

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.

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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 4085 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
		2019
		This Form is Open to Public Inspection

Part I Annual Report Identification Information For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan <input checked="" type="checkbox"/> a single-employer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.) <input type="checkbox"/> a DFE (specify) _____
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. <input type="checkbox"/>	
D Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description) _____

Part II Basic Plan Information—enter all requested information	
1a Name of plan MISTER CAR WASH HEALTH PLAN	1b Three-digit plan number (PN) ▶ <u>503</u>
	1c Effective date of plan <u>07/01/2015</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) CAR WASH PARTNERS, INC. 222 EAST 5TH STREET TUCSON, AZ 85705	2b Employer Identification Number (EIN) <u>04-3299064</u> 2c Plan Sponsor's telephone number <u>520-615-4000</u> 2d Business code (see instructions) <u>811190</u>

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	01/14/2021	JAN E. MYERS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
	Signature of DFE	Date	Enter name of individual signing as DFE

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3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 30px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
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 (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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2), 6b, and 6c..... 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 who terminated employment during the plan year with accrued benefits that were less than 100% vested	6a(1) 3992 6a(2) 4116 6b 10 6c 0 6d 4126 6e 6f 6g 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F 4H 4L	
9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> 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) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	b General Schedules (1) <input type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> 7 A (Insurance Information) (4) <input type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ☐ Yes ☐ No

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 _____

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2019 This Form is Open to Public Inspection
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For calendar plan year 2019 or fiscal plan year beginning 07/01/2019 and ending 06/30/2020

A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>	B Three-digit plan number (PN) ▶ <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>	D Employer Identification Number (EIN) <u>04-3299064</u>

Part I	Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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1 Coverage Information:

(a) Name of insurance carrier
LINCOLN LIFE ASSURANCE COMPANY OF BOSTON

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<u>04-6076039</u>	<u>65315</u>	<u>SA3-890LF008601</u>	<u>4202</u>	<u>07/01/2019</u>	<u>06/30/2020</u>

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
<u>38618</u>	<u>6853</u>

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

MERCER HEALTH AND BENEFITS, LLC 4565 PAYSHERE CIRCLE
CHICAGO, IL 60674

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
<u>38618</u>	<u>6853</u>	<u>SUPPLEMENTAL COMPENSATION</u>	<u>3</u>

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 5500. Schedule A (Form 5500) 2019 v. 190130

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

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

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

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

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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

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Part II Investment and Annuity Contract Information	
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4 Current value of plan's interest under this contract in the general account at year end	4
5 Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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 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	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

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☒ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contract
m ☒ Other (specify) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

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 reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....	9a(4)		0
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)		0
	(4) Claims charged.....	9b(4)		
c	Remainder 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)		
	(H) Total retention.....	9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	9d(1)		
	(2) Claim reserves.....	9d(2)		
	(3) Other reserves.....	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e		
10	Nonexperience-rated contracts:			
a	Total premiums or subscription charges paid to carrier.....	10a		376815
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		
	Specify nature of costs.....			

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	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 2019 This Form is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>		
A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>		B Three-digit plan number (PN) ▶ <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>		D Employer Identification Number (EIN) <u>04-3299064</u>
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier <u>LINCOLN LIFE ASSURANCE COMPANY OF BOSTON</u>		
(b) EIN	(c) NAIC code	(d) Contract or identification number
04-6076039	65315	GD3-890LF008801
		(e) Approximate number of persons covered at end of policy or contract year 4165
		Policy or contract year (f) From 07/01/2019 (g) To 06/30/2020
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid 20688		(b) Total amount of fees paid 3704
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid <u>MERCER HEALTH AND BENEFITS, LLC</u> <u>4565 PAYSHERE CIRCLE</u> <u>CHICAGO, IL 60674</u>		
(b) Amount of sales and base commissions paid 20688	Fees and other commissions paid	
	(c) Amount 3704	(d) Purpose SUPPLEMENTAL COMPENSATION
	(e) Organization code 3	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		
	(c) Amount	(d) Purpose
	(e) Organization code	

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

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

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

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

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

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

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

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

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

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

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Schedule A (Form 5500) 2019

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Part II Investment and Annuity Contract Information		Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6 Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶			
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>			
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)			
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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	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	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

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☐ Life insurance
e ☒ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ 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 reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....		9a(4)	0
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)	0
	(4) Claims charged.....		9b(4)	
c	Remainder 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)		
	(H) Total retention.....		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
	(2) Claim reserves.....		9d(2)	
	(3) Other reserves.....		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	206882
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs.

Part IV Provision of Information

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No
- 12 If the answer to line 11 is "Yes," specify the information not provided. ▶

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Insurance Information <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>► File as an attachment to Form 5500.</p> <p>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<small>OMB No. 1210-0110</small> <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2019</div> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection</p>
For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>		
A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>		B Three-digit plan number (PN) ► <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>		D Employer Identification Number (EIN) <u>04-3299064</u>
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier <u>LINCOLN LIFE ASSURANCE COMPANY OF BOSTON</u>		
(b) EIN <u>04-6076039</u>	(c) NAIC code <u>65315</u>	(d) Contract or identification number <u>GF3-890LF008601</u>
		(e) Approximate number of persons covered at end of policy or contract year <u>433</u>
		(f) From <u>07/01/2019</u>
		(g) To <u>06/30/2020</u>
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid <u>8212</u>		(b) Total amount of fees paid <u>1453</u>
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid <u>MERCER HEALTH AND BENEFITS, LLC</u> <u>4565 PAYSHERE CIRCLE</u> <u>CHICAGO, IL 60674</u>		
(b) Amount of sales and base commissions paid <u>8212</u>	Fees and other commissions paid	
	(c) Amount <u>1453</u>	(d) Purpose <u>SUPPLEMENTAL COMPENSATION</u>
	(e) Organization code <u>3</u>	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		
Fees and other commissions paid		
	(c) Amount	(d) Purpose
	(e) Organization code	

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

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

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

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

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

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

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

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

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

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

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Part II	Investment and Annuity Contract Information	
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.		
4	Current value of plan's interest under this contract in the general account at year end	4
5	Current value of plan's interest under this contract in separate accounts at year end	5
6	Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b
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)
d	Total of balance and additions (add lines 7b and 7c(6))	7d
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)	7e(4)
	(5) Total deductions	7e(5)
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- | | | | |
|---|--|--|---|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input checked="" type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> 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 reserve.....	9a(3)		
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
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)	0
(4) Claims charged.....		9b(4)	
c Remainder 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)		
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier.....	10a	82117
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	
Specify nature of costs.		

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Insurance Information <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>► File as an attachment to Form 5500.</p> <p>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<small>OMB No. 1210-0110</small> <div style="border: 1px solid black; padding: 5px; text-align: center; font-weight: bold; font-size: 1.2em;">2019</div> <p>This Form is Open to Public Inspection</p>
For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>		
A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>		B Three-digit plan number (PN) ► <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>		D Employer Identification Number (EIN) <u>04-3299064</u>
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier <u>FIDELITY SECURITY LIFE INSURANCE COMPANY</u>		
(b) EIN	(c) NAIC code	(d) Contract or identification number
43-0949844	71870	1001877/9697004
(e) Approximate number of persons covered at end of policy or contract year		2343
Policy or contract year		
(f) From		(g) To
07/01/2019		06/30/2020
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid		(b) Total amount of fees paid
18232		0
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid <u>MERCER HEALTH AND BENEFITS, LLC</u> <u>4565 PAYSPHERE CIRCLE</u> <u>CHICAGO, IL 60674</u>		
(b) Amount of sales and base commissions paid	Fees and other commissions paid	
18232	(c) Amount	(d) Purpose
		(e) Organization code
		3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		
Fees and other commissions paid		
(c) Amount	(d) Purpose	
	(e) Organization code	

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

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

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

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

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

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

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

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

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

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

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Part II Investment and Annuity Contract Information	
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.	
4 Current value of plan's interest under this contract in the general account at year end.....	4
5 Current value of plan's interest under this contract in separate accounts at year end.....	5
6 Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	6d
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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 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.....	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

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Part III	Welfare Benefit Contract Information		
	If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.		
8 Benefit and contract type (check all applicable boxes)			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;">a <input type="checkbox"/> Health (other than dental or vision)</div> <div style="width: 50%;">b <input type="checkbox"/> Dental</div> <div style="width: 50%;">c <input checked="" type="checkbox"/> Vision</div> <div style="width: 50%;">d <input type="checkbox"/> Life insurance</div> <div style="width: 50%;">e <input type="checkbox"/> Temporary disability (accident and sickness)</div> <div style="width: 50%;">f <input type="checkbox"/> Long-term disability</div> <div style="width: 50%;">g <input type="checkbox"/> Supplemental unemployment</div> <div style="width: 50%;">h <input type="checkbox"/> Prescription drug</div> <div style="width: 50%;">i <input type="checkbox"/> Stop loss (large deductible)</div> <div style="width: 50%;">j <input type="checkbox"/> HMO contract</div> <div style="width: 50%;">k <input type="checkbox"/> PPO contract</div> <div style="width: 50%;">l <input type="checkbox"/> Indemnity contract</div> <div style="width: 50%;">m <input type="checkbox"/> Other (specify) ▶</div> </div>			
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 reserve.....		9a(3)	
(4) Earned ((1) + (2) - (3)).....		9a(4)	0
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)	0
(4) Claims charged.....		9b(4)	
c Remainder 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)	
(H) Total retention.....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
(2) Claim reserves.....		9d(2)	
(3) Other reserves.....		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier.....		10a	202674
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....		10b	
Specify nature of costs.			

Part IV	Provision of Information		
11 Did the insurance company fail to provide any information necessary to complete Schedule A? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
12 If the answer to line 11 is "Yes," specify the information not provided. ▶			

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation</small>	Insurance Information <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>► File as an attachment to Form 5500.</p> <p>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<small>OMB No. 1210-0110</small> 2019 This Form 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 Three-digit plan number (PN) ► 503
C Plan sponsor's name as shown on line 2a of Form 5500 CAR WASH PARTNERS, INC.		D Employer Identification Number (EIN) 04-329064
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier DELTA DENTAL OF ARIZONA		
(b) EIN	(c) NAIC code	(d) Contract or identification number
86-0274899	53597	31652 00001
		(e) Approximate number of persons covered at end of policy or contract year 1384
		Policy or contract year (f) From 07/01/2019 (g) To 06/30/2020
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid 71109		(b) Total amount of fees paid 0
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid MERCER HEALTH AND BENEFITS, LLC 4565 PAYSPHERE CIRCLE CHICAGO, IL 60674		
(b) Amount of sales and base commissions paid 71109	Fees and other commissions paid	
	(c) Amount	(d) Purpose
		(e) Organization code 3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid		
Fees and other commissions paid		(e) Organization code
(c) Amount	(d) Purpose	

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

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

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

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

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

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

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

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

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

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

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Part II	Investment and Annuity Contract Information		
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.		
4	Current value of plan's interest under this contract in the general account at year end.....	4	
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	
6	Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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	Total of balance and additions (add lines 7b and 7c(6)).		0
e	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

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Part III	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
-----------------	--

8 Benefit and contract type (check all applicable boxes)

- | | | | |
|---|---|--|---|
| a <input type="checkbox"/> Health (other than dental or vision) | b <input checked="" type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts:

a Premiums: (1) Amount received.....		9a(1)	671204
(2) Increase (decrease) in amount due but unpaid.....		9a(2)	
(3) Increase (decrease) in unearned premium reserve		9a(3)	
(4) Earned ((1) + (2) - (3)).....		9a(4)	671204
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)	440034
(4) Claims charged		9b(4)	440034
c Remainder of premium: (1) Retention charges (on an accrual 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)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)	231170	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves	9d(2)	46636	
(3) Other reserves	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier		10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount		10b	

Specify nature of costs.

Part IV	Provision of Information
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11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

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

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SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Insurance Information <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>► File as an attachment to Form 5500.</p> <p>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<small>OMB No. 1210-0110</small> 2019 This Form is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>		
A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>		B Three-digit plan number (PN) <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>		D Employer Identification Number (EIN) <u>04-3299064</u>
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier <u>DELTA DENTAL OF ARIZONA</u>		
(b) EIN <u>86-0274899</u>	(c) NAIC code <u>53597</u>	(d) Contract or identification number <u>31652 00002</u>
		(e) Approximate number of persons covered at end of policy or contract year <u>439</u>
		(f) From <u>07/01/2019</u>
		(g) To <u>06/30/2020</u>
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid <u>13404</u>		(b) Total amount of fees paid <u>0</u>
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid <u>MERCER HEALTH AND BENEFITS, LLC</u> <u>4565 PAYSPHERE CIRCLE</u> <u>CHICAGO, IL 60674</u>		
(b) Amount of sales and base commissions paid <u>13404</u>	Fees and other commissions paid	
	(c) Amount	(d) Purpose
		(e) Organization code <u>3</u>
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
(b) Amount of sales and base commissions paid	Fees and other commissions paid	
	(c) Amount	(d) Purpose
		(e) Organization code

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

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

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

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

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

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

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

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

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

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

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Part II	Investment and Annuity Contract Information		
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.		
4	Current value of plan's interest under this contract in the general account at year end.....	4	
5	Current value of plan's interest under this contract in separate accounts at year end.....	5	
6	Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> 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	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.....	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

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- a ☐ Health (other than dental or vision) b ☒ Dental c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contract
m ☐ Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received.....	9a(1)	126492	
	(2) Increase (decrease) in amount due but unpaid.....	9a(2)		
	(3) Increase (decrease) in unearned premium reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....	9a(4)	126492	
b	Benefit charges (1) Claims paid.....	9b(1)	61711	
	(2) Increase (decrease) in claim reserves.....	9b(2)	-89	
	(3) Incurred claims (add (1) and (2)).....	9b(3)	61622	
	(4) Claims charged.....	9b(4)	61622	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions.....	9c(1)(A)	13404	
	(B) Administrative service or other fees.....	9c(1)(B)	29726	
	(C) Other specific acquisition costs.....	9c(1)(C)		
	(D) Other expenses.....	9c(1)(D)		
	(E) Taxes.....	9c(1)(E)	2530	
	(F) Charges for risks or other contingencies.....	9c(1)(F)		
	(G) Other retention charges.....	9c(1)(G)		
	(H) Total retention.....	9c(1)(H)	45680	
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....	9d(1)		
	(2) Claim reserves.....	9d(2)	8483	
	(3) Other reserves.....	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e		

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs.

Part IV Provision of Information

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No
12 If the answer to line 11 is "Yes," specify the information not provided. ▶

Summary Annual Report



SCHEDULE A (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Insurance Information <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>► File as an attachment to Form 5500.</p> <p>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<small>OMB No. 1210-0110</small> 2019 This Form is Open to Public Inspection
For calendar plan year 2019 or fiscal plan year beginning <u>07/01/2019</u> and ending <u>06/30/2020</u>		
A Name of plan <u>MISTER CAR WASH HEALTH PLAN</u>		B Three-digit plan number (PN) <u>503</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>CAR WASH PARTNERS, INC.</u>		D Employer Identification Number (EIN) <u>04-3299064</u>
Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.		
1 Coverage Information:		
(a) Name of insurance carrier <u>MASSACHUSETTS MUTUAL LIFE INSURANCE COMPANY</u>		
(b) EIN	(c) NAIC code	(d) Contract or identification number
04-1590850	65935	VARIOUS
(e) Approximate number of persons covered at end of policy or contract year		69
Policy or contract year		
(f) From		(g) To
07/01/2019		06/30/2020
2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.		
(a) Total amount of commissions paid		(b) Total amount of fees paid
26561		0
3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).		
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
<u>LOCKTON FINANCIAL ADVISORS, LLC</u> <u>444 W 47TH ST</u> <u>SUITE 900</u> <u>KANSAS CITY, MO 64112</u>		
(b) Amount of sales and base commissions paid	Fees and other commissions paid	
26530	(c) Amount	(d) Purpose
		(e) Organization code
		3
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid		
<u>JOHN BACK DAVIES</u> <u>1259 WESTERN AVE</u> <u>WESTFIELD, MA 01085</u>		
(b) Amount of sales and base commissions paid	Fees and other commissions paid	
27	(c) Amount	(d) Purpose
		(e) Organization code
		3

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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
 SALVADORE R SALVO 4 CAMPUS DRIVE
 PARSIPPANY, NJ 07054

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4			3

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

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

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

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

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

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

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

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

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Schedule A (Form 5500) 2019

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Part II	Investment and Annuity Contract Information		
	Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.		
4	Current value of plan's interest under this contract in the general account at year end	4	
5	Current value of plan's interest under this contract in separate accounts at year end	5	
6	Contracts 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 connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b	Balance at the end of the previous year	7b	
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	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	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

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Schedule A (Form 5500) 2019

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- ☐ a Health (other than dental or vision)
 ☐ b Dental
 ☐ c Vision
 ☐ d Life insurance
☐ e Temporary disability (accident and sickness)
 ☒ f Long-term disability
 ☐ g Supplemental unemployment
 ☐ h Prescription drug
☐ i Stop loss (large deductible)
 ☐ j HMO contract
 ☐ k PPO contract
 ☐ l 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 reserve.....	9a(3)		
	(4) Earned ((1) + (2) - (3)).....		9a(4)	0
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)	0
	(4) Claims charged.....		9b(4)	
c	Remainder 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)		
	(H) Total retention.....		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....		9d(1)	
	(2) Claim reserves.....		9d(2)	
	(3) Other reserves.....		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....		9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier.....	10a	106303
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b	

Specify nature of costs.

Part IV Provision of Information

- 11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No
 12 If the answer to line 11 is "Yes," specify the information not provided. ▶

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