

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

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

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... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension... 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: ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST
1b Three-digit plan number (PN): 501
1c Effective date of plan: 02/25/1965
2a Plan sponsor's name (employer, if for a single-employer plan): BOARD OF TRUSTEES, ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST
2b Employer Identification Number (EIN): 92-6003453
2c Plan Sponsor's telephone number: 503-486-2100
2d Business code (see instructions): 445110

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 rows for employer/plan sponsor and 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	1728
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)	1696
	6a(2)	1097
	6b	16
	6c	0
	6d	1113
	6e	
	6f	1113
	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	15

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

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

9a Plan funding arrangement (check all that apply)	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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST</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, ALASKA UNITED FOOD AND COMMERCIAL</p>	<p>D Employer Identification Number (EIN) 92-6003453</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
UNITED OF OMAHA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0322111	69868	G0005D27	1062	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
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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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(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)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions		7e(5)	0	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	0

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
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	27453
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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, ALASKA UNITED FOOD AND COMMERCIAL	D Employer Identification Number (EIN) 92-6003453

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

1 Coverage Information:

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-7089668	53031	12103707	958	01/01/2024	12/31/2024

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)		55454
	(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)	55454
b	Benefit charges (1) Claims paid	9b(1)		51110
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))		9b(3)	51110
	(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)		4344
	(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)	4344
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
	(2) Claim reserves		9d(2)	
	(3) Other reserves		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

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

<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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST</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, ALASKA UNITED FOOD AND COMMERCIAL</p>	<p>D Employer Identification Number (EIN) 92-6003453</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
RELIASTAR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
41-0451140	67105	0072746-6	1062	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 7500	(b) Total amount of fees paid 64685
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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
CENTERSTONE INS & FS INC **4851 LBJ FWY STE 100**
DALLAS, TX 75244

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7500	64685	ADMINISTRATION FEE	3

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

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

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

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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
	(c) Amount	(d) Purpose	

Part II Investment and Annuity Contract Information
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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)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
	(2) Administration charge made by carrier.....	7e(2)		
	(3) Transferred to separate account	7e(3)		
	(4) Other (specify below)	7e(4)		
(5) Total deductions		7e(5)	0	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	0

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	1293709
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, ALASKA UNITED FOOD AND COMMERCIAL	D Employer Identification Number (EIN) 92-6003453	

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

GOLDENTREE ASSET MANAGEMENT LP

13-4118850

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

VANGUARD

23-1945930

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

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

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

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

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

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

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

ZENITH AMERICAN SOLUTIONS

52-1590516

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 36 38	NONE	547692	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)

AETNA

06-6033492

(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 12 15	NONE	406999	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)

BEACON OCCUPATIONAL HEALTH & SAFETY

92-0166824

(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	68333	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)

RAEL & LETSON

94-1701048

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	159505	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)

BARLOW & COUGHRAN, P.S.

91-0889948

(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	34178	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)

CLIFTONLARSONALLEN LLP

41-0746749

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	51071	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)

TRANSCARENT

84-3296541

(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	115958	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)

MARSH MCLENNAN AGENCY LLC

36-1436000

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	3710	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

MEKETA INVESTMENT GROUP, INC.

04-2659023

(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?
17 27 50	NONE	12500	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)

US BANK, NATIONAL ASSOCIATION

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 50 62 68	NONE	15977	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

a Name: CLIFTONLARSONALLEN, LLP	b EIN: 41-0746749
c Position: ACCOUNTANT	
d Address: 601 W RIVERSIDE AVE SPOKANE, WA 99201	e Telephone: 503-808-4135

Explanation: PART OF COMPETITIVE BIDDING PROCESS.

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.	OMB No. 1210-0110 <hr/> 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>ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST</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, ALASKA UNITED FOOD AND COMMERCIAL</u>	D Employer Identification Number (EIN) <u>92-6003453</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)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>GOLDENTREE MS FD OFFSHORE ERISA LTD</u>		
b Name of sponsor of entity listed in (a): <u>GOLDENTREE ASSET MANAGEMENT</u>		
c EIN-PN <u>98-1018819-002</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1907850</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)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, ALASKA UNITED FOOD AND COMMERCIAL	D Employer Identification Number (EIN) 92-6003453

Part I	Asset and Liability Statement
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1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets	(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a 422524	1581207
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1) 1744126	1713252
(2) Participant contributions	1b(2) 91315	79275
(3) Other	1b(3) 2458943	8271143
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1) 1207257	296536
(2) U.S. Government securities	1c(2)	
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other	1c(3)(B)	
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	
(9) Value of interest in common/collective trusts	1c(9)	
(10) Value of interest in pooled separate accounts	1c(10)	
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12) 2029971	1907850
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13) 13667019	9766075
(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	21621155	23615338
Liabilities			
g Benefit claims payable.....	1g	3103223	7159000
h Operating payables.....	1h	14950	7661
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	3118173	7166661
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	18502982	16448677

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)	20688769	
(B) Participants.....	2a(1)(B)	1426342	
(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)		22115111
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	51201	
(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)		51201
(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)	409384	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		409384
(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)		
(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)		177913
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		374649
c Other income	2c		11091
d Total income. Add all income amounts in column (b) and enter total	2d		23139349

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	21914703	
(2) To insurance carriers for the provision of benefits	2e(2)	2369109	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		24283812
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)	547692	
(3) Recordkeeping fees	2i(3)	12568	
(4) IQPA audit fees	2i(4)	38503	
(5) Investment advisory and investment management fees	2i(5)	12500	
(6) Bank or trust company trustee/custodial fees	2i(6)	19390	
(7) Actuarial fees	2i(7)	159505	
(8) Legal fees	2i(8)	34178	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	10798	
(11) Other expenses	2i(11)	74708	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		909842
j Total expenses. Add all expense amounts in column (b) and enter total	2j		25193654

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-2054305
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: MILLER KAPLAN ARASE LLP

(2) EIN: 95-2036255

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

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

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**

FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023



INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Alaska United Food and Commercial Workers
Health and Welfare Trust
12205 SW Tualatin Road, Suite 200
Tualatin, Oregon 97062

Members of the Board:

Opinion

We have audited the accompanying financial statements of the Alaska United Food and Commercial Workers Health and Welfare Trust (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the year then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of December 31, 2024, and the changes in its net assets available for benefits and benefit obligations for the year then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with generally accepted auditing standards, we:

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

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

Other Matter

The financial statements of the Plan as of and for the year ended December 31, 2023, were audited by other auditors whose report dated October 13, 2024, expressed an unmodified opinion on those statements.

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

Burbank, California

October 6, 2025

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	December 31, 2024	December 31, 2023
ASSETS		
CASH	\$ 1,581,207	\$ 422,524
INVESTMENTS, AT FAIR VALUE		
Short-Term Investment Fund	\$ 296,536	\$ 1,207,257
103-12 Investment Entity	1,907,850	2,029,971
Mutual Funds	9,766,075	13,667,019
	11,970,461	16,904,247
TOTAL CASH AND INVESTMENTS	13,551,668	17,326,771
OTHER ASSETS		
Employer Contributions Receivable	1,713,252	1,744,126
Participant Contributions Receivable	79,275	91,315
Accrued Interest and Dividends	2,329	5,397
Stop-Loss Refunds Receivable	-	2,089,891
Formulary Rebate Receivable	340,795	363,655
Due from Pension	7,928,019	-
TOTAL OTHER ASSETS	10,063,670	4,294,384
TOTAL ASSETS	23,615,338	21,621,155
LIABILITIES		
Accounts Payable	7,661	14,950
TOTAL LIABILITIES	7,661	14,950
NET ASSETS AVAILABLE FOR BENEFITS	23,607,677	21,606,205
MEMORANDUM:		
Benefit Obligations Other Than Postretirement Benefit Obligations	7,159,000	5,221,223
Excess of Net Assets Available For Benefits Over Benefit Obligations Other Than Postretirement Benefit Obligations	\$ 16,448,677	\$ 16,384,982

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

	<u>January 1, 2024 to December 31, 2024</u>	<u>January 1, 2023 to December 31, 2023</u>
ADDITIONS		
INVESTMENT INCOME		
Dividends and Interest	\$ 460,585	\$ 355,064
Net Appreciation of Investments	552,562	814,845
Less: Investment Fees	<u>(14,484)</u>	<u>(13,924)</u>
NET INVESTMENT INCOME	<u>998,663</u>	<u>1,155,985</u>
CONTRIBUTIONS AND OTHER INCOME		
Employer Contributions	20,688,769	21,464,797
Participant Contributions	1,426,342	1,348,730
Other Income	<u>11,091</u>	<u>14,191</u>
TOTAL CONTRIBUTIONS AND OTHER INCOME	<u>22,126,202</u>	<u>22,827,718</u>
TOTAL ADDITIONS	<u>23,124,865</u>	<u>23,983,703</u>
DEDUCTIONS		
BENEFITS PAID		
Claims, Net	18,291,144	21,419,013
Premiums	1,728,359	1,471,709
HRA Funding	158,357	193,953
Claims Administration Fees	<u>50,175</u>	<u>432,211</u>
NET BENEFITS PAID	<u>20,228,035</u>	<u>23,516,886</u>
ADMINISTRATIVE EXPENSES		
Administration	547,692	292,942
Consultant Fees	159,505	178,741
Legal Fees	34,178	38,933
Audit Fees	38,503	23,985
Payroll Compliance Fees	12,568	30,900
Bank Fees	17,406	8,279
Printing, Postage and Office Expenses	47,193	31,580
Insurance	22,072	14,970
Meetings and Conferences	10,798	13,196
PCORI Fees	<u>5,443</u>	<u>5,724</u>
TOTAL ADMINISTRATIVE EXPENSES	<u>895,358</u>	<u>639,250</u>
TOTAL DEDUCTIONS	<u>21,123,393</u>	<u>24,156,136</u>
NET INCREASE (DECREASE) FOR THE YEAR	2,001,472	(172,433)
NET ASSETS AVAILABLE FOR BENEFITS		
BEGINNING OF YEAR	<u>21,606,205</u>	<u>21,778,638</u>
END OF YEAR	<u>\$ 23,607,677</u>	<u>\$ 21,606,205</u>

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST
STATEMENTS OF BENEFIT OBLIGATIONS**

	December 31, 2024	December 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Claims Payable	\$ <u> -</u>	\$ <u> 349,223</u>
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Claims Incurred but not Reported	3,759,000	2,754,000
Accumulated Eligibility Credits	<u>3,400,000</u>	<u>2,118,000</u>
	<u>7,159,000</u>	<u>4,872,000</u>
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	<u>7,159,000</u>	<u>5,221,223</u>
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Current Retirees and Spouses	1,760,700	2,615,300
Other Participants Fully Eligible for Benefits	239,600	299,100
Other Participants Not Yet Fully Eligible for Benefits	<u>74,500</u>	<u>59,000</u>
	<u>2,074,800</u>	<u>2,973,400</u>
PLAN'S TOTAL BENEFIT OBLIGATIONS	<u>\$ <u>9,233,800</u></u>	<u>\$ <u>8,194,623</u></u>

* The calculation of postretirement benefit obligations is provided solely to comply with accounting principles generally accepted in the United States of America. It does not imply that the Plan has a legal liability to provide postretirement benefits, nor is there any implication the Plan is required to implement a funding policy to satisfy projected expenses.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

	<u>January 1, 2024 to December 31, 2024</u>	<u>January 1, 2023 to December 31, 2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Claims Payable at Beginning of Year	\$ 349,223	\$ -
Net Change During the Year:		
Benefits Reported and Approved for Payment	19,878,812	23,866,109
Benefits Paid	<u>(20,228,035)</u>	<u>(23,516,886)</u>
Claims Payable at End of Year	<u>-</u>	<u>349,223</u>
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Balance at Beginning of Year	4,872,000	8,651,373
Net Change During the Year:		
Claims Incurred but not Reported	1,005,000	(2,364,000)
Accumulated Eligibility Credits	<u>1,282,000</u>	<u>(1,415,373)</u>
Balance at End of Year	<u>7,159,000</u>	<u>4,872,000</u>
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	<u>7,159,000</u>	<u>5,221,223</u>
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Balance at Beginning of Year	2,973,400	3,238,100
Net Changes During the Year:		
Benefits Earned and Other Changes	(791,400)	(314,400)
Changes in Actuarial Assumptions and Methods	<u>(107,200)</u>	<u>49,700</u>
	<u>2,074,800</u>	<u>2,973,400</u>
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	<u><u>\$ 9,233,800</u></u>	<u><u>\$ 8,194,623</u></u>

* The calculation of postretirement benefit obligations is provided solely to comply with accounting principles generally accepted in the United States of America. It does not imply that the Plan has a legal liability to provide postretirement benefits, nor is there any implication the Plan is required to implement a funding policy to satisfy projected expenses.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 1 - DESCRIPTION OF THE PLAN

The Alaska United Food and Commercial Workers Health and Welfare Trust (the "Plan") is a multi-employer welfare benefit plan formed in 1965 under collective bargaining agreements between signatory employers and Retail Food Clerks Local 1496 to provide benefits for eligible employees. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

THE PLAN DOCUMENTS INCLUDE DETAILED RULES FOR EACH SITUATION. PARTICIPANTS SHOULD REFER TO THE PLAN AGREEMENT AND ANY AMENDMENTS REGARDING SPECIFIC PROVISIONS OF THE PLAN.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

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

B. Estimates

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

C. Contributions

Employer contributions as reported are contributions made for hours worked during the year. Employer contributions are based on covered hours of active member work and are made in accordance with rates set forth in the collective bargaining or participation agreements. Contributions receivable is estimated based on contributions received subsequent to the end of the year. No allowance is provided for uncollectible accounts.

Employees may contribute specified amounts to extend coverage.

D. Payroll Compliance Program

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

E. Investment Valuation and Income Recognition

Accounting standards establish a fair value hierarchy that prioritizes valuation inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market:

Level 1 – Inputs are quoted prices in active markets.

Level 2 – Inputs are based on quoted prices for similar instruments and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

E. Investment Valuation and Income Recognition (Continued)

Level 3 – Inputs are generally unobservable and typically reflect management’s estimates of assumptions that market participants would use in pricing the asset or liability.

The following tables represent the Plan’s investments at fair value, based on the inputs used to value them:

	December 31, 2024			
	Level 1	Level 2	Level 3	Total
Short-Term Investment Fund	\$ 296,536	\$ -	\$ -	\$ 296,536
Mutual Funds	9,766,075	-	-	9,766,075
	<u>\$ 10,062,611</u>	<u>\$ -</u>	<u>\$ -</u>	10,062,611
Investments Measured at Net Asset Value ^A				<u>1,907,850</u>
				<u>\$ 11,970,461</u>
	December 31, 2023			
	Level 1	Level 2	Level 3	Total
Short-Term Investment Fund	\$ 1,207,257	\$ -	\$ -	\$ 1,207,257
Mutual Funds	13,667,019	-	-	13,667,019
	<u>\$ 14,874,276</u>	<u>\$ -</u>	<u>\$ -</u>	14,874,276
Investments Measured at Net Asset Value ^A				<u>2,029,971</u>
				<u>\$ 16,904,247</u>

^A In accordance with ASC 820, investments measured at fair value using the net asset value per share (or its equivalent) as a practical expedient 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 amounts to the amounts presented in the statements of net assets available for benefits.

Level 1 investments include a short-term investment fund and mutual funds valued based on quoted prices in an active market.

The 103-12 investment entity is valued at net asset value; the unfunded commitments and significant terms of redemption are as follows:

	December 31, 2024 Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Goldentree Multi-Sector Fd Offshore	\$ 1,907,850	None	Quarterly	90 days

The investment strategy is to capture risk adjusted returns across a broad universe of performing credit instruments, focusing primarily on leveraged loans, high yield bonds and structured credit seeking to deliver attractive single digit net returns across market cycles.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

E. Investment Valuation and Income Recognition (Continued)

Purchases and sales of securities are reported on the trade date basis. Dividends are recorded on the ex-dividend date and interest income is recorded on the accrual basis. Net appreciation of investments includes gains and losses on investments bought and sold as well as held during the year.

F. Tax-Exempt Status

No provision for federal income tax is made. The Plan has received tax-exempt status from the federal government under Internal Revenue Code Section 501(c)(9). The Plan administrator believes the Plan is currently designed and being operated in compliance with the Internal Revenue Code.

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

G. Concentration of Credit Risk

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

H. Benefits and Benefit Obligations

Benefits are recorded when paid. The obligations for claims payable and claims incurred but not reported are an estimate of the cost to the Plan for claims incurred under the terms of the Plan at December 31, 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 in November and December which provides eligibility for the following January and February.

I. Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation was determined by actuaries and is the amount that results from applying actuarial assumptions to historical benefit cost data to estimate future annual incurred benefit 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 payment.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

I. Postretirement Benefits (Continued)

The significant actuarial assumptions and methods used at December 31, 2024 (2023) were: (a) Discount Rate: 5.5% (4.75%), (b) Postretirement Mortality Rates: Scale MP-2019 generational projection of the Pri-2012 Blue Collar table, (c) 100% retirement at age 70, and (d) Modified Projected Unit Credit actuarial cost method.

The health care cost trend rate and retiree contribution trend rate have a significant effect on the postretirement benefit obligations. A 1% increase in the health care cost trend rate would not increase the net postretirement benefit obligation as of December 31, 2024.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of postretirement benefit obligations.

J. Reclassification

Certain amounts reported in the December 31, 2023 financial statements have been reclassified to conform to the current year presentation. The reclassification had no effect on the previously reported net assets available for benefits.

K. Risks and Uncertainties

Plan investments are exposed to various risks such as interest rate, market fluctuations and credit risk. Some estimated values may differ from values that would have been used had a ready market existed for the investment. Due to the level of risk associated with investments and the level of uncertainty with respect to the changes in the value of investments, it is reasonably possible that changes in market values, interest rates or other factors in the near term could materially affect the amounts reported in the financial statements.

Benefit obligations are reported based on certain assumptions pertaining to health care inflation rates and participant demographics which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

NOTE 3 - HEALTH REIMBURSEMENT ACCOUNTS

Effective May 1, 2018, the Board of Trustees established a health reimbursement arrangement (HRA) for Medicare eligible retirees and their dependents. The participant HRA accounts are funded with trust assets in an amount equal to 50% of the monthly premium costs capped at a pre-determined maximum. Participant contributions are not permitted. At December 31, 2024 and 2023, the total health reimbursement account ("HRA") balances totaled approximately \$68,630 and \$38,195, respectively.

The balance of a participant's HRA account will be forfeited upon termination of the participant in the Plan. Forfeitures totaling \$0 and \$2,102 were processed for the years ended December 31, 2024 and 2023, respectively.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 4 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500

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

	<u>December 31, 2024</u>	<u>December 31, 2023</u>
Net Assets Available for Benefits Per the Financial Statements	\$ 23,607,677	\$ 21,606,205
Less: Plan's Total Benefit Obligations Other Than Postretirement Benefit Obligations	<u>(7,159,000)</u>	<u>(5,221,223)</u>
Net Assets Per the Form 5500	<u>\$ 16,448,677</u>	<u>\$ 16,384,982</u>

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

	<u>January 1, 2024 to December 31, 2024</u>
Net Benefits Per the Financial Statements	\$ 20,228,035
Add: Benefit Obligations Other Than Postretirement Benefit Obligations at December 31, 2024	7,159,000
Less: Benefit Obligations Other Than Postretirement Benefit Obligations at December 31, 2023	<u>(5,221,223)</u>
Total Benefits Per the Form 5500	<u>\$ 22,165,812</u>

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

NOTE 5 - PLAN TERMINATION

Although there has been no expressed intent to do so, the Plan may be terminated at any time by the Board of Trustees. The trust agreement shall be automatically terminated upon the expiration of all collective bargaining agreements and special agreements requiring the payments of contributions to the trust fund, provided that, for purposes of this provision, a collective bargaining agreement or special agreement shall not be deemed to have expired in a strike or lockout situation, unless said strike or lockout continues for more than six months.

Upon the termination of the trust agreement, any and all monies and assets remaining after payment of expenses shall be used for continuance of the benefits provided by the then-existing benefit plan until such monies and assets have been exhausted.

NOTE 6 - RELATED PARTY TRANSACTIONS

Labor Trust Services, Inc. was a participating employer in the Plan while providing services as its third-party administrator until January 1, 2024. Administration fees paid for the year ended December 31, 2023 was \$288,146.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 6 - RELATED PARTY TRANSACTIONS (Continued)

The Plan shares collection, employer compliance and other common expenses with the Alaska United Food and Commercial Workers Pension Trust. Costs are paid and allocated in accordance with agreements periodically approved by the Board of Trustees.

Certain Plan assets are managed by the custodian or an affiliate. Any purchases and sales of these investments are performed in the open market at fair value. Such transactions, while considered party-in-interest transactions under ERISA regulations, are permitted under the provisions of the Plan and are specifically exempt from the prohibitions of party-in-interest transactions under ERISA. These transactions qualify as party in interest transactions, which are exempt from the prohibited transaction rules of ERISA.

NOTE 7 - SUBSEQUENT EVENTS

Management has evaluated subsequent events through October 6, 2025, the date on which the financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosures in these financial statements.

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**

FORM 5500

SCHEDULE H - LINE 4i

E.I.N. 92-6003453; PLAN NO. 501

SUPPLEMENTAL SCHEDULES REQUIRED BY
THE DEPARTMENT OF LABOR



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

Board of Trustees
Alaska United Food and Commercial Workers
Health and Welfare Trust
12205 SW Tualatin Road, Suite 200
Tualatin, Oregon 97062

Members of the Board:

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of December 31, 2024 and reportable transactions for the year ended December 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the 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 generally accepted auditing standards.

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

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

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

Burbank, California

October 6, 2025

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 92-6003453; PLAN NO. 501
DECEMBER 31, 2024

<u>No of Shares</u>		<u>Fair Value</u>	<u>Cost</u>
	<u>Short-Term Investment Fund</u>		
296,536	First American Government Obligation Fund	\$ 296,536	\$ 296,536
	<u>Mutual Funds</u>		
23,777	Vanguard Total World Stock Index	\$ 988,877	\$ 750,959
796,495	Vanguard Short-Term Bond Ldx I	8,068,493	8,424,297
29,165	Vanguard Short-Term Infl Prot Sec Idx	708,705	734,503
	<u>TOTAL - MUTUAL FUNDS</u>	<u>\$ 9,766,075</u>	<u>\$ 9,909,759</u>
	<u>103-12 Investment Entity</u>		
826	Goldentree Multi-Sector Fd Offshore	\$ 1,907,850	\$ 1,499,113
	<u>TOTAL INVESTMENTS</u>	<u>\$ 11,970,461</u>	<u>\$ 11,705,408</u>

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
FORM 5500
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
E.I.N. 92-6003453; PLAN NO. 501
JANUARY 1, 2024 TO DECEMBER 31, 2024

Description of Asset	Interest Rate (%)	Maturity Date	Purchase Price	Selling Price	Cost of Asset	Net Gain or (Loss)
First American Government Obligation Fund	-	-	\$ 5,039,246 -	\$ - 5,950,000	\$ 5,039,246 5,950,000	\$ - -
Vanguard Short-Term Bond	-	-	354,631 -	- 3,250,000	354,631 3,378,167	- (128,167)
Vanguard Total World Stock Index	-	-	-	1,250,000	918,938	331,062

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. 1510-0110 1510-0089 <div style="text-align: center; font-size: 24pt; font-weight: bold;">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 <u>01/01/2024</u> and ending <u>12/31/2024</u>	
A This return/report is for: <input checked="" type="checkbox"/> a multi-employer plan	<input type="checkbox"/> a multiple-employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is:	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> the first return/report <input type="checkbox"/> an amended return/report
C If the plan is a collectively-bargained plan, check here <input checked="" type="checkbox"/>	<input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the final return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
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 ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">1b Three-digit plan number (PN) ▶</td> <td style="width:50%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">02/25/1965</td> </tr> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">92-6003453</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">503-486-2100</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">445110</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan	02/25/1965	2b Employer Identification Number (EIN)	92-6003453	2c Plan Sponsor's telephone number	503-486-2100	2d Business code (see instructions)	445110
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2b Employer Identification Number (EIN)	92-6003453										
2c Plan Sponsor's telephone number	503-486-2100										
2d Business code (see instructions)	445110										
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, ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST 12205 SW TUALATIN RD STE 200 TUALATIN, OR 97062											

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	<i>Silvana Tirban</i>	10-14-25	Silvana Tirban
	Signature of plan administrator trustee	Date	Enter name of individual signing as plan administrator trustee
SIGN HERE	<i>Brent R. Bohn</i>	10/11/25	Brent R. Bohn
	Signature of employer/plan sponsor trustee	Date	Enter name of individual signing as employer or plan sponsor trustee
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
FORM 5500
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
E.I.N. 92-6003453; PLAN NO. 501
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**ALASKA UNITED FOOD AND COMMERCIAL WORKERS
HEALTH AND WELFARE TRUST**
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 92-6003453; PLAN NO. 501
DECEMBER 31, 2024

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