

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

Part II	Basic Plan Information—enter all requested information
1a	Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 01/01/2011
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) OMNITRADE HEALTH TRUST PO BOX 6 MUKILTEO, WA 98275
2b	Employer Identification Number (EIN) 27-6838771
2c	Plan Sponsor's telephone number 425-771-7359
2d	Business code (see instructions) 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	JOHN SCATES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	JOHN SCATES
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN		
	3c Administrator's telephone number		
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN		
	4d PN		
5 Total number of participants at the beginning of the plan year	5	4411	
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) 4411	
	6a(2) 4294	6b	
	6c	6d 4294	
	6e	6f	
	6g(1)	6g(2)	
	6h		
	7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4Q 4T

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

a Pension Schedules

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

b General Schedules

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 10
- (4) ☒ **C** (Service Provider Information)
- (5) ☒ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code 158107704

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
DELTA DENTAL OF WASHINGTON

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0621480	47341	352 776 777 ETC	3520	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
0	0

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

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 ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	1819156
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
PREMERA BLUE CROSS

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0499247	47570	100000055	1273	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
0	0

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

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	10791151	
(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)	10791151	
b Benefit charges (1) Claims paid	9b(1)	10627385	
(2) Increase (decrease) in claim reserves	9b(2)	73222	
(3) Incurred claims (add (1) and (2))	9b(3)	10700607	
(4) Claims charged	9b(4)	10515523	
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)	1462376	
(E) Taxes	9c(1)(E)	232612	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)	1694988	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☒ credited.)	9c(2)	-1419360	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
(2) Claim reserves	9d(2)	856000	
(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	839472	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b		

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
PREMERA BLUE CROSS

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0499247	47570	100000021	1502	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
0	0

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	17562544	
(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)	17562544	
b Benefit charges (1) Claims paid	9b(1)	18418379	
(2) Increase (decrease) in claim reserves	9b(2)	1186002	
(3) Incurred claims (add (1) and (2))	9b(3)	19604381	
(4) Claims charged	9b(4)	18543350	
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)	1907922	
(E) Taxes	9c(1)(E)	372263	
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)	2280185	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☒ credited.)	9c(2)	-3260991	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
(2) Claim reserves	9d(2)	2400000	
(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	1050592	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b		

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-7089668	53031	12032443	2616	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
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	208359
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(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
01-0278678	62235	151567	2970	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
0	3523

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
ABD INSURANCE AND FINANCIAL SERVICE 777 MARINERS ISLAND BLVD, STE 250
SAN MATEO, CA 94404

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	3523	ADDITIONAL COMPENSATION	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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

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) ▶ **ACCIDENTAL DEATH & DISMEMBERMENT**

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 ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	361435
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(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
01-0278678	62235	151568	103	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
0	621

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
ABD INSURANCE AND FINANCIAL SERVICE 777 MARINERS ISLAND BLVD STE 250
SAN MATEO, CA 94404

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

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) ▶ **ACCIDENTAL DEATH & DISMEMBERMENT**

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 ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	35501
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan	B Three-digit plan number (PN)	501
OMNITRADE HEALTH TRUST ARRANGEMENT		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
OMNITRADE HEALTH TRUST	27-6838771	

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

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(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
01-0278678	62235	934370	87	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
0	282

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
ABD INSURANCE AND FINANCIAL SERVICE
777 MARINERS ISLAND BLVD STE 250
SAN MATEO, CA 94404

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	16140
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan	B Three-digit plan number (PN)	501
OMNITRADE HEALTH TRUST ARRANGEMENT		
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
OMNITRADE HEALTH TRUST	27-6838771	

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

(a) Name of insurance carrier
UNUM LIFE INSURANCE COMPANY OF AMERICA

(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
01-0278678	62235	934420	87	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
0	513

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
ABD INSURANCE AND FINANCIAL SERVICE
777 MARINERS ISLAND BLVD STE 250
SAN MATEO, CA 94404

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

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 ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	29310
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
MODA HEALTH

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0438772	47098	100000057-61	1982	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
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	15940177
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Insurance Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500. ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

(a) Name of insurance carrier
OREGON DENTAL SERVICE DBA DELTA DENTAL PLAN OF ALASKA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0438772	54941	100000057-61	1079	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
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

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

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

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

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 ☐ paid in cash, or ☐ credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	581418
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110
		2024
		This Form is Open to Public Inspection.
For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024		
A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

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

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

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

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

ABD INSURANCE & FINANCIAL SERVICES,

27-0673528

(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?
15 16 22 23 49 50 53 61 70	NONE	1596694	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VIMLY BENEFIT SOLUTIONS, INC

91-1603312

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 13 15 36 38 50 64	NONE	625169	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASSOCIATED INDUSTRIES MANAGEMENT SE

91-1485366

(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 13 15 36 38 50 64	NONE	461570	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

DIGITAL INSURANCE, LLC

58-2522668

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	312270	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ARMFIELD, HARRISON & THOMAS TECH

54-0654623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	259618	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ACRISURE LLC DBA RISQ CONSULTI

26-3554645

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	224096	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PARKER SMITH & FEEK INSURANCE, LLC

87-2544519

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	192118	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DAVIS WRIGHT TREMAINE, LLP

91-0839480

(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 29 50	NONE	153587	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALASKA EMPLOYEE BENEFITS, INC

71-0869170

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	130935	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ASSUREDPARTNERS OF WA DBA FORTUNE

45-2712335

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	113974	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

HUB INTERNATIONAL NORTHWEST, LLC

91-2036015

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	113542	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WILSON ALBERS AN ALERA GROUP AGENCY

82-3775054

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	113239	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PAYNEWEST INSURANCE, A MARSH & MCLE

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 50 53	NONE	99511	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

AURORA NATIONAL INSURANCE

82-1257465

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	88978	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JOHN B. SCATES

4565 FLYING GOAT AVE NE B240
BAINBRIDGE ISLAND, WA 98110

(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?
20 50	NONE	83078	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

GALLAGHER BENEFIT SERVICES

36-4291971

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	76584	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

B & F INSURANCE, LLC

35-2384961

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	71870	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MARSH USA, INC. DBA MARSH & MC

26-3237575

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	67556	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SPRAGUE ISRAEL GILES, INC.

91-0683304

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	64308	Yes ☐ No ☐	Yes ☐ No ☒	0	Yes ☐ No ☐

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

BTG AND ASSOCIATES DBA BTG BENEFITS

84-3131974

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	62579	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BELL-ANDERSON AGENCY, INC

91-0756278

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	53602	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

GREGORY A MYHRE

12931 STEPHENSON ST.
ANCHORAGE, AK 99515

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	50474	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BENEFIT DESIGN SERVICES, LLC

27-3460566

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	49896	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ACRISURE NW PARTNERS INSURANCE SERV

92-1242214

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	38708	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

SCHOEDEL & SCHOEDEL CPAS, PLLC

91-0614823

(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	38200	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEA-MOUNTAIN INSURANCE BROKERS

19630 76TH AVE W
LYNNWOOD, WA 98036

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	34257	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WESTLEY PRICE INSURANCE, LLC

87-4625895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	25962	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

MADDOCK & ASSOCIATES, LLC

83-2655931

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	25890	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PSG WASHINGTON, INC

20-2040193

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	25443	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WHITFIELDS DBA LEAVITT GROUP BEN

91-1366133

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	25075	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

WELLSPRING FAMILY SERVICES EAP

91-0567261

(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 14 50	NONE	22619	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

USI INSURANCE SERVICES NATIONAL

56-1882208

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	20589	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BENEFIT SOLUTIONS NORTHWEST LLC

84-4089157

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	20533	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

TRUEBENEFITS, LLC

91-2034415

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	19974	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DAVE TUTTLE INSURANCE, INC

1764 W LAKE LUCILLE DR
WASILLA, AK 99654

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	19146	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TERRIL LEWIS & WILKE INSURANCE

91-1137671

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	15549	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

BENEFIT CONSULTING SERVICES, LLC

PO BOX 2088
ISSAQUAH, WA 98027-0093

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	14282	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NICHOLSON & ASSOCIATES INSURANCE

91-1991902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	13581	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CUMMINGS, FRASER, & ASSOCIATES, LLC

68-0609841

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	13472	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ALLIANT INSURANCE SERVICES, INC

33-0785439

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12758	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MITCHELL REED & SCHMITTEN INSURANCE

91-1745509

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12610	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KIBBLE & PRENTICE HOLDING CO DBA US

91-1176315

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12320	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

LOCKTON COMPANIES

20-3354970

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	11512	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WALTERS & ASSOCIATES INSURANCE, INC

92-0084414

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	10825	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

R.L. EVANS COMPANY, INC.

91-0849754

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	10614	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

PILKEY-HOPPING & EKBERG, INC.

91-1050022

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	10343	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INSURANCE OFFICE OF AMERICA, INC.

59-2472656

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	9792	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

IMPACT CG, LLC

87-2379951

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	9057	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

STEVENSON INSURANCE AGENCY, LLC

88-1229056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	8397	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASSUREDPARTNERS OF WA, LLC DBA RGIA

38-2942963

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	8289	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DUNCAN & ASSOCIATES INSURANCE BROKE

91-1577971

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	7271	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

COORDINATED BENEFITS - THE SIMMONS

27-1158624

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	6785	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PCF INSURANCE OF THE WEST, LLC

82-1368960

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	6428	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALASKA BENEFITS - PATRICIA IRENE MA

PO BOX 221148
ANCHORAGE, AK 99522

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	6293	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

CLG EMPLOYER RESOURCES

27-4743785

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	5903	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions) (complete as many entries as needed)	
a Name: SCHOEDEL & SCHOEDEL, CPAS, PLLC	b EIN: 91-0614823
c Position: AUDITOR	
d Address: 422 W RIVERSIDE AVE, SUITE 1420 SPOKANE, WA 99201-0395	e Telephone: 509-747-2158

Explanation: [A NEW AUDITOR WAS SELECTED BY THE TRUSTEES AS A RESULT OF THE PRIOR AUDITOR ISSUING A NOTICE OF DISCONTINUATION OF SERVICES.](#)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	907 ELECTRIC INC.	c EIN-PN 82-5095105-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	A&A ROOFING	c EIN-PN 92-0032279-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	A1 SAFETY TREE SERVICE, INC.	c EIN-PN 83-2884680-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	A-ALPHA BIO	c EIN-PN 82-3070666-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ABACUS BIOSCIENCE	c EIN-PN 81-0544756-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ACE ACADEMY	c EIN-PN 81-2983424-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ACH HOMES, LLC	c EIN-PN 45-3578432-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AD LIGHTNING, INC.	c EIN-PN 81-2569597-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ADVANCED CELLULAR DYNAMICS, INC.	c EIN-PN 83-1611949-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AGLIETTI OFFRET & WOOFER LLC	c EIN-PN 82-5130244-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AK LEASING, INC.	c EIN-PN 26-4818914-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AK RADIATION ONCOLOGY SPECIALISTS INC	c EIN-PN 20-3533934-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA BILLING SERVICES	c EIN-PN 92-0166134-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA CENTER FOR PEDIATRICS	c EIN-PN 92-0132089-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA COMMERCIAL DEVELOPMENT GROUP	c EIN-PN 91-1925050-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA COMMERCIAL FISHING & AGRICULTURE BANK	c EIN-PN 92-0073648-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA EXECUTIVE SEARCH INC	c EIN-PN 92-0081458-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA FUEL SERVICES LLC	c EIN-PN 36-4782074-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA PERMANENT CAPITAL MGMT CO	c EIN-PN 92-0139234-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SHOULDER & ORTHOPAEDIC INSTITUTE	c EIN-PN 85-0738158-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SPCA	c EIN-PN 92-0068910-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SPRING & PERFORMANCE INC	c EIN-PN 26-2659231-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA WOMENS CANCER CARE	c EIN-PN 80-0722946-501
a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALL AMERICAN OILFIELD LLC	c EIN-PN 47-2629914-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ALL PRO ALASKA
c	EIN-PN	92-0170261-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ALLIANCE PARTITION SYSTEMS
c	EIN-PN	80-0516178-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ALSC ARCHITECTS, P.S.
c	EIN-PN	91-0890436-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ALUTIIQ HERITAGE FOUNDATION
c	EIN-PN	92-0150422-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	AMERICAN PLUMBING CONTRACTORS, INC.
c	EIN-PN	20-3952179-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	AMPED ELECTRIC INC
c	EIN-PN	20-5131487-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ANCHORAGE BARIATRICS LLC
c	EIN-PN	81-1634305-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ANCHORAGE COMMUNITY DEV AUTHORITY
c	EIN-PN	92-0102697-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ANCHORAGE DOWNTOWN PARTNERSHIP
c	EIN-PN	92-0157658-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ANCHORAGE HOME BUILDERS ASSOCIATION
c	EIN-PN	51-0173290-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ANCHORAGE PRINTING INC
c	EIN-PN	92-0085472-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	APEX CUSTOM BUILDERS, LLC
c	EIN-PN	84-3849572-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ARCHON BIOSCIENCES	c EIN-PN 92-1879724-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ARCTIC FOUNDATIONS INC.	c EIN-PN 92-0044919-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ARCTIV DESIGN MECHANICAL, LLC	c EIN-PN 99-1344745-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ARETE FAMILY CARE LLC	c EIN-PN 86-3599685-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ARSENAL ENTERPRISES, INC.	c EIN-PN 91-1783009-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ART PRIMO	c EIN-PN 20-5166073-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ASSET ROOFING COMPANY, LLC	c EIN-PN 91-1953703-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ATHIRA PHARMA, INC.	c EIN-PN 45-3368487-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ATOSSA THERAPEUTICS, INC.	c EIN-PN 26-4753208-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ATR INC DBA CHENA VETERINARY CLINIC	c EIN-PN 80-0786059-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AURORA ANIMAL CARE INC	c EIN-PN 45-3593880-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AURORA LAUNCH SERVICES	c EIN-PN 82-3393700-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AVALYN PHARMA, INC.	c EIN-PN 45-2463191-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AVM BIOTECHNOLOGY, INC.	c EIN-PN 92-1634578-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	AXIS ARCHITECTURE + DESIGN	c EIN-PN 94-3410939-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	B&C TRUCKING, INC.	c EIN-PN 91-1818925-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	B. THOMPSON COMPANY, LLC	c EIN-PN 93-0717301-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BAIR CONSTRUCTION, INC.	c EIN-PN 91-1603978-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BAKER EXCAVATING LLC	c EIN-PN 83-3668132-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BALUSTER DISCOVERY, LLC	c EIN-PN 20-8034690-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BANYAN, LLC	c EIN-PN 20-1552040-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BARTOW ASSOCIATES INC	c EIN-PN 92-0161790-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BATTGENIE, INC.	c EIN-PN 82-3541103-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BC EXCAVATING	c EIN-PN 27-1432653-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BEADEDSTREAM INC.
c	EIN-PN	87-0804934-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BERHOLZ & GRAHAM T & C
c	EIN-PN	91-1821502-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BHAG LLC DBA FLORCRAFT CARPET ONE
c	EIN-PN	46-4180422-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BICKNELL INC
c	EIN-PN	92-0139552-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BIRCHWOOD RECREATION & SHOOTING PARK
c	EIN-PN	92-6004399-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BLACK GALLINA CONSULTING, LLC
c	EIN-PN	83-1364343-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BLACKTHORNE CONSULTING, LLC
c	EIN-PN	84-4397401-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BLAZE BIOSCIENCE INC.
c	EIN-PN	27-4410926-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BLAZY CONSTRUCTION INC
c	EIN-PN	71-0920220-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BONUM THERAPEUTICS, INC.
c	EIN-PN	87-2883314-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BOYNTON OFFICE SYSTEMS
c	EIN-PN	92-0162313-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	BRAINSPACE, INC.
c	EIN-PN	86-1755179-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BROADWAY ALASKA ENTERPRISE	c EIN-PN 92-0170093-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BROOKS HOMES INC	c EIN-PN 91-1642433-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BROWN'S ELECTRICAL SUPPLY INC	c EIN-PN 92-0074068-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BRUMBAUGH & ASSOCIATES, LLC	c EIN-PN 91-1379387-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BRUNO INVESTMENTS	c EIN-PN 84-2804578-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BUILDING TRANSPARENCY	c EIN-PN 84-2727715-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	BULL TROUT, LLC	c EIN-PN 84-3105300-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	C&T FIRE PROTECTION INC.	c EIN-PN 47-1314262-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CALICO ENERGY SERVICES	c EIN-PN 27-1606271-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CARUS CRUISE, INC.	c EIN-PN 61-1754040-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CASCADE LUMBER, INC.	c EIN-PN 91-1276475-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CASCADIA DRUG DEVELOPMENT GROUP	c EIN-PN 81-4588886-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CLEAN ENERGY TRANSITION INSTITUTE	c EIN-PN 83-0644369-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CLOUDENGAGE	c EIN-PN 46-3505425-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CODE FELLOWS HOLDINGS, INC.	c EIN-PN 81-3249617-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COLD SPOT FEEDS, INC.	c EIN-PN 87-0803237-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COMMERCIAL CONTRACTORS INC.	c EIN-PN 92-0035013-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COMMERCIAL SALES, INC.	c EIN-PN 91-1295353-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COMMUNITY SERVICES OF MOSES LAKE, INC.	c EIN-PN 91-0664984-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CONSOLIDATED CONTRACTING AND ENGINEERING	c EIN-PN 45-2801311-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CONTANGO ORE	c EIN-PN 27-3431051-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COPACINO + FUJIKADO, LLC	c EIN-PN 91-1875614-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	COPPER RIVER AUTO PARTS DBA NAPA	c EIN-PN 81-2587938-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CORVUS DESIGN INC	c EIN-PN 26-2906074-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CROSSROADS COUNSELING AND TRAINING SERVICES	c EIN-PN 92-0159057-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CULTIVAR FARMS	c EIN-PN 47-2107654-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	CYCLONE SERVICES, LLC	c EIN-PN 84-2260064-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DC 907 DIESELS INC	c EIN-PN 81-4794300-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DELIGHT LABS	c EIN-PN 45-4039339-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DENALI CONCRETE INC	c EIN-PN 92-0167703-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DEVERRA THERAPUTICS	c EIN-PN 47-5261773-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DIRECTAMS	c EIN-PN 20-1178470-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DJOULE, LLC	c EIN-PN 83-1101973-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DKS, INC.	c EIN-PN 91-1161010-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DOGWOOD INDUSTRIES	c EIN-PN 74-3038275-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	DOOR SYSTEMS OF ALASKA INC	c EIN-PN 92-0173130-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	DURA-SHINE CLEAN
c	EIN-PN	27-0502696-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	DYNAMIC METALS, INC.
c	EIN-PN	81-0881602-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	E8
c	EIN-PN	26-0796304-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	EARTH SOLUTIONS NORTHWEST, LLC
c	EIN-PN	32-0139742-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ECELLIX, INC.
c	EIN-PN	82-4187096-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ELEVATED ACOUSTICS, LLC
c	EIN-PN	84-3975044-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	EMULATE THERAPEUTICS
c	EIN-PN	91-2174500-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ENCORE ELECTRIC LLC
c	EIN-PN	46-4176438-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ENERGY WEST
c	EIN-PN	88-3907838-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ENVIRONMENTAL HEALTH SCIENCES ALASKA INC
c	EIN-PN	92-0120819-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	EP ROOFING INC
c	EIN-PN	20-8817906-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	EVERGREEN RENEWABLES, INC.
c	EIN-PN	87-3323912-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	EVERY DOOR HOME SERVICES, LLC	c EIN-PN 88-2214101-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	EXSELON	c EIN-PN 20-5848284-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	F & F FOUNDATIONS, INC.	c EIN-PN 91-1618351-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FAIRBANKS PET MEMORIAL SERVICES LLC	c EIN-PN 88-2104796-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FAR NORTH GEN SURGERY & SURGICAL ONCOLOGY	c EIN-PN 46-5203728-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FARWEST FABRICATION	c EIN-PN 91-1593253-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FARWEST PAINT MANUFACTURING CO.	c EIN-PN 91-0216910-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FELIX GOLD ALASKA OPERATIONS INC	c EIN-PN 88-0877412-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FICKLIN CONSTRUCTION LLC	c EIN-PN 45-4583041-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FINPILOT INC.	c EIN-PN 92-3590522-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FIRE & FLOOD SERVICES INC.	c EIN-PN 82-0563359-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FIRST RATE FINANCIAL LLC	c EIN-PN 20-3009026-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FISCHER BROS EXCAVATION LLC	c EIN-PN 75-3145378-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FLATTOP ROOFING & CONSTRUCTION, INC.	c EIN-PN 80-0885169-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FLEXCHARGING	c EIN-PN 82-1989536-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FOX ENERGY SERVICES LLC	c EIN-PN 85-3046539-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FOX ISLAND MUTUAL WATER ASSOC	c EIN-PN 91-1031720-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FOX TIRE SERVICE LLC DBA AK TIRE & RIM	c EIN-PN 20-5628296-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FR BELL & ASSOCIATES INC	c EIN-PN 92-0128211-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FRIEND CONTRACTORS	c EIN-PN 92-0141813-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	FUNL TECHNOLOGIES, INC.	c EIN-PN 85-2290939-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GAGE TREE SERVICE	c EIN-PN 61-1212258-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GAPPS	c EIN-PN 81-4625437-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GEMATEG	c EIN-PN 83-1795906-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GENERAL BUILDERS SUPPLY, INC.	c EIN-PN 91-1196010-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GENESIS ADVANCED TECHNOLOGIES	c EIN-PN 13-4205465-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GLYPH LANGUAGE SERVICES	c EIN-PN 73-1630914-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GRANGER PAINTING, LLC	c EIN-PN 45-0606450-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GRANITE CITY ALASKA INC	c EIN-PN 20-3518674-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GRAYLING CONSTRUCTION	c EIN-PN 91-1841964-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GREAT ALASKAN HOLIDAYS INC	c EIN-PN 92-0165766-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GREATER FAIRBANKS CHAMBER OF COMMERCE	c EIN-PN 92-0006532-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GREER TANK INC	c EIN-PN 92-0041673-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	GRITTON BUILDING CO., INC.	c EIN-PN 45-5135092-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	H2O 2U LLC	c EIN-PN 06-1784743-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HAPPY POTATO INC.	c EIN-PN 93-4536160-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HAPPY SKEETER INC DBA B&J SPORTING GOODS	c EIN-PN 83-2770812-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HAPPY TAILS INC MIDNIGHT SUN ANIMAL HOSP	c EIN-PN 27-3044674-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HARRIS SAND & GRAVEL INC	c EIN-PN 92-0056819-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HASCO INC	c EIN-PN 92-0020430-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HEADSET, INC.	c EIN-PN 47-4361329-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HEARTLAND, LLC	c EIN-PN 91-1876752-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HINKLE PROPERTIES	c EIN-PN 91-1759781-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HISTONE THERAPEUTICS CORP	c EIN-PN 86-3543907-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOCHSTATTER ELECTRIC, INC.	c EIN-PN 91-1004291-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOGBACK DEVELOPMENT COMPANY	c EIN-PN 46-4807555-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOMER SCIENTIFIC HOLDINGS, INC.	c EIN-PN 83-0634981-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOTROCK ENERGY RESEARCH ORGANIZATION	c EIN-PN 47-3849152-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOUSEAMP, INC.	c EIN-PN 83-4556628-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HOYLU, INC.	c EIN-PN 81-4444699-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	HULTQUIST HOMES INC	c EIN-PN 92-0167090-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	IGNYTE BIO	c EIN-PN 87-3594710-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	IMAGINOMIX, LLC	c EIN-PN 82-4558990-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	IMPACT BIOENERGY, INC.	c EIN-PN 46-4310848-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	IMPORT AUTO BODY DBA COLLISION MASTERS	c EIN-PN 92-0127484-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	IMPORTERS FORWARDING	c EIN-PN 91-1169518-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	INFINITE HEATING & COOLING, LLC	c EIN-PN 47-5520506-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	INTELLIGENT ENERGY SYSTEMS	c EIN-PN 26-0684716-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	INTERIOR AIDS ASSOCIATION	c EIN-PN 92-0127274-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	INTERIOR EXCAVATING & TRUCKING INC.	c EIN-PN 92-0163995-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	INTERIOR REGION EMS COUNCIL INC
c	EIN-PN	92-0072567-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	INTERIOR WEATHERIZATION INC
c	EIN-PN	92-0112206-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	INTERSTATE SAWING & DRILLING, LLC
c	EIN-PN	26-4815020-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JEEVA ACQUISITION COMPANY, INC.
c	EIN-PN	93-3398116-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JERMAIN DUNNAGAN & OWENS PC
c	EIN-PN	92-0116216-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JOON CARE MEDICAL CORPORATION
c	EIN-PN	87-0929469-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JOSEPH MIRCI DMD DBA PENINSULA FAMILY DENTAL
c	EIN-PN	93-1557973-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JR TRANSPORTATION, INC.
c	EIN-PN	47-1825274-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	J-S CONTRACTING, INC.
c	EIN-PN	91-1683839-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	JSA CIVIL, LLC
c	EIN-PN	87-1588415-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	KAZIA THERAPEUTICS
c	EIN-PN	80-0911755-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	KCL EXCAVATING, INC.
c	EIN-PN	81-2004766-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KELLEY & CANTERBURY LLC	c EIN-PN 92-0159079-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KINTER ELECTRIC, INC.	c EIN-PN 46-0506111-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KODIAK REGIONAL AQUACULTURE ASSOC	c EIN-PN 91-0115279-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KONE CONSULTING, LLC	c EIN-PN 27-2877213-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KRAUTSCHEID FARM CONSULTING, LLC	c EIN-PN 20-1911941-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KUBOTA VISION, INC.	c EIN-PN 81-3239491-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	KYOTO FUSIONEERING AMERICA	c EIN-PN 92-0458353-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LABELS & LISTS, INC.	c EIN-PN 91-1319158-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LANDTEK ENTERPRISES, INC.	c EIN-PN 68-0617724-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LANKTREE LAND SURVEYING, INC.	c EIN-PN 45-5446952-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LAST FRONTIER MOTOR SPORTS DBA THE OUTPOST	c EIN-PN 92-0172630-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LIFE SCIENCE WASHINGTON	c EIN-PN 91-1453398-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LODESTAR MARKETING GROUP	c EIN-PN 26-0809006-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LOKEN CONSTRUCTION LLC	c EIN-PN 48-1305701-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LOWE CONSULTING, INC.	c EIN-PN 81-0957677-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LUMEN BIOSCIENCE, INC.	c EIN-PN 82-0810906-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	LYSSN.IO, INC.	c EIN-PN 83-3320512-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	M&M CONSTRUCTORS	c EIN-PN 83-0611888-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	M2C1 INTERNATIONAL LLC	c EIN-PN 16-1643155-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MADSEN ROOFING, INC.	c EIN-PN 91-1179844-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAGNA LLC	c EIN-PN 81-1199831-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAGTEC ALASKA LLC	c EIN-PN 26-2423630-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAIN EVENT SERVICES LLC	c EIN-PN 81-4371112-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAIN LINE, INC.	c EIN-PN 91-1680271-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MALARVX, INC.	c EIN-PN 45-5021055-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MALSAM TSANG ENGINEERING CORP.	c EIN-PN 20-4308875-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MARINE EXCHANGE OF ALASKA	c EIN-PN 92-0173630-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MARKOS INC.	c EIN-PN 99-3788234-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MARTIN ENGINEERING INC	c EIN-PN 54-2164523-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAXIMAL LEARNING, INC.	c EIN-PN 60-5208813-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MAXVAX BIOTECHNOLOGY	c EIN-PN 88-2376159-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MCKENNA BROTHERS PAVING INC	c EIN-PN 91-1828761-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MECHANICAL SPECIALISTS INC	c EIN-PN 43-1978111-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MERIDIAN MANAGEMENT INC.	c EIN-PN 92-0165158-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MERIDIAN SYSTEMS INC.	c EIN-PN 27-1583554-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	METAL EMPIRE MANUFACTURING	c EIN-PN 82-5511704-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MH ELECTRIC, INC.
c	EIN-PN	20-2381114-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MICHELSON & DAUGHTER CONSTRUCTION INC.
c	EIN-PN	92-0141583-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MICRO X
c	EIN-PN	85-3754901-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MILLS GENERAL, LLC
c	EIN-PN	82-1959404-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MODELREMODEL LLC
c	EIN-PN	02-0673639-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MONOD BIO
c	EIN-PN	86-2512911-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MONOLITHIC POWER SYSTEMS
c	EIN-PN	91-2109960-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MONTEGO, LLC
c	EIN-PN	20-3957634-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MONTYCLOUD, INC.
c	EIN-PN	82-5212662-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MORAIR MEDTECH, LLC
c	EIN-PN	84-1779484-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MORRIS THOMPSON CULTURAL VISITORS CENTER
c	EIN-PN	20-1113317-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	MOSEIAN FARMS OF ALASKA INC.
c	EIN-PN	92-0081726-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MOTORCYCLE TIMES INC.	c EIN-PN 92-0098392-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MPH HOLDINGS, LLC	c EIN-PN 52-2370470-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	MRT INC DBA SIGNATURE LAND SERVICES	c EIN-PN 92-0146992-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NATIONAL BUREAU OF ASIAN RESEARCH	c EIN-PN 91-1444105-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NATIONAL METERING & TECHNICAL SERVICES, LLC	c EIN-PN 27-2390637-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NEIGHBORS CONSTRUCTION	c EIN-PN 20-5017408-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NEPPEL ELECTRICAL & CONTROLS, LLC	c EIN-PN 91-2109585-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NETACQUIRE CORPORATION	c EIN-PN 91-1596849-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NEW COURSE	c EIN-PN 27-1971697-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NEWTON PARK, LLC	c EIN-PN 81-3433355-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NEWWAY FORMING, INC.	c EIN-PN 91-1466789-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NORI LLC	c EIN-PN 82-3777492-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NORTHERN ECONOMICS INC	c EIN-PN 92-0162195-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NORTHERN LIGHTS DEVELOPMENT INC	c EIN-PN 92-0144640-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NORTHSTAR SUPPLY LLC	c EIN-PN 82-0959561-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NORTHWEST HEAVY DUTY	c EIN-PN 47-4045863-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NT TECHNOLOGY, INC.	c EIN-PN 25-1814342-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	NW CUTTING-EDGE MASONRY	c EIN-PN 47-5221638-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	O'BUNCO ENGINEERING, INC.	c EIN-PN 91-2048486-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OCO LLC	c EIN-PN 81-4780656-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ODB HOLDINGS LLC	c EIN-PN 85-4257653-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OLYMPIC MOUNTAIN PRODUCTS	c EIN-PN 91-1073888-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OMNI ELECTRIC GROUP LLC	c EIN-PN 86-1920823-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ONTRADE INC	c EIN-PN 99-1967926-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ORCA WAVE. LLC	c EIN-PN 91-2173724-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ORGANIZED VILLAGE OF KASAAN	c EIN-PN 92-0119632-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ORUTSARARMIUT TRADITIONAL NATIVE COUNCIL	c EIN-PN 92-0074128-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OSG DOZING, INC.	c EIN-PN 56-2433453-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OSSENKOP ENTERPRISES	c EIN-PN 92-0082769-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OTTO TRIP, INC.	c EIN-PN 99-2376412-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OUTPACE BIO, INC.	c EIN-PN 85-3122776-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	OVERLAND AI, INC.	c EIN-PN 88-4401693-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PACIFIC AIR CONTROL, INC.	c EIN-PN 91-0987825-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PACIFIC PROPANE NW, LLC	c EIN-PN 86-3620734-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PAUG VIK INC LTD	c EIN-PN 92-0047081-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PEAK HEALTH DENTISTRY LLC	c EIN-PN 47-1184326-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PHASE 3 ELECTRIC, LLC	c EIN-PN 85-0948421-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PHINNEY BISCHOFF	c EIN-PN 91-1267748-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PIERCE CARTWRIGHT COMPANY INC.	c EIN-PN 92-0081444-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PINNACLE PLUMBING & HEATING	c EIN-PN 20-0678939-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PIONEER DOOR INC	c EIN-PN 92-0099939-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PLANTED MATERIALS, INC.	c EIN-PN 92-0784614-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PLURISTYX	c EIN-PN 81-5381269-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	POLLARD WIRELINE INC	c EIN-PN 92-0170650-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	POMRANING EXCAVATION LLC	c EIN-PN 26-4752670-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	POWER DISTRIBUTING	c EIN-PN 91-0922570-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	POWER FIX LLC	c EIN-PN 81-4659806-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PRECISION IMAGE ANALYSIS	c EIN-PN 46-1048686-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PRECLINICAL GPS	c EIN-PN 06-7665113-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PRESAGE BIOSCIENCES	c EIN-PN 26-3690569-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PRICE FORD, INC.	c EIN-PN 91-1699072-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PRO ELECTRICAL SVCS	c EIN-PN 47-5117385-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PROBUILD CONSTRUCTION LLC	c EIN-PN 84-1901576-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PROJECT MANAGEMENT CONSULTING & ASSOC.	c EIN-PN 46-1286491-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	PUGET SOUND QUALITY SPECIALIST, INC.	c EIN-PN 27-3037553-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	QUALITY CONTROLS INC	c EIN-PN 26-1335541-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	QUESTIVA.COM INC.	c EIN-PN 91-1880371-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	R & T HOOD AND DUCT SERVICES	c EIN-PN 88-0802621-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	R. MUNN FARMS, LLC	c EIN-PN 91-1720199-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RADICAL INC.	c EIN-PN 88-3174460-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RADIOLOGY CONSULTANTS	c EIN-PN 92-0037168-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RARECYTE, INC.	c EIN-PN 27-0860840-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RC ENTERPRISES INC	c EIN-PN 92-0156805-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RECON LLC	c EIN-PN 75-3090858-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	REDLINE SERVICES GROUP	c EIN-PN 82-2691274-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	REDPOINT, INC.	c EIN-PN 36-5042504-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	REED TRUCKING & EXCAVATING, INC.	c EIN-PN 91-1938552-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	REMOTE ALASKA SOLUTIONS INC	c EIN-PN 45-4509607-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RENT A CAN TOILET CO INC	c EIN-PN 92-0093054-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	REPAIRING ALASKA LLC	c EIN-PN 82-3324420-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	RESA LLC DBA THE MOSQUITO AUTHORITY	c EIN-PN 46-2239300-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	ROBINSON & WARD PC	c EIN-PN 92-0176403-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	RODARTE CONSTRUCTION, INC.
c	EIN-PN	91-1016627-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ROLLUDA ARCHITECTS, INC.
c	EIN-PN	45-0487361-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ROY BRILEY INC
c	EIN-PN	27-1583554-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	RURAL ENERGY ENTERPRISES
c	EIN-PN	92-0130133-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	RUSTAIR INC
c	EIN-PN	92-0132311-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	RUSTY BRADEEN TRUCKING, INC.
c	EIN-PN	91-1609115-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	RYAN SNIDER PAINTLESS DENT REPAIR, LLC
c	EIN-PN	71-1008413-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	S&P CERTIFIED CAR CARE
c	EIN-PN	26-2527087-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	S.W. FRANCK LLC
c	EIN-PN	33-2236669-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SAGE & STONE, LLC
c	EIN-PN	47-4354810-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SANCTUART II ALH
c	EIN-PN	20-8157991-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SCOOP TROOP, LLC
c	EIN-PN	85-2929777-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEALEVEL PROPERTIES	c EIN-PN 45-3578432-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEAPRO	c EIN-PN 92-0139334-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEATTLE CONSTRUCTION RESOURCES	c EIN-PN 91-1452233-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEATTLE GALVANIZING	c EIN-PN 20-2875388-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEATTLE SHOWER DOOR LLC	c EIN-PN 83-2279632-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEAVIEW COMMUNITY SERVICES	c EIN-PN 92-0043803-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEGAL RANCH, LLC	c EIN-PN 20-2573221-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEI NW GREEN, LLC	c EIN-PN 93-4914246-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SEINERGY	c EIN-PN 46-1456684-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SELKIRK PHARMA, INC.	c EIN-PN 82-0831982-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SHARC ENERGY	c EIN-PN 32-0676410-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SHIFLETT'S, INC.	c EIN-PN 91-0957388-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SINARD AUTOMOTIVE INC
c	EIN-PN	47-0851783-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SINGLETTO, INC.
c	EIN-PN	85-2799793-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SLABJACK NW LLC
c	EIN-PN	20-5050153-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SM STEMPER ARCHITECTS
c	EIN-PN	91-2005611-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SMILE BREAK
c	EIN-PN	99-3332706-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SMULTEA ENVIRONMENT SCIENCE
c	EIN-PN	27-1661548-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SNAPLINC CONSULTING, LLC
c	EIN-PN	82-4612620-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SNBL USA
c	EIN-PN	54-1595945-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SOUND PHARMACEUTICALS, INC.
c	EIN-PN	91-2135919-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SPALDING DENTAL LLC
c	EIN-PN	46-2447195-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SPANNERWERKS, LLC
c	EIN-PN	47-4303808-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	SPECIALTY IMPORTS INC
c	EIN-PN	92-0074411-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SPECTER OPS, INC.	c EIN-PN 81-5433354-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SPERNAK & SON LLC	c EIN-PN 47-3732688-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SPINELL HOMES INC.	c EIN-PN 92-0120043-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SPOKANE REGIONAL BROADBAND DEVELOPMENT AUTHORITY BROADLINC	c EIN-PN 92-2660984-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	STAR EQUITY MANAGEMENT, LLC	c EIN-PN 45-0492821-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	STARFISH NEUROSCIENCE, INC.	c EIN-PN 87-2081594-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	STATELY CLOUD, INC.	c EIN-PN 93-2572996-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	STERIFIRE MEDICAL, INC.	c EIN-PN 46-2546677-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SUMMIT WINDOWS & DOORS, INC.	c EIN-PN 92-0133038-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SUPER SMASH TRASH BROS.	c EIN-PN 86-3508135-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SYNTHESIZE BIO, INC.	c EIN-PN 93-2744178-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SYSTEMS INTERFACE, INC.	c EIN-PN 91-1271056-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	SYSTIMMUNE, INC.	c EIN-PN 46-5743763-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TAGBOARD INC.	c EIN-PN 45-2545444-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TEAM ROOFING NORTHWEST, LLC	c EIN-PN 84-4396097-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TEKNOLOGIZE, LLC	c EIN-PN 45-2967757-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TEKTONIC AI, INC.	c EIN-PN 93-3025463-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TERRACLEAR INC	c EIN-PN 82-3691924-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TERRAVISTA NW, LLC	c EIN-PN 47-4216346-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TERSULI CONSTRUCTION	c EIN-PN 26-4835842-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	TETHER, INC.	c EIN-PN 26-2265778-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	THE METALSMITHS, INC.	c EIN-PN 91-0958362-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	THE PRATOR ORGANIZATION LLC	c EIN-PN 83-2774931-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT	
b	Name of plan sponsor	THE SAMSON HARDWARE COMPANY	c EIN-PN 92-0279122-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	THINK OFFICE LLC
c	EIN-PN	27-0474541-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TOM M SIMS INCORPORATED
c	EIN-PN	93-4334017-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TOOL & TRADE CONSTRUCTION
c	EIN-PN	84-4110387-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TOP POD, INC.
c	EIN-PN	47-2906228-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TRANSITION COMPOSITES ENGINEERING, INC.
c	EIN-PN	26-1752683-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TRAPPERS CREEK INC
c	EIN-PN	92-0124989-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TREINEN ASSOCIATES, INC.
c	EIN-PN	91-2180560-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TRUE BLUE ROOFING, LLC
c	EIN-PN	85-1238832-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TSCM LLC
c	EIN-PN	46-4283059-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TSIGONIS COMPANIES INC
c	EIN-PN	92-0170506-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TTT ENVIRONMENTAL LLC
c	EIN-PN	71-0939336-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TWIGS GIFTS INC.
c	EIN-PN	82-3635911-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)		
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)		
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	TWO RAVENS, LLC
c	EIN-PN	92-2756445-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	ULTRABAC SOFTWARE
c	EIN-PN	91-1178250-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	UMV LLC
c	EIN-PN	20-8896315-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	VALLEY PAINT CENTER INC
c	EIN-PN	92-0176332-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	VAN BELLE EXCAVATING, LLC
c	EIN-PN	27-0720919-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	VEGA CLOUD, INC.
c	EIN-PN	83-2611695-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	VIOLETT
c	EIN-PN	85-3808849-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	WALLNER EXCAVATION
c	EIN-PN	92-0153624-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	WAMARITIME LLC
c	EIN-PN	93-2885038-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	WAYFINDER BIOSCIENCES, INC.
c	EIN-PN	86-1515703-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	WESTERN ENTERPRISES INC
c	EIN-PN	92-0041695-501
a	Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT
b	Name of plan sponsor	WILLOW PHYSICAL THERAPY LTD
c	EIN-PN	92-0143841-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name OMNITRADE HEALTH TRUST ARRANGEMENT**b** Name of plan sponsor WITHROW CONSTRUCTION**c** EIN-PN 91-1407077-501**a** Plan name OMNITRADE HEALTH TRUST ARRANGEMENT**b** Name of plan sponsor Y & B POSTAL COMPANY INC.**c** EIN-PN 34-2059386-501**a** Plan name OMNITRADE HEALTH TRUST ARRANGEMENT**b** Name of plan sponsor YOR LABS, INC.**c** EIN-PN 81-2647569-501**a** Plan name OMNITRADE HEALTH TRUST ARRANGEMENT**b** Name of plan sponsor ZAP ENERGY, INC.**c** EIN-PN 82-1706466-501**a** Plan name OMNITRADE HEALTH TRUST ARRANGEMENT**b** Name of plan sponsor ZILA BIOWORKS, SPC**c** EIN-PN 86-2177088-501**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN

SCHEDULE H (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
	For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
	A Name of plan OMNITRADE HEALTH TRUST ARRANGEMENT	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 OMNITRADE HEALTH TRUST	D Employer Identification Number (EIN) 27-6838771	

Part I	Asset and Liability Statement		
1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.			
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1091122	1143346
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	57068	95935
(2) Participant contributions.....	1b(2)	11725	1728
(3) Other	1b(3)	1043	8490
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	255318	256591
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	1416276	1506090
Liabilities			
g Benefit claims payable	1g	200862	156348
h Operating payables	1h	170194	173655
i Acquisition indebtedness	1i		
j Other liabilities	1j	675616	652215
k Total liabilities (add all amounts in lines 1g through 1j)	1k	1046672	982218
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	369604	523872

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)	54236030	
(B) Participants	2a(1)(B)	458814	
(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)		54694844
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	10749	
(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)		10749
(2) Dividends:			
(A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(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)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		14799
d Total income. Add all income amounts in column (b) and enter total	2d		54720392

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	48881016	
(3) Other	2e(3)	24956	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		48905972
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)	1086739	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	38200	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	153587	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	83078	
(11) Other expenses	2i(11)	4298548	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		5660152
j Total expenses. Add all expense amounts in column (b) and enter total	2j		54566124

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		154268
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: **ANASTASI, MOORE & MARTIN, PLLC**

(2) EIN: **20-8140984**

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.)			
4a			
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	
4b			
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	
4c			
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	
4d			
e Was this plan covered by a fidelity bond?			
4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
4f			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4g			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?			
4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
4i			
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	
4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
4k			
l Has the plan failed to provide any benefit when due under the plan?		X	
4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			
4n			

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

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

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

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

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

Omnitrade Health Trust Arrangement

Financial Statements and Independent Auditors' Report

December 31, 2024 and 2023



Omnitrade Health Trust Arrangement

December 31, 2024 and 2023

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INDEPENDENT AUDITORS' REPORT

Trustee
Omnitrade Health Trust Arrangement
Mukilteo, Washington

Opinion on the 2024 Financial Statements

We have audited the accompanying financial statements of the Omnitrade Health Trust Arrangement (the Arrangement), 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 Arrangement as of December 31, 2024, and the changes in its net assets available for benefits and of changes in benefit obligations for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion on the 2024 Financial Statements

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 Arrangement 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.

2023 Financial Statements

The financial statements of the Arrangement as of December 31, 2023, were audited by other auditors whose report, dated October 12, 2024, expressed an unmodified opinion on those financial statements.

As part of our audit of the 2023 financial statements, we also audited adjustments described in Note 9 that were applied to restate the 2023 financial statements. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review, or apply any procedures to the 2023 financial statements of the Arrangement other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2023 financial statements as a whole.

Responsibilities of Management for the 2024 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 Arrangement'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 arrangement instrument, including all arrangement amendments; administering the arrangement; and determining that the arrangement's transactions that are presented and disclosed in the financial statements are in conformity with the arrangement'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 2024 Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with 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 Arrangement'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 Arrangement'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.

2024 Supplemental Schedule Required by ERISA

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets held for investment is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements.

The information has been subjected to the auditing procedures applied in the 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 schedule, we evaluated whether the supplemental schedule, including its form and content, is presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

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

Anastasi, Moore & Martin, PLLC

Spokane, Washington

October 14, 2025

OmniTrade Health Trust Arrangement

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
		(Restated)
ASSETS:		
Cash	\$ 1,143,346	\$ 1,091,122
Investments	256,591	255,318
Employer contributions receivable	95,935	57,068
Participant contributions receivable	1,728	11,725
Prepaid expenses	8,490	1,043
Total assets	<u>1,506,090</u>	<u>1,416,276</u>
LIABILITIES:		
Accounts payable and accrued expenses	173,655	170,194
Unearned employer contributions	635,781	665,840
Unearned participant contributions	16,434	9,776
Total liabilities	<u>825,870</u>	<u>845,810</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u><u>\$ 680,220</u></u>	<u><u>\$ 570,466</u></u>

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
		(Restated)
ADDITIONS:		
Employer contributions, net	\$ 54,236,030	\$ 48,273,900
Participant contributions, net	458,814	347,628
Employer late fees	14,799	22,472
Interest income	10,749	3,157
Total additions	<u>54,720,392</u>	<u>48,647,157</u>
DEDUCTIONS:		
Insurance premiums paid, net	48,950,486	43,773,843
Cost of administration:		
Accounting and audit fees	38,200	33,600
Administrative fees	1,086,739	968,897
Bank service charges	1,768	1,657
Consultant fees	1,486,072	1,327,653
Insurance and bonding	12,747	7,915
Insurance broker commissions	2,785,735	2,451,086
Legal fees	153,587	140,264
Promotional services	4,450	170
Supplies, postage, and printing	6,278	7,589
Trustee fees	83,078	73,903
Website and maintenance	1,498	1,127
Total deductions	<u>54,610,638</u>	<u>48,787,704</u>
CHANGE IN NET ASSETS AVAILABLE FOR BENEFITS	109,754	(140,547)
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year	<u>570,466</u>	<u>711,013</u>
End of year	<u>\$ 680,220</u>	<u>\$ 570,466</u>

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
		(Restated)
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Premiums due to insurers	\$ 156,348	\$ 200,862

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
		(Restated)
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Balance, beginning of year	\$ 200,862	\$ 344,171
Insurance premiums approved for payment	48,905,972	43,630,534
Insurance premiums paid	<u>(48,950,486)</u>	<u>(43,773,843)</u>
Balance, end of year	<u>\$ 156,348</u>	<u>\$ 200,862</u>

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Notes to Financial Statements



Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 1 – Description of the Arrangement

The Omnitrade Health Trust Arrangement (the Arrangement) was established on September 1, 2010. The Arrangement was established to hold insurance policies through which participating employers can provide programs of health and other insurance benefits under the employee benefit plans they maintain for their employees and dependents.

This Arrangement is considered a “group insurance arrangement” as defined by the regulations promulgated under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA regulations define a “group insurance arrangement” as an arrangement providing benefits to the employees of two or more unaffiliated employers, fully insuring one or more welfare plans of each participating employer, and using a trust as the holder of the insurance contracts and conduit for payment of premiums to the insurance company(ies). The types of benefits currently available through the Arrangement are described as follows: medical, hospital, surgical, prescription drug, dental, vision, group life, accidental death and dismemberment, short-term disability, long-term disability, and employee assistance benefits.

Participation in the Arrangement is limited to qualified employers of endorsing sponsors. With the approval of the Trustee, an industry association in the states of Washington or Alaska, or another similar group, may become an endorsing sponsor. An endorsing sponsor enters into an endorsement agreement in the form approved by the Trustee and agrees to abide by the terms and conditions of the Arrangement and to endorse to its members the welfare benefits offered under the Arrangement.

Qualified employers include any endorsing sponsor itself, and any member of an endorsing sponsor, who have executed an Adoption Agreement. The only individuals who are entitled to participate in and to receive benefits from the Arrangement are those employees, dependents, and/or retirees identified by participating employers.

Under the trust agreement, the Trustee has all necessary authority to receive contributions to pay welfare benefits and premiums on the group insurance policies owned by the Arrangement and to pay reasonable expenses of the Arrangement. Each employer agrees to provide information, including payroll information and data, to the Arrangement regarding the employer’s participants and employees of any controlled group in which the employer may be a member. Each employer agrees to pay to the Arrangement the amount of contributions required to maintain welfare benefits coverage for each employer’s participants in the amounts and at times described in the Adoption Agreement. In the event that any employer fails or refuses to remit the employer’s or the participants’ contributions due to the Arrangement on a timely basis, the Trustee will cancel and terminate the coverage afforded the employer’s participants, and the employer will be notified accordingly by the insurer and/or the Trustee.

Employer and participant contributions are received and held, pending payment of approved insurance premiums and welfare benefits. Such contributions are determined via a rate schedule based upon the type of coverage for employees and their dependents.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 1 – Description of the Arrangement (Continued)

The endorsing sponsors of the Arrangement are Life Science Washington, CleanTech Alliance Washington, and Associated Industries of the Inland Northwest. The Arrangement is administered by the Trustee of the Omnitrade Health Trust and the industry specific trusts, with the assistance of Vimly Benefit Solutions, Inc. and Associated Industries Management Services, contract administration organizations; Davis Wright Tremaine, LLP, a legal services firm; and ABD Insurance and Financial Services, Inc., DBA Advanced Professionals Insurance and Benefit Solutions (AP), a benefits consulting services firm. The Arrangement is marketed to employers by various insurance brokers, including AP.

Note 2 – Summary of Significant Accounting Policies

- a. **Basis of accounting** – The accompanying financial statements of the Arrangement are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.
- b. **Use of estimates** – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Trustee to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.
- c. **Investment valuation** – The Arrangement's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 6 for a discussion of fair value measurements.
- d. **Contract experience surpluses/deficits** – Certain benefits are provided through experience rated insurance contracts with Premiera Blue Cross (Premera). As part of the provisions of the contracts, experience surpluses will be refunded to the Arrangement whereas experience deficits of ongoing contracts will be funded by the Arrangement. If the contracts with Premiera were terminated, all eligible claims would be paid by the carrier, and any contract deficits would remain unfunded by the Arrangement. The Arrangement recognizes contract experience surpluses as assets and contract experience deficits as obligations. As of the contract years ended December 31, 2024 and 2023, the Arrangement recognized no contract experience surpluses or deficits. See Note 9
- e. **Rate stabilization reserves** – As part of the experience rated insurance contracts, the insurance provider may retain funds as rate stabilization reserves to assist in the mitigation of significant rate adjustments. The insurance provider may credit the reserves for interest earned. Any other changes to the reserves are a result of contract negotiations between the Arrangement and the insurance provider. If a contract was terminated, any funds in the reserves would be refunded to the Arrangement after the contract's experience results were settled. The reserves are recognized as assets of the Arrangement. As of the contract years ended December 31, 2024 and 2023, Premiera held no rate stabilization reserves.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 2 – Summary of Significant Accounting Policies (Continued)

- f. **Claim reserves** – As part of the provisions of the experience rated contracts with Premera, funds are retained, as reserves, to pay future claims and expenses of the Arrangement. In the event the contracts with Premera are terminated, any excess funds remaining in these reserves will be refunded to the Arrangement after all claims associated with the insurance provider are settled. These reserves are not recognized as assets on the financial statements, as the amounts of future claims and refunds cannot be determined. As of the contract years ended December 31, 2024 and 2023, the claim reserves held by Premera totaled \$3,256,000 and \$1,996,776, respectively.
- g. **Contributions recognition** – Employer and participant contributions are recognized as the Arrangement becomes obligated for the payment of insurance premiums and benefits. Therefore, contributions received after December 31 for benefits provided before the beginning of the subsequent year are recognized as contributions receivable. On the other hand, contributions received before December 31 for premiums paid and benefits provided in the subsequent year are recognized as unearned.
- h. **Payment of insurance premiums** – Insurance premiums are recognized when paid.
- i. **Reclassification** – Certain amounts in the 2023 financial statements have been reclassified for comparative purposes. These reclassifications had no effect on net assets or change in assets as of or for the year ended December 31, 2024.
- j. **Subsequent events** – Subsequent events have been evaluated through October 14, 2025, which is the date the financial statements were available to be issued.

Note 3 – Income Tax Status

The trust established under the Plan to hold the assets of the Arrangement is qualified as a tax-exempt organization under Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the net investment income of the trust is exempt from income taxes. The Omnitrade Health Trust obtained its latest tax determination letter from the Internal Revenue Service (IRS) with an effective date of exemption of September 1, 2010. In the letter, the IRS stated that the Omnitrade Health Trust, as then designed, was in compliance with the applicable requirements of the IRC. The other trusts are unfunded and have not applied for tax determination letters. The Trustee and legal counsel believe the trusts and related Arrangement are designed and have been operated through December 31, 2024, in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Arrangement and recognize a tax liability (or asset) if the Arrangement has taken an uncertain position that more likely than not would not be substantiated upon examination by the IRS. The plan administrator has analyzed the tax positions taken by the Arrangement, and has concluded that as of December 31, 2024 and 2023, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 3 – Income Tax Status (Continued)

The Arrangement is subject to routine audits by taxing jurisdictions, and the Arrangement could be subject to income tax if certain issues were found by the IRS that could result in the disqualification of the tax-exempt status; however, there are currently no audits for any tax periods in progress.

Note 4 – Priorities Upon Termination

The Arrangement may be terminated by the endorsing sponsors. In addition, it may be amended or terminated by written resolution adopted by the Trust Administrative Committee or by a writing delivered to the Trust Administrative Committee and signed by participating employers whose contributions during the preceding 12 months have totaled more than 50% of all contributions provided; however, no such resolution can be contrary to terms as written in the trust agreement.

Upon the dissolution or termination of the Arrangement, all assets remaining, after payment of all expenses incidental to the dissolution or termination, will be used to provide benefits for which the Arrangement was established. This method will continue until all funds are exhausted.

Note 5 – Risks and Uncertainties

The Arrangement and related insurance carriers face an increasingly challenging regulatory environment. Certain interpretations of laws, rules, and regulations could potentially result in adverse effects to the Arrangement.

Currently, the Arrangement operates as a fully insured arrangement and, therefore, is contracted with particular insurance carriers. In the Arrangement's service area, there are limited qualified insurance carriers willing and capable of meeting the Arrangement's insured benefit needs.

In determining the fair value of financial instruments, the Trustee uses a variety of methods and assumptions that are based on market conditions and risks existing at the date of the statements of net assets available for benefits. All methods of assessing fair value result in a general approximation of value, and such value may never actually be realized.

The Arrangement maintains its cash balances in various high credit quality financial institutions. Accounts at these institutions are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 per depositor, per insured bank, through December 31, 2024, at which time the insured coverage amount may be changed. To mitigate concentration risk and ensure full FDIC insurance coverage, the Arrangement utilizes sweep accounts and participates in the IntraFi Cash Service network. Through this network, funds are distributed across multiple partner banks, to help ensure that no single deposit exceeds the insured threshold. However, at times, other cash balances may be in excess of the insurance limit.

OmniTrade Health Trust Arrangement

Notes to Financial Statements

Note 6 – Fair Value Measurements

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

The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

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

Level 2 – Inputs to the valuation methodology include:

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

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

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

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

Following is a description of the valuation methodologies used for assets at fair value. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Level 1 – The fair values of short-term funds are based on the closing price reported on the active market in which the individual securities are traded.

Level 2 – The Arrangement has no investments that are classified as Level 2 at December 31, 2024 or 2023.

Level 3 – The Arrangement has no investments that are classified as Level 3 at December 31, 2024 or 2023.

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

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 6 – Fair Value Measurements (Continued)

The following tables set forth by level, within the fair value hierarchy, the Arrangement's assets at fair value:

	December 31, 2024			
	Level 1	Level 2	Level 3	Total
Short-term funds	\$ 256,591	\$ -	\$ -	\$ 256,591

	December 31, 2023			
	Level 1	Level 2	Level 3	Total
Short-term funds	\$ 255,318	\$ -	\$ -	\$ 255,318

Note 7 – Related-party Transactions

Related party contributions

During the years ended December 31, 2024 and 2023, employer contributions from Life Science Washington, one of the three endorsing sponsors of the Arrangement, totaled \$195,012 and \$153,285, respectively.

Dues and fees forwarded to related parties

Per agreed-upon billing arrangements, the Arrangement bills and collects from employers certain dues and fees on behalf of the three endorsing sponsors of the Arrangement, and then forwards those dues and fees to them. The Arrangement collected and forwarded fees totaling:

	December 31,	
	2024	2023
Life Science Washington	\$ 280,276	\$ 255,230
CleanTech Alliance Washington	315,516	275,801
Associated Industries of the Inland Northwest	184,629	155,569

Amounts due (overpaid) for fees collected but not yet forwarded totaled:

	December 31,	
	2024	2023
Life Science Washington	\$ (559)	\$ 4,173
CleanTech Alliance Washington	530	835
Associated Industries of the Inland Northwest	-	-

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 8 – Reconciliation of Financial Statements to Form 5500

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

	December 31,	
	2024	2023
Net assets available for benefits per the financial statements	\$ 680,220	\$ 570,466
Premiums due to insurers	(156,348)	(200,862)
Net assets available for benefits per Schedule H of Form 5500	<u>\$ 523,872</u>	<u>\$ 369,604</u>

The following is a reconciliation of net insurance premiums paid per the accompanying financial statements to the Schedule H of Form 5500:

	Years Ended December 31,	
	2024	2023
Insurance premiums paid, net	\$ 48,950,486	\$ 43,773,843
Less payments to Wellspring Family Services EAP	(22,619)	(24,486)
Less payments to CuraLinc LLC	(2,337)	-
Add premiums due to insurers, end of year	156,348	200,862
Less premiums due to insurers, beginning of year	(200,862)	(344,171)
Insurance premiums paid to insurance carriers per Schedule H of Form 5500	<u>\$ 48,881,016</u>	<u>\$ 43,606,048</u>

For the year ended December 31, 2024, other payments to provide benefits per Schedule H of Form 5500 consisted of payments of \$22,619 to Wellspring Family Services EAP and \$2,337 to CuraLinc LLC for employee assistance program (EAP) benefits, for a total of \$24,956. Wellspring Family Services EAP was acquired by CuraLinc LLC in late 2024.

For the year ended December 31, 2023, other payments to provide benefits per Schedule H of Form 5500 consisted of payments totaling \$24,486 to Wellspring Family Services EAP for EAP benefits.

Note 9 – Restatement of Previously Issued Financial Statements

Subsequent to the issuance of the Arrangement's financial statements as of and for the year ended December 31, 2023, management determined that certain contract experience deficits had been improperly recognized as benefit obligations in prior periods.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 9 – Restatement of Previously Issued Financial Statements (Continued)

Under the terms of the Arrangement's funding arrangements with participating employers and insurance carriers, contract experience deficits represent differences between premiums charged and actual claims experience. These deficits do not represent obligations of the Arrangement unless and until specific contractual terms require the Arrangement to fund such deficits. Management determined that, as of December 31, 2023, the Arrangement did not have a present obligation under those arrangements that met criteria for recognition. Therefore, the previously recognized contract experience deficits were overstated, resulting in an overstatement of benefit obligations.

Accordingly, the 2023 financial statements have been restated to correct this error. The correction decreased benefit obligations by \$31,330,750 as of December 31, 2023.

Omnitrade Health Trust Arrangement

Supplemental Information

Omnitrade Health Trust Arrangement

Form 5500, Schedule H – Part IV, Line 4i
December 31, 2024

EIN: 27-6838771 PN: 501

Assets Held for Investment				
(a)	(b)	(c)	(d)	(e)
Identity of Issue	Description of Investment	Cost	Current Value	
SHORT-TERM FUNDS:				
NexBank	Deposit account	\$ 9,496	\$ 9,496	
Western Alliance Bank	Deposit account	247,095	247,095	
		<u>\$ 256,591</u>	<u>\$ 256,591</u>	

See accompanying independent auditors' report.

Omnitrade Health Trust Arrangement

Form 5500, Schedule H – Part IV, Line 4i
December 31, 2024

EIN: 27-6838771 PN: 501

Assets Held for Investment				
(a)	(b)	(c)	(d)	(e)
Identity of Issue	Description of Investment	Cost	Current Value	
SHORT-TERM FUNDS:				
NexBank	Deposit account	\$ 9,496	\$ 9,496	
Western Alliance Bank	Deposit account	247,095	247,095	
		<u>\$ 256,591</u>	<u>\$ 256,591</u>	

See accompanying independent auditors' report.