

SUMMARY ANNUAL REPORT FOR MISTER CAR WASH HEALTH PLAN

This is a summary of the annual report of the Mister Car Wash Health Plan (Employer Identification Number 04-3299064, Plan Number 503) for the plan year 07/01/2019 through 06/30/2020. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Car Wash Partners, Inc. has committed itself to pay certain health and prescription drug claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with Lincoln Life Assurance Company of Boston, Fidelity Security Life Insurance Company, Delta Dental of Arizona, and Massachusetts Mutual Life Insurance Company to pay certain life insurance, accidental death and dismemberment, temporary disability, long-term disability, vision, and dental claims incurred under the terms of the plan. The total premiums paid for the plan year ending 06/30/2020 were \$1,772,687.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 06/30/2020, the premiums paid under such "experience-rated" contracts were \$797,696 and the total of all benefit claims paid under these experience-rated contracts during the plan year was \$501.656.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call Car Wash Partners, Inc., the plan administrator, at 222 East 5th Street, Tucson, AZ 85705 and phone number, 520-615-4000.

You also have the legally protected right to examine the annual report at the main office of the plan: 222 East 5th Street, Tucson, AZ 85705, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.



		Annual Return/Repo	rt of Employ	ee Renefit Plan	OMB Nos. 1210-0110
	Form 5500	This form is required to be filed fo	1	1210-0089	
	epartment of the Treasury Internal Revenue Service	and 4065 of the Employee Retirem sections 6057(b) and 6058(a)	ent Income Security	Act of 1974 (ERISA) and	2019
E	Department of Labor imployee Benefits Security Administration		entries in accordan		
Pensio	n Benefit Guaranty Corporation				This Form is Open to Public Inspection
Part I	Annual Report Ide	entification Information		•	
For cale	ndar plan year 2019 or fisca	l plan year beginning 07/01/2019		and ending 06/30/20	20
A This	return/report is for:	a multiemployer plan		ployer plan (Filers checking the mployer information in accord	nis box must attach a list of dance with the form instructions.)
		X a single-employer plan	a DFE (specify	y)	
B This	return/report is:	the first return/report	the final return	/report	
	•	an amended return/report	a short plan ye	ear return/report (less than 12	months)
C If the	plan is a collectively-bargai	ned plan, check here			
	k box if filing under:	Form 5558	automatic exter	nsion	the DFVC program
		special extension (enter description))		
Part II	Basic Plan Inform	ation—enter all requested informatio	n		
	ne of plan R CAR WASH HEALTH PLA	N .			1b Three-digit plan number (PN) > 503
					1c Effective date of plan 07/01/2015
Mail City	ing address (include room, a or town, state or province, or	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instr	uctions)	2b Employer Identification Number (EIN) 04-3299084
CAR WA	SH PARTNERS, INC.				2c Plan Sponsor's telephone number 520-615-4000
	T 5TH STREET I, AZ 85705				2d Business code (see instructions) 811190
Caution	: A penalty for the late or i	incomplete filing of this return/repor	t will be assessed	unless reasonable cause is	established.
		penalties set forth in the instructions, I			
statemer	nts and attachments, as wel	as the electronic version of this return	/report, and to the b	est of my knowledge and bel	ief, it is true, correct, and complete.
SIGN	Filed with authorized/valid	electronic signature.	01/14/2021	JAN E. MYERS	
HERE	Signature of plan admin	istrator	Date	Enter name of individual si	gning as plan administrator
SIGN					
HERE Signature of employer/plan sponsor Date Enter name of individual signing as employer or plan s					oning as employer or plan sponsor
SIGN	, 5,557	•			
HERE	Signature of DFE		Dete	Fater area of individual of	i DEE
For Pap		ice, see the Instructions for Form 55	Date 500.	Enter name of individual si	Form 5500 (2019) v. 190130

Page **2** of **33**



	Form 5500 (2019)	Page 2			
3a Plan administrator's name and address 🗵 Same as Plan Sponsor					
		3c Administrator's telephone number			
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from		4b EII	N	
	Sponsor's name Plan Name		4d PN	ı	
5	Total number of participants at the beginning of the plan year		5	4007	
6	Number of participants as of the end of the plan year unless otherwise stated $6a(2)$, $6b$, $6c$, and $6d$).	(welfare plans complete only lines 6a(1),			
a(1) Total number of active participants at the beginning of the plan year		6a(1)	3992	
a(2) Total number of active participants at the end of the plan year		6a(2)	4116	
b	Retired or separated participants receiving benefits		6b	10	
С	Other retired or separated participants entitled to future benefits		6c	0	
d	Subtotal. Add lines 6a(2), 6b, and 6c	6d	4126		
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits	6e		
f	Total. Add lines 6d and 6e		6f		
g	Number of participants with account balances as of the end of the plan year (complete this item)	only defined contribution plans	6g		
h	Number of participants who terminated employment during the plan year with less than 100% vested	accrued benefits that were	6h		
7	Enter the total number of employers obligated to contribute to the plan (only n	multiemployer plans complete this item)	7		
8a	If the plan provides pension benefits, enter the applicable pension feature coo	des from the List of Plan Characteristics Code	-	instructions:	
b	If the plan provides welfare benefits, enter the applicable welfare feature code 4A 4B 4D 4E 4F 4H 4L	es from the List of Plan Characteristics Codes	in the in	nstructions:	
9a	Plan funding arrangement (check all that apply) (1) Insurance	9b Plan benefit arrangement (check all that	at apply)		
	(2) Code section 412(e)(3) insurance contracts	(2) Code section 412(e)(3) i	insurano	e contracts	
	(3) Trust	(3) Trust			
_	(4) X General assets of the sponsor	(4) X General assets of the sp			
10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and, where indicated, enter the numb	er attach	hed. (See instructions)	
а	Pension Schedules	b General Schedules			
	(1) R (Retirement Plan Information)	(1) H (Financial Inform			
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2) I (Financial Inform		Small Plan)	
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3) X 7 A (Insurance Infor			
	_	(4) C (Service Provide		-	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5) D (DFE/Participation (6) G (Financial Trans	-		
		_			



	Form 5500 (2019)	Page 3			
Part III	Form M-1 Compliance Information (to be completed by welfa	are henefit plane)			
11a If the 2520.	plan provides welfare benefits, was the plan subject to the Form M-1 filing requiren 101-2.)				
11b Is the	plan currently in compliance with the Form M-1 filing requirements? (See instruction	ons and 29 CFR 2520.101-2.)			
11c Enter the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 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					



SCHEDULE		Insurance Information				OMB No. 1210-0110	
(Form 5500))						
Department of the Treas Internal Revenue Servi	sury ice	This schedule is require Employee Retirement In					2019
Department of Labor Employee Benefits Security Ad		▶ File as an	attachment to Form 55	i00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies pursuant to 	are required to provide t ERISA section 103(a)(2)		ion	This For	m is Open to Public
For calendar plan year 20	19 or fiscal plan	n year beginning 07/01/2019		and en	ding 06/3	0/2020	
A Name of plan				B Thre	e-digit		
MISTER CAR WASH HEA	ALTH PLAN			plan	number (PN	I) >	503
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
CAR WASH PARTNERS,	INC.			04-	3299064		
5 11 Informat				- 10-			
		rning Insurance Contrac L. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca LINCOLN LIFE ASSURAN		OF BOSTON					
EINOOEIV EII E ASSONAIV							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or c	ontract year
(D) EIN	code	identification number	policy or contrac		(f)	From	(g) To
04-6076039	65315	SA3-890LF008601	SA3-890LF008601 4202		07/01/2019		06/30/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
	amount of com	missions paid		(b) To	otal amount	of fees paid	
` ` `		38618		- ' '			6853
3 Persons receiving com	missions and f	ees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker,			ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC	4565 P	AYSPHERE CIRCLE				
		CHICA	GO, IL 60674				
(b) Amount of sales ar	nd barn	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
	38618	6853 S	UPPLEMENTAL COMP	ENSATION			3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base		es and other commissio	missions paid			
commissions pa	id	(c) Amount		(d) Purpos	e		(e) Organization code
For Panenwork Reductio	n Act Notice	see the Instructions for Form	5500			Scho	dule A /Form 5500\ 2019



Schedule A (Form 5500) 2019 Page 2 – 1							
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
(b) Amount of calor and base		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid					
			(1)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nar	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) Nar	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				



	Schedule A (Form 5500) 2019	Page 3		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	vidual contracts with each carrier ma	y be treated	as a unit for purposes of
4 Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5 Curr	ent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cont	tracts With Allocated Funds:			
а	State the basis of premium rates 🕨			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6с	
d	If the carrier, service, or other organization incurred any specific costs in co		6d	
	retention of the contract or policy, enter amount.			
	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 Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
-	(3) guaranteed investment (4) other			
	(3) guaranteed investment (4) other 7			
	Delegand the seed of the services		. 7b	
b	Balance at the end of the previous year.		10	U
С	Additions: (1) Contributions deposited during the year			
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
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)		
	•			
	(F) Total de destina		70/E\	0
	(5) Total deductions.		7e(5) 7f	0
1	Balance at the end of the current year (subtract line 7e(5) from line 7d)		/1	U



	Schedule A (Form 5500) 2019		Page	e 4		
	,					
Part III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individent	group of employees of the ting purposes if such cont	racts are exp	perience-rated as a un	it. Where con	tracts cover individual
8 Benefit	and contract type (check all applicable boxes)		,			
	lealth (other than dental or vision)	b Dental	-1	Vision	,	1 X Life insurance
		□		₹		브
=	emporary disability (accident and sickness)				iployment l	Prescription drug
i∐s	top loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m 🗵 C	Other (specify) ACCIDENTAL DEATH AND	DISMEMBERMENT				
9 Experier	nce-rated contracts:					
	niums: (1) Amount received		9a(1)			
	Increase (decrease) in amount due but unpai		9a(2)			
	Increase (decrease) in uneamed premium re		9a(3)			
(4)	Earned ((1) + (2) - (3))			•	9a(4)	(
b Be	nefit charges (1) Claims paid		9b(1)			
(2)	Increase (decrease) in claim reserves		9b(2)			
(3)	Incurred claims (add (1) and (2))				9b(3)	0
(4)	Claims charged				9b(4)	
C Re	mainder of premium: (1) Retention charges (on an accrual basis)				
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			
	(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)			
	(F) Charges for risks or other contingencies.		9c(1)(F)			
	(G) Other retention charges		9c(1)(G)		0.4000	,
	(H) Total retention	_	_		9c(1)(H)	
	Dividends or retroactive rate refunds. (These				9c(2)	
	itus of policyholder reserves at end of year: (1				9d(1)	
	Claim reserves				. 9d(2)	
	Other reserves				9d(3)	
	idends or retroactive rate refunds due. (Do n	ot include amount entered	d in line 9c(2).)	9e	
	perience-rated contracts:				40-	
	tal premiums or subscription charges paid to				10a	376815
	he carrier, service, or other organization incur				10b	
	ention of the contract or policy, other than rep nature of costs.	orted in Part I, line 2 abov	e, report am	ount	100	
Орсону	natare of oosts.					
Part IV	Provision of Information					
11 Did the	insurance company fail to provide any inform	nation necessary to comp	lete Schedul	e A?	Yes	No
12 If the a	inswer to line 11 is "Yes," specify the information	tion not provided.		· •		_



SCHEDULE	Α	Insuran	ce Informatio	n			
(Form 5500))					OMB No. 1210-0110	
Department of the Treas Internal Revenue Serv	sury ice		his schedule is required to be filed under section 104 of the mployee Retirement Income Security Act of 1974 (ERISA).			2019	
Department of Labo Employee Benefits Security Ad		File as an	attachment to Form 55	00.			
Pension Benefit Guaranty Co	rporation	Insurance companies pursuant to	are required to provide t ERISA section 103(a)(2)		on		m is Open to Public Inspection
For calendar plan year 20	19 or fiscal plan	year beginning 07/01/2019		and end	ling 06/3	0/2020	
A Name of plan MISTER CAR WASH HEA	ALTH PLAN			B Three plan	-digit number (PN	l) >	503
C Plan sponsor's name a CAR WASH PARTNERS,		e 2a of Form 5500			yer Identific 299084	ation Number (EIN)
		ning Insurance Contrac . Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance ca LINCOLN LIFE ASSURAN		OF BOSTON					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	ontract year
(D) EIN	code	identification number	policy or contrac	(f)		From	(g) To
04-6076039	65315	GD3-890LF008601	4165	5	07/01/2019)	06/30/2020
2 Insurance fee and com descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3 t	he agents,	brokers, and of	ther persons in
(a) Total a	amount of comm			(b) To	tal amount	of fees paid	
		20688					3704
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker		m commissi	ons or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		PAYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales ar	nd base	Fe	es and other commissio	ns paid			
commissions pa	id	(c) Amount		(d) Purpose			(e) Organization code
	20688	3704 S	UPPLEMENTAL COMP	ENSATION			3
	(-) N	-111					
	(a) Name a	nd address of the agent, broker	, or other person to who	m commissi	ons or fees	were paid	
(b) Amount of sales ar	nd base	<u>Fe</u>	es and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
For Paperwork Reduction	n Act Notice,	see the Instructions for Form	5500.			Sched	fule A (Form 5500) 2019 v. 190130



Schedule A (Form 5500)	Page 2 — 1						
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	•						
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid					
(b) Assessed of color and base		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization 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 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 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	me and address of the agent, broke	r, or other person to whom commissions or fees were paid					
	•						
NA Assessed of soles and the		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				



	Schedule A (Form 5500) 2019	Page 3		
Par	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivitiis report.	ridual contracts with each carrier ma	y be treated	as a unit for purposes of
4 Cu	rrent value of plan's interest under this contract in the general account at year	end	. 4	
	rrent value of plan's interest under this contract in separate accounts at year e		. 5	
6 Co	ntracts With Allocated Funds:		•	
а	State the basis of premium rates 🕨			
b	Premiums paid to carrier		. 6b	
С	Premiums due but unpaid at the end of the year		. 6c	
d	If the carrier, service, or other organization incurred any specific costs in co		6d	
	retention of the contract or policy, enter amount.		-	
	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	aintained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	(-,			
b	Balance at the end of the previous year		7b	0
	Additions: (1) Contributions deposited during the year	. 7c(1)		_
	(2) Dividends and credits	- :-:	i	
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	. 7c(5)		
	•			
	(6)Total additions		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	7 (0)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)		
	•			
			70(5)	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		. 7f	U



Schedule A (Form 5500) 2019		Page	4		
Part III Welfare Benefit Contract Information If more than one contract covers the same growthe information may be combined for reporting	up of employees of the purposes if such cont	racts are exp	erience-rated as a uni	t. Where cont	racts cover individual
employees, the entire group of such individual	contracts with each ca	arrier may be	treated as a unit for p	urposes of this	report.
8 Benefit and contract type (check all applicable boxes)	н	ь	1		
<u> </u>	Dental		Vision		Life insurance
e X Temporary disability (accident and sickness) f	Long-term disabili	ty g	Supplemental unem	ployment h	Prescription drug
i Stop loss (large deductible) j	HMO contract	k	PPO contract	- 1	Indemnity contract
m ☐ Other (specify) ▶			•		
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			
(2) Increase (decrease) in amount due but unpaid		9a(2)			
(3) Increase (decrease) in unearned premium reserv	e	9a(3)			
(4) Eamed ((1) + (2) - (3))				. 9a(4)	
b Benefit charges (1) Claims paid		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 (on a					
(A) Commissions		9c(1)(A)			
(B) Administrative service or other fees		9c(1)(B)			
(C) Other specific acquisition costs		9c(1)(C) 9c(1)(D)			
(D) Other expenses		9c(1)(E)			
(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)	
(2) Dividends or retroactive rate refunds. (These an	_	cash or	craditad)		
d Status of policyholder reserves at end of year: (1) Ar				9c(2) 9d(1)	
(2) Claim reserves(2) Claim reserves		benefits after	r retirement	9d(2)	
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do not in		l in line 9c/2)	11	. 9e	
10 Nonexperience-rated contracts:	iorade amount entered	a in time outz		. 00	
Total premiums or subscription charges paid to carri	er			. 10a	20688
b If the carrier, service, or other organization incurred					20000
retention of the contract or policy, other than reporte Specify nature of costs.				10b	
Specify nature of costs.					
Part IV Provision of Information					
			н	V H	N-
11 Did the insurance company fail to provide any information		ete Schedule	e A?	Yes X	No
12 If the answer to line 11 is "Yes," specify the information	not provided. 🕨				



SCHEDULE (Form 5500		Insurance Information			OMB No. 1210-0110		
(FOITH 3300 Department of the Treas	,	This schedule is required	to be filed under section	on 104 of th	e l		
Internal Revenue Servi	ice	Employee Retirement Inc					2019
Department of Labor Employee Benefits Security Ad		File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	rporation	 Insurance companies a pursuant to E 	re required to provide t RISA section 103(a)(2)		ion		n is Open to Public
For calendar plan year 20	19 or fiscal plan	year beginning 07/01/2019		and en	ding 06/3	0/2020	
A Name of plan MISTER CAR WASH HEA	ALTH PLAN			B Three plan	e-digit number (PI	N) •	503
C Plan sponsor's name a CAR WASH PARTNERS,		e 2a of Form 5500			yer Identific 3299064	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:		•					
(a) Name of insurance ca LINCOLN LIFE ASSURAN		OF BOSTON					
	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract	(+)		From	(g) To
04-6076039	65315	GF3-890LF008601	433	_	07/01/201	9	06/30/2020
2 Insurance fee and com- descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comn	missions paid		(b) To	tal amount	of fees paid	
		8212					1453
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
·	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		AYSPHERE CIRCLE 3O, IL 60674				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpose			(e) Organization code
	8212	1453 SU	JPPLEMENTAL COMP	ENSATION			3
	(a) Name a	nd address of the agent, broker,	or other person to who	m commissi	ons or fees	were naid	
	(2)	•					
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 5	500.			Sched	ule A (Form 5500) 2019 v. 190130



Schedule A (Form 5500) 2019 Page 2 — 1							
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid							
	•						
		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
			_				
that described and a send have		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
#14		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization 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				
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	•						
(b) Assessed of soles and been		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				



	Schedule A (Form 5500) 2019	Page 3		
Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts are provided.	vidual contracts with each carrier ma	y be treated a	as a unit for purposes of
4 Currer	nt value of plan's interest under this contract in the general account at year	end	4	
5 Currer	nt value of plan's interest under this contract in separate accounts at year e	end	5	
6 Contra	acts With Allocated Funds:			
a s	State the basis of premium rates 🕨			
	Premiums paid to carrier		6b	
	Premiums due but unpaid at the end of the year		6с	
	f the carrier, service, or other organization incurred any specific costs in co		6d	
	retention of the contract or policy, enter amount			
•	specify flature of costs			
e 1	Type of contract: (1) individual policies (2) group deferre	d appuits		
		a annuity		
((3) other (specify)			
		-		
f	f contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here		
7 Contra	acts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
a	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	_			
b	Balance at the end of the previous year		7b	0
c /	Additions: (1) Contributions deposited during the year	7c(1)		
(2) Dividends and credits	7c(2)		
(3) Interest credited during the year	7c(3)		
(4) Transferred from separate account	7c(4)		
(5) Other (specify below)	7c(5)		
)	•			
(6)Total additions		7c(6)	0
d T	otal of balance and additions (add lines 7b and 7c(6))		7d	0
	eductions:			
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
(2	2) Administration charge made by carrier	7e(2)		
(3	3) Transferred to separate account	7e(3)		
(4	4) Other (specify below)	7e(4)		
)	•			
e	5) Total deductions		7e(5)	0
	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0



Schedule A (Form 5500) 2019		Page	4		
Part III Welfare Benefit Contract Inform					
If more than one contract covers the same					
the information may be combined for repor employees, the entire group of such individ					
Benefit and contract type (check all applicable boxes		amer may be	dedica as a unit for p	aiposes or ai	этероге.
		- 1	1,,,,,,		4 H
a Health (other than dental or vision)	b Dental		Vision		d Life insurance
e Temporary disability (accident and sickness)	f X Long-term disabil		Supplemental unem	ployment I	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k	PPO contract		I Indemnity contract
m Other (specify)					
9 Experience-rated contracts:					
a Premiums: (1) Amount received		9a(1)			•
(2) Increase (decrease) in amount due but unpai		9a(2)			-
(3) Increase (decrease) in unearned premium re		9a(3)			j
(4) Earned ((1) + (2) - (3))				9a(4)	
b Benefit charges (1) Claims paid		9b(1)			
(2) Increase (decrease) in claim reserves		9b(2)			1
(3) Incurred claims (add (1) and (2))		$\overline{}$		9b(3)	
(4) Claims charged				9b(4)	
C Remainder of premium: (1) Retention charges (
(A) Commissions		9c(1)(A)			1
(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)			<u> </u>
(F) Charges for risks or other contingencies.		9c(1)(F)			Į
(G) Other retention charges		9c(1)(G)			
(H) Total retention		<u>-</u> -		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These	e amounts were paid ir	n cash, or	credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
(2) Claim reserves				9d(2)	
(3) Other reserves				9d(3)	
e Dividends or retroactive rate refunds due. (Do r	ot include amount entere	d in line 9c(2)	.)	. 9e	
10 Nonexperience-rated contracts:					
 Total premiums or subscription charges paid to 	carrier			10a	8211
b If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b	
Specify nature of costs.		-,,			-
Part IV Provision of Information					
11 Did the insurance company fail to provide any inform	nation necessary to comp	lete Schedule	A?	Yes	No
12 If the answer to line 11 is "Yes," specify the informa	tion not provided.				



					-			
SCHEDULE	ce Information			OMB No. 1210-0110				
(Form 5500)								
Department of the Treas Internal Revenue Servi		d under section 104 of the urity Act of 1974 (ERISA). 2019						
Department of Labor Employee Benefits Security Ad	r ministration	▶ File as an a	attachment to Form 55	00.				
Pension Benefit Guaranty Co	rporation	 Insurance companies a pursuant to E 	are required to provide t ERISA section 103(a)(2)		ion		m is Open to Public Inspection	
For calendar plan year 20	19 or fiscal plan	year beginning 07/01/2019		and en	ding 06/3	0/2020		
A Name of plan MISTER CAR WASH HEA			B Thre	e-digit number (Pi	N) >	503		
C Plan sponsor's name a CAR WASH PARTNERS,		e 2a of Form 5500			yer Identific 3299064	ation Number (EIN)	
		ning Insurance Contract . Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca FIDELITY SECURITY LIFE		COMPANY						
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To	
43-0949844	71870	1001877/9697004	2343		07/01/2019	9	06/30/2020	
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	ther persons in	
(a) Total a	amount of comm	missions paid		(b) To	tal amount	of fees paid		
		18232					0	
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).				
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
MERCER HEALTH AND B	ENEFITS, LLC		AYSPHERE CIRCLE GO, IL 60674					
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pai	18232	(c) Amount		(d) Purpose	•		(e) Organization code	
	4.55							
	(a) Name a	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fee	es and other commission	ns paid				
commissions pai		(c) Amount		(d) Purpose	9		(e) Organization code	
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	5500.			Sched	lule A (Form 5500) 2019 v. 190130	



Schedule A (Form 5500)	2019	Page 2 – 1	
(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	(c) Amount	(u) i uipose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
			,
(b) Amount of calor and baco		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization 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
(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
·			



	Schedule A (Form 5500) 2019	Page 3		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv this report.	ridual contracts with each carrier ma	ay be treated	d as a unit for purposes of
4 Cun	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cun	rent value of plan's interest under this contract in separate accounts at year e	end	5	
	tracts With Allocated Funds:			
а	State the basis of premium rates 🕨			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6с	
d	If the carrier, service, or other organization incurred any specific costs in co		6d	
	retention of the contract or policy, enter amount.			
	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 Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	,	
	_ · H	ate participation guarantee		
	(3) guaranteed investment (4) other			
	(o) Sequence intersection (i) order is			
b	Balance at the end of the previous year		7b	0
	Additions: (1) Contributions deposited during the year		10	
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
	(0)T-1-1 - 1-11(70(6)	0
a	(6)Total additions		7c(6) 7d	0
	Total of balance and additions (add lines 7b and 7c(6))		/u	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier	7 (7)		
	(3) Transferred to separate account.	7e(3)		
	(4) Other (specify below)	7e(4)		
	(4) Otter (Specify Delott)			
	•			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0



S	Schedule A (Form 5500) 2019		Page	4		
Part III	Welfare Benefit Contract Inform If more than one contract covers the same the information may be combined for repor employees, the entire group of such individent	group of employees of th ting purposes if such con	tracts are exp	erience-rated as a uni	t. Where cor	ntracts cover individual
8 Benefit a	and contract type (check all applicable boxes)				•	•
	ealth (other than dental or vision)	b Dental	cly	Vision		d ☐ Life insurance
		브		-		
	emporary disability (accident and sickness)				pioyment	h Prescription drug
ı∐s	top loss (large deductible)	j HMO contract	ĸ	PPO contract		I Indemnity contract
m 📙 O	Other (specify)					
9 Experien	nce-rated contracts:					
a Pren	niums: (1) Amount received		. 9a(1)			
(2)	Increase (decrease) in amount due but unpai	d	9a(2)			
	Increase (decrease) in unearned premium re		9a(3)			
	Earned ((1) + (2) - (3))				. 9a(4)	
	nefit charges (1) Claims paid		9b(1)			
	Increase (decrease) in claim reserves		9b(2)			
	Incurred claims (add (1) and (2))				9b(3)	
	Claims charged(1) Retention charges (. 9b(4)	
C Rei	(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 ir	n cash, or	credited.)	9c(2)	
d Sta	itus of policyholder reserves at end of year: (1	Amount held to provide	benefits after	r retirement	. 9d(1)	
(2)	Claim reserves				9d(2)	
(3)	Other reserves				. 9d(3)	
e Div	idends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c(2)	.)	. 9e	
	perience-rated contracts:					
a Tot	tal premiums or subscription charges paid to o	carrier			. 10a	20287
rete	he carrier, service, or other organization incur ention of the contract or policy, other than rep nature of costs.				. 10b	
Part IV 11 Did the	Provision of Information einsurance company fail to provide any inform	nation necessary to comp	lete Schedule	e A?	Yes	× No
	inswer to line 11 is "Yes," specify the informat					_
12 II the a	inswer to line it is lies, specify the informal	ion not provided.				



SCHEDULE A Insurance Information (Form 5500)							B No. 1210-0110
Department of the Treasury This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).							2019
Department of Lat Employee Benefits Security A	dministration	File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty (Corporation	 Insurance companies a pursuant to E 	are required to provide t RISA section 103(a)(2)		ion		m is Open to Public Inspection
For calendar plan year 2	019 or fiscal pla	n year beginning 07/01/2019		and en	ding 06/3	0/2020	1
A Name of plan MISTER CAR WASH HI		B Three	e-digit number (Pf	N) •	503		
C Plan sponsor's name CAR WASH PARTNERS		e 2a of Form 5500			yer Identific 3299064	ation Number (EIN)
		rning Insurance Contract i. Individual contracts grouped as					
1 Coverage Information	:						
(a) Name of insurance of DELTA DENTAL OF ARI							
45 FBI	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
86-0274899	53597	31652 00001	1384		07/01/2019	9	06/30/2020
2 Insurance fee and cor descending order of th		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in
(a) Tota	amount of com			(b) To	tal amount	of fees paid	
		71109					0
3 Persons receiving cor	mmissions and f	ees. (Complete as many entries	as needed to report all	persons).			
		and address of the agent, broker,		m commiss	ions or fees	were paid	
MERCER HEALTH AND	BENEFITS, LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales	and base	Fee	s and other commission	ns paid			
commissions p	aid	(c) Amount		(d) Purpose	9		(e) Organization code
	71109						3
							ı
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales	and base	F _{ee}	s and other commission	ns paid			
commissions p		(c) Amount		(d) Purpose	9		(e) Organization code
For Paperwork Reducti	on Act Notice,	see the Instructions for Form 5	500.			Sched	dule A (Form 5500) 2019 v. 190130



Schedule A (Form 5500)			
(a) Na	me and address of the agent, broke	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
(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
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
	I	Fees and other commissions paid	(a)
(b) Amount of sales and base		(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 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	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of color and by		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code



	Schedule A (Form 5500) 2019	Page 3		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv this report.	ridual contracts with each carrier m	nay be treated a	s a unit for purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	stracts With Allocated Funds:			
a	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.			
	Specify nature of costs			
	To a factor to the Control of the Co	4		
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 Cor	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)	•	
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
	(-,			
b	Balance at the end of the previous year		7b	0
C	Additions: (1) Contributions deposited during the year	7c(1)		_
	(2) Dividends and credits	- :-:		
	(3) Interest credited during the year	_ :-:		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
	Deductions:		/ 4	
_	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)		
	•			
			7-(5)	
	(5) Total deductions			0
T	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	U



	Schedule A (Form 5500) 2019			Page	4			
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 individ	group ing pu	rposes if such cont	racts are exp	erience-rated as a u	nit. Where co	ntract	s cover individual
8 Ben	efit and contract type (check all applicable boxes)							
a	Health (other than dental or vision)	bΧ	Dental	С	Vision		d	Life insurance
e	Temporary disability (accident and sickness)	fΠ	Long-term disabili	tv g. □	Supplemental une	mployment	hΠ	Prescription drug
i i	Stop loss (large deductible)	iП	HMO contract		PPO contract		- 1	Indemnity contract
m	Other (specify)	, п	Timo comunic		110000000		-П	machinity contact
9 Exp	erience-rated contracts:							
a	Premiums: (1) Amount received			9a(1)		671204		
	(2) Increase (decrease) in amount due but unpaid	i		9a(2)				
	(3) Increase (decrease) in unearned premium res	erve		9a(3)				
	(4) Earned ((1) + (2) - (3))					9a(4)		67120
b	Benefit charges (1) Claims paid			9b(1)		438145		
	(2) Increase (decrease) in claim reserves			9b(2)		1889		
	(3) Incurred claims (add (1) and (2))					9b(3)		44003
	(4) Claims charged					9b(4)		44003
С	Remainder of premium: (1) Retention charges (c	n an a	ccrual basis)				_	
	(A) Commissions			9c(1)(A)		71109		
	(B) Administrative service or other fees			9c(1)(B)		146637		
	(C) Other specific acquisition costs			9c(1)(C)			_	
	(D) Other expenses			9c(1)(D)			_	
	(E) Taxes			9c(1)(E)		13424	_	
	(F) Charges for risks or other contingencies			9c(1)(F)			4	
	(G) Other retention charges			9c(1)(G)				
	(H) Total retention		_			9c(1)(H)	_	23117
	(2) Dividends or retroactive rate refunds. (These	amou	nts were paid in	cash, or	credited.)	··· 9c(2)	\perp	
d	Status of policyholder reserves at end of year: (1) Amo	unt held to provide	benefits after	r retirement	9d(1)		
	(2) Claim reserves					9d(2)		4663
	(3) Other reserves					9d(3)	_	
	Dividends or retroactive rate refunds due. (Do n	ot inclu	ide amount entere	d in line 9c(2)	.)	9e	_	
	nexperience-rated contracts:							
а	Total premiums or subscription charges paid to o	arrier.				10a	_	
	If the carrier, service, or other organization incur retention of the contract or policy, other than rep					10b		
Part	Offy nature of costs. IV Provision of Information							
11 Di	d the insurance company fail to provide any inform	ation	necessary to comp	lete Schedule	A?	Yes	X No)
	he answer to line 11 is "Yes," specify the informat					_		



SCHEDULE A Insurance Information							3 No. 1210-0110
Department of the Treas	•	This schedule is required	to be filed under section	n 104 of th	ie.		
Internal Revenue Servi	ice	Employee Retirement Inc					2019
Department of Labor Employee Benefits Security Ad		▶ File as an a	ttachment to Form 55	00.			
Pension Benefit Guaranty Co	orporation	 Insurance companies a pursuant to E 	are required to provide t RISA section 103(a)(2)		tion		n is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning 07/01/2019 and ending 06/30/2020							
A Name of plan MISTER CAR WASH HEA		B Thre plan	e-digit number (Pl	N) •	503		
C Plan sponsor's name a CAR WASH PARTNERS,		e 2a of Form 5500			yer Identific 3299064	ation Number (EIN)
		ning Insurance Contract . Individual contracts grouped as					
1 Coverage Information:							
(a) Name of insurance ca DELTA DENTAL OF ARIZO							
/EX EIN	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract			From	(g) To
86-0274899	53597	31652 00002	 ' ' ' 		07/01/201	9	06/30/2020
2 Insurance fee and communication descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of comm			(b) To	otal amount	of fees paid	
		13404					0
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all	persons).			
		nd address of the agent, broker,		m commiss	ions or fees	were paid	
MERCER HEALTH AND B	ENEFITS, LLC		AYSPHERE CIRCLE GO, IL 60674				
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai	id	(c) Amount		(d) Purpos	e		(e) Organization code
	13404						3
	(a) Name a	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were naid	
	(a) Name a	no dourest or the agent, stoner,	or other person to who		ions or rees	were para	
(b) Amount of sales ar	nd base	Fee	s and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpos	e		(e) Organization code
For Paperwork Reductio	n Act Notice, s	see the Instructions for Form 5	500.			Sched	ule A (Form 5500) 2019



Schedule A (Form 5500)	2019	Page 2 – 1			
(a) Nar	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		
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
the description of the second bases		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Foor and other commissions paid	(e)		
(b) Amount of sales and base		Fees and other commissions paid			
commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Nar	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		
(a) Nar	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		



	Schedule A (Form 5500) 2019	Page 3		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv this report.	vidual contracts with each carrier m	ay be treated as a u	unit for purposes of
4 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	end	5	
6 Cor	ntracts With Allocated Funds:			
a	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			
u	retention of the contract or policy, enter amount.		6d	
	Specify nature of costs			
	. ,			
е	Type of contract: (1) ☐ individual policies (2) ☐ group deferre	ed annuity		
		a dilitary		
	(3) other (specify)			
		_		
f	If contract purchased, in whole or in part, to distribute benefits from a termi	nating plan, check here		
7 Cor	ntracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year		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(5)		
	•			
	(6)Total additions		7c(6)	0
	Total of balance and additions (add lines 7b and 7c(6)).		7d	U
е	Deductions:	7.40		
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier			
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)		
	•			
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0



Sc	chedule A (Form 5500) 2019		Page	<u>4</u>		
Part III	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the	racts are exp	perience-rated as a ur	it. Where contr	racts cover individual
8 Benefit a	nd contract type (check all applicable boxes)					
а∏не	ealth (other than dental or vision)	b X Dental	c	Vision	d	Life insurance
=	mporary disability (accident and sickness)	□		Supplemental unen		Prescription drug
		□ ·		⊒	iipioyiiieiit 11	።
I ∐ Sto	op loss (large deductible)	j HMO contract	K	PPO contract		Indemnity contract
m 📙 Ot	her (specify)					
9 Experience	ce-rated contracts:					
a Prem	iums: (1) Amount received		9a(1)		126492	
(2) Ir	ncrease (decrease) in amount due but unpaid	d	9a(2)			
(3) Ir	ncrease (decrease) in unearned premium res	serve	9a(3)			
	amed ((1) + (2) - (3))				9a(4)	126492
b Ben	efit charges (1) Claims paid		9b(1)		61711	
	ncrease (decrease) in claim reserves		9b(2)		-89	
	ncurred claims (add (1) and (2))				9b(3)	61622
	claims charged				9b(4)	61622
	nainder of premium: (1) Retention charges (c					
	(A) Commissions		9c(1)(A)		13404	
	(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)		29726	
	(C) Other specific acquisition costs(D) Other expenses		9c(1)(D)			
	(E) Taxes		9c(1)(E)		2530	
	(F) Charges for risks or other contingencies		9c(1)(F)		2030	
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention		(-)(-)		9c(1)(H)	45660
	Dividends or retroactive rate refunds. (These	_	cash or	credited)	9c(2)	
	us of policyholder reserves at end of year: (1				9d(1)	
	Claim reserves			r reurement	9d(1)	8483
	Other reserves				9d(3)	0400
(-)	dends or retroactive rate refunds due. (Do n	ot include amount entere	d in line 9c/2	1)	9e	
	erience-rated contracts:					
	al premiums or subscription charges paid to o	arrier			10a	
	e carrier, service, or other organization incur		onnection w	th the acquisition or		
rete	ntion of the contract or policy, other than rep				10b	
	ature of costs.					
Part IV	Provision of Information					
11 Did the	insurance company fail to provide any inform	nation necessary to comp	lete Schedul	e A?	Yes X	No
12 If the an	nswer to line 11 is "Yes," specify the informat	ion not provided. 🕨				



SCHEDULE		Insurance Information					OMB No. 1210-0110	
(Form 5500) Department of the Treasury This schedule is required to be filed under section 104 of the			ne l					
Internal Revenue Service Employee Retirement Income Security Act of 1974 (E						2019		
Department of Labor Employee Benefits Security Administration File as an attachment to Form 5500.								
					m is Open to Public Inspection			
For calendar plan year 2019 or fiscal plan year beginning 07/01/2019 and ending 06/30/2020								
A Name of plan MISTER CAR WASH HEALTH PLAN				B Thre plan	e-digit number (PN	1) >	503	
C Plan sponsor's name a CAR WASH PARTNERS,		e 2a of Form 5500			yer Identifica 3299064	ation Number	(EIN)	
		rning Insurance Contract L. Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca MASSACHUSETTS MUTU		RANCE COMPANY						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a				ontract year	
(6) 2.11	code	identification number	policy or contrac		(f)	From	(g) To	
04-1590850	4-1590850 65935 VARIOUS 69		07/01/2019		06/30/2020			
2 Insurance fee and com descending order of the		ation. Enter the total fees and tot	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in	
(a) Total	amount of com			(b) To	otal amount o	of fees paid		
		26561					0	
3 Persons receiving com		ees. (Complete as many entries						
LOGISTON FINANCIAL AD		and address of the agent, broker,		m commiss	ions or fees	were paid		
LOCKTON FINANCIAL AD	VISORS, LLC	SUITE	47TH ST 900 AS CITY, MO 64112					
(b) Amount of sales ar	nd hase	Fee	es and other commissio	ns paid				
commissions pa	id	(c) Amount		(d) Purpos	oose		(e) Organization code	
26530							3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid								
JOHN BACK DAVIES	(-)	1259 V	VESTERN AVE FIELD, MA 01085					
(b) Amount of calca	ad base	Fee	es and other commissio	ns paid				
(b) Amount of sales ar commissions pa		(c) Amount		(d) Purpos	e		(e) Organization code	
	27						3	
	- A-4 N-6'					0-1-		



Schedule A (Form 5500)	2019	Page 2 — 1	
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
SALVADORE R SALVO	4 CA	MPUS DRIVE SIPPANY, NJ 07054	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
4			3
(a) Nac	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) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	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) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Assessed of soles and base		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
(a) Nar	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of color and be		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code



	Schedule A (Form 5500) 2019	Page 3		
Part	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	ridual contracts with each carrier ma	y be treated	as a unit for purposes of
4 Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5 Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6 Conf	tracts With Allocated Funds:			
а	State the basis of premium rates 🕨			
b	Premiums paid to carrier		6b	
С	Premiums due but unpaid at the end of the year		6с	
d	If the carrier, service, or other organization incurred any specific costs in co		6d	
	retention of the contract or policy, enter amount			
	Specify flature of costs			
	Tons of anothers (1) [1] individual policies (2) [2] around defense	dib-		
е	Type of contract: (1) \coprod individual policies (2) \coprod group deferre	a annuity		
	(3) other (specify)			
		_		
f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, check here		
7 Conf	tracts With Unallocated Funds (Do not include portions of these contracts ma	aintained in separate accounts)		
a	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other	•		
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year	7c(1)		
	(2) Dividends and credits	7c(2)	i	
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
	(6)Total additions		7c(6)	0
d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
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)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0



S	chedule A (Form 5500) 2019			Page	e 4			
Part III	Welfare Benefit Contract Inform If more than one contract covers the same		mnlovees of the	sama amni	lover(s) or members	of the same or	mnlovee oma	nizations(s)
	the information may be combined for repor	ting purpo	ses if such contr	acts are exp	perience-rated as a u	unit. Where co	ntracts cover	
	employees, the entire group of such individ		cts with each ca	rrier may be	e treated as a unit for	r purposes of t	his report.	
	and contract type (check all applicable boxes)							
a 🗌 He	ealth (other than dental or vision)	b De	ental	С	Vision		d Life ins	ırance
e 🗌 Te	emporary disability (accident and sickness)	f X Lo	ng-term disabilit	y g	Supplemental une	employment	h Prescri	otion drug
i ∏ St	top loss (large deductible)	j ∏ HN	IO contract	k	PPO contract		I Indemn	ity contract
m 🗌 o	ther (specify)	Н		•	-		Н	
9 Evnerien	ce-rated contracts:							
	niums: (1) Amount received			9a(1)			1	
	ncrease (decrease) in amount due but unpai			9a(2)			1	
	ncrease (decrease) in unearned premium re			9a(3)			7	
	Earned ((1) + (2) - (3))		•		•	9a(4)		
b Ber	nefit charges (1) Claims paid			9b(1)				
(2) I	ncrease (decrease) in claim reserves			9b(2)				
(3) I	ncurred claims (add (1) and (2))					9b(3)		
	Claims charged					9b(4)		
	mainder of premium: (1) Retention charges (- 1		,		_	
	(A) Commissions			9c(1)(A)			4	
	(B) Administrative service or other fees			9c(1)(B)			4	
	(C) Other specific acquisition costs			9c(1)(C)			-	
	(D) Other expenses		1	9c(1)(D) 9c(1)(E)			-	
	(E) Taxes(F) Charges for risks or other contingencies.			9c(1)(F)			\dashv	
	(G) Other retention charges		r	9c(1)(G)			┥	
	(H) Total retention charges			το(.,,,ο,	1	9c(1)(H)		
	Dividends or retroactive rate refunds. (These		_	cash or	cradited)			
						9c(2)	+	
	tus of policyholder reserves at end of year: (1 Claim reserves	•				9d(1) 9d(2)	+	
	Other reserves					9d(2)	+	
	idends or retroactive rate refunds due. (Do n					9e	+	
	perience-rated contracts:	ot morage	amount entered	in time out	1-1			
	al premiums or subscription charges paid to	arrier				10a		10630
	ne carrier, service, or other organization incur							
	ention of the contract or policy, other than rep					10Ь		
	nature of costs.						•	
Part IV	Provision of Information							
	insurance company fail to provide any inform	nation nec	essary to comple	ete Schedul	e A?	Yes	X No	
	nswer to line 11 is "Yes," specify the informat							



Attachments listed below are currently being reviewed by the Department of Labor for sensitive personally identifiable information and cannot be publicly disclosed at this time:

Attachment Type	Quantity	
ESignatureAlternative	1	