

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 2024 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A	This return/report is for: ☐ a multiemployer plan ☒ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a single-employer plan ☐ a DFE (specify) _____
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 WASHINGTON FARM BUREAU HEALTH CARE TRUST
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 01/01/2004
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) WASHINGTON FARM BUREAU HEALTH CARE TRUST 1322 N. POST ST. SPOKANE, WA 99201
2b	Employer Identification Number (EIN) 20-2326700
2c	Plan Sponsor's telephone number 360-357-9975
2d	Business code (see instructions) 524290

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.	09/09/2025	MARK CHARLTON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ 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 2890
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(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) 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) 2878 6a(2) 2905 6b 9 6c 0 6d 2914 6e 6f 6g(1) 6g(2) 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 4Q

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- (1) ☐ **R** (Retirement Plan Information)
- (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) ☐ **DCG** (Individual Plan Information) – Number Attached _____
- (5) ☐ **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 5
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 157506669

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700	

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

(a) Name of insurance carrier
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	85-89, 97	1732	01/01/2024	12/31/2024

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

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(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	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	794181	
(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)		794181
b Benefit charges (1) Claims paid	9b(1)	650078	
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		650078
(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)	78587	
(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)		78587
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	9c(2)		
d Status of policyholder reserves at end of year: (1) Amount held to provide 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	0
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. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700	

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

(a) Name of insurance carrier
LIFEMAP ASSURANCE 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
93-6030398	97985	WA06899W	2619	01/01/2024	09/30/2024

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	

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	(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	0
c Additions: (1) Contributions deposited during the year	7c(1)	
(2) Dividends and credits.....	7c(2)	
(3) Interest credited during the year.....	7c(3)	
(4) Transferred from separate account	7c(4)	
(5) Other (specify below)..... ▶	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ 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	53564
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. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700	

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

(a) Name of insurance carrier
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	100000105	4450	10/01/2023	09/30/2024

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

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(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	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ 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	24839680
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. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700	

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

(a) Name of insurance carrier
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	30044146	1548	01/01/2024	12/31/2024

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	0
c Additions: (1) Contributions deposited during the year (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account (5) Other (specify below)..... ▶	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	96379
(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)	96379
b Benefit charges (1) Claims paid	9b(1)	71517
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))	9b(3)	71517
(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)	14457
(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)	14457
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide 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	0
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. ▶

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700	

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

(a) Name of insurance carrier
USABLE LIFE

(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
71-0505232	94358	50054920	2757	10/01/2024	12/31/2024

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	0
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
(2) Administration charge made by carrier.....	7e(2)	
(3) Transferred to separate account	7e(3)	
(4) Other (specify below)..... ▶	7e(4)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	0
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ 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	18104
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. ▶

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST	D Employer Identification Number (EIN) 20-2326700

Part I	Service Provider Information (see instructions)
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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

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(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)

BROWN & BROWN OF WASHINGTON

91-0378940

(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?
16 22 49 50 53	NONE	663793	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WA FARM BUREAU SERVICE CO

91-1912012

(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 50	AFFILIATE	565854	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

REHN & ASSOCIATES, INC.

91-1008676

(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?
12 13 15 36 50	NONE	301605	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

HUB INTERNATIONAL NW

200 1ST AVE
SEATTLE, WA 98119

(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 50 53	NONE	133588	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BELL ANDERSON DBA DESERT INSURANCE

1006 W IVY
MOSES LAKE, WA 98837

(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 50 53	NONE	132813	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BENEFITS DIVISION, LLC

518 N WENATCHEE AVE
WENATCHEE, WA 98801

36-3884950

(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 50 53	NONE	120342	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

ACRISURE NORTHWEST PARTNERS INSURAN

100 OTTAWA AVE SW
GRAND RAPIDS, MI 49503

(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 50 53	NONE	79783	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MCGREGOR INSURANCE BENEFITS

91-1604082

(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 50 53	NONE	74166	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PAYNEWEST INSURANCE INC

PO BOX 4386
MISSOULA, MT 59806

(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 50 53	NONE	58431	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

DIGITAL INSURANCE

58-2522668

(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 50 53	NONE	48795	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LLOYD'S LIFE SALES, INC

91-0959143

(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 50 53	NONE	43200	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MITCHELL, REED & SCHMITTEN INS INC

124 PENNY RD
WENATCHEE, WA 98801

(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 50 53	NONE	36903	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

TERRIL, LEWIS & WILKE INSURANCE

91-1337671

(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 50 53	NONE	32404	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EO MEDIA GROUP

2870 BROADWAY ST NE
SALEM, OR 97301

(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 50	NONE	31141	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CRUSE, MCCUNE & ASSOC, INC.

72-1526323

(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 50 53	NONE	30003	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

CC SERVICES INC.

1711 GE RD
BLOOMINGTON, IL 61702

(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 50 53	NONE	29001	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CLIFTONLARSONALLEN LLP

41-0746749

(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 50	NONE	28245	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BARLOW COUGHRAN MORALES & JOSEPHSON

1325 FOURTH AVE
SUITE 910
SEATTLE, WA 98101

(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?
29 50	NONE	26636	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

MANNA INSURANCE GROUP, LLC

1720 FRONT ST
LYNDEN, WA 98264

(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 50 53	NONE	23689	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MADDOCK & ASSOCIATES LLC

1407 E WILLOW RD
FIFE, WA 98424

(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 50 53	NONE	22504	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SCOT M PYLE

421 W. RIVERSIDE AVE
SUITE 904
SPOKANE, WA 99201

(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 50 53	NONE	18884	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

PROPEL INSURANCE AGENCY

91-0830024

(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 50 53	NONE	18820	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GPS FINANCIAL LLC

47-4003407

(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 50 53	NONE	18578	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BRIDGETAL MEDIA LLC

2710 E ANKENY LN
BENGE, WA 99105

(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?
16 50	NONE	18000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

PARKER, SMITH & FEEK

2233 112TH AVE NE
BELLEVUE, WA 98004

(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 50 53	NONE	16922	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

OLYMPIC CREST INSURANCE

91-1717576

(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 50 53	NONE	16832	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KIBBLE & PRENTICE

601 UNION ST
SUITE 1000
SEATTLE, WA 98101

(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 50 53	NONE	16521	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

DENALI BENEFITS

3519 56TH ST
SUITE 225
GIG HARBOR, WA 98335

(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 50 53	NONE	13721	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CHAD J PHILIP

10709 BEARDSLEE BLVD
SUITE 201
BOTHELL, WA 98011

(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 50 53	NONE	13230	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GALLAGHER BENEFITS SERVICES, INC

906 W SECOND AVE
STE 400
SPOKANE, WA 99201

(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 50 53	NONE	13049	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

BISHOP INSURANCE GROUP LLC

7511 W ARROWHEAD AVE
SUITE E
KENNEWICK, WA 99336

(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 50 53	NONE	12238	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KRISTIN MANWARING INSURANCE

20-4650764

(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 50 53	NONE	12070	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EPIC INSURANCE SOLUTIONS LLC

83-4203966

(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 50 53	NONE	12052	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

COORDINATED BENEFITS DBA HIGHSTREET

6917 W GRANDRIDGE BLVD
SUITE C
KENNEWICK, WA 99336

(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 50 53	NONE	11955	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GROUP BENEFITS, LLC

26-2229284

(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 50 53	NONE	11666	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LEAVITT GREAT WEST INSURANCE SERVIC

PO BOX 2518
BILLINGS, MT 59103

(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 50 53	NONE	11364	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

FORTIPHI LLC

811 CLEVELAND AVE
MOUNT VERNON, WA 98273

(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 50 53	NONE	11336	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NARROWS INSURANCE AGENCY

2601 JAHN AVE NW
STE A1
GIG HARBOR, WA 98335

(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 50 53	NONE	10654	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DIAMOND BENEFITS

19125 NORTHCREEK PARKWAY
BOTHELL, WA 98011

(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 50 53	NONE	10104	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

BENEFIT DESIGN SERVICES LLC

7811 73RD PLACE NE
MARYSVILLE, WA 98270

(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 50 53	NONE	9866	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WHEAT & ASSOCIATES INSURANCE INC

91-0756278

(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 50 53	NONE	9402	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FOURNIER & ASSOCIATES, INC.

5712 ORCHARD ST
UNIVERSITY PL, WA 98467

(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 50 53	NONE	9228	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

PSG WASHINGTON

PO BOX 387
EVERETT, WA 98206

(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 50 53	NONE	8653	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FINANCIAL PLANNING CONCEPTS INC

21831 SE 456TH WAY
ENUMCLAW, WA 98022

(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 50 53	NONE	8622	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

THE STUPEY AGENCY

5404 33RD AVE W
EVERETT, WA 98203

(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 50 53	NONE	8448	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

BELL ANDERSON

91-0756278

(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 50 53	NONE	8392	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ESSENTIAL BENEFITS LLC

7900 E GREEN LAKE DR N
SUITE 216
SEATTLE, WA 98103

(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 50 53	NONE	7378	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RICE INSURANCE LLC

1400 BROADWAY ST
BELLINGHAM, WA 98225

(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 50 53	NONE	6665	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

INSURANCE WITH BOB, INC

612 W MAIN ST
CENTRALIA, WA 98531

(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 50 53	NONE	6446	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BELL-ANDERSON DBA BENEFACTS

10811 MAIN ST
BELLEVUE, WA 98004

(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 50 53	NONE	5698	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WASHINGTON HEALTH INSURANCE AGENCY

47-2661410

(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 50 53	NONE	5498	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

CARPENTER MEDIA GROUP

81-0572335

(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 50 53	NONE	5401	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PAYCHEX INSURANCE AGENCY INC

225 KENNETH DR
ROCHESTER, NY 14623

(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 50 53	NONE	5262	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALLIANT INSURANCE SERVICES INC

1420 5TH AVE #1500
SEATTLE, WA 98101

(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 50 53	NONE	5234	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

OAK INSURANCE SERVICES

4570 AVERY LANE SE
SUITE C
LACEY, WA 98503

(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 50 53	NONE	5144	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RIVERSIDE EMPLOYEE BENEFITS LLC

17322 107TH PLACE NE
BOTHELL, WA 98011

(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 50 53	NONE	5119	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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:

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan WASHINGTON FARM BUREAU HEALTH CARE TRUST		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 WASHINGTON FARM BUREAU HEALTH CARE TRUST		D Employer Identification Number (EIN) 20-2326700

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	1596929	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	21118	97519
(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)	4091861	5940540
(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	5709908	6038059
Liabilities			
g Benefit claims payable	1g	115321	153266
h Operating payables	1h	0	76516
i Acquisition indebtedness	1i		
j Other liabilities	1j	594530	441506
k Total liabilities (add all amounts in lines 1g through 1j)	1k	709851	671288
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	5000057	5366771

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)	29661827	
(B) Participants	2a(1)(B)	122688	
(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)		29784515
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	151937	
(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)		151937
(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		29936452

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)	26613579	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		26613579
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	295642	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	28245	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	2577	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	26540	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	2595	
(11) Other expenses.....	2i(11)	2600560	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2956159
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		29569738

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		366714
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** as part of Schedule H because:

(1) ☐ This form is filed for a CCT, PSA, DCG 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. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
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.)		☒	
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.)		☒	
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.)		☒	
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.)		☒	
e Was this plan covered by a fidelity bond?	☒		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		☒	
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?		☒	
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?		☒	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	☒		
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.)		☒	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☒	
l Has the plan failed to provide any benefit when due under the plan?		☒	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		☒	
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.			

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 _____.

WASHINGTON FARM BUREAU HEALTHCARE TRUST

**FINANCIAL STATEMENTS AND
ERISA-REQUIRED SUPPLEMENTAL SCHEDULE**

**AS OF DECEMBER 31, 2024 AND 2023, AND
FOR THE YEAR ENDED DECEMBER 31, 2024**



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**WASHINGTON FARM BUREAU HEALTHCARE TRUST
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AS OF DECEMBER 31, 2024 AND 2023, AND
FOR THE YEAR ENDED DECEMBER 31, 2024**

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Washington Farm Bureau Healthcare Trust
Spokane, Washington

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Washington Farm Bureau Healthcare Trust (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and Plan's benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and changes in Plan's benefit obligations for the year ended December 31, 2024, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of Washington Farm Bureau Healthcare Trust as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in its benefit obligations for the year ended December 31, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits 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 Washington Farm Bureau Healthcare Trust and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Washington Farm Bureau Healthcare Trust's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

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 Washington Farm Bureau Healthcare Trust'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 Washington Farm Bureau Healthcare Trust'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 Schedule Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule H, line 4i—schedule of assets (held at end of year) as of December 31, 2024 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of 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 schedule, we evaluated whether the supplemental schedule, including its form and content, is 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 schedule is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content is presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

A handwritten signature in cursive script that reads "CliftonLarsonAllen LLP".

CliftonLarsonAllen LLP

Spokane, Washington
May 15, 2025

WASHINGTON FARM BUREAU HEALTHCARE TRUST
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
ASSETS		
Investments, at Fair Value	\$ 5,940,540	\$ 5,738,727
Contributions Receivable	<u>97,519</u>	<u>21,118</u>
Total Assets	6,038,059	5,759,845
LIABILITIES		
Checks in Excess of Deposits	44,142	49,937
Accounts Payable	32,374	-
Unearned Contributions	<u>441,506</u>	<u>594,530</u>
Total Liabilities	<u>518,022</u>	<u>644,467</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 5,520,037</u></u>	<u><u>\$ 5,115,378</u></u>

See accompanying Notes to Financial Statements.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEAR ENDED DECEMBER 31, 2024

ADDITIONS:

Interest Income	\$ 151,937
Employer Contributions	29,661,827
COBRA Contributions	<u>122,688</u>
Total Additions	29,936,452

DEDUCTIONS:

Group Insurance Premiums	26,575,634
Administrative Expenses:	
Broker Commissions	1,362,652
General Agent Fees	599,499
Advertising	178,109
Professional Fees	444,864
Administrative Fees	295,642
Audit and Tax Preparation Fees	28,245
Legal Fees	26,540
Office, Printing, and Postage	7,391
Trustee Meeting and Travel	2,595
Insurance	6,803
Miscellaneous	<u>3,819</u>
Total Administrative Expenses	<u>2,956,159</u>
Total Deductions	<u>29,531,793</u>

**NET INCREASE IN NET ASSETS AVAILABLE
FOR BENEFITS**

404,659

NET ASSETS AVAILABLE FOR BENEFITS:

Beginning of Year	<u>5,115,378</u>
End of Year	<u><u>\$ 5,520,037</u></u>

See accompanying Notes to Financial Statements.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
STATEMENTS OF PLAN'S BENEFIT OBLIGATIONS
DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS		
Premiums Payable	<u>\$ 153,266</u>	<u>\$ 115,321</u>
TOTAL BENEFIT OBLIGATIONS	<u><u>\$ 153,266</u></u>	<u><u>\$ 115,321</u></u>

See accompanying Notes to Financial Statements.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
STATEMENT OF CHANGES IN PLAN'S BENEFIT OBLIGATIONS
YEAR ENDED DECEMBER 31, 2024

**OBLIGATIONS FOR CURRENT BENEFIT COVERAGE,
AT PRESENT VALUE OF ESTIMATED AMOUNTS**

Balance - Beginning of Year	\$ 115,321
Premiums Approved for Payment	26,613,579
Premiums Paid	<u>(26,575,634)</u>
Balance - End of Year	<u>153,266</u>

TOTAL BENEFIT OBLIGATIONS	<u>\$ 153,266</u>
----------------------------------	--------------------------

See accompanying Notes to Financial Statements.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 1 DESCRIPTION OF PLAN

Nature of Operations

The following description of the Washington Farm Bureau Healthcare Trust (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 Plan provides health and other benefits for eligible employees and their dependents. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Eligibility

To be eligible for benefits, participants must be employed by a participating employer and must meet eligibility requirements set by their employer.

Participating employers set the eligibility requirements for their employees within parameters established by the Plan. The parameters are as follows:

The probationary period selected by participating employers can be from the first of the month following the date of hire to up to 60 days (but not to exceed 90 days). Participating employers may set different probationary periods by class of employee.

Participating employers may specify the minimum hours of work per week for employee eligibility as long as the minimum hours are not less than 20 hours per week. Participating employers may set different hour requirements by class of employee but not by individual employee.

Retired employees who are not compensated through a participating employer's payroll system are not eligible to participate in the Plan.

Eligibility for coverage under the Plan will terminate at the earliest of any one of the following: (1) the end of the calendar month in which the employee ceases to be actively employed by a participating employer, (2) on the last day of the calendar month in which an employer ceases to participate in the Plan, or (3) on the date the Plan itself terminates.

Continuation of health care benefits to employees who would otherwise lose those benefits due to certain events, as mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA), normally applies to all employers employing 20 or more employees during a calendar year. Due to Plan provisions, all participants in the Plan are COBRA eligible. The Plan provides these benefits on a self-pay basis if a participant loses coverage because they no longer satisfy the requirements for eligibility. The contribution amount is set by the Plan.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Contributions

The Plan agreement provides that participating employers make monthly contributions to the Plan of a specified amount for each employee to provide benefits. In addition to deductibles and copayments, participants contribute specified amounts based on applicable monthly premiums for their respective benefit elections. Contributions are accrued based upon reported months worked during the year by covered employees.

Benefits

The Plan provides life insurance, accidental death and dismemberment, hospital, medical, surgical, major medical, dental, vision, and prescription drug benefits for eligible employees and their dependents. The Plan fully insures these benefits. Premiums are paid by the Plan.

Administration

The Plan is administered by a Board of Trustees 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 accompanying financial statements are prepared on the accrual basis of accounting.

Contributions Receivable

Employer contributions due but not paid at year-end are recorded as contributions receivable. Delinquent contributions are recorded when collected. Amounts recorded as of December 31, 2024 and 2023, were considered fully collectible and, accordingly, no allowance for doubtful accounts was presented. The estimate for expected credit losses considers historical loss experience, current economic conditions, and forward-looking information, including factors such as payment history, employer financial condition, and labor trends. As of December 31, 2024 and 2023, the allowance for credit losses was insignificant.

Contribution Revenue

Accounting principles generally accepted in the United States of America require separate disclosure of employer and employee contributions. Each employer determines the cost allocation between employee and employer to provide benefits. 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.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Investments Valuation and Income Recognition

The Plan's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 3 for discussion of fair value measurements.

Purchases and sales are recorded on a trade-date basis. Interest income is recorded on an accrual basis.

Unearned Contributions

Participants pay for coverage by the first day of the month for the period of coverage. Accordingly, premiums collected in December for coverage in the subsequent year are recorded as unearned contributions.

Benefit Obligations

Premiums payable are estimated based on participant eligibility earned as a result of work performed by participants through December 31 and paid by the Plan subsequent to year-end. The Plan has no obligation to provide benefits to retirees; therefore, postretirement benefit obligations are not recorded on the financial statements.

Advertising

The Plan's policy is to expense advertising costs when incurred. Advertising costs were \$178,109 for the year ended December 31, 2024.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires Plan management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Premiums

Premiums are recorded when paid.

Administrative Expenses

All expenses of maintaining the Plan are paid by the Plan.

Concentration of Credit Risk

The Plan's cash balances are held at one financial institution. Accounts at this institution are insured by a government agency up to \$250,000. At times, the balances in the account may exceed the insured limit.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Reclassifications

Certain amounts in the 2023 financial statements have been reclassified to conform with the 2024 presentation. These reclassifications do not affect net assets available for benefits as previously reported.

Subsequent Events

The Plan has evaluated subsequent events through May 15, 2025, the date the financial statements were available to be issued.

NOTE 3 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.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 3 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 December 31, 2024 and 2023.

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

Short-Term Investments – Investments in the short-term funds are valued at the daily closing price as reported by the fund.

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:

2024				
	Level 1	Level 2	Level 3	Total
Short-Term Investments	\$ 1,746,355	\$ -	\$ -	\$ 1,746,355
Money Market Mutual Fund	4,194,185	-	-	4,194,185
Total Assets at Fair Value	<u>\$ 5,940,540</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 5,940,540</u>

2023				
	Level 1	Level 2	Level 3	Total
Short-Term Investments	\$ 1,646,866	\$ -	\$ -	\$ 1,646,866
Money Market Mutual Fund	4,091,861	-	-	4,091,861
Total Assets at Fair Value	<u>\$ 5,738,727</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 5,738,727</u>

NOTE 4 TAX STATUS

The trust established under the Plan to hold the Plan's assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the trust's net investment income is exempt from income taxes. The trust has obtained a favorable tax exemption letter in which the Internal Revenue Service (IRS) stated that the trust, as then designed, was in compliance with the applicable requirements of the IRC. The Plan administrator believes that the trust, as amended, continues to qualify and to operate in accordance with the applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) 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.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 5 PRIORITIES UPON 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 6 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.

NOTE 7 TRUSTEE TRAVEL AND MEETINGS

The Plan's administrative and accounting offices are in Spokane, Washington. The Plan incurs the cost of bringing the trustees to meetings of the Board of Trustees which are usually held in Washington. Managing a health benefit plan requires specialized knowledge. In order to fulfill their fiduciary responsibility to the participants, the trustees may attend specialized training sessions and conferences. The Plan incurs the cost of sending the trustees to these meetings.

NOTE 8 RELATED PARTIES

Effective December 8, 2014, the Plan entered into an agreement with WFB Service Company, a for-profit wholly owned subsidiary of Washington Farm Bureau, with WFB Service Company providing marketing, employer outreach, and relationship services for the Plan. The agreement provides compensation to WFB Service Company based on a percentage of contributions. For the year ended December 31, 2024, the fee was 1.5% of contributions and totaled \$442,287. This fee is presented as a component of professional fees on the statement of changes in net assets. WFB Service Company is a participating employer in the Plan.

WASHINGTON FARM BUREAU HEALTHCARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 9 PARTY-IN-INTEREST TRANSACTIONS

Certain Plan assets are units in investment funds held by Farm Bureau Bank. Rehn & Associates provides certain accounting and administrative services to the Plan. Farm Bureau Bank is the Plan's custodian, and Rehn & Associates is the Plan's third-party administrator; therefore, these transactions qualify as party-in-interest transactions. Such transactions, while considered party-in-interest transactions under ERISA regulations, are permitted under the provisions of the Plan and are specifically exempt from the prohibition of party-in-interest transactions under ERISA.

NOTE 10 RISKS AND UNCERTAINTIES

The Plan provides for investment in a variety of investment securities. 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.

The liability for premiums payable at December 31, 2024 and 2023, was estimated using actual payments to insurance carriers subsequent to year-end. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in this estimate and assumptions in the near term would be material to the financial statements.

NOTE 11 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Form 5500 as of December 31:

	2024	2023
Net Assets Available for Benefits per the Financial Statements	\$ 5,520,037	\$ 5,115,378
Premiums Payable	<u>(153,266)</u>	<u>(115,321)</u>
Net Assets Available for Benefits per Form 5500	<u>\$ 5,366,771</u>	<u>\$ 5,000,057</u>

The following is a reconciliation of the costs benefits paid per the financial statements to Form 5500 for the year ended December 31, 2024:

Group Premiums Per the Financial Statements	\$ 26,575,634
Add: Current Year Premiums Payable	153,266
Less: Prior Year Premiums Payable	<u>(115,321)</u>
Benefits Paid Per Form 5500	<u>\$ 26,613,579</u>

WASHINGTON FARM BUREAU HEALTHCARE TRUST
E.I.N 20-2326700 PLAN NO. 501
SCHEDULE H, LINE 4i — SCHEDULE OF ASSETS (HELD AT END OF YEAR)
DECEMBER 31, 2024

(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
*	Short-Term Investments	Interest Bearing Cash, variable rate	\$ 1,746,355	\$ 1,746,355
*	Farm Bureau Org Money Market	Money Market Account	<u>4,194,185</u>	<u>4,194,185</u>
			<u>\$ 5,940,540</u>	<u>\$ 5,940,540</u>

* Indicates party-in-interest

Washington Farm Bureau Health Care Trust
E.I.N. 20-2326700 Plan No. 501

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
VanLierop Farms LLC	911402560	1.38%
JRT Nurseries, INC.	270629957	1.31%
Girard Resources and Recycling LLC	202811834	1.29%
Stevens Hay Farms Inc.	264087807	1.15%
Ward Rugh, Inc	910775639	1.13%
Washington Farmland Trust	912021165	1.12%
Yakima Chief Ranches	10692184	1.12%
Northern Fish Products	910890894	1.10%
Washington State Farm Bureau	910462136	1.07%
Grange Supply of Odessa	910239430	1.07%
Nussbaum Group Inc	721543310	1.06%
Paco Ventures, LLC	208876374	1.05%
Deep Sea Fisheries Inc	911142417	1.01%
Double M Orchards	911512301	0.99%
Alaskan Leader Fisheries	611503131	0.98%
SCAFCO Grain LLC	881673149	0.95%
Balcom & Moe, Inc.	910696421	0.94%
Bar E Dairy LLC	912172310	0.94%
WAFLA	260611911	0.93%
Triple E Farms	862510269	0.89%
Scratch And Peck LLC	273030784	0.89%
Harmony Farms LLC	383941039	0.87%
Specialized Landscaping Inc.	911667938	0.81%
Van Well Nursery	910690556	0.81%
Quincy Gold	911947931	0.80%
Springbrook Farms Inc	910554866	0.80%
United Sales, Inc.	911984238	0.77%
Bogaard Hay Company	911099573	0.76%
Boersma Farms Inc	264053195	0.74%
Independent Warehouse Inc.	910918296	0.71%
Water & Wastewater Services LLC	912090239	0.70%
GMR Family Farms	472845779	0.69%
Circle B Holdings, LLC	203556741	0.69%
Norwest Ingredients, LLC	912020914	0.66%
Rich Richmond Logging LLC	201739531	0.65%
No. 9 Hay Trading Co., LLC	461373144	0.65%
Land Expressions LLC	911580746	0.65%
McKay Seed Company Inc	911301100	0.65%
Werkhoven Dairy, Inc	911074270	0.63%
The Markets, LLC	912122791	0.63%
W. Brotherton Seed Co., Inc.	910626763	0.63%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Land Dirt Pipe Construction LLC	271079790	0.59%
Joe Hall Construction, Inc.	910948422	0.58%
Class A Properties, LLC	203993646	0.58%
Soiltest Farm Consultants Inc	911008674	0.57%
Tripp Distributing, Inc	910928194	0.57%
Thaemert Farms, LLC	911618758	0.57%
Friehe Farms, LLC	471944970	0.56%
Brent Roylance & Sons	202311337	0.56%
Charlton Farms, Inc	911426317	0.56%
Roylance Coulee LLC	472845949	0.54%
Greenleaf Landscaping, Inc.	911533913	0.54%
Fidelitas Wines, LLC	912151293	0.53%
Green Crow Corporation	911299016	0.51%
Snohomish Co-Op Inc	910529375	0.51%
405 Labs LLC	843392117	0.50%
Vintners Logistics, LLC	261127184	0.50%
Empire Well Drilling	462811478	0.49%
Stokrose Farms Inc	300144547	0.49%
Rowe Farms, Inc.	910567044	0.48%
Geotech Consultants Inc	911357962	0.48%
Jensen Farms Inc	910966448	0.48%
Kooy's Irrigation, Inc.	600163930	0.46%
J-NH Wine Group LLC dba Novelty Hill Winery	161629314	0.46%
L J Olsen, Inc	910960510	0.46%
Lynden Ice Co., LLC	200652301	0.46%
Abeja, LLC	912077076	0.45%
North Pacific Corporation	911595062	0.45%
Central Wine Grape Management, LLC	843457966	0.45%
Nello Pistoiresi & Son Inc	910783806	0.44%
O.L. Luther Company, Inc.	911043478	0.42%
Center Valley Orchards LLC dba Finnriver Cidery	640951599	0.42%
Compu-Tech, Inc	910978037	0.42%
Johnson Agriprises, Inc	910867266	0.41%
Flamingo Trucking Inc.	911944658	0.40%
Terra Gold Farms, Inc.	264401708	0.39%
Steve and Edie Mader LLC dba Palouse Trading	460464576	0.39%
Dibb Enterprises	200473025	0.38%
Diamond Nets, LLC	911804056	0.38%
Leo Gasseling & Sons, Inc.	910901700	0.38%
7 Seas Brewing	262490179	0.37%
Valley Nursery	911541837	0.37%
Kiperts Korner Feed LLC	911914080	0.36%
Modern Ag Products, LLC	202240773	0.36%
Granite Farm, LLC	208599866	0.36%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Prosit LLC	275154429	0.35%
Bay Baby Produce, Inc.	61672467	0.35%
H-4 Farms Partnership	200504683	0.34%
Salish Coast Company	830144537	0.34%
Central Washington Wine Production Group LLC	262366676	0.33%
Empey Orchards Inc.	461498996	0.33%
Del Fox Meats Inc	910955594	0.33%
Fidalgo Animal Medical Center	204526086	0.33%
Dahlman Pump & Well	910918545	0.32%
Svik-Silvernale, Inc.	208245193	0.32%
Tri-State Seed Company, LLC	204232704	0.32%
National Fish & Oyster Co. Inc	911788627	0.32%
The New Royal Bluff Orchards LLC	461897149	0.31%
Ovenell Farm Services	472007729	0.30%
Gold Crown Nursery	261917079	0.30%
Desert Farms Inc	481292321	0.29%
Uniontown Co-operative Association	910449180	0.29%
Grieb Optimal Wine Crafting, LLC dba Treveri Cellars	204640818	0.29%
Lewis Clark Terminal Inc	820294124	0.29%
Stone Wings II LLC dba HD Logistics	911541292	0.28%
Precision Seed Production	911936985	0.28%
North Wind Aviation, LLC	461123463	0.28%
Gilbert Cellars, LLC	203046245	0.27%
Machias Materials, LLC	452393585	0.27%
Inland Empire Milling Co	910777903	0.27%
Qualls Agriculture Lab, Inc	911686553	0.27%
Colville Retail Marijuana Sales, LLC.	850888226	0.27%
Everybody's Brewing LLC	260191236	0.27%
Fire Mountain Farms, Inc.	911639995	0.27%
J & T's Lawn Care dba Greenscape	204043167	0.26%
North Olympic Land Trust	911500378	0.26%
Benson Farms Inc	911717470	0.26%
Mosby Bros Farms Inc	911581547	0.26%
Knutzen Farms, LP	911733385	0.25%
Triple S Ranch, Inc. Bogar GP	910979026	0.25%
Mead Ranch	910567950	0.25%
Washington Association of Wheat Growers	910621075	0.25%
Van Dyke and Cedergreen Farms, LLC	465090526	0.25%
Agrahumana Inc dba Daycreek Organic Farms	871362525	0.25%
Coulee Flats Dairy, LLC	270660963	0.24%
Chimacum Corner Farmstand LLC	320308264	0.24%
Ames Lake Water Association	237065656	0.24%
Okanogan Irrigation District	651266185	0.24%
Angus Meats Inc	910910484	0.24%
Janean's Hauling, LLC	814753134	0.24%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Firman Pollen Production Inc.	261614647	0.23%
Hopewell Farm LLC - NDA 12773	450938424	0.23%
Harvest Against Hunger	911229941	0.23%
W.C.W. Enterprises, LLC	472067229	0.22%
SBV Tulip Town, LLC	842094076	0.22%
Kulshan Brewing Co.	452477861	0.22%
Environments East, Inc	202612618	0.22%
Timoteo LLC	452759906	0.22%
Steven Shiflett Orchard, Inc.	911551449	0.22%
Agrow Solutions LLC	364869060	0.22%
Double DD Meats	910722946	0.22%
Greg and Pam Harrington Wines, LLC	202157391	0.22%
Central Washington Corn Processors	320028655	0.22%
Washington State Dairy Federation	910837244	0.22%
Fekkes Dairy, LLC	911546690	0.21%
Soundview Landscapes & Sprinklers Co	911577968	0.21%
Cornerstone Construction of Seattle	911541292	0.21%
Carl's Mower & Saw, Inc.	270093198	0.21%
Woodward Canyon Winery	911318092	0.21%
JMC Enterprises Inc.	911780560	0.21%
Always Transport Inc	911399170	0.21%
Tim Brown Logging	208125950	0.20%
R&SL Inc dba Total Employment & Management	911698329	0.19%
Horning Brothers, LLC	911703781	0.19%
Millennium Landscaping & Construction Inc	822039814	0.19%
Doebler Orchards, Inc.	911666649	0.19%
Stemma Brewing	831364074	0.19%
Blue Mountain Seed, Inc	911515699	0.19%
JSZABO LLC	991142141	0.19%
KingWest, LLC	472041219	0.19%
ALM Farming Inc	911510760	0.19%
Central Washington NSY, LLC	911940576	0.18%
Kincaid Partners GP	208495950	0.18%
Lazy B Farms	814831837	0.18%
Rob Sole dba Chet's Honda	911160448	0.18%
Buckley Nursery Company	910669450	0.18%
Rifle Ridge Joint Venture	204177287	0.18%
Desert Green Farms Inc	911629016	0.18%
Radach Farms, Inc	916929896	0.18%
HR Cascade Group, PLLC	820998989	0.18%
Bordeaux Wine Locators, Inc.	911366271	0.17%
Wild Fish Conservancy	911451405	0.17%
Valley Grain Inc dba Kapa Seed Services	911072376	0.17%
Ted Tschirky Farms	911185320	0.17%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
M & S Buckley Farms LLC	814440743	0.17%
Cline Air Services, LLC	911864108	0.17%
Milbrandt Family Wines LLC	205813784	0.17%
Desert Sun Produce	214028672	0.17%
Clennon & Associates	911026615	0.17%
Lakeland Veterinary Hospital, LLC	815108159	0.17%
CK Agri LLC	770623194	0.17%
Spuds Produce Market, Inc	454712889	0.17%
Innovative Landscape LLC	352813741	0.16%
Callahan Dairy LLC	603258318	0.16%
H.F. Hauff Company, Inc.	203677792	0.16%
Archer UR Ranch, Inc.	910931444	0.16%
Paradise Farms, Inc	910855710	0.16%
BC Water Company LLC	710931306	0.16%
Prins Dairy LLC - NDA 32763	202302547	0.16%
Farm Power Northwest LLC	300415541	0.16%
DeTray Cattle Company LLC	911977055	0.16%
Sedona Trucking LLC	204646966	0.16%
Juergens Brothers Dairy, LLC	912058471	0.16%
Baird Orchards, LLC	472386270	0.15%
Cave B, LLC	912156911	0.15%
Hairpin Ranch	911585521	0.15%
Oneal Farms Joint Venture	911504040	0.15%
Innotech Metal Designs LLC	454464110	0.15%
Pure Magic, LLC	812539816	0.15%
Alaska Seafood Cooperative	261317661	0.15%
Jon E Fox	30503958	0.15%
Ovenell Farms - Termed	911992600	0.15%
Northwest Biologic LLC	862863763	0.14%
Finger Lakes Partners, Inc.	832725302	0.14%
Sattler Freight LLC	882472147	0.14%
Complete Logistic Services. LLC	463720157	0.14%
S & B Farms, Inc.	912123493	0.14%
Brothers in Farm	813115334	0.14%
Two Coops	264458118	0.14%
Direct Line Service	464855186	0.14%
Air-Trac, Inc	911296321	0.14%
Manterola Hay, Inc	721556503	0.14%
COR Wine Cellars	861101210	0.14%
Circle H Ranch	262834009	0.13%
Christmas Hills Tree Farm	911243855	0.13%
Dru Bru LLC	460935239	0.13%
Grand Vin Wine Merchants	274322906	0.13%
Hajny Trading LLC	815274604	0.13%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Dependable Ground Spray, Inc	911578410	0.13%
Chuck Yarbrow Auctioneers Inc	810819093	0.13%
Capitol Analysis Group LLC	812816975	0.13%
Coulee Creek Farms, Inc	911524929	0.13%
J.E. Love Company	571185168	0.13%
SYG Nursery & Landscaping, Inc	912180936	0.13%
Backhoe NW 315 LLC	452649268	0.13%
DMG Farms LLC	813186169	0.13%
Rosebud Vineyards, Inc	261669797	0.13%
Squak Mountain Nursery LLC	461257078	0.12%
Bates Farms Inc	800153068	0.12%
Country Animal Hospital	934933446	0.12%
MTN Lodge Farm, LLC	274362498	0.12%
East High Flying	465558231	0.12%
E3 Farms	472763877	0.12%
AgriTrade International LLC	870713172	0.12%
Spot On Spraying	454021439	0.12%
DeGroot Dairy Othello LLC	10705510	0.12%
Franz Farms	910940137	0.12%
TR Reapers Inc	208125950	0.12%
Carlton Farms Inc	911692050	0.12%
Zuger Ranch	911511353	0.12%
Rafter C Livestock Transportation, Inc	273645541	0.12%
Manzana Products Company Inc	941049819	0.12%
In-Stock Ag LLC	710926337	0.12%
Holland Legacy LLC	464234743	0.12%
Hay Boy Farms, Inc	873923242	0.12%
Hanson 4W Farms, LLC	204240425	0.12%
Wagner & Sons Landscaping	911578138	0.12%
Freedom Ridge Orchards	832438539	0.12%
Trinidad Production, LLC	842297722	0.11%
Struthers Farms, Inc	910941350	0.11%
Treeline Analytics	824673630	0.11%
West Fork Properties, LLC	830991918	0.11%
Horse Flat Ranch Inc	911321563	0.11%
Troia Dairy Distributing., Inc.	223891977	0.11%
English Hay Company	911975940	0.11%
Leitz Farms Inc	770600121	0.11%
Unique Gardens LLC	270972185	0.11%
Storm Lake Growers Inc	911753775	0.11%
M2-Ag Assurance LLC	842069321	0.11%
Five Star Cellars, Inc	912106965	0.11%
C & L Cloaninger Inc	208364870	0.11%
Gfeller Ranches Inc	911740504	0.11%
Schneider Farms-Pasco, LLC	911199873	0.11%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Kamiak Creek Inc	911675246	0.11%
Wiser Hay Co.	710999655	0.11%
Randall Trucking LLC	901511109	0.10%
Wright Distributing, Inc.	260506445	0.10%
Columbia View Farms LLC	911251237	0.10%
Icon Northwest LLC	201053855	0.10%
Griggs Orchards Inc	203875441	0.10%
Edwin Enterprises	911462395	0.10%
Olympia Farm Stand	452677148	0.10%
JS Farms dba Midland Trucking	462550616	0.10%
Vignette Holdings, LLC	455452549	0.10%
B&S Ranch LLC	920787411	0.10%
Dewald Farms	911491232	0.10%
Three Lakes Public Golf Club	910610252	0.10%
D and S Deife Farms, Inc	260530805	0.10%
D & M Chem Inc	911769065	0.09%
Tanneberg & Son, Joint Venture	274153925	0.09%
Key Farms, Inc	911596755	0.09%
Jadan Enterprises Inc.	260012531	0.09%
American Horse Transportation, LLC	203078283	0.09%
Circle J Orchards, LLC	832584958	0.09%
Dykes Cattle CO LLC	473727539	0.09%
Dirks Farms, Inc.	910923055	0.09%
John Grant & Son, Partnership	911321434	0.09%
EJ Freight LLC	471979869	0.09%
Ronald Roylance Farms	911675534	0.09%
LFZ Orchard Operations, Inc. - Termed	823414965	0.09%
C-Lightning Ranch	823696156	0.08%
Kiesz Farms, Inc. - Termed	911657596	0.08%
Salt Aire Inc	453304009	0.08%
Elma Feed & Farm Supply Inc	270744467	0.08%
Tompkins Brothers	911434592	0.08%
Multistar Industries	911408823	0.08%
Harris Fabrication LLC	455406524	0.08%
Stallings Farms, LLC	271420708	0.08%
Luft Trailer Sales	911712607	0.08%
Treat Farms Operations Corp.	464505604	0.08%
Lambert Family Ranch Inc	455590276	0.08%
Simonson Farms Inc	911609920	0.08%
TDC Excavation & Logging, Inc.	461631799	0.08%
TMI Farms Inc	274633114	0.08%
Ocean Hill Pacific LLC	843109385	0.08%
Hardrock Farms Inc	262108409	0.08%
Stingley Ranch, Inc.	465126759	0.08%
JW & K Farms, LLC	472926918	0.08%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Vanderpool Logging Inc	202559279	0.07%
Watts Leafcutter Bees Corp	753006708	0.07%
Native Springs LLC	923025750	0.07%
D9 Farms	823031804	0.07%
Devona, LLC	474635446	0.07%
Cawood Orchards	911648529	0.07%
Deboer Dairy LLC	911620771	0.07%
WW Family Farms	262039421	0.07%
Environmental Technologies Inc.	911654474	0.07%
Premium Landscape Services	810716976	0.07%
Sildahl Farms LLC	821977892	0.07%
Steven J. DeJong dba Steve DeJong Hauling	911192827	0.07%
Lagerwood Farms, Inc	911714253	0.07%
MacKenzie Farms Inc	364802875	0.07%
4 Ransom Farms, LLC	454509759	0.07%
Plagerman Farms, Inc	911592708	0.07%
Woodward Canyon Family Farm	464617835	0.07%
Parypa & Balmelli Chehalis Livestock Market - Termed	911340694	0.07%
Britton Shepard Landscapes	823918076	0.07%
Seaton III, James A	680495665	0.07%
Ryan Houston Inc	911636462	0.07%
Pixlee Farms Inc	911864121	0.07%
Calaway Company Inc	911952377	0.06%
Kregger Family Farms	260581008	0.06%
Hiett Logging, Inc	203065165	0.06%
Northwest Lime LLC	834526432	0.06%
Schafer Ranch LTD	910979831	0.06%
L. Sheffels & Son, Inc.	910707298	0.06%
Happy Lark, LLC	208323759	0.06%
SSH Enterprises Inc.	263774173	0.06%
Apache Trucking Inc	260779689	0.06%
Trinity Farms, Inc	611811103	0.06%
The Farm Stand LLC	923248298	0.06%
Daniel C Hart	911059788	0.06%
Ron Smith Farms	474751025	0.06%
Double Arrow Farms	260023629	0.06%
Weaver Ranch LLC	471309627	0.06%
Richard W. Allen Farms	912060624	0.06%
LaShaw Ag, Inc.	461647314	0.06%
Ryan Stingley dba Ryan Stingley Trucking	471722920	0.06%
BM LaShaw, Inc.	453629461	0.06%
Port Townsend Winery LLC	810731345	0.05%
Steward Farms, Inc	275554529	0.05%
Miller's Diversified Services, Inc dba Wenatchee Wind	600550728	0.05%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Elloom Farms	463643773	0.05%
Ruark Century Farm, Inc	911537574	0.05%
Titan Landscaping, LLC	10856926	0.05%
Thomsen Enterprises LLC	916543500	0.05%
Fernwood Ranch	602583723	0.05%
Kenneth M Hanson	536928448	0.05%
Swannack Farms Inc	910917708	0.05%
Quad A Farms Inc	261565908	0.05%
Farmstrong, LLC	472341911	0.05%
Rocky Top Arena	911729407	0.05%
SBV Fairhaven Mill LLC	842152207	0.05%
Lohman Farms, Inc.	208802314	0.05%
Brandt Orchards Inc	911824727	0.05%
WB Farm, LLC	264139156	0.05%
Sunny Ridge Farms	832161745	0.05%
Randall Kulm Farms	452424987	0.05%
Brandon Lewis Orchards Inc	208630649	0.05%
Rocking WR Farms, Inc.	900787850	0.05%
American Lady Growers	451271575	0.05%
Bernt Lehn Farms	911543028	0.05%
Kellan J. Wegner	211398812	0.05%
WeeHoot Orchards	911256527	0.05%
Limon Fruit Inc	921090847	0.05%
Lake Breeze Vineyards, LLC	912069075	0.05%
Gorham Farms Partnership	911513597	0.05%
Stephens Orchards Inc	202044204	0.05%
Rod Rottinghaus Farms LLC	454614793	0.05%
K&K Farms, Inc	911926533	0.04%
Joe N DeAguiar	911553779	0.04%
51 West, LLC	850568907	0.04%
Windy Prairie Inc	911537787	0.04%
Cody Stoltman Trucking LLC	455516580	0.04%
Puyallup Bark Supply	910818431	0.04%
Barker Ranch LTD	911644514	0.04%
Small Ranches	911723872	0.04%
Kiesz Joint Venture	992112315	0.03%
Curtis Hennings	911130648	0.03%
Lazy L Ranch	461325546	0.03%
Duris Farm, LLC	911919681	0.03%
Ag Health Laboratories, Inc.	912083176	0.03%
Chehalis Livestock Market	992885423	0.03%
R&K Basin Farms, Inc	880822003	0.03%
Archie Den Hoed Farm	911357099	0.03%
Leatherneck Farms LLC	439320550	0.03%

(a) Name of Participating Employer	(b) EIN	(c) Percentage of total contribution
Godwin Organic Orchards LLC	820653709	0.03%
Professional Turf Growers LLC	911673755	0.03%
Piper Orchards LLC	465057083	0.02%
Van Ess Farms, LLC	844273050	0.02%
Pacific Growers, Inc	911570769	0.02%
Turner Farms, Inc	911807526	0.02%
C&C Welding, Inc.	911709354	0.01%
Rafter Heart Farms LLC	272333394	0.01%
Cowan Fruit	911404778	0.01%
S&T Wines, LLC dba Dossier Wine Collective	862362152	0.01%
Glen Cove Company	474071927	0.01%
Mickelsen Ranch	911684295	0.01%
Stone Farms Inc	911110121	0.01%
Bare Bones Livestock Inc	161700104	0.01%
Brock Ranch Partnership	460195856	0.01%
Brindle Technical Logging, Inc	911992272	0.01%
T.J. VeenAcre Farms Inc	910908552	0.01%

WASHINGTON FARM BUREAU HEALTH CARE TRUST

EIN 20-2326700 PN 501 FYE 12/31/2024

Schedule H, Line 4i - Schedule of Assets (Held at End of Year) - included in the Accountant's audit report attachment.