naid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code	
commissions paid		,	<u>, </u>	code	
(1)					
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid		
All American Control		Fees and other commissions	paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code	

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	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 cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	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	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)).		İ	7d	
		Deductions:	Γ			
	•	(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(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

F	art	III	Welfare Benefit Contract Information from the information may be combined for report employees, the entire group of such individ	group of employees of the	racts are expe	erience-rated as a unit	t. Where co	ontracts cover individual),
8	Ber	efit a	nd contract type (check all applicable boxes)						
	а	He	ealth (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	_	emporary disability (accident and sickness)	f Long-term disabilit	ty g	Supplemental unem	nlovment	h Prescription drug	
		_			: :=	<u>.</u>	pioyinciii	<u> </u>	
	Ī		op loss (large deductible)	j HMO contract	K_	PPO contract		I Indemnity contract	Į.
	m	X Ot	her (specify) AD&D						
_									
9			ce-rated contracts:	!	- (1)				
	а		iums: (1) Amount received		9a(1)				
			ncrease (decrease) in amount due but unpaid						
			ncrease (decrease) in unearned premium res	•			0-(4)		
	L	. ,	arned ((1) + (2) - (3))				. 9a(4)		
	b		efit charges (1) Claims paid						
			ncrease (decrease) in claim reserves				01- (0)		
			ncurred claims (add (1) and (2))						
	_	` '	Claims charged(1) Betarties absence (2)				. 9b(4)		
	С		nainder of premium: (1) Retention charges (c	,	00/41/41				
			(A) Commissions		9c(1)(A) 9c(1)(B)				
			(B) Administrative service or other fees (C) Other specific acquisition costs		9c(1)(C)				
			(D) Other expenses						
			(E) Taxes		A (4)(=)				
			(F) Charges for risks or other contingencies.						
			(G) Other retention charges		0 (4)(0)				
			(H) Total retention				9c(1)(H))	
			Dividends or retroactive rate refunds. (These						
	d		us of policyholder reserves at end of year: (1						
	u		Claim reserves	•			9d(1)		
		` '	Other reserves						
	е	` '	dends or retroactive rate refunds due. (Do n						
10			erience-rated contracts:	5t moldae amount enteree	2 111 1111C 3C(2)	.)	., 30		
•	a		al premiums or subscription charges paid to o	arrier			. 10a		33041
	b		e carrier, service, or other organization incuri				100		000+1
		rete	ntion of the contract or policy, other than repeature of costs.			•	10b		
F	Part '	IV	Provision of Information						
				nation nonconnected commit	oto Cobodul-	. Д	Yes	X No	
11			insurance company fail to provide any inform		ete Schedule	9 A?	169	^ INU	
12	2 If	ne an	nswer to line 11 is "Yes," specify the informat	on 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

2017

This Form is Open to Public Inspection

		parsaant to i	EI(10/4 300tion 103(a)(2)	·			Inspection
For calendar plan year 20	17 or fiscal plar	n year beginning 08/01/2017		and en	ding 07/31/201	8	
A Name of plan GENSCO, INC. HEALTH	CARE BENEF	ITS PLAN			e-digit number (PN)	•	501
C Plan sponsor's name a GENSCO, INC.	s shown on line	e 2a of Form 5500		-	oyer Identification 0539873	Number ((EIN)
		ning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca							
(1.) FINI	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	l	(g) To
35-1817054	92711	HCL13540	611		08/01/2017		07/31/2018
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	tal commissions paid. Li	st in line 3	the agents, broke	rs, and o	ther persons in
(a) Total a	amount of comr	missions paid		(b) To	otal amount of fee	s paid	
		0					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
	(a) Name a	and address of the agent, broker,	, or other person to whor	n commiss	ions or fees were	paid	
(b) Amount of sales ar	nd base	Fee	es and other commissior	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	e		(e) Organization code
	(a) Name a	and address of the agent, broker,	, or other person to whor	n commiss	ions or fees were	paid	
(b) Amount of sales and base		Fee	es and other commissior	sions paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

Schedule A (Form 5500)	2017	Page 2 – [1	
(a) No.			omicciono ar foco ware noid	
(a) Nai	me and address of the agent, broker	, or other person to whom con	nimissions or lees were paid	
4.1.		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code
(a) Na	me and address of the agent, broker	or other person to whom con	nmissions or fees were paid	
(-)		,		
(b) Amount of sales and base		Fees and other commissions p	paid	(e) Organization
commissions paid	(c) Amount	((d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
	<u> </u>			
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(1	d) Purpose	code
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
		Fees and other commissions p	naid	(e)
(b) Amount of sales and base commissions paid	(c) Amount		d) Purpose	Organization code
commissions paid		,	<u>, </u>	code
(1)				
(a) Nai	me and address of the agent, broker	, or other person to whom con	nmissions or fees were paid	
All American Control		Fees and other commissions	paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(0	d) Purpose	Organization code

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	I as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in separate accounts at year er			5	
		tracts With Allocated Funds:				
-	а	State the basis of premium rates				
	_	otato dio sado di promini ratos				
	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 cor				
	u	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan, c	heck here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participat	ion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶		-		
		(5) U guaranteed investment (4) U other 7				
				ı		
	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	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)).		İ	7d	
		Deductions:	Γ			
	•	(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(3)			
		(4) Outer (specify below)	. / C (+)			
		•				
		(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		i	7f	

ı	Page	4

Р	art	III Welfare Benefit Contract Informa	ation				
		If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	ting purposes if such cont	racts are exp	perience-rated as a un	it. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)		-	<u> </u>	-	· · · ·
	а	Health (other than dental or vision)	b Dental	С	Vision		d Life insurance
	e	Temporary disability (accident and sickness)	f Long-term disabilit	<u> </u>	Supplemental uner	nloumont	h Prescription drug
				- 5		ipioyment	
	ı	X Stop loss (large deductible)	j HMO contract	K	PPO contract		I Indemnity contract
	m	Other (specify)					
9		erience-rated contracts:			1		_
	а	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			_
		(3) Increase (decrease) in unearned premium res	•			02(4)	
	b	(4) Earned ((1) + (2) - (3))	i			9a(4)	
	D	(2) Increase (decrease) in claim reserves		(-)			_
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o					
		(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					
		(E) Taxes					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges	•				
		(H) Total retention				<u>9c(1)(H)</u>	
	_	(2) Dividends or retroactive rate refunds. (These	_				
	d	Status of policyholder reserves at end of year: (1				` ` `	
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	
10	<u>e</u>	Dividends or retroactive rate refunds due. (Do no nexperience-rated contracts:	ot include amount entered	in line 9c(2	<i>]</i> .)	9e	
10	a	Total premiums or subscription charges paid to c	earrier .			10a	189006
	_					104	109000
	b	If the carrier, service, or other organization incurretention of the contract or policy, other than report				10b	
	Spe	cify nature of costs.	5.10a a.t .,o <u>=</u> a.501	o, .opo a			.
_		Decide of before the					
P	art					1	П
11	Die	d the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No
12	lf t	he answer to line 11 is "Yes," specify the informati	ion not provided.				

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

2017

This Form is Open to Public Inspection.

For calendar plan year 2017 or fiscal plan year beginning 08/01/2017	and ending 07/31/2018	3
A Name of plan	B Three-digit	
GENSCO, INC. HEALTH CARE BENEFITS PLAN	plan number (PN)	501
	. , ,	
	_	
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Nun	nber (EIN)
GENSCO, INC.	91-0539873	
Port I Comice Dravider Information (see instructions)		
Part I Service Provider Information (see instructions)		
You must complete this Part, in accordance with the instructions, to report the inform or more in total compensation (i.e., money or anything else of monetary value) in conplan during the plan year. If a person received only eligible indirect compensation fo answer line 1 but are not required to include that person when completing the remain	nection with services rendered to the pla r which the plan received the required di	an or the person's position with the
1 Information on Persons Receiving Only Eligible Indirect Compe	ensation	
a Check "Yes" or "No" to indicate whether you are excluding a person from the remaind	der of this Part because they received on	ly eligible
indirect compensation for which the plan received the required disclosures (see instru	uctions for definitions and conditions)	Yes X No
b If you answered line 1a "Yes," enter the name and EIN or address of each person p received only eligible indirect compensation. Complete as many entries as needed (s		service providers who
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comp	pensation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comm	pensation
(b) Lines flame and Lin of address of person who provided	you disclosures on eligible mairect comp	Perisation
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comm	pensation
(b) Lines frame and Line of address of person who provided	you disclosures on eligible mander comp	Periodion
(b) Enter name and EIN or address of person who provided	you disclosures on eligible indirect comp	pensation
(W) Enter hame and Env of address of person who provided	you alsolosures on eligible mullect comp	- Ioution

Schedule C (Form 5500) 2017	Page 2- 1
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract	no provided you disclosures on eligible indirect compensation
(D) Enter name and EIN or address of person wh	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract	no provided you disclosures on eligible indirect compensation
(b) Enter name and EIN or address of person when	no provided you disclosures on eligible indirect compensation

Page 3 -	1]	
-----------------	---	---	--

Schedule C	(Earm	EE()()	2017
Scriedule C	(FOIIII	3300	201

2. Info	rmation on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you
	red "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 oney 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).
(1.6., 111	oney or anything else of value) in connection with services rendered to the plan of their position with the plan during the plan year. (See instructions).
	(a) Enter name and EIN or address (see instructions)

TRUSTEED PLANS SERVICE CORPORATION

91-0780588

Code(s) employed organ person	er, employee con	Enter direct impensation paid the plan. If none, enter -0	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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 NONE		159616	Yes No X	Yes No X	0	Yes No X

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

CWI BENEFITS

57-0870204

(b) Service Code(s)			(e) 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	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	127967	Yes No 🛚	Yes No 🛚	0	Yes No 🛚

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

FIRST CHOICE HEALTH

91-1272766

(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	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	organization, or	by the plan. If none,	compensation? (sources	compensation, for which the	service provider excluding	formula instead of
	person known to be	enter -0	other than plan or plan	plan received the required	eligible indirect	an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you	
					answered "Yes" to element	
					(f). If none, enter -0	
49	NONE	10344			0	
			Yes No X	Yes No X		Yes No X

Page	3 -	2
------	-----	---

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)	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?	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)	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?	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)	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?	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	

Page	4	-	I
------	---	---	---

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compen or provides contract administrator, consulting, custodial, investment advisory, investment ma questions for (a) each source from whom the service provider received \$1,000 or more in ind 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.	nagement, broker, or recordkeepinç lirect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes	(c) Enter amount of indirect
	(see instructions)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he 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 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 the service provider's eligibility the indirect compensation.

Page **5 -** 1

D(II O 1 D		No. 20 1 1 1 1 1 1					
this Schedule.	ide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete Schedule.						
(a) Enter name and E	IN 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 E	IN 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 E	IN 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 E	IN 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 E	IN 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 E	IN 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				

Schedule C (Form 5500) 2017

Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)				
	(complete as many entries as needed)	<u> </u>			
а	Name:	b EIN:			
С	Position:				
d	Address:	e Telephone:			
u	Address.	С теюрионе.			
Ex	planation:				
а	Name:	b EIN:			
С	Position:				
d	Address:	e Telephone:			
-		2 - S. Spriono.			
	nlanation:				
⊏X	planation:				
а	Name:	b EIN:			
С	Position:				
d	Address:	e Telephone:			
		·			
Ex	planation:				
a	Name:	b EIN:			
C	Position:				
d	Address:	e Telephone:			
Ex	planation:				
а	Name:	b EIN:			
C	Position:	₩ LIIV.			
d		e Telephone:			
u	Address:	с тејернопе:			
Ex	planation:				