Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2016

This Form is Open to Public Inspection

Part I Annual Report Identification Information			
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016		and ending 12/31/2016	
A This return/report is for:		ployer plan (Filers checking this employer information in accordan	
	a DFE (specify	y)	
B This return/report is: ☐ the first return/report	the final return	n/report	
an amended return/report	a short plan ye	ear return/report (less than 12 m	onths)
C If the plan is a collectively-bargained plan, check here			
D Check box if filing under:	automatic exte	nsion	the DFVC program
special extension (enter description			
Part II Basic Plan Information—enter all requested information	on ·		
1a Name of plan EMERITI RETIREE HEALTH PLAN FOR ST. OLAF COLLEGE			1b Three-digit plan number (PN) ▶ 513
			1c Effective date of plan 01/01/2006
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	e (if foreign, see instr	ructions)	2b Employer Identification Number (EIN) 41-0693979
ST. OLAF COLLEGE			2c Plan Sponsor's telephone number 507-786-3022
1520 ST OLAF AVENUE NORTHFIELD, MN 55057			2d Business code (see instructions) 611000
Caution: A penalty for the late or incomplete filing of this return/repor	t will be assessed	unless reasonable cause is es	tablished.
Under penalties of perjury and other penalties set forth in the instructions, statements and attachments, as well as the electronic version of this return	I declare that I have	examined this return/report, inclu	uding accompanying schedules,
SIGN Filed with authorized/valid electronic signature.	09/15/2017	NATHAN ENGLE	
HERE Signature of plan administrator	Date	Enter name of individual signii	ng as plan administrator
SIGN			
HERE Signature of employer/plan sponsor	Date	Enter name of individual signir	ng as employer or plan sponsor
SIGN HERE			
Signature of DFE	Date	Enter name of individual signir	ng as DFE
Preparer's name (including firm name, if applicable) and address (include r	oom or suite numbe	r) Prepa	rer's telephone number

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### If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name. ### Ab EIN ### Ab EIN ### Ab EIN ### Ab EIN ### Ab Sponsor's name	3a	Plan administrator's name and address X Same as Plan Sponsor			3b Ad	lministrator's EIN
Ell and the plan number from the last return/report: a Sponsor's name 5 Total number of participants at the beginning of the plan year 6 Rel(2), 66, 6c, and 6d). a(1) Total number of participants at the beginning of the plan year. 6a(1) 65 6a(2), 66, 6c, and 6d). 6a(1) 65 6a(2) 65 6a(2) 65 6a(2) 65 6a(2) 65 6a(2) 65 6a(3) 65 6a(2) 65 6a(3) 65 6a(2) 65 6a(3) 65 6a(3) 65 6a(4) 65 6a(5) 65 6a(6) 65 6a(7) 65 6a(8) 301 6a(9) 301 6a(8) 301 6a(9) 301 6a(1) 401 6a(1) 401					1	•
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5 Total number of participants at the beginning of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year	4		n/report filed for this	s plan, enter the name,	4b EI	N
Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year	а	Sponsor's name			4c PN	1
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). a(1) Total number of active participants at the beginning of the plan year	5	Total number of participants at the beginning of the plan year	,		5	93:
According to the participants at the end of the plan year Sa(2) 656	6		d (welfare plans co	mplete only lines 6a(1),		
b Retired or separated participants receiving benefits	a(1) Total number of active participants at the beginning of the plan year			6a(1)	66
C Other retired or separated participants entitled to future benefits	a(2) Total number of active participants at the end of the plan year			6a(2)	656
d Subtotal. Add lines 6a(2), 6b, and 6c	b	Retired or separated participants receiving benefits			6b	30
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e. g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item). h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	С	Other retired or separated participants entitled to future benefits			6c	
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a(2), 6b, and 6c.			6d	957
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	е	Deceased participants whose beneficiaries are receiving or are entitled to re	ceive benefits		6e	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested. 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	f	Total. Add lines 6d and 6e.			6f	A CONTRACTOR
less than 100% vested	g				6g	
Ba 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 4D 9a Plan funding arrangement (check all that apply)	h	Number of participants that terminated employment during the plan year with less than 100% vested	n accrued benefits t	that were	6h	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4D 9a Plan funding arrangement (check all that apply) (1)	7	Enter the total number of employers obligated to contribute to the plan (only	multiemployer plan	ns complete this item)	7.	
(1)	b	If the plan provides welfare benefits, enter the applicable welfare feature coc 4A 4D	des from the List of	Plan Characteristics Codes	s in the ir	
(3) X Trust (4) General assets of the sponsor (4) General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) X Trust General assets of the sponsor b General Schedules (1) H (Financial Information) (1) H (Financial Information – Small Plan) (3) A (Insurance Information) C (Service Provider Information) C (Service Provider Information) D (DFE/Participating Plan Information)	9a				at apply)	
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(4) General assets of the sponsor 10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (4) General assets of the sponsor (5) General assets of the sponsor (6) General assets of the sponsor (7) General assets of the sponsor (8) General assets of the sponsor (9) I (Financial Information) (1) X H (Financial Information – Small Plan) (3) A (Insurance Information) C (Service Provider Information) D (DFE/Participating Plan Information)			\-/		ii isarario	Contracts
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Purchase Plan Actuarial Information) - signed by the plan actuary (3)					nation)	
(-)		Purchase Plan Actuarial Information) - signed by the plan	(3)	4 A (Insurance Inform C (Service Provide	mation) er Informa	ation)
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Part III Form M-1 Compliance Information (to be o	completed by welfare benefit plans)		
11a If the plan provides welfare benefits, was the plan subject to the 2520.101-2.) ☐ Yes ☑ No	Form M-1 filing requirements during the plan year? (S	ee instruction	ons and 29 CFR
If "Yes" is checked, complete lines 11b and 11c.			
11b Is the plan currently in compliance with the Form M-1 filing requ	uirements? (See instructions and 29 CFR 2520.101-2.)		Yes No
11c Enter the Receipt Confirmation Code for the 2016 Form M-1 an Receipt Confirmation Code for the most recent Form M-1 that w Receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code for the 2016 Form M-1 and Receipt Confirmation Code for the 2016 Form M-1 and Receipt Confirmation Code for the most recent Form M-1 that we receipt Confirmation Code for the most recent Form M-1 and Receipt Confirmation Code for the most recent Form M-1 and Receipt Confirmation Code for the most recent Form M-1 and Receipt Confirmation Code for the most recent Form M-1 that we receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form 5500 filing to receipt Confirmation Code will subject the Form Source Code will subject the Form Sou	vas required to be filed under the Form M-1 filing requir		
Receipt Confirmation Code			

SCHEDULE A

(Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

For calendar plan year 20	16 or fiscal pla	n year beginning 01/01/2016		and e	nding 12/31/2016	mapection
A Name of plan EMERITI RETIREE HEAL	TH PLAN FOR	R ST. OLAF COLLEGE			ee-digit n number (PN)	513
C Plan sponsor's name a ST. OLAF COLLEGE	s shown on lir	e 2a of Form 5500			oyer Identification Numb 0693979	er (EIN)
Part I Informat on a separa	ion Conce ate Schedule A	rning Insurance Contract. Individual contracts grouped	ct Coverage, Fees, as a unit in Parts II and II	and Cor	nmissions Provide in eported on a single Sche	formation for each contract dule A.
1 Coverage Information:						
(a) Name of insurance car AETNA LIFE INSURANCE						
(1) FILL	(c) NAIC	(d) Contract or	(e) Approximate nu		Policy or	contract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
06-6033492	60054	82036382038637	9	*	01/01/2016	12/31/2016
descending order of the	mission information amount paid.	ation. Enter the total fees and to	tal commissions paid. Li		the agents, brokers, and	other persons in
3 Persons receiving comm		ees. (Complete as many entries			cions or fees were naid	
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(b) Amount of sales an	d base	Fe	es and other commission	s paid		
commissions paid		(c) Amount	· (d) Purpos	е	(e) Organization code
	(a) Name a	and address of the agent, broker	or other person to whom	n commiss	ions or fees were paid	
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(b) Amount of sales and commissions paid		(c) Amount	es and other commission	s paid d) Purpose	e	(e) Organization code
SAMMOOTO PAIC	-	(5). 3.130111		<u>-, r urposi</u>	<u></u>	(e) Organization code

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4 Current value of plan's interest under this contract in the general account at year end	Par	rt II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indi this report.	vidual contracts with each carrier ma	y be treate	ed as a unit for purposes of
5 Current value of plan's interest under this contract in separate accounts at year end	4 Cu		r end	4	
6 Contracts With Allocated Funds: a State the basis of premium rates b b Premiums paid to carrier. c Premiums due but unpaid at the end of the year. d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or rotention of the contract or policy, enter amount. Specify nature of costs b e Type of contract: (1) individual policies (2) group deferred annuity (3) other (specify) b f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here for the contract of the previous year. 7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other b b Balance at the end of the previous year. (2) Dividends and credits. (2) Dividends and credits. (2) Dividends and credits. (3) interest credited during the year. (4) Transferred from separate account. (5) Other (specify below). (6) Other (specify below). (7) Contracts of the previous year annuities during year (2) Administration charge made by carrier. (3) Transferred for separate account. (4) Other (specify below). 7 Ce(3) 7 Ce(3) 7 Ce(4) 7 Ce(3) 7 Ce(4) 7 Ce(4) 7 Ce(5) 7 Ce(5) 7 Ce(6) 7 Ce(6) 7 Ce(6) 7 Ce(6) 7 Ce(7) 7 Ce(
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7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other b Balance at the end of the previous year 7c(1) 7b 0 c Additions: (1) Contributions deposited during the year 7c(2) 7c(2) 7c(3) 7c(3) 7c(3) 7c(3) 7c(4) 7c(5) 7c(5) 7c(5) 7c(5) 7c(5) 7c(6)		(3) other (specify)			
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts) a Type of contract: (1) deposit administration (2) immediate participation guarantee (3) guaranteed investment (4) other b Balance at the end of the previous year 7c(1) 7b 0 c Additions: (1) Contributions deposited during the year 7c(2) 7c(2) 7c(3) 7c(3) 7c(3) 7c(3) 7c(4) 7c(5) 7c(5) 7c(5) 7c(5) 7c(5) 7c(6)					
a Type of contract: (1) deposit administration (2) minmediate participation guarantee (3) guaranteed investment (4) other b Balance at the end of the previous 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 of balance and additions (add lines 7b and 7c(6)) 7c(5) 7c(5) 7c(6) 7d	f	If contract purchased, in whole or in part, to distribute benefits from a termi	nating plan, check here		
a Type of contract: (1) deposit administration (2) minmediate participation guarantee (3) guaranteed investment (4) other b Balance at the end of the previous 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 of balance and additions (add lines 7b and 7c(6)) 7c(5) 7c(5) 7c(6) 7d	7 Co	ontracts With Unallocated Funds (Do not include portions of these contracts m	aintained in separate accounts)		
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b Balance at the end of the previous year 7c(1) c Additions: (1) Contributions deposited during the year 7c(2) (2) Dividends and credits			· · · · · ·		
C Additions: (1) Contributions deposited during the year		(3) guaranteed investment (4) other			
C Additions: (1) Contributions deposited during the year					
C Additions: (1) Contributions deposited during the year					
(2) Dividends and credits				7b	0
(3) Interest credited during the year	С	, ,			
(4) Transferred from separate account (5) Other (specify below) (6)Total additions		· ·			
(6)Total additions 7c(6) 0 d Total of balance and additions (add lines 7b and 7c(6)). 7d 0 e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier 7e(2) (3) Transferred to separate account (4) Other (specify below) 7e(4)		(3) Interest credited during the year			
(6)Total additions					
d Total of balance and additions (add lines 7b and 7c(6)). e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier. (3) Transferred to separate account. (4) Other (specify below). (5) Total deductions. 7d 7e(1) 7e(2) 7e(3) 7e(4)		(5) Other (specify below)	7c(5)		
d Total of balance and additions (add lines 7b and 7c(6)). e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier. (3) Transferred to separate account. (4) Other (specify below). (5) Total deductions. 7e(5) 7d 7e(1) 7e(2) 7e(3) 7e(4)					
d Total of balance and additions (add lines 7b and 7c(6)). e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier. (3) Transferred to separate account. (4) Other (specify below). (5) Total deductions. 7d 7e(1) 7e(2) 7e(3) 7e(4)					
d Total of balance and additions (add lines 7b and 7c(6)). e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier. (3) Transferred to separate account. (4) Other (specify below). (5) Total deductions. 7d 7e(1) 7e(2) 7e(3) 7e(4)	7				
d Total of balance and additions (add lines 7b and 7c(6)). e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier. (3) Transferred to separate account. (4) Other (specify below). (5) Total deductions. 7d 7e(1) 7e(2) 7e(3) 7e(4)		(6)Total additions		7c(6)	0
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier	ď				0
(1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier		• • • • • • • • • • • • • • • • • • • •			
(2) Administration charge made by carrier			7e(1)		
(3) Transferred to separate account					
(4) Other (specify below)				·	
(5) Total deductions					
		(4) Other (specify below)	15(4)		
		(5) Total deductions		7e(5)	0
	f			7f	0

Page	4
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	Part	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for report employees, the entire group of such individe	group of employeting purposes if s	uch contracts a	re experiei	nce-rated as a	unit. Where co	ntracts cove	
8	Ве	nefit and contract type (check all applicable boxes) "						
	а	Health (other than dental or vision)	b X Dental		C Vi	sion		d ☐ Life in	surance
	е	Temporary disability (accident and sickness)	f Long-term	n disability	g∏ su	upplemental une	emplovment	h Presc	ription drug
	i	Stop loss (large deductible)	j ∏ HMO con	-		O contract		=	nity contract
	m		, []	ar u o c	• . □	o donti dot		· 🗆 macin	They contract
	m	Other (specify)							
	Evr	erience-rated contracts:	·						
·		Premiums: (1) Amount received		9a((1)				
	, ,	(2) Increase (decrease) in amount due but unpai		· · · · · · · · · · · · · · · · · · ·					
		(3) Increase (decrease) in unearned premium re-							
		(4) Earned ((1) + (2) - (3))		<u>-</u>		· · · · · · · · · · · · · · · · · · ·	9a(4)		C
	b	Benefit charges (1) Claims paid					54(4)		
		(2) Increase (decrease) in claim reserves							
		(3) Incurred claims (add (1) and (2))					9b(3)	ZHI SANGENIK DANGANGUAK	C
		(4) Claims charged						1.	
	С	Remainder of premium: (1) Retention charges (
		(A) Commissions		,)(A)				
		(B) Administrative service or other fees							
		(C) Other specific acquisition costs						1	
		(D) Other expenses				-			
		(E) Taxes		0.74					
		(F) Charges for risks or other contingencies		9c(1))(F)	*			
\$ \$		(G) Other retention charges)(G)				
		(H) Total retention	*				9c(1)(H)		0
		(2) Dividends or retroactive rate refunds. (These	e amounts were	paid in cash,	or Credi	ited.)			
** · · ·	d	Status of policyholder reserves at end of year: (1	<u> </u>						
11 31		(2) Claim reserves							
		(3) Other reserves							
	e	Dividends or retroactive rate refunds due. (Do n							
1	0 N	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to o	carrier				. 10a		5952
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep	red any specific c	osts in connecti	on with the	e acquisition or			
	Spi	cify nature of costs.							
				•			•		
200889	en departmen	PROMOBER OF THE PROMOBER OF TH							
	art	V Provision of Information							

X No

Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?

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

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2016

This Form is Open to Public

For colondor size was 2041	Confined at	a veer beginning a very		ر. استام	adina 40/03/0040	mspection
	o or iiscai plai	n year beginning 01/01/2016		and e		
A Name of plan EMERITI RETIREE HEALT	H DI AN EOR	ST OLAF COLLEGE		ľ	ee-digit	513
	III LANI ON	OT, OLAI COLLLOL		plar	n number (PN)	1919
		•				
C Plan sponsor's name as	shown on line	e 2a of Form 5500	· · · · · · · · · · · · · · · · · · ·	D Emple	oyer Identification Numbe	r (FINI)
ST. OLAF COLLEGE	SHOWN ON MIN	C 24 011 01111 0000			0693979	(LIIV)
Part I Information	on Concer	ning Insurance Contrac	ct Coverage Fees	and Cor	nmissions Provide inf	ormation for each contract
		. Individual contracts grouped				
1 Coverage Information:		,				
1 Coverage information.						
(a) Name of insurance carri	ier					
HEALTHPARTNERS, INC.					•	
· · · · · · · · · · · · · · · · · · ·						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a		Policy or	contract year
(0) 2.11	code	identification number	policy or contract		(f) From	(g) To
41-1693838	95766	19946	20)	01/01/2016	12/31/2016
2 Insurance fee and comm	ieeion informs	ition. Enter the total fees and to	otal commissions paid. I	iet in line 3	the agents brokers and	other persons in
descending order of the a		ation. Enter the total lees and to	otal commissions paid. L	ist iii iiiie o	the agents, brokers, and	other persons in
(a) Total an	nount of comr	missions paid		(b) T	otal amount of fees paid	
3 Poreone receiving comm	iecione and fo	ees. (Complete as many entrie	e as pooded to report all	norcone)		
• reisons receiving comm					ione or food word noid	
	(a) Name a	nd address of the agent, broke	r, or other person to who	n commiss	ions or rees were paid	
						•
			•			
		Fe	ees and other commission	ns paid		T
(b) Amount of sales and commissions paid	base —	(c) Amount		(d) Purpos	e .	(e) Organization code
Commissione para		(6) / 1110 2111	· · · · · · · · · · · · · · · · · · ·	(u) : u.poc		(e) organization code
						•
	(a) Name a	nd address of the agent, broke	r, or other person to who	n commiss	ions or fees were paid	·
•						
	· ·					
(b) Amount of sales and	base		ees and other commission			
commissions paid		/-\ A		(d) Purpos	e .	(e) Organization code
Continuosiono paia		(c) Amount		(u) i dipos	<u> </u>	(c) Organization code
COMMISSIONS PAID		(c) Amount		(d) i dipos	<u> </u>	(c) Organization code
oommoordio pala		(c) Amount		(u) 1 ui pos		(c) Organization code

Schedule A (Form 5500)	2016	Page 2 - 4	
		Page 2 - 1	
(a) Na	me and address of the agent, broke	er, 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	Organizat code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(4)	and address of the agent, broke	w, at eather person to whom commissions of 1600 word part	
b) Amount of sales and base		Fees and other commissions paid	(e)
commissions paid	(c) Amount	(d) Purpose	Organizat code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
			* .
b) Amount of sales and base		Fees and other commissions paid	(e) Organizati
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
b) 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) Organizati code
	(c) Amount		Organizati
	(c) Amount		Organizati
commissions paid		(d) Purpose	Organizati
commissions paid			Organizati
commissions paid		(d) Purpose	Organizati
commissions paid		(d) Purpose	Organizati
commissions paid (a) Na		(d) Purpose	Organizati code
commissions paid		(d) Purpose r, or other person to whom commissions or fees were paid	Organizati code (e) Organizati
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizati code
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizati code (e) Organizati
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizati code (e) Organizati
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizati code (e) Organizati
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizati code (e) Organizati
commissions paid (a) Nai (b) Amount of sales and base	me and address of the agent, broke	(d) Purpose r, or other person to whom commissions or fees were paid Fees and other commissions paid	Organizat 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 treate	ed as a unit for purposes of
	this report.			
	Current value of plan's interest under this contract in the general account at		4	
	Current value of plan's interest under this contract in separate accounts at y	ear end	5	<u> </u>
ь	Contracts With Allocated Funds:			
	a State the basis of premium rates			
				T
	b Premiums paid to carrier	· · · · · · · · · · · · · · · · · · ·	6b	
	Premiums due but unpaid at the end of the year		6c	
	d If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
	e Type of contract: (1) ☐ individual policies (2) ☐ group de	ferred annuity		
	(3) other (specify)			
	f If contract purchased, in whole or in part, to distribute benefits from a to	orminating plan, check here		
7	, , , , , , , , , , , , , , , , , , , ,			
	Contracts With Unallocated Funds (Do not include portions of these contract			
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	nediate participation guarantee		
	(3) guaranteed investment (4) dth	er 🕨		
		•		
	b Balance at the end of the previous year		7b	0
	b Balance at the end of the previous year		7b	0
	C Additions: (1) Contributions deposited during the year	7c(1)	7b	O
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2)	7b	0
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3)	7b	0
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	O
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	O
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)		
	C Additions: (1) Contributions deposited during the year (2) Dividends and credits. (3) Interest credited during the year. (4) Transferred from separate account. (5) Other (specify below).	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	0
	C Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6)Total additions d Total of balance and additions (add lines 7b and 7c(6))	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)		
	C Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6)Total additions d Total of balance and additions (add lines 7b and 7c(6)) e Deductions:	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7c(1)	7c(6)	0000
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	
	C Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) ar	7c(6)	

Page	4
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12 If the answer to line 11 is "Yes," specify the information not provided.

Part III 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	acts are exp	perience-rated as a	unit. Where co	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)					
a Health (other than dental or vision)	b X Dental	c	Vision		d Life insurance
e Temporary disability (accident and sickness)	f Long-term disabilit	y g	Supplemental une	employment	h Prescription drug
i ☐ Stop loss (large deductible)	j HMO contract		PPO contract		I Indemnity contract
] /		. [
m ☐ Other (specify) ▶					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)	<u> </u>		
(2) Increase (decrease) in amount due but unpaid	F	9a(2)			
(3) Increase (decrease) in unearned premium rese	F	9a(3)			
(4) Earned ((1) + (2) - (3))	-			9a(4)	
b Benefit charges (1) Claims paid	F	9b(1)	:		
(2) Increase (decrease) in claim reserves		9b(2)			
(3) Incurred claims (add (1) and (2))				9b(3)	
(4) Claims charged				9b(4)	
c Remainder of premium: (1) Retention charges (or	an accrual basis)	* 1			
(A) Commissions		9c(1)(A)	-		
(B) Administrative service or other fees		9c(1)(B)		-	
(C) Other specific acquisition costs		9c(1)(C)			
(D) Other expenses		9c(1)(D)			
(E) Taxes		9c(1)(E)			
(F) Charges for risks or other contingencies		9c(1)(F)			
(G) Other retention charges		9c(1)(G)			
(H) Total retention	_	_		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These	amounts were [] paid in	cash, or	credited.)	· 9c(2)	
d Status of policyholder reserves at end of year: (1)	Amount held to provide b	enefits after	retirement	9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do no	include amount entered	in line 9c(2)	.),	9e	
10 Nonexperience-rated contracts:				-	
a Total premiums or subscription charges paid to ca	rrier			10a	137
b If the carrier, service, or other organization incurre retention of the contract or policy, other than report Specify nature of costs.				10b	
opeony nature or costs.					
	* * * * * * * * * * * * * * * * * * * *		•		
	•				
Part IV Provision of Information					
DD/8800290-2-8-000-00-3007-00-2-0				7	7
11 Did the insurance company fail to provide any informa	tion necessary to comple	te Schedule	: A?	Yes	No

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

2016

	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).			This Form is Open to Public Inspection			
For calendar plan year 2016	or fiscal pla	n year beginning 01/01/2016		and e	nding 12/31/20	016	
A Name of plan EMERITI RETIREE HEALTH	H PLAN FOR	R ST. OLAF COLLEGE			ee-digit n number (PN)		513
		<u> </u>					
C Plan sponsor's name as s ST. OLAF COLLEGE	shown on lin	e 2a of Form 5500			oyer Identificatio -0693979	n Number	(EIN)
		rning Insurance Contract . Individual contracts grouped as					
1 Coverage information.							· · · · · · · · · · · · · · · · · · ·
(a) Name of insurance carrie AETNA LIFE INSURANCE CO					.		
	(c) NAIC	(d) Contract or	(e) Approximate nu	mber of		Policy or c	contract year
(b) EIN	code	identification number	persons covered at policy or contract		(f) Fro	om	(g) To
06-6033492	0054	820363	21		01/01/2016		12/31/2016
2 Insurance fee and commis descending order of the ar		ation. Enter the total fees and total	l commissions paid. Lis	st in line 3	the agents, brol	kers, and o	other persons in
(a) Total am	ount of com	missions paid		(b) T	otal amount of fe	of fees paid	
				* .			
3 Persons receiving commis	ssions and f	ees. (Complete as many entries a	as needed to report all p	ersons).			
	(a) Name a	and address of the agent, broker, o	or other person to whon	commiss	sions or fees wer	re paid	
	•	•					
					-		
(h) Amount of color and	haaa	Fees	and other commission	s paid			
(b) Amount of sales and I commissions paid	base –	(c) Amount		d) Purpos	e		(e) Organization code
AND THE RESIDENCE OF THE PROPERTY OF THE PROPE	(a) Name a	and address of the agent, broker, o	or other person to whom	commiss	sions or fees wer	e paid	SSANETHER SECTIONS IN THE SEASON OF THE SECTION OF
	· · · · · · · · · · · · · · · · · · ·		•		-		
					•	. F	
(b) Amount of sales and I	hase	Fees	and other commission	s paid		72.0	
commissions paid	Jase	(c) Amount	(d) Purpos	e	-	(e) Organization code
For Denominary Poduction	Act Notice	see the Instructions for Form 55	500	-		Saha	dule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
			T (2)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Nar	ne and address of the agent, broke	er, 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	Organizati code
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organizatio
commissions paid	(c) Amount	(a) i dipose	code
(a) Nar	ne and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(4)	To unit during the unit during		
		Fees and other commissions paid	(e)
b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(c) No.	no and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, bloke	a, or other person to whom commissions or lees were paid	,
	:	Fees and other commissions paid	(0)
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organizatio

Par	t II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	vidual contracts with each carrier	may be treate	d as a unit for purposes of
	this report.			· · · · · · · · · · · · · · · · · · ·
	rrent value of plan's interest under this contract in the general account at year			
	rrent value of plan's interest under this contract in separate accounts at year of	end	5	
	ntracts With Allocated Funds:			
a	State the basis of premium rates			
h	Duamai uma maid ta aannian		- Ch	<u> </u>
b	Premiums paid to carrier		6b	
C d	Premiums due but unpaid at the end of the year			
u	retention of the contract or policy, enter amount		6d	
	Specify nature of costs			
e	Type of contract: (1) individual policies (2) group deferre	ed annuity		
	(3) other (specify)			
	(2) (-1-20-1)			
· · · · · · · · · · · · · · · · · · ·	If contract nurchased, in whole or in part, to distribute benefits from a termin	nating plan, shock here	7	
	If contract purchased, in whole or in part, to distribute benefits from a termin			
	ntracts With Unallocated Funds (Do not include portions of these contracts ma			
а		ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year		7b	0
b	Balance at the end of the previous year	7c(1)	7b	0
		7c(1) 7c(2)	7b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3)	7b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7 b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4)	7 b	0
	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7b	0
C	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below)	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account. (5) Other (specify below) (6)Total additions.	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6) Total additions Total of balance and additions (add lines 7b and 7c(6)). Deductions:	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6) Total additions Total of balance and additions (add lines 7b and 7c(6)).	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2)	7c(6)	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6)Total additions Total of balance and additions (add lines 7b and 7c(6)) Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2)	7c(6)	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below) (6)Total additions Total of balance and additions (add lines 7b and 7c(6)) Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier	7c(1) 7c(2) 7c(3) 7c(4) 7c(5)	7c(6)	
c	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2) 7e(3)	7c(6)	
c	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2) 7e(3)	7c(6)	
c	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2) 7e(3)	7c(6)	
c	Additions: (1) Contributions deposited during the year	7c(1) 7c(2) 7c(3) 7c(4) 7c(5) 7e(1) 7e(2) 7e(3)	7c(6)	

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Part III Welfare Benefit Contract Information		,	
If more than one contract covers the same group of employees	s of the same employer(s) or members	s of the same en	nployee organizations(s),
the information may be combined for reporting purposes if suc employees, the entire group of such individual contracts with e			
8 Benefit and contract type (check all applicable boxes)		, , , , , , , , , , , , , , , , , , ,	
a ☐ Health (other than dental or vision) b ☐ Dental	c		d Life insurance
	<u> </u>		빌
e ☐ Temporary disability (accident and sickness) f ☐ Long-term o	• • • • • • • • • • • • • • • • • • • •	lemployment	h 🛛 Prescription drug
i Stop loss (large deductible) j HMO contra	ct k X PPO contract		I Indemnity contract
m			
·			
9 Experience-rated contracts:			
a Premiums: (1) Amount received			
(2) Increase (decrease) in amount due but unpaid		<u> </u>	
(3) Increase (decrease) in unearned premium reserve		1 2 (2)	
(4) Earned ((1) + (2) - (3))		9a(4)	(C
b Benefit charges (1) Claims paid			
(2) Increase (decrease) in claim reserves		01 (0)	
(3) Incurred claims (add (1) and (2))			0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis)		· · · · · · · · · · · · · · · · · · ·	
(A) Commissions			
(B) Administrative service or other fees	0-(4)(0)		
(C) Other specific acquisition costs	0 (4)(5)		
(D) Other expenses	0-(4)(5)		
(E) Charges for rights an other partiagencies			
(F) Charges for risks or other contingencies(G) Other retention charges			
	·	9c(1)(H)	
(H) Total retention	_		U
(2) Dividends or retroactive rate refunds. (These amounts were			
d Status of policyholder reserves at end of year: (1) Amount held to pr			
(2) Claim reserves			
(3) Other reserves			
 e Dividends or retroactive rate refunds due. (Do not include amount e 10 Nonexperience-rated contracts: 	entered in line 9C(z).)	9e	
a Total premiums or subscription charges paid to carrier		10a	47231
			4/231
b If the carrier, service, or other organization incurred any specific cos retention of the contract or policy, other than reported in Part I, line 2			
Specify nature of costs.	above, report amount.		
		•	
	, · · · · · · · · · · · · · · · · · · ·		
Part IV Provision of Information			·
Examples on the development of the contract of		□ v _e . □	7 No.
11 Did the insurance company fail to provide any information necessary to		Yes	No
12 If the answer to line 11 is "Yes," specify the information not provided.	•		

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

·		pursuant to t	ERISA section 103(a)(2)	·		Inspection
For calendar plan year 2016	or fiscal plar	year beginning 01/01/2016		and e	nding 12/31/2010	6
A Name of plan EMERITI RETIREE HEALTI	H PLAN FOR	ST. OLAF COLLEGE		B Three-digit plan number (PN) ▶		513
C Plan sponsor's name as	shown on line	e 2a of Form 5500		D Emplo	oyer Identification	Number (EIN)
ST. OLAF COLLEGE			,	41-	0693979	
		ning Insurance Contract . Individual contracts grouped a				vide information for each contract Schedule A.
1 Coverage Information:						
(a) Name of insurance carri GROUP HEALTH PLAN, INC						
/ \	(c) NAIC	(d) Contract or	(e) Approximate nu		Po	olicy or contract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) From	(g) To
11-0797853 5	2628	19946	168		01/01/2016	12/31/2016
2 Insurance fee and commi descending order of the a		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents, broke	rs, and other persons in
(a) Total am	ount of comm	nissions paid		(b) T	otal amount of fee	s paid
			· · · · · · · · · · · · · · · · · · ·	1.3		
3 Persons receiving commi	ssions 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 whor	n commiss	sions or fees were	paid
(h) Assessed of soles and	.	Fee	es and other commission	ns paid		
(b) Amount of sales and commissions paid	base	(c) Amount		(d) Purpos	е	(e) Organization code
	(a) Name a	nd address of the agent, broker,	or other person to whor	n commiss	sions or fees were	paid
(b) Amount of sales and	base	Fee	es and other commission	ns paid		
commissions paid	Dasc	(c) Amount		(d) Purpos	e	(e) Organization code
· · · · · · · · · · · · · · · · · · ·		see the Instructions for Form 5	1500			Schedule A (Form 5500) 2016

Schedule A (Form 5500) 2	2016	Page 2 – 1	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organizatior
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	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
international de la company de la company (a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(h) Amount of calco and have		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base 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	
(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	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code

_		•
Pα	MA	
· u	y	•

Par	t II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	ridual contracts with each carrier may	be treate	d as a unit for purposes of
	this report.	·	1 - 2	T
	rrent value of plan's interest under this contract in the general account at year	· · · · · · · · · · · · · · · · · · ·	4	• • •
	rrent value of plan's interest under this contract in separate accounts at year e	nd	5	<u> </u>
	ntracts With Allocated Funds:			
а	State the basis of premium rates			
				T
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 retention of the contract or policy, enter amount		.6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Co	ntracts With Unallocated Funds (Do not include portions of these contracts ma	<u></u>		
a		ate participation guarantee		
. a	· · · · · · · · · · · · · · · · · · ·			
	(3) guaranteed investment (4) other			
b	Balance at the end of the previous year	T = 2.3 T	7b	0
С	Additions: (1) Contributions deposited during the year		· · · · · · · · · · · · · · · · · · ·	
	(2) Dividends and credits			
	(3) Interest credited during the year		·	
	(4) Transferred from separate account			
	(5) Other (specify below)	7c(5)		
	(6)Total additions	CONTRACTOR OF THE CONTRACTOR O	7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	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)		
	(1) 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f .	0

Page	4
- auc	7

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the				
the information may be combined for reporting purposes if such contemployees, the entire group of such individual contracts with each c				
Benefit and contract type (check all applicable boxes)	,		•	
a ☐ Health (other than dental or vision) b ☐ Dental	с∏	Vision		d Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability	ity g	Supplemental unem	nlovment	h Prescription drug
i Stop loss (large deductible)		PPO contract	pioyment	I Indemnity contract
m ☐ Other (specify) ▶		110 contract		I Indemnity contract
III Utilei (Specify)				
9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid				
(3) Increase (decrease) in unearned premium reserve				
(4) Earned ((1) + (2) - (3))	L		9a(4)	THE TRANSPORTER OF THE PROPERTY OF THE PROPERT
b Benefit charges (1) Claims paid			1 3.(.)	
(2) Increase (decrease) in claim reserves	, , , , , , , , , , , , , , , , , , ,			
(3) Incurred claims (add (1) and (2))	<u> </u>	- 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 	9b(3)	
(4) Claims charged			9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)		•	05(4)	
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
	9c(1)(C)		·····	
(C) Other specific acquisition costs(D) Other systems	9c(1)(D)			
(D) Other expenses	9c(1)(E)	· · · · · · · · · · · · · · · · · · ·		
(E) Taxes	9c(1)(F)			
(F) Charges for risks or other contingencies				
(G) Other retention charges		· · · · · · · · · · · · · · · · · · ·	0o(4)(H)	
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were paid in			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered	d in line 9c(2).)		9 <u>e</u>	
10 Nonexperience-rated contracts:				
Total premiums or subscription charges paid to carrier			10a	414392
b If the carrier, service, or other organization incurred any specific costs in content or policy, other than reported in Part I, line 2 above			10b	
Specify nature of costs.				
$\mathcal{L}_{i} = \mathcal{L}_{i} $				
	• .			
		*		v *
Part IV Provision of Information				
ences december set and proposition of the set of the se	1.1.0.1.1.1		Van K	7 No
11 Did the insurance company fail to provide any information necessary to comp	iele Schedule A	۸٢	Yes	No No
49 If the appropriate the 44 is 60/as 2 and if the information not provided				

SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Employee Benefits Security Administration

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

2016

This Form is Open to Public Inspection.

Perision Benefit Guaranty Corpor		· · · · · · · · · · · · · · · · · · ·					<u> </u>
For calendar plan year 2016 o	r fiscal plan year beginning	01/01/2016		and ending 12/31/2	016		
A Name of plan			5	B Three-digit			
EMERITI RETIREE HEALTI	HPLAN FOR ST. OLAF COL	LEGE		plan number (PN))	513	
		•					
	nown on line 2a of Form 5500)		D Employer Identification	Number (E	IN)	
ST. OLAF COLLEGE				41-0693979			
	•						
Part I Service Prov	ider Information (see	instructions)	·				
or more in total compensati plan during the plan year.	rt, in accordance with the inson (i.e., money or anything elf a person received only eligonized to include that person	else of monetary value gible indirect compens	e) in connection value of the connection of the connection for which the connection of the connection	with services rendered to the he plan received the require	plan or the	e person's posit	ion with the
					-		
1 Information on Pers		-	· -				
a Check "Yes" or "No" to indic		· - · ·		•			_
indirect compensation for w	hich the plan received the re	quired disclosures (se	ee instructions fo	r definitions and conditions).		⊠Y∈	s No
	ct compensation. Complete	as many entries as ne	eeded (see instru	uctions).			· · · · · · · · · · · · · · · · · · ·
	Enter name and EIN or add	ress of person who pr	rovided you discl	osures on eligible indirect co	mpensatio	n	
TIAA-CREF MUTUAL FUND	S-TEACHERS ADV						
					4		
13-3760073	•						
(b)	Enter name and EIN or add	ress of person who pr	rovided you discl	osures on eligible indirect co	mpensatio	muskuisikseisse n	
							
		•					
						•	
(b)	Enter name and EIN or add	ress of person who pr	ovided you discl	osures on eligible indirect co	mpensation	n	
MALESAN PINCHER NUBER (NO PROTECTIVE AND TO MAKE A MATERIAL PROTECTION OF THE PROTEC	TANKER A SAN'T ANG ING ARK TERRETE SANGET SHEET FOR BARKAN MENANGAN PARKAN MENANGAN PARKAN MENANGAN PARKAN MENANGAN PARKAN PARKA	TO THE STATE OF TH	CONDUCTOR OR OTHER DESIGNATION OF THE SECOND	INCENSION TOWNS OF THE SANGHEST AND THE SANGH SECTION OF THE SANGE	CONTROL OF STREET		***************************************
(L)							
(D)	Enter name and EIN or addr	ress of person who pr	oviaea you discl	osures on eligible indirect co	mpensation	n 	
				,			

	(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
To be the control of	
<u> </u>	(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
	(-)

	Schedule C (Form 55	00) 2016	:	Page 3 - 1		
answered	d "Yes" to line 1a abov	e, complete as many	entries as needed to list ea	r Indirect Compensatio ach person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in	total compensation
			(a) Enter name and EIN or	r address (see instructions)		
EMERITI	RETIREE HEALTH SO	DLUTIONS				
						•
57-119422	27					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
70	CONSULTANT	46094	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
CBIZ SAV	ITZ					
31-158209	8					
(b) Service Code(s)	(c) Relationship to employer, employer 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?
12 15	BENEFITS PROCESSOR	26809	Yes No 🗵	Yes No		Yes No
	nors Statististististis avaidtaa attass	aliosoofin kantaa ka k	a) Enter name and EIN or	address (see instructions)		
THE SAVI	TZ ORGANIZATION		,			
., O, 101						

23-1700844

(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		receive indirect	include eligible indirect		provider give you a
		by the plan. If none,		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	estimated amount?
					answered "Yes" to element	
	·				(f). If none, enter -0	
12 15	BENEFITS	8664				· .
	PROCESSOR		Yes No 🛛	Yes No No		Yes ☐ No ☐
*						

Page 3	3 -
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answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in	total compensation
		1	(a) Enter name and EIN o	r address (see instructions)		
TIAA OF A	MERICA					
13-162420	3					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-	(h) Did the service provider give you a formula instead of an amount or estimated amount?
64	RECORDKEEPER	7728	Yes X No	Yes 🛛 No 🗌	0	Yes No X
			3) Enter name and EIN or	address (see instructions)		
			a) Enter hame and Env or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes 📗 No 🗍		Yes No
			a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

Page	4	_	7

Part I Service Provider Information (continue)	

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source. (a) Enter service provider name as it appears on line 2 (b) Service Codes (c) Enter amount of indirect (see instructions) compensation (d) Enter name and EIN (address) of source of indirect compensation (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. (a) Enter service provider name as it appears on line 2 (b) Service Codes (c) Enter amount of indirect (see instructions) compensation (d) Enter name and EIN (address) of source of indirect compensation (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. (a) Enter service provider name as it appears on line 2 (b) Service Codes (c) Enter amount of indirect (see instructions) compensation (e) Describe the indirect compensation, including any (d) Enter name and EIN (address) of source of indirect compensation formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Pa	rt II Service Providers Who Fail or Refuse to P	rovide Infor	mation
4	Provide, to the extent possible, the following information for each this Schedule.	n service provide	r who failed or refused to provide the information necessary to complete
	(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
((a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
	a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
	a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Schedule	C	(Form	5500	2016
Scriedule	0	11110 1	3300	, 2010

Page	6 -	1	

Pi	art III Termination Information on Accountants and Enrolled Actuaries (see (complete as many entries as needed)	e instructions)
a	Name:	b ein:
С	Position:	
d	Address:	e Telephone:
Ex	xplanation:	
SCONDERS 181		
a	Name:	b EIN:
C	Position:	
d	Address:	e Telephone:
_	, and obtain	
Ex	planation:	
	Name:	b EIN:
<u>a</u>		D EIN.
d d	Position:	O Tolophono:
u	Address:	e Telephone:
	planation:	
^	ранавон.	
	Ni-mar.	b FIN.
<u>a</u>	Name:	b ein:
<u>c</u> d	Position:	O Tolophono:
u	Address:	e Telephone:
Ev	planation	
E.X	planation:	
<u>a</u> .	Name:	b EIN:
C	Position:	
d	Address:	€ Telephone:
EX	planation:	

SCHEDULE H (Form 5500)

Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2016

This Form is Open to Public Inspection

	Inspection
For calendar plan year 2016 or fiscal plan year beginning 01/01/2016	and ending 12/31/2016
A Name of plan EMERITI RETIREE HEALTH PLAN FOR ST. OLAF COLLEGE	B Three-digit plan number (PN) ▶ 513
C Plan sponsor's name as shown on line 2a of Form 5500 ST. OLAF COLLEGE	D Employer Identification Number (EIN) 41-0693979

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
C General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	323468	390286
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		. ,
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		4
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	7968870	8796229
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	8292338	9186515
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
Net Assets			
Net assets (subtract line 1k from line 1f)	11	8292338	9186515

Part II Income and Expense Statement

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	855222	
	(B) Participants	2a(1)(B)	309876	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		1165098
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	406942	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		406942
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
٠.	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

						_		
				(a) Am	ount		(t	o) Total
	(6) Net investment gain (loss) from common/collective trusts	2b(6)						• .
	(7) Net investment gain (loss) from pooled separate accounts	2b(7)						
	(8) Net investment gain (loss) from master trust investment accounts	2b(8)						
	(9) Net investment gain (loss) from 103-12 investment entities	2b(9)						
	(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)					,	124690
C	Other income	2c						
d	Total income. Add all income amounts in column (b) and enter total	2d						1696730
	Expenses							
ė	Benefit payment and payments to provide benefits:						· ·	
	(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)			23	5375		
	(2) To insurance carriers for the provision of benefits	2e(2)			47	7883		
	(3) Other	2e(3)		*				
	(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)						713258
f	Corrective distributions (see instructions)	2f						
g	Certain deemed distributions of participant loans (see instructions)	2g						
h	Interest expense	2h						
· i	Administrative expenses: (1) Professional fees	2i(1)						
	(2) Contract administrator fees	2i(2)						
	(3) Investment advisory and management fees	2i(3)						
	(4) Other	2i(4)			8	9295		
	(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)						89295
j	Total expenses. Add all expense amounts in column (b) and enter total	2j						802553
-	Net Income and Reconciliation				,			
k	Net income (loss). Subtract line 2j from line 2d	2k						894177
ı	Transfers of assets:							
	(1) To this plan	21(1)						
	(2) From this plan	21(2)						
Pi	art III Accountant's Opinion							·
3	Complete lines 3a through 3c if the opinion of an independent qualified public attached.	accountant	is attached t	o this F	orm 5	500. Co	mplete line 3d i	f an opinion is not
а	The attached opinion of an independent qualified public accountant for this pla	ın is (see in	structions):					
	(1) Unqualified (2) Qualified (3) Disclaimer (4)	Adverse)					
b	Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103	3-8 and/or	103-12(d)?				X Yes	No
С	Enter the name and EIN of the accountant (or accounting firm) below:							
	(1) Name:BAKER TILLY VIRCHOW KRAUSE, LLP		(2) EIN	l: 39-08	359910	-		
d	The opinion of an independent qualified public accountant is not attached bed (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached		next Form 5	500 pu	rsuant	to 29 Cl	FR 2520.104-5	0.
n.	art IV Compliance Questions							
4	art IV Compliance Questions CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete		e lines 4a, 4	e, 4f, 4	g, 4h, 4	1k, 4m,	4n, or 5.	
	During the plan year:	5 III IC 41.		F	Yes	No	Ar	nount
-		n the #:	•					
а	Was there a failure to transmit to the plan any participant contributions within period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction I	prior year fa	ailures until	4a		X		
b	Were any loans by the plan or fixed income obligations due the plan in defauclose of the plan year or classified during the year as uncollectible? Disrega secured by participant's account balance. (Attach Schedule G (Form 5500) checked.)	rd participa	nt loans s" is	4h		X		

ac	ıe	4-	1	

Schedule H (Form 5500) 2016

			Yes	No	,	Amount
C	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		Х		
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X		
е	Was this plan covered by a fidelity bond?	4e	Х			500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		Х		
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X		
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X		
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	x			
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j		X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		Χ		
ı	Has the plan failed to provide any benefit when due under the plan?	41	-	X		
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m				
n	If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3	4n				
0	Defined Benefit Plan or Money Purchase Pension Plan Only: Were any distributions made during the plan year to an employee who attained age 62 and had not separated from service?	40				
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If "Yes," enter the amount of any plan assets that reverted to the employer this year	es [No	Amo	unt:	
5b	If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), ide transferred. (See instructions.)	ntify t	he plan(s) to w	hich assets or	iabilities were
	5b(1) Name of plan(s)	-			5b(2) EIN(s)	5b(3) PN(s)
		-				
-						
	f the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section f "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan y		21.)?	📗 Y	es No	Not determined (See instructions.)
Par	Trust Information					
6a N	lame of trust			61	b Trust's EIN	
6c 1	Name of trustee or custodian 6d Trustee'	s or c	ustodiar	's tele	phone number	
			÷			
						, r