

| | | |
|---|---|---|
| <p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: small;">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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p> |
|---|---|---|

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

| | |
|--|--|
| <p>1a Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>501</u></p> |
| <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p> <p><u>5608 17TH AVE NW #131</u> <u>SEATTLE, WA 98107</u></p> | <p>1c Effective date of plan <u>11/01/1984</u></p> <p>2b Employer Identification Number (EIN) <u>93-0864012</u></p> <p>2c Plan Sponsor's telephone number <u>503-224-0048</u></p> <p>2d Business code (see instructions) <u>483000</u></p> |

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. | 10/14/2025 | MILLER KAPLAN ARASE LLP |
| | 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 <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 1594 |
| 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) | 1475 |
| | 6a(2) | 1485 |
| | 6b | 116 |
| | 6c | 0 |
| | 6d | 1601 |
| | 6e | |
| | 6f | 1601 |
| | 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 | 24 |

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 4L

| | |
|---|---|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input type="checkbox"/> Insurance | (1) <input checked="" type="checkbox"/> Insurance |
| (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts | (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts |
| (3) <input checked="" type="checkbox"/> Trust | (3) <input checked="" type="checkbox"/> Trust |
| (4) <input type="checkbox"/> General assets of the sponsor | (4) <input type="checkbox"/> General assets of the sponsor |

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

| | |
|--|---|
| a Pension Schedules | b General Schedules |
| (1) <input type="checkbox"/> R (Retirement Plan Information) | (1) <input checked="" type="checkbox"/> H (Financial Information) |
| (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary | (2) <input type="checkbox"/> I (Financial Information – Small Plan) |
| (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary | (3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>5</u> |
| (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ | (4) <input checked="" type="checkbox"/> C (Service Provider Information) |
| (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information) | (5) <input type="checkbox"/> D (DFE/Participating Plan Information) |
| | (6) <input type="checkbox"/> G (Financial Transaction Schedules) |

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

| | | |
|---|--|--|
| <p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>501</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH</p> | <p>D Employer Identification Number (EIN) 93-0864012</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
| | | | | (f) From | (g) To |
| 93-0242990 | 69019 | 645929 | 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 | 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 | |
| e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| | (5) Total deductions | |
| 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) | 133488 | |
| | (2) Increase (decrease) in amount due but unpaid | 9a(2) | 12641 | |
| | (3) Increase (decrease) in unearned premium reserve | 9a(3) | | |
| | (4) Earned ((1) + (2) - (3)) | 9a(4) | | 146129 |
| b | Benefit charges (1) Claims paid | 9b(1) | 105000 | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | 150 | |
| | (3) Incurred claims (add (1) and (2)) | 9b(3) | | 105150 |
| | (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) | 19482 | |
| | (E) Taxes | 9c(1)(E) | | |
| | (F) Charges for risks or other contingencies | 9c(1)(F) | 11691 | |
| | (G) Other retention charges | 9c(1)(G) | 9807 | |
| | (H) Total retention | 9c(1)(H) | | 40980 |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | 9c(2) | | |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | 9d(1) | | |
| | (2) Claim reserves | 9d(2) | | 11076 |
| | (3) Other reserves | 9d(3) | | |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | 9e | | |

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

**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

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

| | |
|---|--|
| A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH | D Employer Identification Number (EIN) 93-0864012 |

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

1 Coverage Information:

(a) Name of insurance carrier
SYMETRA LIFE INSURANCE COMPANY

| (b) EIN | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year | |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
| | | | | (f) From | (g) To |
| 91-0742147 | 68608 | 16-015930-000 | 1419 | 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 | 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 | | |
| 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) |
| b | Benefit charges (1) Claims paid | 9b(1) | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) |
| | (4) Claims charged | | 9b(4) |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| | (A) Commissions | 9c(1)(A) | |
| | (B) Administrative service or other fees | 9c(1)(B) | |
| | (C) Other specific acquisition costs | 9c(1)(C) | |
| | (D) Other expenses | 9c(1)(D) | |
| | (E) Taxes | 9c(1)(E) | |
| | (F) Charges for risks or other contingencies | 9c(1)(F) | |
| | (G) Other retention charges | 9c(1)(G) | |
| | (H) Total retention | | 9c(1)(H) |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) |
| | (2) Claim reserves | | 9d(2) |
| | (3) Other reserves | | 9d(3) |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e |

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|---------|
| a | Total premiums or subscription charges paid to carrier | 10a | 2252783 |
| 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. ▶

| | | |
|---|--|--|
| <p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>501</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH</p> | <p>D Employer Identification Number (EIN) 93-0864012</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
HAWAII MEDICAL SERVICE ASSOCIATION

| (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 |
| 99-0040115 | 49948 | 52258 | 242 | 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 | 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 | |
| e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| | (5) Total deductions | |
| 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) |
| b | Benefit charges (1) Claims paid | 9b(1) | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) |
| | (4) Claims charged | | 9b(4) |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| | (A) Commissions | 9c(1)(A) | |
| | (B) Administrative service or other fees | 9c(1)(B) | |
| | (C) Other specific acquisition costs | 9c(1)(C) | |
| | (D) Other expenses | 9c(1)(D) | |
| | (E) Taxes | 9c(1)(E) | |
| | (F) Charges for risks or other contingencies | 9c(1)(F) | |
| | (G) Other retention charges | 9c(1)(G) | |
| | (H) Total retention | | 9c(1)(H) |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) |
| | (2) Claim reserves | | 9d(2) |
| | (3) Other reserves | | 9d(3) |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e |

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|---------|
| a | Total premiums or subscription charges paid to carrier | 10a | 1691030 |
| b | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | 10b | |

Specify nature of costs.

Part IV Provision of Information

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

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

**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

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

| | |
|---|--|
| A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH | D Employer Identification Number (EIN) 93-0864012 |

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

1 Coverage Information:

(a) Name of insurance carrier

KAISER FOUNDATION HEALTH PLAN OF HAWAII

| (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 |
| 94-1340523 | 60053 | 78 | 43 | 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 | 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 | |
| e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| | (5) Total deductions | |
| 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) |
| b | Benefit charges (1) Claims paid | 9b(1) | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) |
| | (4) Claims charged | | 9b(4) |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| | (A) Commissions | 9c(1)(A) | |
| | (B) Administrative service or other fees | 9c(1)(B) | |
| | (C) Other specific acquisition costs | 9c(1)(C) | |
| | (D) Other expenses | 9c(1)(D) | |
| | (E) Taxes | 9c(1)(E) | |
| | (F) Charges for risks or other contingencies | 9c(1)(F) | |
| | (G) Other retention charges | 9c(1)(G) | |
| | (H) Total retention | | 9c(1)(H) |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) |
| | (2) Claim reserves | | 9d(2) |
| | (3) Other reserves | | 9d(3) |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e |

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|--------|
| a | Total premiums or subscription charges paid to carrier | 10a | 302205 |
| 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. ▶

| | | |
|---|--|--|
| <p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</p> | <p>B Three-digit plan number (PN) ▶</p> | <p>501</p> |
| <p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH</p> | <p>D Employer Identification Number (EIN) 93-0864012</p> | |

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

1 Coverage Information:

(a) Name of insurance carrier
KAISER FOUNDATION HEALTH PLAN INC

| (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 |
| 94-1340523 | 00000 | 18308 | 153 | 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 | 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 | |
| e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| | (5) Total deductions | |
| 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) |
| b | Benefit charges (1) Claims paid | 9b(1) | |
| | (2) Increase (decrease) in claim reserves | 9b(2) | |
| | (3) Incurred claims (add (1) and (2)) | | 9b(3) |
| | (4) Claims charged | | 9b(4) |
| c | Remainder of premium: (1) Retention charges (on an accrual basis) -- | | |
| | (A) Commissions | 9c(1)(A) | |
| | (B) Administrative service or other fees | 9c(1)(B) | |
| | (C) Other specific acquisition costs | 9c(1)(C) | |
| | (D) Other expenses | 9c(1)(D) | |
| | (E) Taxes | 9c(1)(E) | |
| | (F) Charges for risks or other contingencies | 9c(1)(F) | |
| | (G) Other retention charges | 9c(1)(G) | |
| | (H) Total retention | | 9c(1)(H) |
| | (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) | | 9c(2) |
| d | Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement | | 9d(1) |
| | (2) Claim reserves | | 9d(2) |
| | (3) Other reserves | | 9d(3) |
| e | Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) | | 9e |

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|---------|
| a | Total premiums or subscription charges paid to carrier | 10a | 2062403 |
| b | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | 10b | |

Specify nature of costs.

Part IV Provision of Information

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

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

| | | |
|--|--|---|
| SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | 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. | <small>OMB No. 1210-0110</small> 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 IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH | D Employer Identification Number (EIN) 93-0864012 | |

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

ISHARES **525 WASHINGTON BLVD STE 1405**
JERSEY CITY, NJ 07310

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

SSGA FUNDS MANAGEMENT, INC. **1 IRON ST**
BOSTON, MA 02210

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

VERSUS CAPITAL **5555 DTC PKWY STE 330**
GREENWOOD VILLAGE, CO 80111

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

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

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

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

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

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

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

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

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

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

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

BENESYS

PMB #116, 5331 S MACADAM AVE #258
PORTLAND, OR 97239

| (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 14 15 36 38 49 50 | NONE | 765867 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

FERGUSON WELLMAN CAPITAL MANAGEMENT

93-0646988

| (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? |
|------------------------|---|--|--|--|---|--|
| 51 68 | NONE | 137638 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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

BROWNSTEIN RASK

1 SW COLUMBIA ST
PORTLAND, OR 97258

| (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 | 15504 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

PREMERA BLUECROSS

91-0499247

| (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 50 62 | NONE | 390523 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

MILLIMAN INC

91-0675641

| (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 | 122096 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

INNOVATIVE CARE MANAGEMENT

15 82ND DR #180
GLADSTONE, OR 97027

| (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 | 71510 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

MODA HEALTH PLAN INC.

93-0989307

| (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 50 | NONE | 169535 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

US BANK N.A.

31-0841368

| (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? |
|------------------------|---|--|--|--|---|--|
| 18 19 50 52 | NONE | 62822 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | 0 | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

(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 | 15150 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

SMART SOURCE LLC

PO BOX 2314
COLUMBUS, GA 31902

| (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? |
|------------------------|---|--|--|--|---|--|
| 36 50 | NONE | 36943 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

MILLER KAPLAN ARASE LLP

95-2036255

| (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 | 34000 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

| | | |
|--|--|--|
| SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small> | Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500. | <small>OMB No. 1210-0110</small> 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 IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | B Three-digit plan number (PN) 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH | D Employer Identification Number (EIN) 93-0864012 |

| | |
|---------------|--------------------------------------|
| 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.

| | | (a) Beginning of Year | (b) End of Year |
|--|-----------------|-----------------------|-----------------|
| Assets | | | |
| a Total noninterest-bearing cash | 1a | 7529700 | 405362 |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 4288688 | 4377463 |
| (2) Participant contributions | 1b(2) | | |
| (3) Other | 1b(3) | 882110 | 1504709 |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 674305 | 10619270 |
| (2) U.S. Government securities | 1c(2) | 16228098 | 17317777 |
| (3) Corporate debt instruments (other than employer securities): | | | |
| (A) Preferred | 1c(3)(A) | 4621393 | 12556508 |
| (B) All other | 1c(3)(B) | 7752546 | 0 |
| (4) Corporate stocks (other than employer securities): | | | |
| (A) Preferred | 1c(4)(A) | | |
| (B) Common | 1c(4)(B) | 6827873 | 8405946 |
| (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) | 4543696 | 4778891 |
| (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 | 53348409 | 59965926 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | 15460093 | 14160473 |
| h Operating payables..... | 1h | 261681 | 405984 |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 170941 | 359714 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 15892715 | 14926171 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 37455694 | 45039755 |

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) | 34261348 | |
| (B) Participants..... | 2a(1)(B) | 168622 | |
| (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) | | 34429970 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 36122 | |
| (B) U.S. Government securities..... | 2b(1)(B) | 493509 | |
| (C) Corporate debt instruments..... | 2b(1)(C) | 477620 | |
| (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) | | 1007251 |
| (2) Dividends: | | | |
| (A) Preferred stock..... | 2b(2)(A) | | |
| (B) Common stock..... | 2b(2)(B) | 98077 | |
| (C) Registered investment company shares (e.g. mutual funds)..... | 2b(2)(C) | 110334 | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 208411 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | 9578650 | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | 9703879 | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | -125229 |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | 1633860 | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | | |

| | | (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) | | 235195 |
| c Other income | 2c | | 17565 |
| d Total income. Add all income amounts in column (b) and enter total..... | 2d | | 37407023 |

Expenses

| | | | |
|--|---------------|----------|----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers..... | 2e(1) | 21840029 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | 6074195 | |
| (3) Other..... | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 27914224 |
| 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) | 765867 | |
| (3) Recordkeeping fees | 2i(3) | 12360 | |
| (4) IQPA audit fees | 2i(4) | 36790 | |
| (5) Investment advisory and investment management fees | 2i(5) | 137638 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | 62822 | |
| (7) Actuarial fees | 2i(7) | | |
| (8) Legal fees | 2i(8) | 15504 | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses..... | 2i(11) | 877757 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 1908738 |
| j Total expenses. Add all expense amounts in column (b) and enter total..... | 2j | | 29822962 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 7584061 |
| 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: MILLER KAPLAN ARASE LLP

(2) EIN: 95-2036255

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.) | | X | |
| 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.) | | X | |
| c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.) | | X | |
| d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.) | | X | |
| e Was this plan covered by a fidelity bond? | X | | 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? | | X | |
| 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? | | X | |
| h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser? | | X | |
| i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.) | X | | |
| j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.) | X | | |
| k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC? | | X | |
| l Has the plan failed to provide any benefit when due under the plan? | | X | |
| 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 _____.

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023



INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Inlandboatmen's Union of the Pacific
National Health Benefit Plan
Seattle, Washington

Members of the Board:

Opinion

We have audited the accompanying financial statements of the Inlandboatmen's Union of the Pacific National Health Benefit Plan (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 of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and benefit obligations for the years then ended, 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan 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 the Plan's ability to continue as a going concern for one year after the date 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.

Auditor's 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 auditor's 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 generally accepted auditing standards 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 generally accepted auditing standards, 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 the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

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

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

San Francisco, California

October 10, 2025

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

| | December 31, 2024 | | December 31, 2023 |
|---|-------------------|---------------|-------------------|
| ASSETS | | | |
| INVESTMENTS, AT FAIR VALUE | | | |
| Money Market Fund | \$ 379,078 | | \$ 674,305 |
| Corporate Debt Securities | 12,556,508 | | 12,373,939 |
| U.S. Government Debt Securities | 17,317,777 | | 16,228,098 |
| Common Stock | 8,405,946 | | 6,827,873 |
| Mutual and Exchange Traded Funds | 4,778,891 | \$ 43,438,200 | 4,543,696 |
| | | | \$ 40,647,911 |
| CASH | | 10,645,554 | 7,529,700 |
| TOTAL CASH AND INVESTMENTS | | 54,083,754 | 48,177,611 |
| RECEIVABLES | | | |
| Employer Contributions | 4,377,463 | | 4,288,688 |
| Accrued Investment Income | 261,750 | | 244,506 |
| Stop Loss Reimbursements | 608,241 | | 52,561 |
| Due From Other Trusts | 52,350 | | - |
| Rx Rebates | 578,664 | | 575,398 |
| TOTAL RECEIVABLES | | 5,878,468 | 5,161,153 |
| PREPAID EXPENSES | | 3,704 | 9,645 |
| TOTAL ASSETS | | 59,965,926 | 53,348,409 |
| LIABILITIES | | | |
| Accounts Payable | 89,993 | | 120,760 |
| Due to Retiree Plan | 307,473 | | 114,207 |
| Due to Other Trusts | 8,518 | | 26,714 |
| Unprocessed Contributions | 359,714 | | 170,941 |
| TOTAL LIABILITIES | | 765,698 | 432,622 |
| NET ASSETS AVAILABLE FOR BENEFITS | | 59,200,228 | 52,915,787 |
| MEMORANDUM: | | | |
| Benefit Obligations | | 14,160,473 | 15,460,093 |
| Excess of Net Assets Available for Benefits Over Benefit Obligations | | \$ 45,039,755 | \$ 37,455,694 |

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

| | January 1, 2024 to December 31, 2024 | January 1, 2023 to December 31, 2023 |
|---------------------------------------|--|--|
| ADDITIONS | | |
| INVESTMENT INCOME | | |
| Interest and Dividends | \$ 1,215,662 | \$ 1,074,316 |
| Net Appreciation of Investments | 1,743,826 | 2,052,210 |
| Less: Investment Expenses | <u>(137,638)</u> | <u>(121,082)</u> |
| Net Investment Income | \$ 2,821,850 | \$ 3,005,444 |
| CONTRIBUTIONS | | |
| Employers | 34,786,628 | 33,656,691 |
| Participant Self-Payments | 168,622 | 246,594 |
| Less: Transfers to Retiree Plan | <u>(525,280)</u> | <u>(440,027)</u> |
| Total Contributions | 34,429,970 | 33,463,258 |
| OTHER INCOME | <u>17,565</u> | <u>14,167</u> |
| TOTAL ADDITIONS | <u>37,269,385</u> | <u>36,482,869</u> |
| DEDUCTIONS | | |
| BENEFITS PAID | | |
| Premiums | 6,074,195 | 6,200,722 |
| Claims, Net | <u>23,139,649</u> | <u>23,433,576</u> |
| Net Benefits Paid | 29,213,844 | 29,634,298 |
| ADMINISTRATIVE EXPENSES | | |
| Administration Fees: | | |
| Trust Administration Office | 765,867 | 734,278 |
| Premera | 390,523 | 389,724 |
| ODS | 169,535 | 67,437 |
| Alaska Seafood Processors | - | 8,000 |
| Case Management | 71,510 | 71,039 |
| Audit Fees | 49,150 | 41,809 |
| Bank Service Charges | 62,822 | 43,604 |
| Printing, Postage and Office Supplies | 72,148 | 79,714 |
| Consultant Fees | 122,096 | 94,077 |
| Insurance | 28,444 | 28,057 |
| Legal Fees | 15,504 | 20,690 |
| Conferences and Meetings | 15,721 | 12,106 |
| PCORI Fee | <u>7,780</u> | <u>7,182</u> |
| Total Administrative Expenses | <u>1,771,100</u> | <u>1,597,717</u> |
| TOTAL DEDUCTIONS | <u>30,984,944</u> | <u>31,232,015</u> |
| NET INCREASE FOR THE YEAR | 6,284,441 | 5,250,854 |
| NET ASSETS AVAILABLE FOR BENEFITS | | |
| Balance, Beginning of Year | <u>52,915,787</u> | <u>47,664,933</u> |
| Balance, End of Year | <u>\$ 59,200,228</u> | <u>\$ 52,915,787</u> |

(Attached notes are an integral part of this statement)

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF BENEFIT OBLIGATIONS**

| | <u>December 31, 2024</u> | <u>December 31, 2023</u> |
|---|-----------------------------|-----------------------------|
| AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS | | |
| Claims Payable | <u>\$ 839,004</u> | <u>\$ 1,945,314</u> |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS | | |
| Claims Incurred But Not Reported | 3,269,000 | 3,936,000 |
| Lag Months Eligibility Coverage | 5,773,037 | 5,432,682 |
| Participants' Individual Accounts | 3,618,204 | 3,541,875 |
| Participants' Supplement Accounts | <u>661,228</u> | <u>604,222</u> |
| | <u>13,321,469</u> | <u>13,514,779</u> |
| PLAN'S TOTAL BENEFIT OBLIGATIONS | <u><u>\$ 14,160,473</u></u> | <u><u>\$ 15,460,093</u></u> |

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

| | <u>January 1, 2024 to December 31, 2024</u> | <u>January 1, 2023 to December 31, 2023</u> |
|--|---|---|
| AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS | | |
| Premiums Payable at Beginning of Year | \$ - | \$ - |
| Premiums for Participants Eligible for Coverage During the Year | 6,074,195 | 6,200,722 |
| Premiums Paid | <u>(6,074,195)</u> | <u>(6,200,722)</u> |
| Premiums Payable at End of Year | <u>-</u> | <u>-</u> |
| Claims Payable at Beginning of Year | 1,945,314 | 1,856,470 |
| Claims Reported and Approved for Payment | 22,033,339 | 23,522,420 |
| Claims Paid, Net | <u>(23,139,649)</u> | <u>(23,433,576)</u> |
| Claims Payable at End of Year | <u>839,004</u> | <u>1,945,314</u> |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS | | |
| Balance at Beginning of Year | 13,514,779 | 12,511,927 |
| Net Change During the Year: | | |
| Claims Incurred But Not Reported | (667,000) | 235,533 |
| Lag Months Eligibility Coverage | 340,355 | 660,872 |
| Participants Individual Accounts | 76,329 | 106,958 |
| Participants Supplement Accounts | <u>57,006</u> | <u>(511)</u> |
| Balance at End of Year | <u>13,321,469</u> | <u>13,514,779</u> |
| PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR | <u><u>\$ 14,160,473</u></u> | <u><u>\$ 15,460,093</u></u> |

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 1 - DESCRIPTION OF THE PLAN

The following description of the Inlandboatmen's Union of the Pacific National Health Benefit Plan (the "Plan") provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

The Plan document includes detailed rules for each situation. Participants should refer to the Plan agreement and any amendments regarding specific provisions of the Plan.

A. General

The Plan is maintained pursuant to the terms of collective bargaining agreements between participating employers and the Inlandboatmen's Union of the Pacific, Marine Division of I.L.W.U., and other employers who have signed joinder agreements with the Plan, all of whom have been accepted by the Board of Trustees. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

B. Benefits

The Plan provides medical, dental, vision, and prescription drug benefits for active participants and their dependents and death and time loss benefits for active participants. The Plan provides medical and prescription drug benefits for retired participants and their dependents who are not eligible for Medicare. The Plan also offers HMO options. Benefits are provided to all active participants who have sufficient credits in their individual reserve accounts to pay for a month of coverage.

The Plan also has an agreement to provide coverage for All Alaska Longshore Health and Welfare Trust Fund eligible participants and their dependents. The Plan provided dental, vision, death, and accidental death and dismemberment benefits for certain employees who work in the seafood processing industry in Alaska. This provision of benefits ceased effective September 30, 2023.

The Plan has a Retiree Health Reimbursement Arrangement (HRA Plan), available to Medicare eligible retirees and their Medicare eligible dependents. The Plan contributed \$525,280 and \$440,027 in employer contributions to the HRA Plan during 2024 and 2023, respectively.

The cost of the postretirement benefit plan coverage is shared by the Plan's participating employers and retirees. The premiums paid by and on behalf of the pre-65 retirees are estimated to cover the cost of providing postretirement benefits therefore the Plan's consulting actuary recommended that no valuation be performed as the postretirement benefit obligation would likely be less than zero.

Post-65 retirees are covered by the HRA Plan.

C. Contributions

The Plan provides that participating employers make monthly or bi-monthly contributions to the Plan of a specified amount as specified in the collective bargaining agreement or joinder agreement to provide health benefits for participants. Participants generally only contribute to extend their coverage under the Plan in accordance with the provisions of COBRA or to extend their coverage under the Plan as retirees.

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

The financial statements of the Plan are prepared on the accrual basis of accounting.

B. Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

C. Employer Contributions Receivable

Employer contributions receivable is estimated based on contributions received subsequent to the end of the year. No allowance is provided for uncollectible accounts. Retiree co-payments and participant self-payments are contributions made by participants for coverage during the year.

D. Payroll Compliance Program

Employer remittance reports were accepted as submitted, without examination or verification of employers' payroll records. The system of internal control provides for examination of employers' records under a separate payroll compliance program.

E. Investment 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.

Purchases and sales of securities are recorded on the trade date basis. Dividends are recorded on the ex-dividend date and interest income is recorded on the accrual basis. Realized and unrealized gains and losses are computed using investments' carry values for financial statement purposes. For Form 5500 reporting, realized and unrealized gains and losses are computed using investments' market values as of the beginning of the year.

NOTE 3 - PARTICIPANT'S INDIVIDUAL AND SUPPLEMENTAL ACCOUNTS

Each participant will have established on his or her behalf an individual account whereby employer contributions will be credited. At the end of each month, an amount will be deducted from the individual account to provide future coverage. The amount to be deducted for coverage may be changed from time to time by the Board of Trustees. As long as the participant maintains a balance sufficient to provide the deduction, his or her coverage will remain in force.

One-time per Plan year, a participant may transfer contributions from the participant's individual account into his or her supplemental account, provided there is at least one month of coverage remaining in his or her individual account.

The balance of the supplemental account is to be limited to \$5,000 and the funds can only be utilized under two conditions:

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 3 - PARTICIPANT'S INDIVIDUAL AND SUPPLEMENTAL ACCOUNTS (Continued)

- a. To reimburse the participant and dependents for any portion of a medical expense not covered by the Plan or other group insurance up to the balance in his or her account.
- b. In the event the participant's individual account is insufficient to provide coverage, the administrator of the Plan will withdraw funds to keep his or her Plan coverage in force unless otherwise instructed by the participant.

The Plan's supplemental account requirements include that in addition to the participant being required to have at least one month of coverage remaining in his or her individual account, the participant also must have health and welfare plan coverage through a plan offered by the Board of Trustees in the month the transfer from the participant's individual account to the participant's supplemental account is scheduled to occur.

The Plan has the ability for participants to opt out and forfeit the money in his or her supplemental account by completing an opt-out form. Should a participant opt-out, the money forfeited will go to the Plan and not the participant. There were no forfeitures during the years ending December 31, 2024 and 2023.

NOTE 4 - FAIR VALUE MEASUREMENTS

FASB ASC 820 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 measurements) and the lowest priority to unobservable inputs (level 3 measurements). 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; and
- 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.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023. Level 1 investments include a money market fund valued at \$1 per share based on the daily closing price,

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 4 - FAIR VALUE MEASUREMENTS (Continued)

and common stock, mutual and exchange traded funds, and U.S. treasury securities valued at the closing price reported in active markets. Level 2 investments consist of corporate debt securities and non-U.S. treasury securities valued at fair value using matrices of trades in similar securities or third-party pricing vendors.

The preceding methods described 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 summarize the Plan's investments based on the inputs used to value them:

| | December 31, 2024 | | |
|----------------------------------|-------------------|---------------|---------------|
| | Level 1 | Level 2 | Total |
| Money Market Fund | \$ 379,078 | \$ - | \$ 379,078 |
| Corporate Debt Securities | - | 12,556,508 | 12,556,508 |
| U.S. Government Debt Securities | 17,293,668 | 24,109 | 17,317,777 |
| Common Stock | 8,405,946 | - | 8,405,946 |
| Mutual and Exchange Traded Funds | 4,778,891 | - | 4,778,891 |
| | \$ 30,857,583 | \$ 12,580,617 | \$ 43,438,200 |

| | December 31, 2023 | | |
|----------------------------------|-------------------|---------------|---------------|
| | Level 1 | Level 2 | Total |
| Money Market Fund | \$ 674,305 | \$ - | \$ 674,305 |
| Corporate Debt Securities | - | 12,373,939 | 12,373,939 |
| U.S. Government Debt Securities | 16,200,107 | 27,991 | 16,228,098 |
| Common Stock | 6,827,873 | - | 6,827,873 |
| Mutual and Exchange Traded Funds | 4,543,696 | - | 4,543,696 |
| | \$ 28,245,981 | \$ 12,401,930 | \$ 40,647,911 |

NOTE 5 - RELATED PARTY TRANSACTIONS

Contributions for the IBU Pension Plan, IBU 401(k) Plan, and the IBU HRA Plan are collected by the Plan through a lockbox arrangement and then allocated and transferred to the respective related Plans. Amounts due to the related Plans represent cash deposits that have been made into the Plan as of December 31, 2024 and 2023, but have not yet been allocated and transferred to the related Plans.

NOTE 6 - TAX-EXEMPT STATUS

No provision for federal income tax is made. The Plan has received tax-exempt status from the federal government under Internal Revenue Code Section 501(c)(9). However, the plan administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 6 - TAX-EXEMPT STATUS (Continued)

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken a tax position that more likely than not would not be sustained upon examination by a tax authority. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 7 - PLAN TERMINATION

Although it has not expressed any intent to do so, the Board of Trustees has the right under the Plan to terminate the Trust.

In any event, the Trust shall be automatically terminated upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Plan; provided, however, that such termination shall not result from the expiration of all collective bargaining agreements so long as any employer continues to have a legal obligation to continue to make contributions to the Plan, or continues during contract negotiations to voluntarily contribute to the Plan without the union's objection, and provided the Plan is permitted by law to receive such contributions.

Upon the termination of the Trust, the Board of Trustees shall wind up the affairs of the Trust and Plan. In the event of any termination, any and all monies and assets remaining in the Trust, after the payment of expenses, shall be used for the payment of benefits in accordance with the purposes of the Plan, until such monies and assets have been exhausted, unless some other disposition is required by law.

In no event shall any of the remaining monies or assets be paid to or be recoverable by any participating employer, employer association, or labor organization.

NOTE 8 - CONCENTRATION OF CREDIT RISK

During the year ended December 31, 2024, the Plan maintained bank accounts with cash balances in excess of the federally insured limit of \$250,000 per bank. The amount in excess of the limit was subject to risk if the financial institution did not perform. The Plan has not incurred any losses on the uninsured balances.

NOTE 9 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500

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

| | <u>December 31, 2024</u> | <u>December 31, 2023</u> |
|---|--------------------------|--------------------------|
| Net Assets Available for Benefits Per the Financial Statements | \$ 59,200,228 | \$ 52,915,787 |
| Less: Plan's Benefit Obligations | <u>(14,160,473)</u> | <u>(15,460,093)</u> |
| Net Assets Per the Form 5500 | <u>\$ 45,039,755</u> | <u>\$ 37,455,694</u> |

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 9 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500 (Continued)

The following is a reconciliation of benefits paid per the financial statements to the Form 5500:

| | January 1, 2024 to December 31, 2024 |
|--|--|
| Benefits Paid Per the Financial Statements | \$ 29,213,844 |
| Add: Benefit Obligations at December 31, 2024 | 14,160,473 |
| Less: Benefit Obligations at December 31, 2023 | <u>(15,460,093)</u> |
| Benefits Paid Per the Form 5500 | <u>\$ 27,914,224</u> |

Amounts currently payable to or for participants, dependents, and beneficiaries are reported on the Form 5500 for benefits that have been incurred prior to December 31, but not yet paid as of that date.

NOTE 10 - RISKS AND UNCERTAINTIES

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

The estimates for claims payable and claims incurred but not reported are based on prior claims experience and actual lag patterns of the Plan. The estimate for participants' individual and supplemental accounts is based on the number of months of future coverage earned and estimated benefit costs per eligible participant. The estimate for lag months eligibility coverage is based on certain assumptions pertaining to health care trends and inflation rates. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

NOTE 11 - STOP-LOSS INSURANCE REIMBURSEMENTS

The Plan has stop-loss insurance on behalf of the participants covered under the self-insured health plan to limit Plan exposure, which will reimburse the Plan for total individual claims and total aggregate claims exceeding certain limits. For the years ended December 31, 2024 and 2023, the Plan received stop-loss reimbursements of \$608,241 and \$454,266, respectively.

NOTE 12 - SUBSEQUENT EVENTS

Management has evaluated subsequent events through October 10, 2025, the date on which the financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosures in these financial statements.

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN
FORM 5500
SCHEDULE H, LINE 4
E.I.N. 93-0864012; PLAN NO. 501

SUPPLEMENTAL SCHEDULES REQUIRED
BY THE DEPARTMENT OF LABOR



Independent Auditor's Report on Supplemental
Schedules Required by the Department of Labor

Board of Trustees
Inlandboatmen's Union of the Pacific
National Health Benefit Plan
Seattle, Washington

Members of the Board:

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of December 31, 2024 and reportable transactions for the year ended December 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are 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 generally accepted auditing standards.

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

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

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

San Francisco, California

October 10, 2025

INLANDBOATMEN'S UNION OF THE PACIFIC

NATIONAL HEALTH BENEFIT PLAN

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| <u>Face</u> <u>Value</u> | <u>Money Market Fund</u> | <u>Fair</u> <u>Value</u> | <u>Cost</u> |
|--|--|-----------------------------|----------------------|
| \$ 379,078 | FIRST AMERICAN US TREASURY MM | \$ 379,078 | \$ 379,078 |
| | | | |
| <u>Corporate Debt Securities</u> | | | |
| \$ 700,000 | ABBVIE INC 4.250 11/14/2028 | \$ 689,318 | \$ 790,248 |
| 675,000 | AMGEN INC 2.300 02/25/2031 | 574,715 | 701,888 |
| 750,000 | BANK OF AMERICA CORP 3.500 04/19/2026 | 738,803 | 748,480 |
| 325,000 | BIOGEN INC 4.050 09/15/2025 | 323,167 | 371,511 |
| 450,000 | BLACKROCK INC SR NT 1.900 01/28/2031 | 379,184 | 446,981 |
| 700,000 | COMCAST CORP 4.150 10/15/2028 | 682,661 | 782,087 |
| 590,000 | DISNEY WALT CO SR GLBL NT 3.800 03/22/2030 | 564,707 | 574,135 |
| 525,000 | GILEAD SCIENCES INC 3.650 03/01/2026 | 518,711 | 594,418 |
| 800,000 | GOLDMAN SACHS GROUP INC 3.8 03/15/2030 | 750,224 | 754,632 |
| 725,000 | HOME DEPOT INC4.500 09/15/2032 | 705,505 | 715,845 |
| 200,000 | INTEL CORP 3.700 07/29/2025 | 198,656 | 209,170 |
| 600,000 | INTERCONTINENTAL EXCHANGE INC 2.100 06/15/2030 | 518,512 | 608,556 |
| 800,000 | JPMORGAN CHASE CO 3.300 04/01/2026 | 787,784 | 839,483 |
| 500,000 | LOWES COS INC 3.750 04/01/2032 | 457,890 | 484,480 |
| 750,000 | MCDONALD S CORP 3.600 07/01/2030 | 703,523 | 812,337 |
| 600,000 | MORGAN STANLEY 4.000 07/23/2025 | 597,546 | 632,966 |
| 600,000 | ORACLE CORP 3.250 11/15/2027 | 576,876 | 652,098 |
| 400,000 | STARBUCKS CORP 3.550 08/15/2029 | 378,696 | 433,937 |
| 625,000 | UNION PACIFIC CORP 3.950 09/10/2028 | 608,181 | 631,184 |
| 750,000 | UNITEDHEALTH GROUP INC 3.750 07/15/2025 | 754,718 | 770,225 |
| 700,000 | VERIZON COMMUNICATIONS 3.875 02/08/2029 | 675,157 | 818,000 |
| 375,000 | WELLS FARGO COMPANY 3.550 09/29/2025 | 371,974 | 383,288 |
| | <u>TOTALS - CORPORATE DEBT SECURITIES</u> | <u>\$ 12,556,508</u> | <u>\$ 13,755,949</u> |
| | | | |
| <u>U.S. Government Debt Securities</u> | | | |
| \$ 91 | F H L M C GOLD PARTN CERT 4.000 07/01/2025 | \$ 91 | \$ 93 |
| 10,897 | F N M A PARTN CERT 4.000 09/01/2041 | 10,278 | 11,476 |
| 25,910 | F N M A PARTN CERT 5.500 07/01/2038 | 2,611 | 2,780 |
| 3,323 | F N M A PARTN CERT 5.000 06/01/2040 | 3,311 | 3,479 |
| 8,286 | F N M A PARTN CERT 4.000 11/01/2040 | 7,818 | 8,426 |
| 530,000 | U S TREASURY BILL 4.434 01/23/2025 | 528,686 | 506,224 |
| 535,000 | U S TREASURY BILL 4.358 04/18/2025 | 528,510 | 509,933 |
| 540,000 | U S TREASURY BILL 4.258 07/10/2025 | 528,374 | 518,454 |
| 545,000 | U S TREASURY BILL 4.252 10/30/2025 | 526,773 | 522,832 |
| 1,375,000 | U S TREASURY NOTE 1.625 5/15/2031 | 1,160,005 | 1,399,061 |
| 1,200,000 | U S TREASURY NOTE 4.125 11/15/2032 | 1,170,384 | 1,254,766 |
| 1,425,000 | U S TREASURY NOTE 3.5 2/15/2033 | 1,325,663 | 1,411,611 |
| 355,000 | U S TREASURY NOTE 4.00 2/29/2028 | 351,773 | 352,083 |
| 1,335,000 | U S TREASURY NOTE 4.000 2/15/2030 | 1,310,289 | 1,298,809 |
| 1,400,000 | U S TREASURY NOTE 4.000 2/15/2034 | 1,340,304 | 1,386,226 |
| 1,250,000 | U S TREASURY NOTE 2.25 11/15/2025 | 1,228,613 | 1,247,561 |
| | <u>Forward</u> | <u>\$ 10,023,483</u> | <u>\$ 10,433,814</u> |

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| Face Value | U.S. Government Debt Securities (Continued) | Fair Value | Cost |
|---------------|---|----------------------|----------------------|
| | <u>Forwarded</u> | \$ 10,023,483 | \$ 10,433,814 |
| \$ 1,000,000 | U S TREASURY NOTE 2.000 11/15/2026 | 959,760 | 966,271 |
| 1,300,000 | U S TREASURY NOTE 2.125 5/15/2025 | 1,289,821 | 1,319,742 |
| 1,375,000 | U S TREASURY NOTE 2.375 5/15/2027 | 1,316,796 | 1,419,123 |
| 1,300,000 | U S TREASURY NOTE 1.625 8/15/2029 | 1,153,802 | 1,312,340 |
| 300,000 | U S TREASURY NOTE .625 5/15/2030 | 246,162 | 299,484 |
| 1,200,000 | U S TREASURY NOTE 3.125 11/15/2028 | 1,148,268 | 1,201,875 |
| 1,200,000 | U S TREASURY NOTE 2.625 1/31/206 | 1,179,685 | 1,246,965 |
| | <u>TOTALS - U.S. GOVERNMENT DEBT SECURITIES</u> | <u>\$ 17,317,777</u> | <u>\$ 18,199,614</u> |

| No. of Shares | Common Stock | Fair Value | Cost |
|------------------|------------------------------|---------------------|---------------------|
| 950 | ABBVIE INC | \$ 168,815 | \$ 114,239 |
| 3,600 | ALPHABET INC CL A | 681,480 | 180,204 |
| 1,645 | AMAZON COM INC | 360,897 | 273,246 |
| 860 | AMERICAN ELEC | 79,318 | 67,895 |
| 1,330 | AMERICAN INTERNATIONAL GROUP | 96,824 | 79,999 |
| 330 | CENCORA INC | 74,144 | 50,781 |
| 2,281 | APPLE INC COM | 571,208 | 182,268 |
| 790 | AUTONATION INC | 134,174 | 60,518 |
| 420 | AVALONBAY COMMUNITIES INC | 92,387 | 89,215 |
| 340 | AVERY | 63,624 | 73,534 |
| 1,300 | BROADCOM INC | 301,392 | 38,674 |
| 1,060 | BROWN BROWN INC | 108,141 | 68,992 |
| 1,365 | CHEVRON CORPORATION | 197,707 | 171,538 |
| 485 | CROWDSTRIKE HOLDINGS INC A | 165,947 | 61,275 |
| 2,210 | ENTERGY CORPORATION | 167,562 | 109,697 |
| 3,270 | FORTIVE CORP WI | 245,250 | 225,354 |
| 320 | HOME DEPOT INC | 124,476 | 56,346 |
| 1,225 | JPMORGAN CHASE CO | 293,645 | 130,415 |
| 1,225 | MERCK CO INC | 121,863 | 140,415 |
| 1,855 | MICROSOFT CORP COM | 781,883 | 160,497 |
| 1,210 | MONSTER BEVERAGE CORP | 63,598 | 51,816 |
| 310 | MOTOROLA SOLUTIONS INC | 143,291 | 56,810 |
| 4,975 | NVIDIA CORP | 668,093 | 177,169 |
| 1,038 | PALO ALTO NEWTORKS INC | 188,874 | 97,875 |
| 389 | PARKER HANNIFIN CORP | 247,416 | 94,698 |
| 1,200 | PHILIP MORRIS | 144,420 | 95,759 |
| 1,275 | PROCTER GAMBLE CO | 213,754 | 169,782 |
| 154 | SERVICENOW INC | 163,258 | 85,847 |
| 2,675 | STATE STR CORP | 262,551 | 203,567 |
| 490 | STRYKER CORP | 176,425 | 126,470 |
| 1,390 | TJX COMPANIES | 167,926 | 93,158 |
| 755 | T MOBILE US | 166,651 | 139,625 |
| 1,500 | TEXTRON INC | 114,735 | 130,889 |
| 293 | THERMO FISHER | 152,427 | 121,309 |
| | <u>Forward</u> | <u>\$ 7,704,156</u> | <u>\$ 3,979,876</u> |

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| <u>No. of Shares</u> | <u>Common Stock (Continued)</u> | <u>Fair Value</u> | <u>Cost</u> |
|--------------------------|--|-----------------------|---------------------|
| | <u>Forwarded</u> | \$ 7,704,156 | \$ 3,979,876 |
| 390 | UNITED HEALTH | 197,285 | 155,394 |
| 1,440 | VERALTO CORP | 146,664 | 128,956 |
| 830 | VISA INC COM | 262,313 | 140,728 |
| 1,360 | WELLS FARGO | 95,528 | 104,245 |
| | <u>TOTALS - COMMON STOCK</u> | <u>\$ 8,405,946</u> | <u>\$ 4,509,199</u> |
| | <u>MUTUAL AND EXCHANGE TRADED FUNDS</u> | | |
| 19,225 | ISHARE CORE S&P MID CAP ETF | \$ 1,197,910 | \$ 427,307 |
| 4,035 | ISHARE CORE RUSSELL 2000 ETF | 891,574 | 542,212 |
| 34,210 | ISHARE MSCI ACWI EX US ETF | 1,784,394 | 1,451,269 |
| 750 | CONSUMER STAPLES SESLECT SECTOR ETF | 58,958 | 45,092 |
| 19,564 | VERSUS CAPITAL REAL ESTATE | 479,914 | 534,131 |
| 13,095 | VERSUS CAP RI EST | 366,141 | 330,000 |
| | <u>TOTALS - MUTUAL AND EXCHANGE TRADED FUNDS</u> | <u>\$ 4,778,891</u> | <u>\$ 3,330,011</u> |

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS

E.I.N. 93-0864012; PLAN NO. 501

JANUARY 1, 2024 TO DECEMBER 31, 2024

| <u>Description of Asset</u> | <u>Transaction</u> | <u>Purchase Price</u> | <u>Selling Price</u> | <u>Cost of Asset</u> | <u>Net Gain or (Loss)</u> |
|----------------------------------|--------------------|---------------------------|--------------------------|--------------------------|-------------------------------|
| FIRST AMERICAN US TREASURY MM | Purchases | \$ 6,175,923 | \$ - | \$ 6,175,923 | \$ - |
| | Sales | - | 6,471,150 | 6,471,150 | - |

| | | |
|---|---|--|
| <p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|---|--|

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning _____ and ending _____

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.)

B This return/report is: a single-employer plan a DFE (specify) _____
 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 | 1b Three-digit plan number (PN) ▶ | 501 |
| IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | 1c Effective date of plan | 11/01/1984 |
| 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) | 2b Employer Identification Number (EIN) | 93-0864012 |
| | 2c Plan Sponsor's telephone number | 503-224-0048 |
| | 2d Business code (see instructions) | 483000 |
| BOARD OF TRUSTEES, IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST | | |
| 5608 17TH AVE NW #131 SEATTLE, WA 98107 | | |

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 | | 10/10/2025 4:10 PM EDT | |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | 10/10/2025 5:06 PM EDT | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

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

Form 5500 (2024)
v. 240311

| | |
|--|--|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN 93-0864012 |
| | 3c Administrator's telephone number 503-224-0048 |

| | | | |
|--|---|--------------|------|
| 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 | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">5</td> <td style="text-align: right;">1594</td> </tr> </table> | 5 | 1594 |
| 5 | 1594 | | |
| 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 | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6a(1)</td> <td style="text-align: right;">1475</td> </tr> </table> | 6a(1) | 1475 |
| 6a(1) | 1475 | | |
| a(2) Total number of active participants at the end of the plan year | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6a(2)</td> <td style="text-align: right;">1485</td> </tr> </table> | 6a(2) | 1485 |
| 6a(2) | 1485 | | |
| b Retired or separated participants receiving benefits | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6b</td> <td style="text-align: right;">116</td> </tr> </table> | 6b | 116 |
| 6b | 116 | | |
| c Other retired or separated participants entitled to future benefits. | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6c</td> <td style="text-align: right;">0</td> </tr> </table> | 6c | 0 |
| 6c | 0 | | |
| d Subtotal. Add lines 6a(2), 6b, and 6c. | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6d</td> <td style="text-align: right;">1601</td> </tr> </table> | 6d | 1601 |
| 6d | 1601 | | |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6e</td> <td style="text-align: right;">0</td> </tr> </table> | 6e | 0 |
| 6e | 0 | | |
| f Total. Add lines 6d and 6e. | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6f</td> <td style="text-align: right;">1601</td> </tr> </table> | 6f | 1601 |
| 6f | 1601 | | |
| g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6g(1)</td> <td style="text-align: right;">0</td> </tr> </table> | 6g(1) | 0 |
| 6g(1) | 0 | | |
| g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6g(2)</td> <td style="text-align: right;">0</td> </tr> </table> | 6g(2) | 0 |
| 6g(2) | 0 | | |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">6h</td> <td style="text-align: right;">0</td> </tr> </table> | 6h | 0 |
| 6h | 0 | | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">7</td> <td style="text-align: right;">24</td> </tr> </table> | 7 | 24 |
| 7 | 24 | | |

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 4L

| | |
|--|---|
| 9a Plan funding arrangement (check all that apply) | 9b Plan benefit arrangement (check all that apply) |
| (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor | (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor |

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

| | |
|---|---|
| a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information) | b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>5</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules) |
|---|---|

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS

E.I.N. 93-0864012; PLAN NO. 501

JANUARY 1, 2024 TO DECEMBER 31, 2024

| <u>Description of Asset</u> | <u>Transaction</u> | <u>Purchase Price</u> | <u>Selling Price</u> | <u>Cost of Asset</u> | <u>Net Gain or (Loss)</u> |
|----------------------------------|--------------------|---------------------------|--------------------------|--------------------------|-------------------------------|
| FIRST AMERICAN US TREASURY MM | Purchases | \$ 6,175,923 | \$ - | \$ 6,175,923 | \$ - |
| | Sales | - | 6,471,150 | 6,471,150 | - |

INLANDBOATMEN'S UNION OF THE PACIFIC

NATIONAL HEALTH BENEFIT PLAN

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| <u>Face</u> <u>Value</u> | <u>Money Market Fund</u> | <u>Fair</u> <u>Value</u> | <u>Cost</u> |
|--|--|-----------------------------|----------------------|
| \$ 379,078 | FIRST AMERICAN US TREASURY MM | \$ 379,078 | \$ 379,078 |
| | | | |
| <u>Corporate Debt Securities</u> | | | |
| \$ 700,000 | ABBVIE INC 4.250 11/14/2028 | \$ 689,318 | \$ 790,248 |
| 675,000 | AMGEN INC 2.300 02/25/2031 | 574,715 | 701,888 |
| 750,000 | BANK OF AMERICA CORP 3.500 04/19/2026 | 738,803 | 748,480 |
| 325,000 | BIOGEN INC 4.050 09/15/2025 | 323,167 | 371,511 |
| 450,000 | BLACKROCK INC SR NT 1.900 01/28/2031 | 379,184 | 446,981 |
| 700,000 | COMCAST CORP 4.150 10/15/2028 | 682,661 | 782,087 |
| 590,000 | DISNEY WALT CO SR GLBL NT 3.800 03/22/2030 | 564,707 | 574,135 |
| 525,000 | GILEAD SCIENCES INC 3.650 03/01/2026 | 518,711 | 594,418 |
| 800,000 | GOLDMAN SACHS GROUP INC 3.8 03/15/2030 | 750,224 | 754,632 |
| 725,000 | HOME DEPOT INC4.500 09/15/2032 | 705,505 | 715,845 |
| 200,000 | INTEL CORP 3.700 07/29/2025 | 198,656 | 209,170 |
| 600,000 | INTERCONTINENTAL EXCHANGE INC 2.100 06/15/2030 | 518,512 | 608,556 |
| 800,000 | JPMORGAN CHASE CO 3.300 04/01/2026 | 787,784 | 839,483 |
| 500,000 | LOWES COS INC 3.750 04/01/2032 | 457,890 | 484,480 |
| 750,000 | MCDONALD S CORP 3.600 07/01/2030 | 703,523 | 812,337 |
| 600,000 | MORGAN STANLEY 4.000 07/23/2025 | 597,546 | 632,966 |
| 600,000 | ORACLE CORP 3.250 11/15/2027 | 576,876 | 652,098 |
| 400,000 | STARBUCKS CORP 3.550 08/15/2029 | 378,696 | 433,937 |
| 625,000 | UNION PACIFIC CORP 3.950 09/10/2028 | 608,181 | 631,184 |
| 750,000 | UNITEDHEALTH GROUP INC 3.750 07/15/2025 | 754,718 | 770,225 |
| 700,000 | VERIZON COMMUNICATIONS 3.875 02/08/2029 | 675,157 | 818,000 |
| 375,000 | WELLS FARGO COMPANY 3.550 09/29/2025 | 371,974 | 383,288 |
| | <u>TOTALS - CORPORATE DEBT SECURITIES</u> | <u>\$ 12,556,508</u> | <u>\$ 13,755,949</u> |
| | | | |
| <u>U.S. Government Debt Securities</u> | | | |
| \$ 91 | F H L M C GOLD PARTN CERT 4.000 07/01/2025 | \$ 91 | \$ 93 |
| 10,897 | F N M A PARTN CERT 4.000 09/01/2041 | 10,278 | 11,476 |
| 25,910 | F N M A PARTN CERT 5.500 07/01/2038 | 2,611 | 2,780 |
| 3,323 | F N M A PARTN CERT 5.000 06/01/2040 | 3,311 | 3,479 |
| 8,286 | F N M A PARTN CERT 4.000 11/01/2040 | 7,818 | 8,426 |
| 530,000 | U S TREASURY BILL 4.434 01/23/2025 | 528,686 | 506,224 |
| 535,000 | U S TREASURY BILL 4.358 04/18/2025 | 528,510 | 509,933 |
| 540,000 | U S TREASURY BILL 4.258 07/10/2025 | 528,374 | 518,454 |
| 545,000 | U S TREASURY BILL 4.252 10/30/2025 | 526,773 | 522,832 |
| 1,375,000 | U S TREASURY NOTE 1.625 5/15/2031 | 1,160,005 | 1,399,061 |
| 1,200,000 | U S TREASURY NOTE 4.125 11/15/2032 | 1,170,384 | 1,254,766 |
| 1,425,000 | U S TREASURY NOTE 3.5 2/15/2033 | 1,325,663 | 1,411,611 |
| 355,000 | U S TREASURY NOTE 4.00 2/29/2028 | 351,773 | 352,083 |
| 1,335,000 | U S TREASURY NOTE 4.000 2/15/2030 | 1,310,289 | 1,298,809 |
| 1,400,000 | U S TREASURY NOTE 4.000 2/15/2034 | 1,340,304 | 1,386,226 |
| 1,250,000 | U S TREASURY NOTE 2.25 11/15/2025 | 1,228,613 | 1,247,561 |
| | <u>Forward</u> | <u>\$ 10,023,483</u> | <u>\$ 10,433,814</u> |

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| Face Value | U.S. Government Debt Securities (Continued) | Fair Value | Cost |
|---------------|---|----------------------|----------------------|
| | <u>Forwarded</u> | \$ 10,023,483 | \$ 10,433,814 |
| \$ 1,000,000 | U S TREASURY NOTE 2.000 11/15/2026 | 959,760 | 966,271 |
| 1,300,000 | U S TREASURY NOTE 2.125 5/15/2025 | 1,289,821 | 1,319,742 |
| 1,375,000 | U S TREASURY NOTE 2.375 5/15/2027 | 1,316,796 | 1,419,123 |
| 1,300,000 | U S TREASURY NOTE 1.625 8/15/2029 | 1,153,802 | 1,312,340 |
| 300,000 | U S TREASURY NOTE .625 5/15/2030 | 246,162 | 299,484 |
| 1,200,000 | U S TREASURY NOTE 3.125 11/15/2028 | 1,148,268 | 1,201,875 |
| 1,200,000 | U S TREASURY NOTE 2.625 1/31/206 | 1,179,685 | 1,246,965 |
| | <u>TOTALS - U.S. GOVERNMENT DEBT SECURITIES</u> | <u>\$ 17,317,777</u> | <u>\$ 18,199,614</u> |

| No. of Shares | Common Stock | Fair Value | Cost |
|------------------|------------------------------|---------------------|---------------------|
| 950 | ABBVIE INC | \$ 168,815 | \$ 114,239 |
| 3,600 | ALPHABET INC CL A | 681,480 | 180,204 |
| 1,645 | AMAZON COM INC | 360,897 | 273,246 |
| 860 | AMERICAN ELEC | 79,318 | 67,895 |
| 1,330 | AMERICAN INTERNATIONAL GROUP | 96,824 | 79,999 |
| 330 | CENCORA INC | 74,144 | 50,781 |
| 2,281 | APPLE INC COM | 571,208 | 182,268 |
| 790 | AUTONATION INC | 134,174 | 60,518 |
| 420 | AVALONBAY COMMUNITIES INC | 92,387 | 89,215 |
| 340 | AVERY | 63,624 | 73,534 |
| 1,300 | BROADCOM INC | 301,392 | 38,674 |
| 1,060 | BROWN BROWN INC | 108,141 | 68,992 |
| 1,365 | CHEVRON CORPORATION | 197,707 | 171,538 |
| 485 | CROWDSTRIKE HOLDINGS INC A | 165,947 | 61,275 |
| 2,210 | ENTERGY CORPORATION | 167,562 | 109,697 |
| 3,270 | FORTIVE CORP WI | 245,250 | 225,354 |
| 320 | HOME DEPOT INC | 124,476 | 56,346 |
| 1,225 | JPMORGAN CHASE CO | 293,645 | 130,415 |
| 1,225 | MERCK CO INC | 121,863 | 140,415 |
| 1,855 | MICROSOFT CORP COM | 781,883 | 160,497 |
| 1,210 | MONSTER BEVERAGE CORP | 63,598 | 51,816 |
| 310 | MOTOROLA SOLUTIONS INC | 143,291 | 56,810 |
| 4,975 | NVIDIA CORP | 668,093 | 177,169 |
| 1,038 | PALO ALTO NEWTORKS INC | 188,874 | 97,875 |
| 389 | PARKER HANNIFIN CORP | 247,416 | 94,698 |
| 1,200 | PHILIP MORRIS | 144,420 | 95,759 |
| 1,275 | PROCTER GAMBLE CO | 213,754 | 169,782 |
| 154 | SERVICENOW INC | 163,258 | 85,847 |
| 2,675 | STATE STR CORP | 262,551 | 203,567 |
| 490 | STRYKER CORP | 176,425 | 126,470 |
| 1,390 | TJX COMPANIES | 167,926 | 93,158 |
| 755 | T MOBILE US | 166,651 | 139,625 |
| 1,500 | TEXTRON INC | 114,735 | 130,889 |
| 293 | THERMO FISHER | 152,427 | 121,309 |
| | <u>Forward</u> | <u>\$ 7,704,156</u> | <u>\$ 3,979,876</u> |

**INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN**

FORM 5500

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

E.I.N. 93-0864012; PLAN NO. 501

DECEMBER 31, 2024

| <u>No. of Shares</u> | <u>Common Stock (Continued)</u> | <u>Fair Value</u> | <u>Cost</u> |
|--------------------------|--|-----------------------|---------------------|
| | <u>Forwarded</u> | \$ 7,704,156 | \$ 3,979,876 |
| 390 | UNITED HEALTH | 197,285 | 155,394 |
| 1,440 | VERALTO CORP | 146,664 | 128,956 |
| 830 | VISA INC COM | 262,313 | 140,728 |
| 1,360 | WELLS FARGO | 95,528 | 104,245 |
| | <u>TOTALS - COMMON STOCK</u> | <u>\$ 8,405,946</u> | <u>\$ 4,509,199</u> |
| | <u>MUTUAL AND EXCHANGE TRADED FUNDS</u> | | |
| 19,225 | ISHARE CORE S&P MID CAP ETF | \$ 1,197,910 | \$ 427,307 |
| 4,035 | ISHARE CORE RUSSELL 2000 ETF | 891,574 | 542,212 |
| 34,210 | ISHARE MSCI ACWI EX US ETF | 1,784,394 | 1,451,269 |
| 750 | CONSUMER STAPLES SESLECT SECTOR ETF | 58,958 | 45,092 |
| 19,564 | VERSUS CAPITAL REAL ESTATE | 479,914 | 534,131 |
| 13,095 | VERSUS CAP RI EST | 366,141 | 330,000 |
| | <u>TOTALS - MUTUAL AND EXCHANGE TRADED FUNDS</u> | <u>\$ 4,778,891</u> | <u>\$ 3,330,011</u> |