

<div>Form 5500</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Annual Return/Report of Employee Benefit Plan</div> <div>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div>	<div>OMB Nos. 1210-0110 1210-0089</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	---	---

Part I	Annual Report Identification Information
For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023	
A	This return/report is for: <div><div><input type="checkbox"/> a multiemployer plan</div><div><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.)</div><div><input type="checkbox"/> a single-employer plan</div><div><input checked="" type="checkbox"/> a DFE (specify) <u>G</u></div><div><input type="checkbox"/> the first return/report</div><div><input type="checkbox"/> the final return/report</div><div><input type="checkbox"/> an amended return/report</div><div><input type="checkbox"/> a short plan year return/report (less than 12 months)</div></div>
C	If the plan is a collectively-bargained plan, check here. ▶ <input type="checkbox"/>
D	Check box if filing under: <div><div><input checked="" type="checkbox"/> Form 5558</div><div><input type="checkbox"/> automatic extension</div><div><input type="checkbox"/> the DFVC program</div><div><input type="checkbox"/> special extension (enter description)</div></div>
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ <input type="checkbox"/>

Part II	Basic Plan Information—enter all requested information	
1a	Name of plan AWB HEALTHCHOICE	1b Three-digit plan number (PN) ▶ 501
		1c Effective date of plan 07/01/1996
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) ASSOCIATION OF WASHINGTON BUSINESS KRISTOFER JOHNSON PO BOX 658 OLYMPIA, WA 98507-0658 1414 CHERRY ST SE OLYMPIA, WA 98501	2b Employer Identification Number (EIN) 84-1626992 2c Plan Sponsor's telephone number 360-943-1600 2d Business code (see instructions)

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.	08/15/2024	KRISTOFER JOHNSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	08/15/2024	KRISTOFER JOHNSON
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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: 40px;"></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	835
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		6a(1)	830
a(2) Total number of active participants at the end of the plan year		6a(2)	703
b Retired or separated participants receiving benefits		6b	
c Other retired or separated participants entitled to future benefits.....		6c	
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	703
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	
f Total. Add lines 6d and 6e		6f	703
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....		6g	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		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 4Q			
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 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 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 checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> 6 A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)	

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 2022 Form M-1 annual report. If the plan was not required to file the 2022 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 148536164

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

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 WASHINGTON

(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
91-0621480	47341	09450-09457	292	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	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	

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)	248686	
(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)		248686
b Benefit charges (1) Claims paid	9b(1)	180792	
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		180792
(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)	26112	
(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)		26112
(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		
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. Specify nature of costs.	10b		

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. ▶

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023	
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ► 501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992

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 THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
--

(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
35-0472300	65676	168475-6,168505	316	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	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	

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) ▶ **AD&D**

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)	
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 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)	
(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	38877
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. Specify nature of costs.	10b	

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. ▶

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div> <div>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

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 PREMERA BLUE CROSS

(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
91-0499247	47570	200000020	703	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	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	

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)	
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 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)	
(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	7417537
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. Specify nature of costs.	10b	

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. ▶

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

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 VISION SERVICE PLAN
--

(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
23-7089668	53031	122482630011-14	704	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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..... **6d**
Specify nature of costs ▶**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year **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**

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)	
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 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)	
(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	20943
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. Specify nature of costs.	10b	

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. ▶

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023	
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992

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 WILLAMETTE DENTAL GROUP
--

(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
91-1702099	47050	WA385	7	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	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	

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)	5844	
(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)		5844
b Benefit charges (1) Claims paid	9b(1)	4750	
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		4750
(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)	584	
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)	102	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		686
(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	
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. Specify nature of costs.	10b	

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. ▶

<div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection</div>
--	--	--

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

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 METROPOLITAN LIFE INSURANCE COMPANY
--

(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
13-5581829	65978	0234392	707	11/01/2022	10/31/2023

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

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
--

(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	

(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	

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) ☐ individual policies (2) ☐ group deferred annuity
(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee
(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year	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	

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) ▶ **AD&D, PREPAID LEGAL**

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)	
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 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)	
(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	22279
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. Specify nature of costs.	10b	

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. ▶

<div>SCHEDULE C</div> <div>(Form 5500)</div> <div>Department of the Treasury Internal Revenue Service</div> <div>Department of Labor Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div>	<div>Service Provider Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div>	OMB No. 1210-0110
		2022
		This Form is Open to Public Inspection.

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023	
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... ☐ Yes ☒ No
- b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

FORTERRA INC

PO BOX 7508
OLYMPIA, WA 98507

20-3642694

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	217915	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

VIMLY BENEFIT SOLUTIONS INC

PO BOX 6
MUKILTEO, WA 98275

91-1603312

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 49		80258	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

PROPOINT LLC

525 COLUMBIA ST NW
SUITE 204
OLYMPIA, WA 98501

27-3322664

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	616318	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

FROST & COMPANY PLLC

676A WOODLAND SQ LOOP SE
SUITE 309
LACEY, WA 98503

27-5137616

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10		25038	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

<div>SCHEDULE D (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration</div>	<div>DFE/Participating Plan Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>► File as an attachment to Form 5500.</div>	<div>OMB No. 1210-0110</div> <div>2022</div> <div>This Form is Open to Public Inspection.</div>
---	---	---

For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ►	501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
--------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)**a** Name of MTIA, CCT, PSA, or 103-12 IE:**b** Name of sponsor of entity listed in (a):**c** EIN-PN**d** Entity
code**e** Dollar value of interest in MTIA, CCT, PSA, or
103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs)

(Complete as many entries as needed to report all participating plans)

a Plan name [AWB HEALTHCHOICE](#)**b** Name of plan sponsor [SEE SCH D, ATTACHMENT 1](#)**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN

SCHEDULE H (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>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	OMB No. 1210-0110 2022 This Form is Open to Public Inspection
For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023		
A Name of plan AWB HEALTHCHOICE	B Three-digit plan number (PN) ►	501
C Plan sponsor's name as shown on line 2a of Form 5500 ASSOCIATION OF WASHINGTON BUSINESS	D Employer Identification Number (EIN) 84-1626992	

Part I Asset and Liability Statement			
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash.....	1a	3655834	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)		
(2) Participant contributions.....	1b(2)		
(3) Other.....	1b(3)		
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)		3676553
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common.....	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants).....	1c(7)		
(8) Participant loans.....	1c(8)		
(9) Value of interest in common/collective trusts.....	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts.....	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds).....	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	3655834	3676553

Liabilities

g Benefit claims payable	1g		
h Operating payables	1h		
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	0	0

Net Assets

l Net assets (subtract line 1k from line 1f)	1l	3655834	3676553
---	-----------	---------	---------

Part II Income and Expense Statement

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

Income

		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	7860214	
(B) Participants	2a(1)(B)	17753	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		7877967
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	184	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		184
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		7878151
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	7754167	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		7754167
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	25038	
(2) Contract administrator fees	2i(2)	69795	
(3) Investment advisory and management fees	2i(3)	3525	
(4) Other	2i(4)	4907	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		103265
j Total expenses. Add all expense amounts in column (b) and enter total	2j		7857432
Net Income and Reconciliation			
k Net income (loss). Subtract line 2j from line 2d	2k		20719
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) ☒ Unmodified (2) ☐ Qualified (3) ☐ Disclaimer (4) ☐ Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) ☐ DOL Regulation 2520.103-8 (2) ☐ DOL Regulation 2520.103-12(d) (3) ☒ neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: CLIFTONLARSONALLEN LLP

(2) EIN: 41-0746749

d The opinion of an independent qualified public accountant is **not attached** because:

(1) ☐ This form is filed for a CCT, PSA, or MTIA. (2) ☐ It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l.

During the plan year:

a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)

	Yes	No	Amount
4a			

	Yes	No	Amount
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)			
4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)			
4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)			
4d		X	
e Was this plan covered by a fidelity bond?			
4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)			
4i		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)			
4j		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
4k			
l Has the plan failed to provide any benefit when due under the plan?			
4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?..... ☐ Yes ☐ No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

AWB HEALTHCHOICE HEALTH PLAN

**FINANCIAL STATEMENTS AND
ERISA—REQUIRED SUPPLEMENTAL SCHEDULES**

**AS OF OCTOBER 31, 2023 AND 2022 AND
FOR THE YEAR ENDED OCTOBER 31, 2023**



CPAs | CONSULTANTS | WEALTH ADVISORS

CLAconnect.com

**AWB HEALTHCHOICE HEALTH PLAN
TABLE OF CONTENTS
AS OF OCTOBER 31, 2023 AND 2022 AND
FOR THE YEAR ENDED OCTOBER 31, 2023**

INDEPENDENT AUDITORS' REPORT	1
FINANCIAL STATEMENTS	
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS – MODIFIED CASH BASIS	4
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS – MODIFIED CASH BASIS	5
NOTES TO FINANCIAL STATEMENTS	6
ERISA—REQUIRED SUPPLEMENTAL SCHEDULES (ATTACHMENTS TO FORM 5500)	
SCHEDULE H, LINE 4i— SCHEDULE OF ASSETS (HELD END OF YEAR)	14
SCHEDULE H, LINE 4j— SCHEDULE OF REPORTABLE TRANSACTIONS	15



INDEPENDENT AUDITORS' REPORT

Finance Committee – Association of Washington Business
AWB HealthChoice Health Plan
Olympia, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of AWB HealthChoice Health Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statement of net assets available for benefits – modified cash basis as of October 31, 2023, and the related statement of changes in net assets available for benefits – modified cash basis for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits – modified cash basis of AWB HealthChoice Health Plan as of October 31, 2023, and the changes in its net assets available for benefits and benefit obligations – modified cash basis for the year then ended, in accordance with the modified cash basis of account described in Note 2.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of AWB HealthChoice Health Plan and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Emphasis of Matter – Basis of Accounting

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Management is also responsible for maintaining a current plan instrument, including all plan amendments, administering the plan, and determining that the Plan's transactions that are presented and disclosed in the financial statements are in conformity with the Plan's provisions, including maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of AWB HealthChoice Health Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about AWB HealthChoice Health Plan's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) as of October 31, 2023, and the schedule of reportable transactions for the year ended October 31, 2023 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the ERISA. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules are fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Other Matter — Auditors' Report on the 2022 Financial Statements

The 2022 financial statements of AWB HealthChoice Health Plan were audited by Frost & Company, PLLC, whose shareholders and professional staff joined CliftonLarsonAllen LLP as of August 1, 2023, and has subsequently ceased operations. Their report dated July 26, 2023, expressed an unmodified opinion on those statements.

A handwritten signature in black ink that reads "CliftonLarsonAllen LLP". The signature is written in a cursive, flowing style.

CliftonLarsonAllen LLP

Spokane, Washington
August 13, 2024

**AWB HEALTHCHOICE HEALTH PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
MODIFIED CASH BASIS
OCTOBER 31, 2023 AND 2022**

	<u>2023</u>	<u>2022</u>
ASSETS		
Investments at Fair Value	<u>\$ 3,676,553</u>	<u>\$ 3,655,834</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 3,676,553</u></u>	<u><u>\$ 3,655,834</u></u>

See accompanying Notes to Financial Statements.

AWB HEALTHCHOICE HEALTH PLAN
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
MODIFIED CASH BASIS
YEAR ENDED OCTOBER 31, 2023

ADDITIONS:

INVESTMENT INCOME (LOSS)

Interest and Dividends	\$ 184
Less: Investment Fees	(3,525)
Total Investment Loss, Net	<u>(3,341)</u>

CONTRIBUTIONS

Employer Contributions	7,861,967
Participant Contributions	17,753
Refund of Premiums	(1,753)
Total Contributions	<u>7,877,967</u>

Total Additions	7,874,626
-----------------	-----------

DEDUCTIONS:

PREMIUMS PAID	7,754,167
----------------------	-----------

ADMINISTRATIVE EXPENSES

Legal Fees	2,768
Accounting and Auditing Fees	25,038
Administration Fee	69,795
Postage, Phone, and Supplies	2,139
Total Administrative Expenses	<u>99,740</u>

Total Deductions	<u>7,853,907</u>
------------------	------------------

NET INCREASE	20,719
---------------------	--------

NET ASSETS AVAILABLE FOR BENEFITS

Beginning of Year	<u>3,655,834</u>
End of Year	<u><u>\$ 3,676,553</u></u>

See accompanying Notes to Financial Statements.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 1 DESCRIPTION OF PLAN

The following description of AWB HealthChoice Health Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General

The AWB HealthChoice Health Plan (the Plan) is a fully insured health and welfare plan providing medical, life, dental, vision, and other benefits to enrolled eligible employees and dependents of employers that are members of the Association of Washington Business (AWB). The Plan is a group insurance arrangement that operates as a "Multiple Employer Welfare Arrangement" as defined by the Employee Retirement Income Security Act of 1974 (ERISA) and related laws and regulations. The Plan is operated by AWB, in coordination with the participating employers and through contracts with third parties. Each employer that participates in the Plan is the Plan administrator with respect to the coverage for its own employees for purposes of ERISA. AWB acts as the Sponsor of the Plan for ERISA reporting purposes.

Effective August 2003, the Plan established a trust (the Trust), and U.S. Bank was appointed as a trustee for funds held by the Plan. The Trust was created and established by the Sponsor to receive and to hold contributions of participating employers and serve as the conduit for payment of insurance premiums to the insurance companies that provide Plan benefits. AWB and its designated affiliates have exclusive authority to direct the trustee regarding payments from the Trust. The Trust assets are used for the exclusive benefit of Plan participants and beneficiaries and to pay Plan expenses.

Effective with the enactment of the Affordable Care Act on January 1, 2014, the Plan became grandfathered whereby only currently participating employers may continue in the Plan after December 1, 2014. New employers cannot participate in the Plan. A plan is considered grandfathered if it was in effect on March 23, 2010, and the coverage in effect as of March 23, 2010 does not undergo significant changes.

Eligibility

To be eligible for participation in the Plan, an employer must meet the following criteria:

- Must be a firm, corporation, partnership, or proprietorship directly engaged in business employing at least two eligible employees that work at least 20 or more hours per week. For dental coverage, a minimum number of three eligible employees is required.
- Must be a member in good standing of AWB.
- A minimum of 50% of enrolled employees must live and work in Washington State.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Contributions

To become and remain a participating employer in the Plan, the employer must contribute at least 75% of the coverage charge per eligible employee. This is the minimum employer contribution, but the employer may contribute up to 100% of the coverage charge. There is no minimum employer contribution requirement for dependent coverage. Dependent contribution percentage may not be higher than the contribution toward employee coverage.

When the Employer Contributes 100%

If the employer contributes 100% of the cost of employee coverage, then each employee must enroll in the Plan when he or she becomes eligible. When the employer pays 100% of the cost of coverage, an employee does not have the option to refuse or waive coverage even if he or she has coverage elsewhere.

If the employer contributes 100% of the cost of coverage for dependent coverage, then each dependent must enroll in the Plan when he or she becomes eligible. Coverage is automatic as a result of meeting the definition of an eligible dependent as defined in the insurance contract. When the employer pays 100% of the dependent's cost of coverage, the dependent does not have the option to refuse or waive coverage.

If the employer contributes 100% of the cost of employee coverage but not 100% of the dependent cost, 100% of eligible employees must enroll and 70% of the eligible dependents must enroll.

For purposes of determining the aggregate number of eligible dependents, which includes the spouse and children, the employer does not need to count dependents that have medical coverage through another source.

When the Employer Contributes Less Than 100%

The participating employer is required to contribute at least 75% of the cost of coverage per eligible employee. If the employer contributes 75% of the cost of employee coverage, then 75% of eligible employees must enroll and 70% of eligible dependents must enroll. For this purpose, an eligible employee includes each employee who has satisfied the service requirements established by the employer for eligibility. However, employees who are able to provide evidence of another group coverage may be excluded from the enrollment requirement. For purposes of determining the aggregate number of eligible dependents, the group does not need to count dependents that have medical coverage through another source.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Subscription Charges and Premiums Collected

Participating employers pay subscription charges, comprised of premiums, administration fees and commissions. These funds are collected by Vimly Benefit Solutions, Inc. (Vimly), a third-party administrator, into an account which is owned by Vimly and therefore excluded from the Plan and the trust. Vimly pays administrative fees directly to Forterra, Inc. (Forterra), a wholly owned subsidiary of AWB, and commissions directly to ProPoint, LLC (ProPoint), a wholly owned subsidiary of Forterra, prior to transferring the remaining funds to the Plan.

Administrative fees and commissions paid by participants to Vimly and disbursed from the Vimly-owned bank account are accounted for as indirect costs and are therefore not recorded in the Statement of Changes in Net Assets Available for Benefits - Modified Cash Basis. Therefore, the premiums collected as reported in these financial statements exclude the amounts remitted by employers which represent administrative fees paid to Forterra and commissions paid to ProPoint. See Note 3 for additional information, including amounts paid to Forterra and ProPoint. The premiums are based on the type of coverage the participating employers have requested. It is the individual participating employer's discretion to determine whether employees must contribute to the Plan.

Administration

The Plan is administered by a governing body that is assisted by a contract administration organization and various professional service providers. Administrative expenses are borne by the Plan.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The financial statements of the Plan are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Under that basis, certain additions are recognized when received and certain deductions are recognized when paid. Investments are stated at fair value. The modified cash basis of accounting differs from accounting principles generally accepted in the United States of America primarily because the effects of outstanding contributions and outstanding expenses are not included in the financial statements.

Use of Estimates

The preparation of financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of a money market account in the Trust.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Payment of Benefits

Premiums paid by the Company are recorded as premium payments in the accompanying statement of changes in net assets available for benefits when paid. Any premiums due and unpaid as of year-end are recorded as a benefit obligation.

Administrative Expenses

The Plan pays administrative expenses that consist primarily of administrative fees paid to third-party claims administrators, custodians, Plan administrator and subscription charges. These expenses are reported on the statements of changes in net assets available for benefits as administrative expenses.

Subsequent Events

The Plan has evaluated subsequent events through August 13, 2024, the date the financial statements were available to be issued.

NOTE 3 ADMINISTRATION

Services Agreement

Effective October 1, 2010, AWB entered into an amended and restated agreement with Forterra which exclusively designates Forterra to administer the Plan and certain other specified plans and programs sponsored by AWB. The agreement authorizes Forterra to designate and to subcontract the performances of any administrative functions to third party administrators. The agreement has a term of five years with automatic renewal for additional five-year terms unless otherwise terminated in accordance with the provisions of the agreement.

As discussed in Note 1 above, funds are initially received into a custody account managed by Vimly. Forterra receives 2.5% of the remittances as compensation for services it performs. The amounts paid to Forterra have been excluded from these financial statements. Total fees paid to Forterra for the year ended October 31, 2023 were \$217,915. Plan assets at October 31, 2023, exclude October 2023 premiums collected by and held in the Vimly custodial account totaling \$488,677, which were transferred to the Plan in November 2023. Plan assets at October 31, 2022, exclude October 2022 premiums collected by and held in the Vimly custodial account totaling \$308,415, which were transferred to the Plan in November 2022.

Commissions

Forterra has engaged ProPoint to perform certain services for the Plan. The subscription charges paid by participants and participating employers include a percentage which is paid to ProPoint for services rendered. ProPoint has entered into agreements with third party independent insurance brokers and pays them commissions based on a percentage of total subscription charges received by the Plan. Vimly paid ProPoint \$616,298 for the year ended October 31, 2023 for services rendered which are accounted for as indirect expenses and therefore not recognized as expenses in these financial statements.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 3 ADMINISTRATION (CONTINUED)

Third-Party Administrator

The Plan receives services under an agreement with Vimly to act as a third-party administrator. The arrangement renews annually, subject to the right of either party to terminate the agreement at its discretion upon at least 90 days prior written notice. Vimly performs the billing and collection, eligibility determination, benefit processing, recordkeeping, and reporting for the Plan. Fees totaling \$69,795 for the year ended October 31, 2023 are included in administrative fees in the statement of changes in net assets available for benefits.

Other Costs Paid by the Plan Sponsor

AWB pays marketing costs and other expenses associated with the Plan. Amounts paid by AWB have been excluded from these financial statements.

NOTE 4 FAIR VALUE MEASUREMENTS

Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 820, *Fair Value Measurements and Disclosures*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 – Inputs to the valuation methodology include:

- quoted prices for similar assets or liabilities in active markets;
- quoted prices for identical or similar assets or liabilities in inactive markets;
- inputs other than quoted prices that are observable for the asset or liability
- inputs that are derived principally from or corroborated by observable market data by correlation or other means;

If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 4 FAIR VALUE MEASUREMENTS (CONTINUED)

Following is a description of the valuation methodologies used for assets at fair value. There have been no changes in the methodologies used at October 31, 2023 and 2022.

Money Market Mutual Fund: Valued at the quoted net asset value of shares held by the Plan at year-end.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of October 31:

		2023			
		Level 1	Level 2	Level 3	Total
Money Market Mutual Fund		<u>\$ 3,676,553</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 3,676,553</u>

		2022			
		Level 1	Level 2	Level 3	Total
Money Market Mutual Fund		<u>\$ 3,655,834</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 3,655,834</u>

NOTE 5 BENEFIT OBLIGATIONS

The following tables comprise the statements of benefit obligations as of October 31, 2023 and 2022 and statement of changes in benefits obligations for the year ended October 31, 2023.

		2023	2022
Amounts Currently Payable:			
Insurance Premiums Payable		<u>\$ -</u>	<u>\$ -</u>

		2023
Insurance Premiums Payable - Beginning of Year		\$ -
Insurance Premiums Incurred		7,754,167
Insurance Premiums Paid		<u>(7,754,167)</u>
Insurance Premiums Payable - End of Year		<u>\$ -</u>

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 6 FEDERAL TAX STATUS

The trust is not exempt from federal income taxes and is annually required to file a Form 1041. The trust does not have activity that would generate taxable income and therefore no taxes are recorded.

The modified cash basis of accounting requires Plan management to evaluate if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 7 PLAN TERMINATION

In the event the obligations of the employers to make contributions to the Plan terminate, the Trustees shall determine the disposition of any assets in the Trust after all expenses of the Plan have been paid, provided that any such distribution will only be made for the benefit of former participants and for the purposes set forth in the Plan.

If the assets are insufficient to pay all accrued benefits and liabilities, distribution of the assets shall be made in accordance with plan termination provisions and the requirements of ERISA and applicable government regulations.

NOTE 8 FUNDING POLICY

The Plan is financed by employer contributions, participant contributions, and from participants electing COBRA coverage. The monthly contribution rate, including the rate for COBRA coverage, is determined by the coverage type selected by the employer in their Trust Master Application. The employer contribution rate is required to be at least 75% of the monthly contribution rate but can be up to 100% of the monthly contribution rate. Employee contributions include contributions which are being deducted from participant wages when the employer contribution rate is less than 100% of the monthly contribution rate and COBRA contributions. Employee contributions withheld from participant wages were included with employer contributions and are not segregated on the statements of changes in net assets available for benefits. Accounting principles generally accepted in the United States of America require separate disclosure of employer and employee contributions. Based on how the Plan is administered, it is not feasible to segregate between the source of the contributions and, consequently, that information is not disclosed in the accompanying financial statements.

NOTE 9 PARTY-IN-INTEREST TRANSACTIONS

Certain Plan assets were invested in funds managed by the custodian of the Plan. As described in Notes 1 and 2, the Plan has several arrangements with service providers. These transactions are party-in-interest transactions under ERISA.

**AWB HEALTHCHOICE HEALTH PLAN
NOTES TO FINANCIAL STATEMENTS
OCTOBER 31, 2023 AND 2022**

NOTE 10 RISKS AND UNCERTAINTIES

In general, investment securities are exposed to various risks such as interest rate, market, and credit risk. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of the investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

AWB HEALTHCHOICE HEALTH PLAN
E.I.N. 84-1626992 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)
OCTOBER 31, 2023

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Cost	Current Value
	<u>Money Market Mutual Fund:</u>			
	US Bank Money Market (Nnda) It&c		\$ 3,676,553	\$ 3,676,553
	Total		<u>\$ 3,676,553</u>	<u>\$ 3,676,553</u>

* Indicates Party-in-Interest

AWB HEALTHCHOICE HEALTH PLAN
E.I.N. 84-1626692 PLAN NO. 501
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS
YEAR ENDED OCTOBER 31, 2023

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of Party Involved	Description of Asset/Transaction	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net Gain or (Loss)
<u>Category (i) - Single Transaction in Excess of 5% of Plan Assets</u>						
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	\$ 684,932	\$ -	\$ 684,932	\$ 684,932	\$ -
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	614,987	-	614,987	614,987	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	703,330	-	703,330	703,330	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	714,227	-	714,227	714,227	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	657,599	-	657,599	657,599	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	685,268	-	685,268	685,268	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	593,201	-	593,201	593,201	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	616,218	-	616,218	616,218	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	615,689	-	615,689	615,689	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	626,174	-	626,174	626,174	-

AWB HEALTHCHOICE HEALTH PLAN
E.I.N. 84-1626692 PLAN NO. 501
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS (CONTINUED)
YEAR ENDED OCTOBER 31, 2023

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of Party Involved	Description of Asset/Transaction	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net Gain or (Loss)
<u>Category (i) - Single Transaction in Excess of 5% of Plan Assets (Continued)</u>						
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Purchase	\$ 604,449	\$ -	\$ 604,449	\$ 604,449	\$ -
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	685,003	685,003	685,003	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	615,154	615,154	615,154	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	703,735	703,735	703,735	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	714,846	714,846	714,846	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	657,791	657,791	657,791	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	685,466	685,466	685,466	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	606,390	606,390	606,390	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	617,675	26,286,832	26,286,832	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	629,660	629,660	629,660	-

AWB HEALTHCHOICE HEALTH PLAN
E.I.N. 84-1626692 PLAN NO. 501
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS (CONTINUED)
YEAR ENDED OCTOBER 31, 2023

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of Party Involved	Description of Asset/Transaction	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net Gain or (Loss)
<u>Category (i) - Single Transaction in Excess of 5% of Plan Assets (Continued)</u>						
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	\$ -	\$ 626,632	\$ 626,632	\$ 626,632	\$ -
US Bank Money Market Cash Equivalent Fund	Cash Equivalent Sales	-	605,227	605,227	605,227	-
<u>Category (iii) - Series of Transactions in Excess of 5% of Plan Assets</u>						
US Bank Money Market Cash Equivalent Fund	Cash Equivalent 25 Purchases	7,172,026	-	7,172,026	7,172,026	-
US Bank Money Market Cash Equivalent Fund	Cash Equivalent 17 Sales	-	7,151,307	7,151,307	7,151,307	-

Columns (e) and (f) are omitted as they are not applicable.

There were no category (ii) or (iv) reportable transactions for the year ended December 31, 2023.

Association of Washington Business

84-1626992--Plan 501

Schedule D, Attachment 1

Locator	Name	Start Date	Term Date	Tax ID
151	Jim's Detail Shop	10/1/2001	12/1/2023	911593234
1931	Williamson Farms, Inc	6/1/2005		911628827
4246	O-Rings West Inc	10/1/2008		911715070
4802	Page & Beard Architects, PS	5/1/2009		911506010
5218	Executive Investments, LLC	10/1/2009		912093880
5877	Benchmark Farms	3/1/2010		462079590
701	NW Landscape Management	6/1/2003	11/1/2023	911994394
737	Dynamic Data Associates, Inc	8/1/2003		753028826
2894	Sysmatics.com, LLC	6/1/2006	1/1/2023	911967143
2988	Curtis Payne Insurance and Financial Svc	8/1/2006		202215881
3005	Butler Tool and Manufacturing, Inc	8/1/2006	7/1/2024	911665943
4373	DHC, Inc	12/1/2008	2/1/2024	911523006
4663	Foreman, Appel, Hotchkiss & Zimmerman	3/1/2009		472972877
5436	Ebenezer Christian School	12/1/2009		910617532
5497	Christopher Mueller, DDS	1/1/2010		912180254
5847	Gearard X Lomas DDS PC	3/1/2010		912115729
660	Booth & Sons Construction	6/1/2003		912127567
896	Evergreen Pacific Partners	2/1/2004		900148586
2284	Horizon Management, LLC	11/1/2005	5/1/2023	911957119
2681	Skyline Marine Center, LLC	3/1/2006		533687106
2857	Smiley's Pro-Lube, Inc	5/1/2006		911665045
4195	Cambria Corporation	9/1/2008		200273351
4705	Whisler's Inc	4/1/2009		911374314
5870	Woodridge Construction, LLC	3/1/2010		753182409
5637	Vision Service Group	1/1/2010	1/1/2023	602207728
1151	Faw & Sons Produce	6/1/2004		910622388
3272	Davido Consulting Inc	1/1/2007	5/1/2023	912111217
3955	Northwest Home Appliance, Inc	4/1/2008		770595055
4798	Core Cabinet, LLC	5/1/2009		880967884
5148	Evergreen Golf Design Inc	9/1/2009		911423330
3042	McKinney's Appliance Center, Inc	8/1/2006		911061523
3476	Frog Hollow Corp	7/1/2007	7/1/2023	753036377
3553	Pioneer Physical Therapy PLLC	8/1/2007	9/1/2023	470856775
4583	Ken Taylor	3/1/2009		911458431
4787	Little i, Inc.	5/1/2009	1/1/2023	911965913
4873	Northwest Frozen, LLC	6/1/2009		271657846
5217	Riddco, Inc	10/1/2009		911786217
5448	Red Willow Vineyard, Inc	1/1/2010		201857855
5807	Busy Bee Landfill	3/1/2010		911675799
1510	JAJ Inc	2/1/2005	6/1/2023	464051070
2780	Public Affairs of Washington	4/1/2006		010828313

3628	Keith Eric Cash	10/1/2007	205334046
4203	Jim's Automotive Experts Inc	9/1/2008	911180364
4919	Carpenter Drilling	6/1/2009	912160347
5571	Town & Country Enterprises Inc.	1/1/2010	460956734
5833	Butte Mt, Inc	3/1/2010	262236554
4272	Waterline Boats LLC	10/1/2008 1/1/2023	262461937
4473	Hudlow, Inc	1/1/2009	910965065
5046	Pacific Environments, LLC	8/1/2009	861091363
5678	Bosa Concrete Finishing, Inc	2/1/2010	731730213
5772	Meyer Engineered Materials, LLC	3/1/2010 3/1/2024	270834452
239	Evans Funeral Chapel	2/1/2002	911317088
1351	Grays Harbor Equipment Co, Inc	12/1/2004	910666112
3796	Emerald City Gymnastics	1/1/2008	911533454
4410	Pacific Rep Works, LLC	1/1/2009 6/1/2023	203289795
4590	DME Inc	3/1/2009	821219093
5500	Metropolitan Sewer Service, LLC	1/1/2010	562520812
1482	All American Roofing Products Inc	1/1/2005	830853282
3011	Intand, Corp	7/1/2006	204297157
3353	Auto Care Experts LLC	3/1/2007 7/1/2023	912061692
4281	Lammy Industries Inc	10/1/2008	911544892
5197	Gk3, PLLc	9/1/2009	200451935
5418	Arnold's Plumbing	12/1/2009 8/1/2023	531760644
5789	Dagaz Network Services, Inc.	3/1/2010	911889636
1292	Boxwave Corporation	11/1/2004	710907963
2940	Bethany Baptist Church of Puyallup	6/1/2006	910963264
3221	Maudslien, LLC	12/1/2006	536965027
4887	Desert Sky Women's Healthcare Inc PS	6/1/2009 6/1/2024	081074248
4974	Mathew Dorsch DDS PLLC	7/1/2009	465423068
5119	Fannin Litigation Group, PS	9/1/2009	264513022
5177	McCormick Medical Distribution, Inc	9/1/2009	911668113
5303	Hadlock Enterprises LLC	11/1/2009	883795330
2549	Hama Hama Company	1/1/2006	910246150
3757	Benton Bray, PLLC	1/1/2008	821028623
4360	Fuller Orchards	12/1/2008	911502322
4910	Dao & Dea, Inc	6/1/2009 6/1/2023	911884372
5517	Washington Security Products, Inc	1/1/2010	910990775
5543	Koden America, Inc	1/1/2010	592129047
5685	Montaland McGrath Chiropractic Center PS	2/1/2010 1/1/2024	383738735
5771	Brunners Lodge, Inc	3/1/2010	371580222
5787	KKT Corp	3/1/2010	571226435
2053	General Sheet Metal, Inc	8/1/2005	900195406
2152	Alta Group, Inc	9/1/2005	911594383
4256	Argo Farms Inc	10/1/2008	912046112
4330	Khadra Ventures, Inc	12/1/2008	911367365
4337	Reed Shoreline Corporation	12/1/2008	911681971
4380	Bel-Lyn Farms, LLC	12/1/2008	912019965
4534	Sunny E Kim, DDS PLLC	3/1/2009	841645004

4978	HST Construction, Inc	7/1/2009		421739089
5764	Custom Crating Company, Inc	3/1/2010		911085256
5777	Ditty Properties, Inc	3/1/2010		911135050
1515	Law Office of William E Pierson, Jr PC	2/1/2005		201411385
2863	Peregrine Manufacturing, LLC	5/1/2006		911893087
4092	Knutson Farms, Inc.	7/1/2008		910765010
4106	Trifecta Performance Inc	7/1/2008		205443431
4514	Weese Corporation	1/1/2009		910890180
5345	Dave MacHugh	11/1/2009		911246456
5679	D & W Auto Repair LLC	2/1/2010		462918257
2670	TLC Excavation & Construction, Inc	3/1/2006		912094948
3629	Green Lake Chiropractic & Nutritional He	10/1/2007		371559784
4393	Pediatrics For You, PLLC	1/1/2009	1/1/2023	208841810
4521	SAK Properties, LLC	1/1/2009		202711657
5337	La Pina Inc	11/1/2009		911667299
5338	Manufacturing Technology, Inc	11/1/2009		911717314
5677	Agents of Good Roots, LLC	2/1/2010		202043588
1106	Van Dyk & Son Logging	6/1/2004		911739791
2150	Vine Tech Equipment	9/1/2005		320177223
2600	WR Lakewood LLC	2/1/2006		863134045
4549	Pubs, Inc.	2/1/2009		911664326
2450	Cascade Floral Products	1/1/2006		911732798
2590	EK Beverage Company	2/1/2006		912092984
4652	D F Electric, Inc	3/1/2009		911946435
5382	Puget Sound OIC	12/1/2009		912036279
3291	Simple Solutions, Inc	2/1/2007		522452784
3776	SB Owners LLC	1/1/2008		820941307
3804	Glen's Welding & Machine, Inc	1/1/2008	1/1/2023	911080617
3888	David Gilchrist Architect, LLC	3/1/2008		464728641
4553	Artesia Systems Group, Inc	2/1/2009		262146858
4565	Deerfield West Apartments	2/1/2009		263761820
2973	Sterk Dairy of Whatcom County, Inc	7/1/2006		752984177
5754	Udder Pride Dairy, LLC	2/1/2010		912172462
4186	Lynden Family Physical Therapy PS Inc	9/1/2008		911738380
4533	Luminous Corporation	2/1/2009		911749416
4567	Gwerders Swiss Acres, Ltd	2/1/2009		911185832
4642	Roof Therapy, Inc	3/1/2009		912086764
5279	Andrews Horse Heaven Ranch, Inc	10/1/2009		910950002
5402	Westside Windows, Inc	12/1/2009		203177056
3207	Basin Family Chiropractic PS	12/1/2006		912145819
4079	All in 1 RV & Self Storage	7/1/2008		205615600
4298	Lang Custom Concrete & Construction Inc	11/1/2008		205657683
4528	Spray Center Electronics, Inc	1/1/2009		411422049
5404	Design Masonry, Inc	12/1/2009	1/1/2023	911499333
5474	Port Townsend Shipwrights, Inc	1/1/2010	6/1/2024	911172741
1487	Acorn Motor Inn	2/1/2005		916756646
2996	NW Mountain Air, Inc	8/1/2006	12/1/2022	912075634

3529	Dayville Hay & Grain Inc	8/1/2007		911716867
4611	Strange Construction Company	3/1/2009		450511440
4971	Brier Creek Gardens, LLC	7/1/2009		264160253
5207	Westside Family Dental, PLLP	10/1/2009		912054579
5422	Sun-Ton Farm	12/1/2009		910802227
5532	Columbia Environment Group, LLC	1/1/2010		917045710
5562	Provisioners Warehouse & Transportation	1/1/2010		823673491
3890	The Echelbarger Group Inc	3/1/2008	2/1/2024	202315254
4767	Mt Baker Veterinary & E.T. Services, Inc	5/1/2009		911184965
4778	Outdoor Escapes, LLC	5/1/2009		721610220
5507	Swan School	1/1/2010		911247629
4714	Lenssen Dairy, LLC	3/1/2009		912092012
5039	The Sy Group LLC	7/1/2009		651226110
5110	Dash Point Family Dental, Inc	8/1/2009		731705305
5780	Yoogi's Closet, Inc	3/1/2010		262834362

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

▶ **Complete all entries in accordance with the instructions to the Form 5500.**OMB Nos. 1210-0110
1210-0089**2022****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2022 or fiscal plan year beginning 11/01/2022 and ending 10/31/2023

- A** This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
☐ a single-employer plan ☒ a DFE (specify) G
- B** This return/report is: ☐ the first return/report ☐ the final return/report
☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ☐
- D** Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program
☐ special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>AWB HEALTHCHOICE</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
	1c Effective date of plan <u>07/01/1996</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) <u>ASSOCIATION OF WASHINGTON BUSINESS</u> <u>KRISTOFER JOHNSON</u> <u>PO BOX 658</u> <u>OLYMPIA, WA 98507-0658</u> <u>1414 CHERRY ST SE</u> <u>OLYMPIA, WA 98501</u>	2b Employer Identification Number (EIN) <u>84-1626992</u> 2c Plan Sponsor's telephone number <u>360-943-1600</u> 2d Business code (see instructions)

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	<u>Kristofer Johnson</u> <small>Kristofer Johnson (Aug 15, 2024 12:23 PDT)</small>	<u>15/08/24</u>	<u>Kristofer Johnson</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<u>Kristofer Johnson</u> <small>Kristofer Johnson (Aug 15, 2024 12:23 PDT)</small>	<u>15/08/24</u>	<u>Kristofer Johnson</u>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2022)
v. 220413

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
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	5 835
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) 830 6a(2) 703 6b 6c 6d 703 6e 6f 703 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 4Q	

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 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 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 checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> 6 A (Insurance Information) (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)

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 2022 Form M-1 annual report. If the plan was not required to file the 2022 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 148536164

2022-23 AWBHC 5500 - Final Signature Page

Final Audit Report

2024-08-15

Created:	2024-08-15
By:	Kristina Barrett (kristinab@forterra-inc.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAA7BwDKPv1_nZ9OtlWDsoNoA71FHvmkCl1

"2022-23 AWBHC 5500 - Final Signature Page" History

-  Document created by Kristina Barrett (kristinab@forterra-inc.com)
2024-08-15 - 0:26:40 AM GMT
-  Document emailed to Kristofer Johnson (krisj@awb.org) for signature
2024-08-15 - 0:26:44 AM GMT
-  Email viewed by Kristofer Johnson (krisj@awb.org)
2024-08-15 - 7:23:27 PM GMT
-  Document e-signed by Kristofer Johnson (krisj@awb.org)
Signature Date: 2024-08-15 - 7:23:57 PM GMT - Time Source: server
-  Agreement completed.
2024-08-15 - 7:23:57 PM GMT