

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Complete all entries in accordance with the instructions to the Form 5500.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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: [X] 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. [X]
D Check box if filing under: [X] 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 OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 04/01/1954
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) BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS
P.O. BOX 4148 PORTLAND, OR 97208
2b Employer Identification Number (EIN) 93-6024141
2c Plan Sponsor's telephone number 503-282-5581
2d Business code (see instructions) 238900

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes entries for JEFFREY GRITZ (10/09/2025) and JAMES WATTS (10/08/2025).

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	
	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	2747
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)	2519
	6a(2)	2549
	6b	214
	6c	0
	6d	2763
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	298

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F

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>3</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 checked="" type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶ 501</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS</p>	<p>D Employer Identification Number (EIN) 93-6024141</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
COMMENCEMENT BAY RISK MANAGEMENT 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
91-1571623	78879	83942000	4633	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 0	(b) Total amount of fees paid 0
---	--

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

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	436589
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 OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS	D Employer Identification Number (EIN) 93-6024141

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 THE NORTHWEST

(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
93-0798039	95540	1643	1218	07/01/2023	06/30/2024

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

(a) Total amount of commissions paid 0	(b) Total amount of fees paid 0
---	--

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

e Type of contract: (1) individual policies (2) group deferred annuity
 (3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	7644851
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS		D Employer Identification Number (EIN) 93-6024141

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
UNITEDHEALTHCARE OF OREGON, 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
93-0938819	95893	H3805	2	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 0	(b) Total amount of fees paid 0
---	--

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

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

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

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

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	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
----------------	--

4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

e Type of contract: (1) individual policies (2) group deferred annuity
(3) other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	9029
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <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.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS	D Employer Identification Number (EIN) 93-6024141	

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

PACIFIC INVESTMENT MANAGEMENT CO

33-0629048

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

VANGUARD GROUP INC **PO BOX 2600 V26**
VALLEY FORGE, PA 19482

(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

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(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)

REGENCE BC/BS OF OREGON

93-0238155

(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	1300258	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	37319	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

THE WILLIAM C. EARHART CO, INC

93-0509592

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	355329	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)

OREGON LABORERS-EMPLOYERS ADMIN LLC

93-6075363

(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 49 50	LLC MEMBER	253739	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)

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?
11 16 22 50	NONE	201759	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)

KROGER PRESCRIPTION PLANS, INC.

48-0196590

(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 49	NONE	144809	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)

WITHUMSMITH+BROWN, PC

22-2027092

(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	64688	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)

LOOMIS, SAYLES & COMPANY, LP

04-3200030

(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?
28 51	NONE	51763	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)

NEPC, LLC

26-1429809

(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?
27 50	NONE	47818	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)

WEINBERG, ROGER, ROSENFELD

94-2458080

(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	46812	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)

COLETT LAW GROUP, LLP

26-1490900

(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	45411	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)

IRON MOUNTAIN INFORMATION MGMT, INC

04-3038590

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	41935	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?
19 49 50 62 68	NONE	40509	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 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)

METRO PRESORT, INC

93-0799990

(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	37284	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)

WILLAMETTE DENTAL

91-1171647

(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	36325	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)

CANOPY INC.

93-0774210

(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?
23 38 50	NONE	35222	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)

S&A HORN LIMITED

94-3249244

(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?
53	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	7022	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
REGENCE BC/BS OF OREGON	99	13864
(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.	
HINGE HEALTH 455 MARKET STREET, SUITE 700 SAN FRANCISCO, CA 94015	SUPPORT FOR HEALTH MANAGEMENT.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
REGENCE BC/BS OF OREGON	99	10224
(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.	
LIVONGO 2 MANHATTANVILLE RD. PURCHASE, NY 10677	SUPPORT FOR HEALTH MANAGEMENT.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
REGENCE BC/BS OF OREGON	99	7190
(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.	
MULTIPLAN 115 FIFTH AVENUE NEW YORK, NY 10003	SUBROGATION	

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
REGENCE BC/BS OF OREGON	99	6041
(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.	
TRC 1720 SOUTH BELLAIRE ST, SUITE 1250 DENVER, CO 80222	SUBROGATION	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
S&A HORN LIMITED	53	2988
(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.	
CHUBB 13-1963496	INSURANCE COMMISSIONS	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
S&A HORN LIMITED	53	2808
(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.	
ULLICO 13-2988846	INSURANCE COMMISSIONS	

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
S&A HORN LIMITED	53	1226
(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.	
HARTFORD 06-0732738	INSURANCE COMMISSIONS	
(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
IRON MOUNTAIN INFORMATION MGMT, INC 04-3038590	49 50	SERVICE PROVIDER FAILED TO PROVIDE AMOUNT OF INDIRECT COMPENSATION, IF ANY.

(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
KROGER PRESCRIPTION PLANS, INC. 48-0196590	12 49	SERVICE PROVIDER FAILED TO PROVIDE AMOUNT OF INDIRECT COMPENSATION, IF ANY.

(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 D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan 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.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN</u>	B Three-digit plan number (PN)	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS</u>	D Employer Identification Number (EIN) <u>93-6024141</u>	

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

a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NHIT INTERMEDIATE DURATION FIXED IN</u>	b Name of sponsor of entity listed in (a): <u>LOOMIS SAYLES TRUST COMPANY, LLC</u>	
c EIN-PN <u>20-8080381-004</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>21100079</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>STATE STREET MSCI ACWI INDEX NL CTF</u>		
b Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS TRUST COMPANY</u>		
c EIN-PN <u>84-3172952-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>9498164</u>
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

b Name of sponsor of entity listed in (a):

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

b Name of sponsor of entity listed in (a):

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

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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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
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, OREGON LABORERS- EMPLOYERS	D Employer Identification Number (EIN) 93-6024141

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	697081	821914
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3508047	2881876
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	951863	1036093
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	28386402	30598243
(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)	26528559	26753714
(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	60071952	62091840
Liabilities			
g Benefit claims payable.....	1g	4098000	5121000
h Operating payables.....	1h	430782	429923
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	4528782	5550923
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	55543170	56540917

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)	36772248	
(B) Participants.....	2a(1)(B)	1295464	
(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)		38067712
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	1197142	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1197142
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		2267542
(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)		-116456
c Other income	2c		2345595
d Total income. Add all income amounts in column (b) and enter total	2d		43761535

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	31823018	
(2) To insurance carriers for the provision of benefits	2e(2)	8190219	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		40013237
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)	1705244	
(3) Recordkeeping fees	2i(3)	253739	
(4) IQPA audit fees	2i(4)	64688	
(5) Investment advisory and investment management fees	2i(5)	104664	
(6) Bank or trust company trustee/custodial fees	2i(6)	40509	
(7) Actuarial fees	2i(7)	201759	
(8) Legal fees	2i(8)	92223	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	19074	
(11) Other expenses	2i(11)	268651	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2750551
j Total expenses. Add all expense amounts in column (b) and enter total	2j		42763788

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		997747
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: WITHUMSMITH+BROWN, PC

(2) EIN: 22-2027092

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		2000000
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 _____.

**OREGON LABORERS - EMPLOYERS
HEALTH AND WELFARE PLAN
Financial Statements
December 31, 2024 and 2023
With Independent Auditor's Reports**

Oregon Laborers - Employers Health and Welfare Plan
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December 31, 2024 and 2023

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INDEPENDENT AUDITOR'S REPORT

To the Participants and Trustees of
Oregon Laborers - Employers Health and Welfare Plan:

Opinion

We have audited the accompanying financial statements of Oregon Laborers - Employers Health and Welfare 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; 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 Oregon Laborers - Employers Health and Welfare Plan as of December 31, 2024 and 2023, and the changes in 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 ("GAAS"). 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 Oregon Laborers - Employers Health and Welfare 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.

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.

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 Oregon Laborers - Employers Health and Welfare Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

Auditor's Responsibility 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 GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentation, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Oregon Laborers - Employers Health and Welfare 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 Oregon Laborers - Employers Health and Welfare 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.

Withum Smith & Brown, PC

October 9, 2025

**Oregon Laborers - Employers Health and Welfare Plan
Statements of Net Assets Available for Benefits
December 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
Assets		
Investments - at fair value		
Common/collective trust funds	\$ 30,598,243	\$ 28,386,402
Mutual funds	18,430,326	17,630,120
Money market mutual fund	<u>8,323,388</u>	<u>8,898,439</u>
Total investments	<u>57,351,957</u>	<u>54,914,961</u>
Receivables		
Employer contributions	2,881,876	3,508,047
Prescription rebates	990,391	887,075
Medicare Part D subsidy	<u>-</u>	<u>18,550</u>
Total receivables	<u>3,872,267</u>	<u>4,413,672</u>
Prepaid expenses	<u>45,702</u>	<u>46,238</u>
Cash	<u>821,914</u>	<u>697,081</u>
Total assets	<u>62,091,840</u>	<u>60,071,952</u>
Liabilities and Net Assets		
Liabilities		
Accounts payable and accrued expenses	<u>\$ 429,923</u>	<u>\$ 430,782</u>
Total liabilities	<u>429,923</u>	<u>430,782</u>
Net assets available for benefits	<u>\$ 61,661,917</u>	<u>\$ 59,641,170</u>

The Notes to Financial Statements are an integral part of these statements.

Oregon Laborers - Employers Health and Welfare Plan
Statements of Changes in Net Assets Available for Benefits
Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Additions		
Investment income		
Net appreciation in fair value of investments	\$ 2,151,086	\$ 3,154,468
Interest and dividends	<u>1,197,142</u>	<u>849,752</u>
	3,348,228	4,004,220
Less: Investment expenses	<u>(145,173)</u>	<u>(128,221)</u>
Investment income - net	3,203,055	3,875,999
Employer contributions, net of reciprocity	36,772,248	37,432,616
Participant contributions	1,295,464	1,333,552
Medicare Part D subsidy	53,968	92,709
Stop-loss reimbursements	418,852	38,888
Prescription rebates	<u>1,872,775</u>	<u>1,816,946</u>
Total additions	<u>43,616,362</u>	<u>44,590,710</u>
Deductions		
Cost of benefits		
Group medical insurance premiums	8,190,219	7,479,863
Self-funded benefits	<u>30,800,018</u>	<u>26,424,505</u>
Total cost of benefits	<u>38,990,237</u>	<u>33,904,368</u>
Operating expenses		
Administrative fees	1,705,244	1,702,036
Delinquency coordinator	253,739	204,823
Insurance	52,052	51,672
National Health and Safety Fund	90,863	92,991
Printing, postage and other	125,736	95,944
Professional fees	358,670	299,061
Trustee meeting and conference expenses	<u>19,074</u>	<u>9,866</u>
Total operating expenses	<u>2,605,378</u>	<u>2,456,393</u>
Total deductions	<u>41,595,615</u>	<u>36,360,761</u>
Net change	2,020,747	8,229,949
Net assets available for benefits		
Beginning of year	<u>59,641,170</u>	<u>51,411,221</u>
End of year	<u>\$ 61,661,917</u>	<u>\$ 59,641,170</u>

The Notes to Financial Statements are an integral part of these statements.

Oregon Laborers - Employers Health and Welfare Plan
Statements of Benefit Obligations
December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Amounts currently payable		
Claims payable and incurred but not reported	\$ 5,121,000	\$ 4,098,000
Other obligations for current benefit coverage - at present value of estimated amounts, net of amounts currently payable		
Accumulated eligibility credits	<u>14,431,000</u>	<u>13,320,000</u>
Post-retirement benefit obligations - net of amounts currently payable		
Current retirees	11,189,036	11,836,234
Other participants fully eligible for benefits	3,115,073	3,295,256
Other participants not fully eligible for benefits	<u>10,080,145</u>	<u>10,663,203</u>
Total post-retirement benefit obligations	<u>24,384,254</u>	<u>25,794,693</u>
 Total benefit obligations	 <u>\$ 43,936,254</u>	 <u>\$ 43,212,693</u>

The Notes to Financial Statements are an integral part of these statements.

**Oregon Laborers - Employers Health and Welfare Plan
Statements of Changes in Benefit Obligations
Years Ended December 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
Amounts currently payable		
Balance at beginning of year	\$ 4,098,000	\$ 3,259,000
Increase during the year attributable to changes in		
Claims payable and incurred but not reported	<u>1,023,000</u>	<u>839,000</u>
Balance at end of year	<u>5,121,000</u>	<u>4,098,000</u>
Other obligations for current benefit coverage - at present value of estimated amounts, net of amounts currently payable		
Balance at beginning of year	13,320,000	12,916,000
Increase during the year attributable to changes in		
Accumulated eligibility credits	<u>1,111,000</u>	<u>404,000</u>
Balance at end of year	<u>14,431,000</u>	<u>13,320,000</u>
Post-retirement benefit obligations - net of amounts currently payable		
Balance at beginning of year	25,794,693	30,407,005
Increase (decrease) during the year attributable to		
Benefits earned, interest and other changes	779,547	947,673
Claims experience	(1,001,597)	(1,212,570)
Changes in actuarial assumptions and actuarial gains and losses	(2,402,778)	(5,837,821)
Increase for interest	<u>1,214,389</u>	<u>1,490,406</u>
Balance at end of year	<u>24,384,254</u>	<u>25,794,693</u>
Total benefit obligations	<u>\$ 43,936,254</u>	<u>\$ 43,212,693</u>

The Notes to Financial Statements are an integral part of these statements.

Oregon Laborers - Employers Health and Welfare Plan

Notes to Financial Statements

December 31, 2024 and 2023

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting

The accompanying financial statements for Oregon Laborers - Employers Health and Welfare Plan (the "Plan") are prepared using the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

Investment Valuation, Transactions and Income Recognition

General - Investments are carried at fair value, which is determined, presented and disclosed in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 820, Fair Value Measurements and Disclosures. Under FASB ASC 820, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability (i.e., the "exit price") in an orderly transaction between market participants at the measurement date.

FASB ASC 820 establishes a fair value hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are those that market participants would use in pricing the asset or liability based on market data obtained from sources independent of the Plan. Unobservable inputs reflect the Plan's assumptions about inputs that market participants would use in pricing the investments developed based on the best information available in the circumstances. The fair value hierarchy is categorized into three levels, based on the inputs, as follows:

Level 1 - Valuations based on quoted prices in active markets for identical assets or liabilities that the Plan has the ability to access.

Level 2 - Valuations based on quoted prices in markets that are not active, quoted prices for similar investments in active markets or model-based valuations for which all significant assumptions are observable and can be corroborated by observable market data.

Level 3 - Valuations based on unobservable inputs that are supported by little or no market activity and are significant to the overall fair value measurement. Values are determined using proprietary pricing models, discounted cash flow models that include the investment entities' own judgments and estimations, or some other pricing method using unobservable inputs.

Inputs and Valuation Methods - In determining fair value, FASB ASC 820 allows various valuation approaches. The specific methods used for each of the Plan's investment classes are presented below.

Common/Collective Trust Funds: The Plan is invested in the Loomis Sayles Intermediate-Duration Fixed-Income Trust and the State Street MSCI ACWI Index Non-Lending Common Trust Fund. The fair value of these investments have been estimated using the net asset value per share of the investment. The net asset value is being used as a practical expedient to estimate fair value.

The Loomis Sayles Intermediate-Duration Fixed-Income Trust and the State Street MSCI ACWI Index Non-Lending Common Trust Fund have daily liquidity, and the Plan is not required to provide advance notice to redeem units. There are no unfunded commitments to these investments as of December 31, 2024 and 2023.

Mutual Funds: The fair value of the mutual funds is generally based on quoted prices in active markets (Level 1).

Oregon Laborers - Employers Health and Welfare Plan

Notes to Financial Statements

December 31, 2024 and 2023

Money Market Mutual Fund: The fair value of the money market mutual fund, which is not actively traded, is based on amortized cost, which approximates fair value of the underlying investments (Level 2).

Valuation Methods, Consistency -The valuation techniques used in the accompanying financial statements have been consistently applied.

Transactions and Income Recognition - Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Contributions Receivable

Employer contributions due but not paid at year-end are recorded as employer contributions receivable. Allowance for uncollectible accounts is considered unnecessary and is not provided. Contributions due as a result of payroll audits have been recorded net of an allowance equal to the amount due because collectability is uncertain. Therefore, delinquent contributions are recorded when received.

Participant Contributions

Contributions are recognized as income as of the end of the month in which they are received.

Prescription Rebates Receivable

Prescription rebates earned but not received prior to year-end are recorded as receivables.

Benefit Obligations

Claims payable and claims incurred but not reported, and accumulated eligibility credits were estimated based on premiums and claims experience data. Post-retirement benefit obligations were actuarially determined by the Plan's consultant. Claims payable and claims incurred but not reported are an estimate of the cost to the Plan for claims incurred by participants under the terms of the Plan through December 31 of each year but paid by the Plan subsequent to December 31. Accumulated eligibility credits are an estimate of the cost to the Plan for benefits earned based on work performed in November and December, which provides eligibility for the following months of January and February. Accumulated eligibility credits also include an estimate of the cost to the Plan for the hours banked by participants through the work month of December to be used to provide eligibility for a period of up to eight months starting the following March.

Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

Reciprocity

The Plan has entered into agreements with other local jurisdictions around the United States. These agreements allow participants to work around the country and have those contributions remitted back to their home local's health and welfare plan. These agreements require that the funds contributed by the employer to be remitted to the home local health and welfare plan. For the year ended December 31, 2024, the Plan remitted \$1,480,553 and received \$1,091,339 of reciprocal cash payments. For the year ended December 31, 2023, the Plan remitted \$1,663,361 and received \$1,230,577 of reciprocal cash payments. Reciprocal payments received are included in the employer's contributions in the statements of changes in net assets available for benefits. Payments made to other Plans for reciprocal contributions collected on behalf of those Plans are recorded as a reduction to the overall contributions and payments owed at the end of the year are included in the accounts payable.

Oregon Laborers - Employers Health and Welfare Plan

Notes to Financial Statements

December 31, 2024 and 2023

Risks and Uncertainties

The actuarial present value of post-retirement benefit obligations is calculated based on certain assumptions pertaining to interest rates, participant demographics and other assumptions, all of which are subject to change. Due to the inherent uncertainty of the assumption process, it is at least reasonably possible that changes in these assumptions in the near-term would be material to the disclosure to the financial statements of the actuarial present value of post-retirement benefit obligations.

The Plan invests in common/collective trust funds, mutual funds, and a money market mutual fund. Such investments are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investments and the level of uncertainty with respect to changes in the value of investments, it is at least reasonably possible that changes in risks in the near term would materially affect the amounts reported in the statements of net assets available for benefits and the statements of changes in net assets available for benefits.

2. DESCRIPTION OF THE PLAN

General - The Plan was established in 1954 as a result of collective bargaining agreements between the Oregon State District Council of the Laborers and the Oregon-Columbia Chapter of the Associated General Contractors of America, Inc., to provide welfare benefits for eligible employees and their dependents.

Board of Trustees - The Plan is administered by a Board of Trustees composed of three union trustees and three employer trustees.

Eligibility - General eligibility rules under the Plan are as follows:

- a. Initial eligibility requires 200 hours to be worked within three consecutive calendar months.
- b. Effective July 1, 2021, to maintain eligibility, an employee must work at least 130 hours in each month or make self-payments to the Plan. Prior to July 1, 2021, 140 hours were required to maintain eligibility.

Hours worked in excess of the minimum amount required for eligibility each month are accumulated in an hour bank to be used during periods of unemployment. The maximum number of hours a participant is allowed to accumulate in their hour bank is 1,120. At the March 7, 2019, Board of Trustees' meeting, the Plan's hour bank provisions were amended effective June 1, 2019. The maximum number of hours a participant can accumulate in their hour bank, after June 1, 2019, is 420. Participants with greater than 420 hours in their hour bank as of June 1, 2019, will retain their hours, but can no longer accrue additional hours over the 420-hour limit. At the February 27, 2020, Board of Trustees' meeting, the hour bank maximum was increased to 840 hours.

Continuation of health care benefits to persons who would otherwise lose those benefits due to certain events, as mandated by the Consolidated Omnibus Budget Reconciliation Act (COBRA), has been adopted by the Plan.

Benefits - The current Plan provides medical, prescription drug, dental, vision, supplemental income, and accidental death and dismemberment benefits. Benefits are generally paid directly from Plan assets, except for accidental death and dismemberment and some medical and dental benefits for those participants who elect to be covered through health maintenance organizations. Those benefits not paid directly from Plan assets are paid through contracts with an insurance company and various health maintenance organizations.

Oregon Laborers - Employers Health and Welfare Plan
Notes to Financial Statements
December 31, 2024 and 2023

Retirees - The costs of the post-retirement benefit plan are shared by the Plan's participating employers and retirees. In addition to deductibles and co-payments, the estimated cost of providing post-retirement benefits in the current and prior year was funded through retiree contributions, as follows:

Retiree contributions when not eligible for subsidized contribution rates	100%
Retiree contributions when eligible for subsidized contribution rates	
20–24 years of service	60%
25–29 years of service	50%
30+ years of service	40%

Certain retiree benefits are being funded by current employer contributions and monthly co-payments from retirees. Retiree coverage shall be limited to funds available for retiree benefits, as determined by the Trustees. If contributions under the collective bargaining agreements become inadequate to maintain retiree benefits, the Trustees have the right to reduce benefits and/or increase self-pay charges or to terminate retiree coverage.

Participants should refer to the summary Plan description for more complete information.

3. PRIORITIES UPON TERMINATION

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy, or make provisions to satisfy, the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for, or diverted to, purposes other than the exclusive benefit of the participants.

4. TAX STATUS

The Plan obtained a determination letter, dated February 27, 1957, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code. The Plan has been amended since receiving the determination letter. However, the Plan's administrator and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code or that any instances of noncompliance would be eligible for correction, including self-correction, under an applicable Internal Revenue Service corrective procedure. Therefore, they believe that the Plan was qualified, and the related trust was tax exempt as of the financial statement date.

Accounting principles generally accepted in the United States of America require management to evaluate the tax positions taken by the Plan and to recognize a tax liability if the Plan has taken an uncertain tax position that, more likely than not, would not be sustained upon examination by the Internal Revenue Service. The Plan has analyzed the tax positions taken by the Plan and has concluded that, as of December 31, 2024, and 2023 there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the financial statements. The Plan is subject to routine audits by the taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Oregon Laborers - Employers Health and Welfare Plan
Notes to Financial Statements
December 31, 2024 and 2023

5. FUNDING POLICY

The Plan is funded by employer contributions, retiree contributions, and from participants electing COBRA coverage. Employer contributions are based on hours of work and are made in accordance with rates set forth in the collective bargaining agreements. Contribution rates for retirees and participants electing COBRA coverage are set by the Board of Trustees based on information provided by the Plan's consultant.

6. INVESTMENTS AT FAIR VALUE HIERARCHY

Assets measured at fair value on a recurring basis, based on their fair value hierarchy at December 31, 2024 and 2023, are as follows:

Description	December 31, 2024	Fair Value Measurements at Reporting Date Using		
		Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets in the fair value hierarchy				
Mutual fund	\$ 18,430,326	\$ 18,430,326	\$ -	\$ -
Money market mutual fund	8,323,388	-	8,323,388	-
Total assets in the fair value hierarchy	26,753,714	\$ 18,430,326	\$ 8,323,388	\$ -
Investments measured at net asset value*				
Common/collective trust funds	30,598,243			
Total investments at fair value	\$ 57,351,957			

Description	December 31, 2023	Fair Value Measurements at Reporting Date Using		
		Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets in the fair value hierarchy				
Mutual fund	\$ 17,630,120	\$ 17,630,120	\$ -	\$ -
Money market mutual fund	8,898,439	-	8,898,439	-
Total assets in the fair value hierarchy	26,528,559	\$ 17,630,120	\$ 8,898,439	\$ -
Investments measured at net asset value*				
Common/collective trust funds	28,386,402			
Total investments at fair value	\$ 54,914,961			

* In accordance with FASB ASC 820, certain investments that were measured at net asset value per share (or its equivalent) have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the line items presented in the statement of net assets available for benefits.

Oregon Laborers - Employers Health and Welfare Plan
Notes to Financial Statements
December 31, 2024 and 2023

7. INVESTMENTS IN CERTAIN ENTITIES THAT CALCULATE NET ASSET VALUE

Investments in certain entities that calculate net asset value per share, or its equivalent, for which the value is not readily determinable, on the basis of that net asset value per share, or its equivalent, without adjustment, are as follows:

<u>Investment Type</u>	<u>Fair Value at December 31,</u>		<u>Redemption Frequency</u>	<u>Redemption</u>
	<u>2024</u>	<u>2023</u>	<u>(if currently eligible)</u>	<u>Notice Period</u>
Common/Collective Trust Funds				
Loomis Sayles Intermediate Duration Fixed Income Trust	\$ 21,100,079	\$ 20,312,126 (a)	Daily	3-5 days
State Street MSCI ACWI Index Non Lending	<u>9,498,164</u>	<u>8,074,276</u> (a)	Daily	3-5 days
Total common/collective trust funds	<u>30,598,243</u>	<u>28,386,402</u>		
Total investments at net asset value	<u>\$ 30,598,243</u>	<u>\$ 28,386,402</u>		

There were no unfunded commitments as of December 31, 2024 and 2023.

(a) These investments are direct filing entities with the Department of Labor; therefore, information regarding the investment strategy is not disclosed.

8. POST-RETIREMENT BENEFIT OBLIGATIONS

The post-retirement benefit obligations represent the total actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31 reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Post-retirement benefits include future benefits expected to be paid to or for: (1) currently retired employees, and (2) active employees after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the post-retirement benefit obligation is the portion of the expected post-retirement benefit obligation that is attributed to the employee's service in the industry rendered through the valuation date.

The actuarial present value of the expected post-retirement benefit obligations is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of employment.

The trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the post-retirement benefit obligations as of December 31, 2024 and 2023, by \$3,515,000 and \$3,861,000, respectively.

The Board of Trustees in September 2025 approved implementing a group Medicare Advantage plan as a fully insured replacement for the Medicare retirees that were not enrolled in the Kaiser Medicare plan, effective January 1, 2026 which is expected to reduce the Plan's post-retirement benefit obligation by an estimated \$2 to \$3 million. This reduction in the post-retirement benefit obligation is not reflected in the post-retirement benefit obligation shown on the Statement of Benefit Obligations as of December 31, 2024 as the reduction will be reflected in the year the Plan design change was approved (2025).

Some of the more significant actuarial assumptions used to calculate the post-retirement health and death benefit obligations at December 31, 2024 and 2023, are as follows:

Oregon Laborers - Employers Health and Welfare Plan
Notes to Financial Statements
December 31, 2024 and 2023

Mortality rates: Healthy - Pri-2012 Mortality Tables for Males and Females with Blue Collar adjustments projected generationally to 2019 using the MP-2019 mortality improvements rates and projected generationally for years after 2019 using 50% of the MP-2019 improvement rates.

Disabled - Pri-2012 amount weighted disability mortality tables for males and females projected generationally to 2019 using the MP-2019 mortality improvement rates and projected generationally for years after 2019 using 50% of the MP-2019 mortality improvement rates.

Discount rate: 5.5% per annum (2024); 4.8% per annum (2023).

Retirement rate: Retirement rates were based on a study of retirements from 2009 through 2018.

2024 and 2023		
Age	With Rule of 80	Without Rule of 80
45-52	25%	N/A
53	15	5%
54	15	8
55-56	20	8
57-58	15	8
59-60	15	10
61	25	20
62	30	20
63-64	30	30
65	100	100

Retiree contribution increases: Retiree contributions are assumed to be a percentage of claims costs and are assumed to increase at the same annual rate as per-capita costs for total medical and prescription drug claims.

For measurement purposes, the annual rate of increase in the per-capita cost for selected years is as follows:

2024 and 2023		
Year	Non-Medicare	Medicare
2024	7.90%	11.60%
2025	6.4	7.2
2026	5.6	5.5
2027	5.4	5.3
2028	5.2	5.1
2035	4.1	4.0
2045	4.1	4.1
2055	4.1	4.1
2065	4.1	4.1
2075	3.7	3.7

Oregon Laborers - Employers Health and Welfare Plan
Notes to Financial Statements
December 31, 2024 and 2023

9. MEDICARE SUBSIDY

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act) includes a prescription drug benefit under Medicare, as well as a federal subsidy to sponsors of retiree health care benefit plans, which provides a benefit that is at least actuarially equivalent to Medicare Part D. Under the Act, for multiemployer plans, any Medicare subsidy is received directly by the Plan and not the individual employers participating in the Plan. The gross subsidies received by the Plan totaled \$53,968 and \$92,709 for the years ended December 31, 2024 and 2023, respectively.

The effect of the Medicare Part D subsidy has been included as a component of the post-retirement benefit cost for the Plan years ended December 31, 2024 and 2023.

10. CASH CONCENTRATIONS

The Plan places its cash with a financial institution deemed to be creditworthy. Cash balances may at times exceed federally insured deposit limits.

11. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 61,661,917	\$ 59,641,170
Benefit obligations currently payable	<u>(5,121,000)</u>	<u>(4,098,000)</u>
Net assets available for benefits per the Form 5500	<u>\$ 56,540,917</u>	<u>\$ 55,543,170</u>

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

Benefits paid to or for participants per the financial statements	\$ 38,990,237
Add: Amounts currently payable at end of year	5,121,000
Less: Amounts currently payable at beginning of year	<u>(4,098,000)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 40,013,237</u>

12. SUBSEQUENT EVENTS

As discussed in Note 8, the Board of Trustees subsequent to December 31, 2024, approved implementing a group Medicare Advantage plan as a fully insured replacement for the Medicare retirees that were not enrolled in the Kaiser Medicare plan, effective January 1, 2026 which is expected to reduce the Plan's post-retirement benefit obligation by an estimated \$2 to \$3 million.

In preparing these financial statements, management of the Plan has evaluated event and transactions that occurred after December 31, 2024, for potential recognition or disclosure in the financial statements. These event and transactions were evaluated through October 9, 2025, the date that the financial statements were available to be issued, and no items have come to the attention of management that require recognition or disclosure.

SUPPLEMENTARY INFORMATION

INDEPENDENT AUDITOR'S REPORT ON SUPPLEMENTARY INFORMATION

To the Participants and Trustees of
Oregon Laborers - Employers Health and Welfare Plan:

We have audited the financial statements of the Oregon Laborers - Employers Health and Welfare Plan as of and for the year ended December 31, 2024, and have issued our report thereon dated October 9, 2025, which contained an unmodified opinion on those financial statements. Our audit was performed for the purpose of forming an opinion on the financial statements taken as a whole. The Supplemental Schedule H, Part IV, Line 4i - schedule of assets (held at end of year) as of December 31, 2024, and Schedule H, Part IV, Line 4j - schedule of reportable transactions for the year then ended, are presented for purposes of additional analysis and are not a required part of the financial statements, but are supplementary information required by information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("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 audit 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 auditing standards generally accepted in the United States of America.

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.

WithumSmith+Brown, PC

October 9, 2025

Oregon Laborers - Employers Health and Welfare Plan
Schedule H, Part IV, Line 4i - Schedule of Assets (Held at End of Year)
EIN #93-6024141, Plan #501
December 31, 2024

(c) Description of Investment Including Maturity Date,
Rate of Interest, Collateral, Par, or Maturity Value

(a)	(b) Identity of Issue, Borrower, or Similar Party	Description	Collateral	Rate of Interest	Maturity Date	Shares	(d) Cost	(e) Current Value
	<u>Mutual Funds</u>							
	Vanguard Short Duration Investment Grade	Mutual Fund	N/A	N/A	N/A	N/A	\$ 8,388,991	\$ 8,213,354
	Pimco All Asset Fund Institutional Class	Mutual Fund	N/A	N/A	N/A	N/A	<u>11,237,653</u>	<u>10,216,972</u>
							19,626,644	18,430,326
	<u>Common Collective Trusts</u>							
	LS International Duration Fixed Income	CCT	N/A	N/A	N/A	N/A	17,073,758	21,100,079
	SSGA MSCI ACWI Index Non Lend CTF	CCT	N/A	N/A	N/A	N/A	<u>7,391,737</u>	<u>9,498,164</u>
							24,465,495	30,598,243
	<u>Money Market Mutual Fund</u>							
	First American Government Obligations FD	MMF	N/A	N/A	N/A	N/A	<u>8,323,388</u>	<u>8,323,388</u>
	Total						<u>\$ 52,415,527</u>	<u>\$ 57,351,957</u>

See Independent Auditor's Report on Supplementary Information.

Oregon Laborers - Employers Health and Welfare Plan
Schedule H, Part IV, Line 4j - Schedule of Reportable Transactions
EIN #93-6024141, Plan #501
December 31, 2024

See Custodian Report Attachment

See Independent Auditor's Report on Supplementary Information.

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 Period from January 1, 2024 to December 31, 2024

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
BEGINNING MARKET VALUE					51,935,969.08		
COMPARATIVE VALUE (5%)					2,596,798.45		
CATEGORY 1 - SINGLE TRANSACTION EXCEEDS 5% OF VALUE							
Issue: 31846V203 - First Am Govt Ob Fd Cl Y							
01/18/2024 6746020410	B	2,614,239.420	1.0000		- 2,614,239 *	2,614,239	
02/08/2024 6746020410	B	3,159,857.260	1.0000		- 3,159,857 *	3,159,857	
03/11/2024 6746020410	B	2,652,492.090	1.0000		- 2,652,492 *	2,652,492	
04/15/2024 6746020410	B	2,674,854.620	1.0000		- 2,674,855 *	2,674,855	
06/07/2024 6746020410	B	2,765,999.650	1.0000		- 2,766,000 *	2,766,000	
07/19/2024 6746020410	B	3,230,926.880	1.0000		- 3,230,927 *	3,230,927	
08/08/2024 6746020410	B	2,867,622.610	1.0000		- 2,867,623 *	2,867,623	
09/06/2024 6746020410	B	3,512,985.590	1.0000		- 3,512,986 *	3,512,986	
10/09/2024 6746020410	B	3,755,527.920	1.0000		- 3,755,528 *	3,755,528	
11/13/2024 6746020410	B	3,263,224.340	1.0000		- 3,263,224 *	3,263,224	
12/16/2024 6746020410	B	3,275,281.920	1.0000		- 3,275,282 *	3,275,282	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
GRAND TOTAL				0	33,773,013	33,773,013	0

CATEGORY 2 - SERIES OF TRANSACTIONS WITH SAME BROKER EXCEEDS 5% OF VALUE
 NO TRANSACTIONS QUALIFIED FOR THIS SECTION

CATEGORY 3 - SERIES OF TRANSACTIONS IN SAME SECURITY EXCEEDS 5% OF VALUE

Issue: 31846V203 - First Am Govt Ob Fd Cl Y

01/03/2024 6746020410	B	24,781.270	1.0000		- 24,781	24,781	
01/18/2024 6746020410	B	2,614,239.420	1.0000		- 2,614,239 *	2,614,239	
02/02/2024 6746020410	B	22,246.360	1.0000		- 22,246	22,246	
02/06/2024 6746020410	B	153,007.400	1.0000		- 153,007	153,007	
02/08/2024 6746020410	B	3,159,857.260	1.0000		- 3,159,857 *	3,159,857	
03/04/2024 6746020410	B	25,868.050	1.0000		- 25,868	25,868	
03/11/2024 6746020410	B	2,652,492.090	1.0000		- 2,652,492 *	2,652,492	
04/02/2024 6746020410	B	25,905.350	1.0000		- 25,905	25,905	
04/15/2024 6746020410	B	2,674,854.620	1.0000		- 2,674,855 *	2,674,855	
05/02/2024 6746020410	B	22,694.060	1.0000		- 22,694	22,694	
05/03/2024 6746020410	B	2,309,131.270	1.0000		- 2,309,131	2,309,131	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
05/06/2024 6746020410	B	153,740.710	1.0000		- 153,741	153,741	
06/04/2024 6746020410	B	25,968.230	1.0000		- 25,968	25,968	
06/07/2024 6746020410	B	2,765,999.650	1.0000		- 2,766,000 *	2,766,000	
06/10/2024 6746020410	B	181,231.460	1.0000		- 181,231	181,231	
07/02/2024 6746020410	B	24,940.640	1.0000		- 24,941	24,941	
07/19/2024 6746020410	B	3,230,926.880	1.0000		- 3,230,927 *	3,230,927	
08/02/2024 6746020410	B	20,889.900	1.0000		- 20,890	20,890	
08/08/2024 6746020410	B	2,867,622.610	1.0000		- 2,867,623 *	2,867,623	
09/04/2024 6746020410	B	23,205.650	1.0000		- 23,206	23,206	
09/06/2024 6746020410	B	3,512,985.590	1.0000		- 3,512,986 *	3,512,986	
10/02/2024 6746020410	B	22,638.700	1.0000		- 22,639	22,639	
10/09/2024 6746020410	B	3,755,527.920	1.0000		- 3,755,528 *	3,755,528	
11/04/2024 6746020410	B	22,147.550	1.0000		- 22,148	22,148	
11/13/2024 6746020410	B	3,263,224.340	1.0000		- 3,263,224 *	3,263,224	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
12/03/2024 6746020410	B	19,160.810	1.0000		- 19,161	19,161	
12/13/2024 6746020410	B	238,753.790	1.0000		- 238,754	238,754	
12/16/2024 6746020410	B	3,275,281.920	1.0000		- 3,275,282 *	3,275,282	
Total For Buys				0	37,089,324	37,089,324	0
01/02/2024 6746020410	S	- 696,942.830	1.0000		696,943	696,943	
01/05/2024 6746020410	S	- 552,315.180	1.0000		552,315	552,315	
01/09/2024 6746020410	S	- 119,363.010	1.0000		119,363	119,363	
01/11/2024 6746020410	S	- 334,368.490	1.0000		334,368	334,368	
01/22/2024 6746020410	S	- 173,024.660	1.0000		173,025	173,025	
01/24/2024 6746020410	S	- 649,739.160	1.0000		649,739	649,739	
01/26/2024 6746020410	S	- 541,420.080	1.0000		541,420	541,420	
01/30/2024 6746020410	S	- 107,694.430	1.0000		107,694	107,694	
02/02/2024 6746020410	S	- 257,592.300	1.0000		257,592	257,592	
02/05/2024 6746020410	S	- 102,140.270	1.0000		102,140	102,140	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
02/09/2024 6746020410	S	- 251,697.120	1.0000		251,697	251,697	
02/12/2024 6746020410	S	- 11,500.000	1.0000		11,500	11,500	
02/13/2024 6746020410	S	- 110,314.790	1.0000		110,315	110,315	
02/15/2024 6746020410	S	- 446,374.950	1.0000		446,375	446,375	
02/20/2024 6746020410	S	- 115,240.430	1.0000		115,240	115,240	
02/21/2024 6746020410	S	- 945,897.850	1.0000		945,898	945,898	
02/23/2024 6746020410	S	- 490,458.740	1.0000		490,459	490,459	
02/27/2024 6746020410	S	- 63,320.700	1.0000		63,321	63,321	
03/01/2024 6746020410	S	- 278,964.030	1.0000		278,964	278,964	
03/05/2024 6746020410	S	- 54,407.100	1.0000		54,407	54,407	
03/08/2024 6746020410	S	- 601,723.490	1.0000		601,723	601,723	
03/12/2024 6746020410	S	- 166,491.140	1.0000		166,491	166,491	
03/15/2024 6746020410	S	- 368,911.710	1.0000		368,912	368,912	
03/19/2024 6746020410	S	- 172,184.640	1.0000		172,185	172,185	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
03/20/2024 6746020410	S	- 613,633.730	1.0000		613,634	613,634	
03/22/2024 6746020410	S	- 252,745.310	1.0000		252,745	252,745	
03/26/2024 6746020410	S	- 114,404.470	1.0000		114,404	114,404	
04/01/2024 6746020410	S	- 640,433.230	1.0000		640,433	640,433	
04/03/2024 6746020410	S	- 11,500.000	1.0000		11,500	11,500	
04/05/2024 6746020410	S	- 365,876.470	1.0000		365,876	365,876	
04/09/2024 6746020410	S	- 76,586.120	1.0000		76,586	76,586	
04/11/2024 6746020410	S	- 10,000.000	1.0000		10,000	10,000	
04/12/2024 6746020410	S	- 458,807.120	1.0000		458,807	458,807	
04/16/2024 6746020410	S	- 135,031.370	1.0000		135,031	135,031	
04/19/2024 6746020410	S	- 357,202.410	1.0000		357,202	357,202	
04/22/2024 6746020410	S	- 627,723.550	1.0000		627,724	627,724	
04/23/2024 6746020410	S	- 99,639.150	1.0000		99,639	99,639	
04/29/2024 6746020410	S	- 547,856.290	1.0000		547,856	547,856	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
05/07/2024 6746020410	S	- 368,019.620	1.0000		368,020	368,020	
05/08/2024 6746020410	S	- 23,000.000	1.0000		23,000	23,000	
05/10/2024 6746020410	S	- 344,622.460	1.0000		344,622	344,622	
05/14/2024 6746020410	S	- 129,659.630	1.0000		129,660	129,660	
05/15/2024 6746020410	S	- 808,784.790	1.0000		808,785	808,785	
05/17/2024 6746020410	S	- 334,472.430	1.0000		334,472	334,472	
05/21/2024 6746020410	S	- 154,869.790	1.0000		154,870	154,870	
05/23/2024 6746020410	S	- 335,420.370	1.0000		335,420	335,420	
05/28/2024 6746020410	S	- 78,044.370	1.0000		78,044	78,044	
05/31/2024 6746020410	S	- 401,750.190	1.0000		401,750	401,750	
06/04/2024 6746020410	S	- 103,715.760	1.0000		103,716	103,716	
06/06/2024 6746020410	S	- 10,000.000	1.0000		10,000	10,000	
06/11/2024 6746020410	S	- 75,154.290	1.0000		75,154	75,154	
06/14/2024 6746020410	S	- 949,839.650	1.0000		949,840	949,840	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
06/20/2024 6746020410	S	- 490,388.000	1.0000		490,388	490,388	
06/24/2024 6746020410	S	- 115,438.260	1.0000		115,438	115,438	
06/27/2024 6746020410	S	- 956,675.090	1.0000		956,675	956,675	
07/10/2024 6746020410	S	- 137,305.580	1.0000		137,306	137,306	
07/11/2024 6746020410	S	- 713,716.310	1.0000		713,716	713,716	
07/16/2024 6746020410	S	- 156,155.310	1.0000		156,155	156,155	
07/18/2024 6746020410	S	- 1,122,550.020	1.0000		1,122,550	1,122,550	
07/22/2024 6746020410	S	- 10,000.000	1.0000		10,000	10,000	
07/23/2024 6746020410	S	- 202,860.400	1.0000		202,860	202,860	
07/24/2024 6746020410	S	- 928,864.870	1.0000		928,865	928,865	
07/25/2024 6746020410	S	- 4,999.860	1.0000		5,000	5,000	
07/30/2024 6746020410	S	- 109,496.990	1.0000		109,497	109,497	
08/02/2024 6746020410	S	- 254,581.550	1.0000		254,582	254,582	
08/05/2024 6746020410	S	- 30,000.000	1.0000		30,000	30,000	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
08/06/2024 6746020410	S	- 125,646.580	1.0000		125,647	125,647	
08/09/2024 6746020410	S	- 598,371.000	1.0000		598,371	598,371	
08/13/2024 6746020410	S	- 118,392.150	1.0000		118,392	118,392	
08/16/2024 6746020410	S	- 1,067,751.440	1.0000		1,067,751	1,067,751	
08/20/2024 6746020410	S	- 78,102.250	1.0000		78,102	78,102	
08/23/2024 6746020410	S	- 421,374.440	1.0000		421,374	421,374	
08/27/2024 6746020410	S	- 110,373.480	1.0000		110,373	110,373	
08/30/2024 6746020410	S	- 413,556.270	1.0000		413,556	413,556	
09/04/2024 6746020410	S	- 134,606.610	1.0000		134,607	134,607	
09/05/2024 6746020410	S	- 716,280.970	1.0000		716,281	716,281	
09/10/2024 6746020410	S	- 135,560.910	1.0000		135,561	135,561	
09/13/2024 6746020410	S	- 1,043,072.500	1.0000		1,043,073	1,043,073	
09/17/2024 6746020410	S	- 113,081.320	1.0000		113,081	113,081	
09/19/2024 6746020410	S	- 417,431.530	1.0000		417,432	417,432	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
09/24/2024 6746020410	S	- 171,707.750	1.0000		171,708	171,708	
09/26/2024 6746020410	S	- 433,527.610	1.0000		433,528	433,528	
10/01/2024 6746020410	S	- 155,978.260	1.0000		155,978	155,978	
10/03/2024 6746020410	S	- 405,740.010	1.0000		405,740	405,740	
10/08/2024 6746020410	S	- 83,497.960	1.0000		83,498	83,498	
10/10/2024 6746020410	S	- 548,902.400	1.0000		548,902	548,902	
10/11/2024 6746020410	S	- 10,000.000	1.0000		10,000	10,000	
10/15/2024 6746020410	S	- 146,891.910	1.0000		146,892	146,892	
10/16/2024 6746020410	S	- 707,804.300	1.0000		707,804	707,804	
10/17/2024 6746020410	S	- 644,930.500	1.0000		644,931	644,931	
10/18/2024 6746020410	S	- 200,000.000	1.0000		200,000	200,000	
10/23/2024 6746020410	S	- 94,031.030	1.0000		94,031	94,031	
10/24/2024 6746020410	S	- 379,821.050	1.0000		379,821	379,821	
10/29/2024 6746020410	S	- 98,154.790	1.0000		98,155	98,155	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
10/31/2024 6746020410	S	- 555,127.380	1.0000		555,127	555,127	
11/05/2024 6746020410	S	- 120,154.960	1.0000		120,155	120,155	
11/07/2024 6746020410	S	- 427,071.820	1.0000		427,072	427,072	
11/12/2024 6746020410	S	- 98,182.780	1.0000		98,183	98,183	
11/14/2024 6746020410	S	- 591,466.270	1.0000		591,466	591,466	
11/15/2024 6746020410	S	- 10,000.000	1.0000		10,000	10,000	
11/19/2024 6746020410	S	- 841,660.080	1.0000		841,660	841,660	
11/21/2024 6746020410	S	- 382,849.940	1.0000		382,850	382,850	
12/03/2024 6746020410	S	- 808,854.180	1.0000		808,854	808,854	
12/05/2024 6746020410	S	- 297,048.000	1.0000		297,048	297,048	
12/10/2024 6746020410	S	- 149,652.660	1.0000		149,653	149,653	
12/11/2024 6746020410	S	- 323,000.000	1.0000		323,000	323,000	
12/12/2024 6746020410	S	- 484,272.370	1.0000		484,272	484,272	
12/17/2024 6746020410	S	- 125,569.420	1.0000		125,569	125,569	

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FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
12/18/2024 6746020410	S	- 200,000.000	1.0000		200,000	200,000	
12/19/2024 6746020410	S	- 1,144,306.370	1.0000		1,144,306	1,144,306	
12/26/2024 6746020410	S	- 763,733.230	1.0000		763,733	763,733	
Total For Sells				0	38,171,445	38,171,445	0
Total First Am Govt Ob Fd Cl Y				0	75,260,769	75,260,769	0
GRAND TOTAL				0	75,260,769	75,260,769	0

CATEGORY 4 - SINGLE TRANSACTION WITH ONE BROKER EXCEEDS 5% OF VALUE
NO TRANSACTIONS QUALIFIED FOR THIS SECTION

OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN

EIN 93-6024141

Plan No. 501

Plan Year Ended December 31,2024

**Form 5500, Schedule H, Part IV, Line 4i
Schedule of Assets (Held at Year End)**

See attachment to the Accountant's Audit Report attached at Accountant's Opinion

OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN

EIN 93-6024141

Plan No. 501

Plan Year Ended December 31,2024

**Form 5500, Schedule H, Part IV, Line 4j
Schedule of Reportable Transactions**

See attachment to the Accountant's Audit Report attached at Accountant's Opinion

OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN

EIN 93-6024141

Plan No. 501

Plan Year Ended December 31,2024

Form 5500, Schedule H, Part III

Financial Statements used to formulate IQPA's opinion

The entire report has been attached to the Accountant's Opinion

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ Complete all entries in accordance with the instructions to the Form 5500.	OMB Nos. 1210-0110 1210-0089 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A	This return/report is for: <input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____
B	This return/report is: <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report
	<input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. <input checked="" type="checkbox"/>
D	Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program
	<input type="checkbox"/> special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. <input type="checkbox"/>

Part II Basic Plan Information —enter all requested information											
1a Name of plan OREGON LABORERS-EMPLOYERS HEALTH AND WELFARE PLAN 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) BOARD OF TRUSTEES, OREGON LABORERS-EMPLOYERS P.O. BOX 4148 PORTLAND OR 97208	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td colspan="2">1c Effective date of plan 04/01/1954</td> </tr> <tr> <td colspan="2">2b Employer Identification Number (EIN) 93-6024141</td> </tr> <tr> <td colspan="2">2c Plan Sponsor's telephone number (503) 282-5581</td> </tr> <tr> <td colspan="2">2d Business code (see instructions) 238900</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan 04/01/1954		2b Employer Identification Number (EIN) 93-6024141		2c Plan Sponsor's telephone number (503) 282-5581		2d Business code (see instructions) 238900	
1b Three-digit plan number (PN) ▶	501										
1c Effective date of plan 04/01/1954											
2b Employer Identification Number (EIN) 93-6024141											
2c Plan Sponsor's telephone number (503) 282-5581											
2d Business code (see instructions) 238900											

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	JEFFREY GRITZ
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/9/25	JAMES WATTS
	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.

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	2,747
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)	2,519
	6a(2)	2,549
	6b	214
	6c	0
	6d	2,763
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	298

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F

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>3</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 checked="" type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____
