Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

2018

Administration the instructions to the Form 5500.									
Pensio	n Benefit Guaranty Corporation	_			This Form is Open to Public Inspection				
Part I	Annual Report Id	entification Information							
For caler	ndar plan year 2018 or fisc	al plan year beginning 01/01/2018		and ending 12/31/20	018				
A This	A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)								
B This	return/report is:	the first return/report	the final return	·					
		an amended return/report	a short plan ye	ear return/report (less than 1	2 months)				
C If the	plan is a collectively-barga	ained plan, check here				•			
D Chec	k box if filing under:	Form 5558	automatic exter	nsion	the	e DFVC program			
		special extension (enter description	<u> </u>		_				
Part II	Basic Plan Inform	nation—enter all requested information							
_	ne of plan	oner an requested information	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1b	Three-digit plan			
		C WELFARE BENEFIT PLAN				number (PN) ▶	501		
	,				1c	Effective date of pl 01/01/2008	an		
2a Plan sponsor's name (employer, if for a single-employer plan)2bEmployer IdentificationMailing address (include room, apt., suite no. and street, or P.O. Box)Number (EIN)City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)82-0427863							ation		
C-A-L ST	ORES COMPANIES, INC				2c Plan Sponsor's telephone number 208-523-3359				
	NDERSON ALLS, ID 83403	665 E. ANDERSON IDAHO FALLS, ID 83403			2d Business code (see instructions) 453990				
Caution	: A penalty for the late or	incomplete filing of this return/repor	rt will be assessed	unless reasonable cause i	s establis	shed.			
		er penalties set forth in the instructions, ell as the electronic version of this return							
SIGN HERE	Filed with authorized/valid	electronic signature.	04/19/2019	BROCK LEONARDSON					
TILIXE	Signature of plan admir	nistrator	Date	Enter name of individual s	igning as	plan administrator			
SIGN HERE					-				
HEIKE	Signature of employer/	plan sponsor	Date	Enter name of individual s	igning as	employer or plan sp	onsor		

Date

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

SIGN HERE

Signature of DFE

Form 5500 (2018) v. 171027

Enter name of individual signing as DFE

Form 5500 (2018) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **4d** PN a Sponsor's name Plan Name Total number of participants at the beginning of the plan year 162 5 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 162 6a(1) a(1) Total number of active participants at the beginning of the plan year 168 a(2) Total number of active participants at the end of the plan year 6a(2)Retired or separated participants receiving benefits. 6b 6c Other retired or separated participants entitled to future benefits...... 168 6d Subtotal. Add lines 6a(2), 6b, and 6c.... Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e 168 Total. Add lines 6d and 6e. 6f

y	complete this item)	· · · · · · · · · · · · · · · · · · ·]
h	Number of participants who terminated employment during the plan year with less than 100% vested	l 61	1
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer plans complete this item) 7	
8a	If the plan provides pension benefits, enter the applicable pension feature co	des from the List of Plan Characteristics Codes in t	he instructions:
L			
b	If the plan provides welfare benefits, enter the applicable welfare feature code	es from the List of Plan Characteristics Codes in th	e instructions:
	4B 4D 4E 4H		
9a	Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that app	oly)
	(1) X Insurance	(1) X Insurance	,,
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) insura	ance contracts
	(3) Trust	(3) Trust	
	(4) General assets of the sponsor	(4) General assets of the sponso	r
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, where indicated, enter the number at	ached. (See instructions)
а	Pension Schedules	b General Schedules	
	(1) R (Retirement Plan Information)	(1) H (Financial Information	n)
		(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 Informatio	n)
	actuary	(4) C (Service Provider Info	ormation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participating Pla	an Information)
	Information) - signed by the plan actuary	(6) G (Financial Transactio	n Schedules)

Form 5500 (2018)

Page 3

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

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.)
11b Is the 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 2018 Form M-1 annual report. If the plan was not required to file the 2018 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.) Receipt Confirmation Code

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.

OMB No. 1210-0110

2018

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).					This Fo	rm is Open to Public Inspection		
For calendar	plan year 20°	18 or fiscal pla	an year beginning 01/01/2018		and er	nding 12/31	1/2018	
A Name of p		NIES, INC WE	ELFARE BENEFIT PLAN			e-digit number (PN) >	501
C Plan sponsor's name as shown on line 2a of Form 5500 C-A-L STORES COMPANIES, INC D Employer Identification Number 82-0427863					(EIN)			
Part I	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 COLONIAL LI			NCE COMPANY			I	Daliavana	
(b) i	ΞIN	(c) NAIC code	(d) Contract or identification number	` ' ' '	(e) Approximate number of persons covered at end of		From	(g) To
57-0144607		62049	E7760945	12		01/01/2018	}	12/31/2018
		mission inform amount paid	nation. Enter the total fees and tot	tal commissions paid. L	ist in line 3	the agents, t	orokers, and	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
	301							
3 Persons re	eceiving com	missions and	fees. (Complete as many entries	as needed to report all	persons).			
		(a) Name	and address of the agent, broker,	•	m commiss	ions or fees	were paid	
VIRGINIA KE	ZELE			W PINCHOT AVE YEAR, AZ 85395				
(b) Amou	nt of sales ar	nd hase	Fe	es and other commissio	ns paid			
	nmissions pai		(c) Amount		(d) Purpose			(e) Organization code
		7						3
		(a) Name	and address of the agent, broker,	, or other person to who	m commiss	ions or fees	were paid	
ZINA OSTER				FOREST DR ENNE, WY 82001				
(b) Am	nt of aclas ==	nd boos	Fe	es and other commissio	ns paid			
	nt of sales ar nmissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	, ,	9						3
								

Schedule A (Form 5500)	2018	Page 2 - 1		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions o	or fees were paid	
WILLIAM KEZELE	PO B	OX 5597 FALLS, ID 83303		
(b) Assessed of soles and have		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose		Organization code
4				3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions o	or fees were paid	
MATTHEW B WALDRAM	PO B	OX 2751 O FALLS, ID 83403		
(h) Amount of color and base		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose		Organization code
266				3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions o	or fees were paid	
DENISE A MAXWELL		W TORANA DR DIAN, ID 83646		
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose		code
15				3
(a) Na	me and address of the agent, broke	r, or other person to whom commissions o	or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid		(e) Organization
commissions paid	(c) Amount	(d) Purpose		code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions o	or fees were paid	
(h) America ()		Fees and other commissions paid		(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose		Organization code

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of							
		this report.							
		ent value of plan's interest under this contract in the general account at year			4				
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5				
6		racts With Allocated Funds:							
	а	State the basis of premium rates							
	b	Premiums paid to carrier			6b				
	C	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d				
		retention of the contract or policy, enter amount.			0 4				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here					
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)					
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee					
		(3) guaranteed investment (4) other							
		_							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>					
		(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		<u> </u>	7c(6)				
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d				
	е	Deductions:							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)						
		(2) Administration charge made by carrier	. 7e(2)						
		(3) Transferred to separate account	. 7e(3)						
		(4) Other (specify below)	. 7e(4)						
		•							
	_	(5) Total deductions			7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f				

P	art	III	Welfare Benefit Contract Informal If more than one contract covers the same		e same emplo	over(s) or members of t	the same er	mplovee organizations(s).
			the information may be combined for repor employees, the entire group of such individ	ting purposes if such conti	racts are expe	erience-rated as a unit	. Where co	ntracts cover individual	,,
8	Ben	efit a	and contract type (check all applicable boxes)						
	а	Н	ealth (other than dental or vision)	b Dental	С	Vision		d X Life insurance	
	е	= To	emporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental unemp	oloyment	h Prescription drug	
	i	_	top loss (large deductible)	j HMO contract	, 5 <u> </u>	PPO contract		I Indemnity contract	t
	m	_	Other (specify)		_	1			
9	Exp	erien	ce-rated contracts:						
	а		niums: (1) Amount received		9a(1)				
			Increase (decrease) in amount due but unpai						
			Increase (decrease) in unearned premium res	· · · · · · · · · · · · · · · · · · ·			- (1)		
			Earned ((1) + (2) - (3))				9a(4)		C
	b		nefit charges (1) Claims paid						
		. ,	Increase (decrease) in claim reserves				01- (0)		
			Incurred claims (add (1) and (2))				9b(3)		
	_		Claims charged				9b(4)		
	С	Rei	mainder of premium: (1) Retention charges (c	, i	0-(4)(A)				
			(A) Commissions		9c(1)(A)				
			(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)				
			(C) Other specific acquisition costs		9c(1)(D)				
			(E) Taxes		9c(1)(E)				
			(F) Charges for risks or other contingencies.		9c(1)(F)				
			(G) Other retention charges						
			(H) Total retention	•			9c(1)(H)		
		(2)	Dividends or retroactive rate refunds. (These	_	_		9c(2)		
	d		itus of policyholder reserves at end of year: (1				9d(1)		
	u		Claim reserves				9d(2)		
		. ,	Other reserves				9d(3)		
	е	` '	idends or retroactive rate refunds due. (Do n				9e		
10			perience-rated contracts:	<u> </u>		,			
	а		al premiums or subscription charges paid to	carrier			10a		5659
	b		ne carrier, service, or other organization incur						
		rete	ention of the contract or policy, other than rep nature of costs.				10b		
		,							
P	art	IV	Provision of Information						
			insurance company fail to provide any inform	nation noncessu to semal	oto Sobodula	. Д	Yes	X No	
			nsurance company fall to provide any informates insurance company fall to provide any informates insurance company fall to provide any informates.		ere ocheanle	Λ (103	<u> </u>	
12	11 (пе а	nswer to line it is ites, specify the informat	ion not provided. 🔻					

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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018				and ending 12/31/2018			
A Name of plan C-A-L STORES COMPAN	NIES, INC WEL	FARE BENEFIT PLAN		B Thre	501		
				-			
·	·				oyer Identification Number (0427863	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		AMERICA					
(1) FIN	(c) NAIC	(d) Contract or	(e) Approximate nur		Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f) From	(g) To	
01-0278678	62235	R0620849	72		12/31/2017	12/31/2018	
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total a	amount of com	missions paid		(b) To	otal amount of fees paid		
		5746					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	s as needed to report all p	ersons).			
		nd address of the agent, broker		commiss	ions or fees were paid		
CASTLE LAKE INSURANCE	CE LLC		OX 2751 O FALLS, ID 83403				
(b) Amount of sales ar	nd base	Fe	es and other commissions	s paid			
commissions pai		(c) Amount	(0	d) Purpos	e	(e) Organization code	
	1489					3	
	(a) Name a	nd address of the agent, broker	, or other person to whom	commiss	ions or fees were paid		
GRIFFIN, STEVEN RAY STE 1400 2000 MORRIS AVE BIRMINGHAM, AL 35203							
(h) Amount of sales ar	nd hase	Fe	es and other commissions	s paid			
(b) Amount of sales and base commissions paid (c) Amount			(0	d) Purpos	e	(e) Organization code	
	3678	579				3	
For Paperwork Reductio	n Act Notice,	see the Instructions for Form	5500.		Sched	dule A (Form 5500) 2018	

Schedule A (Form 5500) 2018	Page 2 – 1	
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		From and other constitutions and	(-)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
, ,	<u> </u>		
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Na	The standard of the stand business		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization
commissions paid	(0)	(a) supers	code
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
	T		1
(h) Amount of sales and hase		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
			Organization

Part II		Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of							
		this report.							
		ent value of plan's interest under this contract in the general account at year			4				
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5				
6		racts With Allocated Funds:							
	а	State the basis of premium rates							
	b	Premiums paid to carrier			6b				
	C	Premiums due but unpaid at the end of the year			6c				
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d				
		retention of the contract or policy, enter amount.			0 4				
		Specify nature of costs							
	е	Type of contract: (1) individual policies (2) group deferred	d annuity						
		(3) other (specify)							
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here					
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)					
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee					
		(3) guaranteed investment (4) other							
		_							
	b	Balance at the end of the previous year			7b				
	С	Additions: (1) Contributions deposited during the year	. 7c(1)	<u>.</u>					
		(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		<u> </u>	7c(6)				
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d				
	е	Deductions:							
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)						
		(2) Administration charge made by carrier	. 7e(2)						
		(3) Transferred to separate account	. 7e(3)						
		(4) Other (specify below)	. 7e(4)						
		•							
	_	(5) Total deductions			7e(5)				
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f				

Ρ	art III	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	ting purposes if such con	tracts are expe	erience-rated as a unit.	Where cor	ntract	ts cover individual
8	Benefit	t and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	Vision		d X	Life insurance
	е 🗍	Temporary disability (accident and sickness)	f Long-term disabil	ity \mathbf{g}	Supplemental unempl	ovment	h∏	Prescription drug
	. =	Stop loss (large deductible)	j HMO contract	· - <u>-</u>	PPO contract	.,	브	Indemnity contract
			I I I I I I I I I I I I I I I I I I I	K_	FFO Contract		•□	indenning contract
	m X	Other (specify) •ADD						
Δ.	François							
9	•	ence-rated contracts:		00/1)			-	
		emiums: (1) Amount received) Increase (decrease) in amount due but unpaid		 			_	
	,) Increase (decrease) in amount due but unpaid) Increase (decrease) in unearned premium res					-	
) Farned ((1) + (2) - (3))				9a(4)		
	_ `	enefit charges (1) Claims paid				<u> </u>		
) Increase (decrease) in claim reserves		21 (2)			-	
	,) Incurred claims (add (1) and (2))				9b(3)	_	
	•) Claims charged			-	9b(4)	_	
	,	emainder of premium: (1) Retention charges (c			_			
		(A) Commissions	············	9c(1)(A)			_	
		(B) Administrative service or other fees		. (1)(5)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses						
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges		9c(1)(G)	[
		(H) Total retention	_	_	F	9c(1)(H)	<u> </u>	
	(2	2) Dividends or retroactive rate refunds. (These	amounts were paid in	n cash, or	credited.)	9c(2)		
	d S	tatus of policyholder reserves at end of year: (1) Amount held to provide	benefits after	retirement	9d(1)		
	(2	2) Claim reserves				9d(2)	┷	
	,	3) Other reserves				9d(3)		
40		vividends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2) .	.)	9e	_	
10		experience-rated contracts:			Г			
		otal premiums or subscription charges paid to c				10a	+	17452
	re	the carrier, service, or other organization incur- etention of the contract or policy, other than rep- y nature of costs.	, ,		•	10b		
	art IV	Provision of Information						
11	Did th	ne insurance company fail to provide any inform	nation necessary to comp	lete Schedule	A?	Yes	X No	0
12	If the	answer to line 11 is "Yes," specify the informat	ion not provided.					

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

OMB No. 1210-0110

2018

This Form is Open to Public

		pursuant to El	RISA section 103(a)(2).			110 1 011	Inspection	
For calendar plan year 20	18 or fiscal plar	year beginning 01/01/2018		and en	ding 12/3	1/2018		
A Name of plan C-A-L STORES COMPAN	NIES, INC WEL	FARE BENEFIT PLAN		B Three	e-digit number (PN	N) •	501	
C Plan sponsor's name as shown on line 2a of Form 5500 C-A-L STORES COMPANIES, INC D Employer Identification Number (EIN) 82-0427863					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 UNITED HERITAGE LIFE		COMPANY						
# N = N .	(c) NAIC	(d) Contract or	(e) Approximate nur			Policy or co	ontract year	
(b) EIN	code	identification number	persons covered at policy or contract		(f)	From	(g) To	
82-0123320	63983	GV-3106	155		01/01/2018	3	12/31/2018	
	2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.							
(a) Total amount of commissions paid (b) Total amount of fees paid								
		2294						
3 Persons receiving com	missions and fe	ees. (Complete as many entries a	as needed to report all p	ersons).				
	(a) Name a	nd address of the agent, broker, o		commiss	ions or fees	were paid		
MATTHEW WALDRAM			ITLER DR FALLS, ID 83404					
(b) Amount of sales ar	nd base	Fees	s and other commissions	s paid				
commissions pa		(c) Amount	(0	d) Purpose)		(e) Organization code	
	2294						3	
	(a) Name a	nd address of the agent, broker, o	or other person to whom	commissi	ions or fees	were paid		
(b) Amount of sales and base Fees and other commissions paid								
commissions pa		(c) Amount	(0	(d) Purpose			(e) Organization code	

Schedule A (Form 5500) 2018	Page 2 – 1			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
			(5)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me 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) Na					
(a) Na	me 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	(c) Amount	(d) Purpose	Organization		
commissions paid	(0)	(4) - 3-1-2-3	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T				
	•	Fees and other commissions paid			
(b) Amount of sales and base		·	(e) Organization		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
		·	Organization		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d	
		retention of the contract or policy, enter amount.			0 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

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	Jai contracts with each ca	irrier may be	treated as a unit for pu	irposes or t	nis report.
8	Ben	efit and contract type (check all applicable boxes)	_				_
	а	Health (other than dental or vision)	b Dental	CX	Vision		d Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental unemp	oloyment	h Prescription drug
	i	Stop loss (large deductible)	j HMO contract	k □	PPO contract		I Indemnity contract
	m	Other (specify)	• 🗆				
	•••						
a	Evn	erience-rated contracts:					
9		Premiums: (1) Amount received	Г	9a(1)			
	u	(2) Increase (decrease) in amount due but unpaid	•	9a(1)			
		(3) Increase (decrease) in unearned premium res	The state of the s	9a(3)			
		(4) Earned ((1) + (2) - (3))	-			9a(4)	
	b	Benefit charges (1) Claims paid	Г	9b(1)		3a(+)	
		(2) Increase (decrease) in claim reserves	ļ ·				
		(3) Incurred claims (add (1) and (2))	L.	. , ,		9b(3)	
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (o				35(4)	
	C	, , , , , , , , , , , , , , , , , , , ,	· · · · · · · · · · · · · · · · · · ·	9c(1)(A)			
		(A) Commissions(B) Administrative service or other fees		9c(1)(B)			
				9c(1)(C)			
		(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)			
		(E) Taxes					
		(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					
	d	Status of policyholder reserves at end of year: (1	_			9d(1)	
	u	(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do no				9e	
10	_	nexperience-rated contracts:	21 morado dimodrit oritorod	· · · · · · · · · · · · · · · · · · ·	.,		
. •	a	Total premiums or subscription charges paid to c	arrier			10a	22939
		If the carrier, service, or other organization incurr					22000
	b	retention of the contract or policy, other than repo	, ,		•	10b	
	Spe	cify nature of costs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	o, .op o ao			1
	-	•					
P	art	IV Provision of Information					
			untion nonconstruction of the	oto Cobodul-	Λ2 Π	Yes	X No
		d the insurance company fail to provide any inform		ete Schedule	A!	162	NO INO
12	ıt t	he answer to line 11 is "Yes," specify the informati	on not provided. 🕨				

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

OMB No. 1210-0110

2018

	pursuant to ERISA section 103(a)(2).						
For calendar plan year 20)18 or fiscal plar	n year beginning 01/01/2018	and er	nding 12/31/2018			
A Name of plan C-A-L STORES COMPA	NIES, INC WEL	FARE BENEFIT PLAN		e-digit number (PN)	501		
C Plan sponsor's name a		e 2a of Form 5500		oyer Identification N 0427863	lumber (EIN)		
		rning Insurance Contract (Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca							
4 N = 10 L	(c) NAIC	(d) Contract or	(e) Approximate number of	Pol	icy or contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To		
82-0229431	47791	4422	168	01/01/2018	12/31/2018		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	commissions paid. List in line 3	the agents, brokers	s, and other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
		10002			20049		
3 Persons receiving con	nmissions and fo	ees. (Complete as many entries a	s needed to report all persons).				
		and address of the agent, broker, o	or other person to whom commiss	ions or fees were p	paid		
CASTLE LAKE INSURAN	CE LLC	PO BOX IDAHO F	2751 FALLS, ID 83403				
(b) Amount of sales a	nd base	Fees	and other commissions paid				
commissions pa		(c) Amount	(d) Purpos	(e) Organization code			
	10002				3		
	(a) Name a	and address of the agent, broker, o	or other person to whom commiss	ions or fees were p	paid		
DELTA DENTAL OF IDAH		555 E P/	ARKCENTER BLVD D 82029-9431				
(b) Amount of sales a							
commissions pa		(c) Amount	(d) Purpos	(e) Organization code			
		20049 AD	MINISTRATIVE DUTIES		3		
For Donomicont Doducti	an Act Notice	and the Instructions for Form FF	200		Sahadula A (Farm FF00) 2019		

Schedule A (Form 5500) 2018	Page 2 – 1			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
			(5)		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me 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) Na					
(a) Na	me 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	(c) Amount	(d) Purpose	Organization		
commissions paid	(0)	(4) - 3-1-2-3	code		
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid			
	T				
	•	Fees and other commissions paid			
(b) Amount of sales and base		·	(e) Organization		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code		
		·	Organization		

F	Part	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts v	vith each carrier may be	e treated as a	a unit for purposes of
		this report.				
		ent value of plan's interest under this contract in the general account at year			4	
-		ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6		racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co		 	6d	
		retention of the contract or policy, enter amount.			0 4	
		Specify nature of costs				
	е	Type of contract: (1) individual policies (2) group deferred	d annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termination	ating plan, chec	ck here		
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in sepa	rate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(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		<u> </u>	7c(6)	
	ď	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	. 7e(3)			
		(4) Other (specify below)	. 7e(4)			
		•				
	_	(5) Total deductions			7e(5)	
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

P	art	III	Welfare Benefit Contract Information one contract covers the same the information may be combined for report employees, the entire group of such individ	group ting pu	of e	ses if s	such co	ntracts a	re expe	erience-rated as a ur	nit. Where o	ontract	ts cover individual
8	Ben	efit a	nd contract type (check all applicable boxes)										
	а	Не	ealth (other than dental or vision)	bX	De	ental			С	Vision		d	Life insurance
	е	_ Te	emporary disability (accident and sickness)	f∏	Lor	ng-terr	m disab	ility	g	Supplemental uner	mployment	h∏	Prescription drug
	ιĖ	=	op loss (large deductible)	i⊢	-	ЛО con		Í		PPO contract	, ,	- =	Indemnity contract
	L	_		, 🗆	1	10 0011	maor		∟	110001111401		• Ш	machinity contract
	m	_ 0	ther (specify)										
a	Evne	rion	ce-rated contracts:										
,			niums: (1) Amount received					9a(1)		10001	0	
	u .		ncrease (decrease) in amount due but unpaid								22		
			ncrease (decrease) in unearned premium res									_	
		` '	Earned ((1) + (2) - (3))								9a(4)		100245
	b	. ,	efit charges (1) Claims paid										
		(2) lı	ncrease (decrease) in claim reserves					9b((2)				
			ncurred claims (add (1) and (2))								9b(3)		
		(4) (Claims charged								9b(4)		
	C	Ren	nainder of premium: (1) Retention charges (o	n an a	accru	ual bas	sis)		1				
			(A) Commissions										
			(B) Administrative service or other fees					0 (4)					
			(C) Other specific acquisition costs										
			(D) Other expenses					0 - /4					
			(E) Taxes										
			(F) Charges for risks or other contingencies			•••••		90(1))(F)				
			(G) Other retention charges(H) Total retention								9c(1)(H	1)	
			Dividends or retroactive rate refunds. (These			_			_			'	
	٨		tus of policyholder reserves at end of year: (1			L.							
	d		Claim reserves										
		` '	Other reserves										
	е	` '	dends or retroactive rate refunds due. (Do n										
10			perience-rated contracts:						(-/	,			
	а		al premiums or subscription charges paid to c	arrier							10a		
	b Spe	If th	e carrier, service, or other organization incurrention of the contract or policy, other than rependenture of costs.	red an	ny sp	ecific o	costs in	connecti	on wit	h the acquisition or			
	art l		Provision of Information										
11	Dic	l the	insurance company fail to provide any inform	ation	nece	essary	to com	plete Scl	nedule	A?	Yes	X N	0
12	! If t	ne ar	nswer to line 11 is "Yes," specify the informati	ion no	t pro	ovided.	. •						