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

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) G

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☒ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 06/01/1976

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

12121 HARBOUR REACH DR, SUITE 105
PO BOX 6
MUKILTEO, WA 98275

PO BOX 6
MUKILTEO, WA 98275

2b Employer Identification Number (EIN)
90-1075780

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	LANE SAVITCH
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	LANE SAVITCH
	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 [X] 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**	8477
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	**6a(1)**	8477
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	8936
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	8936
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**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:

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)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

a Pension Schedules

- **(1)** [ ] **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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 5
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **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_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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

1 Coverage Information:

(a) Name of insurance carrier
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	653 ET AL	5930	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.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	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** [X] 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)**	4925189		
(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)**	4925189
b Benefit charges (1) Claims paid	**9b(1)**	4532880		
(2) Increase (decrease) in claim reserves	**9b(2)**	18000		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	4550880
(4) Claims charged			**9b(4)**	4550880
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)**	634365		
(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)**	634365
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [X] credited.)			**9c(2)**	-260056
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	207000
(3) Other reserves			**9d(3)**	426000
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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

1 Coverage Information:

(a) Name of insurance carrier
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	416, 655, 656	3895	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.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	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** [X] 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**	1972779
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-7089668	53031	07103793	988	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
1576	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

BROWN & BROWN OF WA., INC
2106 PACIFIC AVE STE 501
TACOMA, WA 98402-3011

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
538			3

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

BROWN & BROWN OF WA., INC
PO BOX 743048
LOS ANGELES, CA 90074

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
415			3

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

MARSH & MCLENNAN AGENCY LLC
PO BOX 4386
MISSOULA, MT 59806-4386

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
327			3

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

ACRISURE, LLC DBA BENEFIT HEALTH AD
9605 S KINGSTON CT STE 150
ENGLEWOOD, CO 80112-6021

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
265			3

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

HUB INTERNATIONAL NORTHWEST LLC
PO BOX 3018
BOTHELL, WA 98041-3018

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
25			3

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

WASHINGTON HEALTH INSURANCE AGENCY
PO BOX 14488
TUMWATER, WA 98511-4488

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
6			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	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	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** [X] 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**	134545
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0242990	69019	145336 ET AL	4448	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
171250	23511

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

KIBBLE AND PRENTICE HOLDING CO
ATTN USI NORTHWEST PO BOX 62949
VIRGINIA BEACH, VA 23466

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
83143			3

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

BROWN & BROWN OF WA., INC DIMARTINO
1325 FOURTH AVE STE 170
SEATTLE, WA 98101

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
38492	11340	CONTINGENT COMPENSATION	3

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

PARKER SMITH AND FEEK

2233 112TH AVE NE
BELLEVUE, WA 98004

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
16069			3

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

GALLAGHER BENEFIT SERVICES

777 108TH AVE NE STE 200
BELLEVUE, WA 98004

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
9165	1389	CONTINGENT COMPENSATION	3

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

KIBBLE AND PRENTICE HOLDING CO

ATTN USI WASHINGTON 601 UNION ST S
SEATTLE, WA 98101

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
	7129	CONTINGENT COMPENSATION	3

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

BROWN & BROWN OF WA., INC

701 5TH AVE STE 550
SEATTLE, WA 98104

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5121	1311	CONTINGENT COMPENSATION	3

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

HUB INTERNATIONAL NORTHWEST LLC

PO BOX 3018
BOTHELL, WA 98004

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3097	1176	CONTINGENT COMPENSATION	3

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

THE PARTNERS GROUP
1111 LAKE WASHINGTON BLVD N STE 400
RENTON, WA 98056

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
3448	349	CONTINGENT COMPENSATION	3

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

ACRISURE LLC
PO BOX 1788
GRAND RAPIDS, MI 49501

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2946	435	CONTINGENT COMPENSATION	3

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

ACRISURE LLC BENEFIT HEALTH ADVISOR
9605 S KINGSTON CT STE 150
ENGLEWOOD, CO 80112

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2986	212	CONTINGENT COMPENSATION	3

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

PARKER SMITH AND FEEK INSURANCE LLC
2233 112TH AVE NE
BELLEVUE, WA 98004

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2367			3

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

KRISTIN MANWARING INS ASSOC
2300 SOUTH PARK AVE
PORT TOWNSEND, WA 98368

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2251			3

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

BENEFIT CONCEPTS INC
1173 BRITTMOORE RD
HOUSTON, TX 77043

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
1542	144	CONTINGENT COMPENSATION	3

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

DIGITAL INSURANCE LLC
200 GALLERIA PARKWAY STE 1950
ATLANTA, GA 30339

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
623			3

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

WATCHTOWER TECHNOLOGIES INC
227 WEST MONROE ST STE 5200
CHICAGO, IL 60606

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	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** [X] Life insurance
- **e** [X] Temporary disability (accident and sickness)
- **f** [X] 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)**	1542064		
(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)**	1542064
b Benefit charges (1) Claims paid	**9b(1)**	881983		
(2) Increase (decrease) in claim reserves	**9b(2)**	-583970		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	298013
(4) Claims charged			**9b(4)**	298013
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	167031		
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**	29884		
(D) Other expenses	**9c(1)(D)**	435534		
(E) Taxes	**9c(1)(E)**	150		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	632599
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [X] credited.)			**9c(2)**	611452
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	2622022
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	611452
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	197494
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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

1 Coverage Information:

(a) Name of insurance carrier
WILLAMETTE DENTAL OF WASHINGTON, INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-1702099	47050	WHIT2, WHITV	1015	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.	6d	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	
c	Additions: (1) Contributions deposited during the year	7c(1)			
	(2) Dividends and credits	7c(2)			
	(3) Interest credited during the year	7c(3)			
	(4) Transferred from separate account	7c(4)			
	(5) Other (specify below)	7c(5)			
	▶				
	(6)Total additions			7c(6)	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** [X] 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**	697865
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**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
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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

PAYDEN & RYGEL
333 S GRAND AVENUE
LOS ANGELES, CA 90071

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

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

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

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

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

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

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

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

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

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

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

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

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

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 55 64	CONTRACT ADMINISTRATOR	166617	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BROWN & BROWN DBA DIMARTINO ASSOCIA

59-0691921

(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 50 53 70	CONSULTANT	142694	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PARKER SMITH AND FEEK, INC

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	INSURANCE BROKER	70968	Yes [ ] No [X]	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)

BROWN & BROWN

91-0378940

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	INSURANCE BROKER	38901	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DIGITAL INSURANCE, INC

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	INSURANCE BROKER	37574	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

AON CONSULTING, INC

22-2232264

(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	INSURANCE BROKER	26506	Yes [ ] No [X]	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)

FIRST CHOICE HEALTH EMPLOYEE ASSIST

91-1272766

(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	OTHER PAYMENT	26004	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WASHINGTON HOSPITAL SERVICES, INC

91-1389170

(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?
50 38	PROGRAM MARKETER	23750	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

(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	AUDITOR	22400	Yes [ ] No [X]	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)

KIBBLE AND PRENTICE DBA USI INS SER

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	INSURANCE BROKER	22346	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MERCER HEALTH & BENEFITS, LLC

13-2834414

(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	INSURANCE BROKER	21414	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE WAGNER LAW GROUP

04-3323315

(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	ATTORNEY	17117	Yes [ ] No [X]	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)

PAYDEN & RYGEL

333 S GRAND AVENUE
LOS ANGELES, CA 90071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 27 28	NONE	14531	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

HUB INTERNATIONAL NW, 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	INSURANCE BROKER	11563	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ALLIANT INSURANCE SERVICES, NC

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	INSURANCE BROKER	6955	Yes [ ] No [X]	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)

ETHIX NORTHWEST, LLC

13-4283589

(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	INSURANCE BROKER	5551	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 BOARD OF 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:

SCHEDULE D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**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 WESTERN HEALTHCARE INSURANCE TRUST	**B** Three-digit plan number (PN) ▶ 501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST	**D** Employer Identification Number (EIN) 90-1075780

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)

(Complete as many entries as needed to report all interests in DFEs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	AESTHETIC SURGERY CENTER PLLC	**c** EIN-PN	90-0210545-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	ALLIANCE FOR SOUTH SOUND HEALTH	**c** EIN-PN	47-4654897-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	BELLEVUE FAMILY MEDICINE	**c** EIN-PN	91-1640113-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	BELLEVUE MEDICAL IMAGING, PLLC	**c** EIN-PN	91-2177853-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	CARROT MEDICAL	**c** EIN-PN	26-1190409-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	CASCADE MEDICAL CENTER	**c** EIN-PN	91-0856279-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	CASCADE TRAUMA AND ACUTE CARE SURGERY	**c** EIN-PN	92-2396444-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	COLUMBIA BASIN HOSPITAL	**c** EIN-PN	91-6001946-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	COLUMBIA VALLEY COMMUNITY HEALTH	**c** EIN-PN	23-7297657-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	COMMUNITY HEALTH CARE OF TACOMA	**c** EIN-PN	91-1349657-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	DIGESTIVE DISEASE AND ENDOSCOPY	**c** EIN-PN	91-2065379-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	EAR, NOSE & THROAT ASSOCIATES	**c** EIN-PN	91-1829653-501

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	EAST ADAMS RURAL HEALTHCARE	**c** EIN-PN	91-6001963-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	EDGEWOOD DENTAL LABORATORY, INC.	**c** EIN-PN	91-0906329-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	EDMONDS EYECARE ASSOCIATES, INC. PS	**c** EIN-PN	91-1545703-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	FAMILY CARE NETWORK, PLLC	**c** EIN-PN	91-1753976-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	FERRY COUNTY PUBLIC HOSPITAL DISTRICT #1	**c** EIN-PN	91-0879683-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	FREEBORN WELLNESS	**c** EIN-PN	47-3280066-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	GARFIELD COUNTY MEMORIAL HOSPITAL	**c** EIN-PN	91-6008648-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	HEALTH PEOPLE, INC.	**c** EIN-PN	91-1825597-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	HOLLY RIDGE CENTER	**c** EIN-PN	91-0757541-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	JEFFERSON HEALTHCARE	**c** EIN-PN	91-0928081-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	JOHN H ADDISON MD PS	**c** EIN-PN	91-2177031-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KING COUNTY PUBLIC HOSPITAL DISTRICT #4	**c** EIN-PN	91-0908129-501

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KIRK'S PHARMACY, INC.	**c** EIN-PN	91-1673559-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KITSAP EYE PHYSICIANS	**c** EIN-PN	91-1690785-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KITSAP PUBLIC HEALTH DISTRICT	**c** EIN-PN	42-1689063-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KITTITAS VALLEY HEALTHCARE	**c** EIN-PN	91-0757683-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KLICKITAT VALLEY HEALTH	**c** EIN-PN	91-6001738-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	KOOTENAI OUTPATIENT SURGERY	**c** EIN-PN	82-0523354-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	LINCOLN HOSPITAL DISTRICT NO. 3	**c** EIN-PN	91-0758051-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	MATRIX ANESTHESIA, PS	**c** EIN-PN	91-1010253-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	NORTH SEATTLE PEDIATRICS, PS	**c** EIN-PN	20-0413755-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	NORTHAVEN INC.	**c** EIN-PN	91-0877707-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	NORTHWEST PHYSICIANS MEDICAL GROUP	**c** EIN-PN	27-3473897-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	ODESSA MEMORIAL HEALTHCARE CENTER	**c** EIN-PN	91-6001722-501

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	OKANOGAN COUNTY PUBLIC HEALTH	**c** EIN-PN	91-0750229-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	OLYMPIA MULTI SPECIALTY CLINIC	**c** EIN-PN	91-1367068-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	OLYMPIA PEDIATRICS, PLLC	**c** EIN-PN	91-2103842-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	OLYMPIC MEDICAL CENTER	**c** EIN-PN	91-6001709-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	OTHELLO COMMUNITY HOSPITAL	**c** EIN-PN	91-6016170-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PACIFIC EYECARE OF POULSBO, P.S.	**c** EIN-PN	91-1081540-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PARTNERS IN CARE	**c** EIN-PN	93-0756143-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PEDIATRIC ASSOCIATES INC., PS	**c** EIN-PN	91-0846502-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PEDIATRICS NORTHWEST PS	**c** EIN-PN	91-2089965-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PENINSULA DERMATOLOGY & LASER CLINIC	**c** EIN-PN	91-1941672-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PORT ORCHARD EYE ASSOCIATES INC PS	**c** EIN-PN	26-0438219-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PROACTIVE SPORTSMED, PLLC	**c** EIN-PN	35-2160184-501

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PULLMAN MEMORIAL HOSPITAL	**c** EIN-PN	91-1031583-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	PUYALLUP DERMATOLOGY	**c** EIN-PN	91-1149545-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	RADIANTCARE PHYSICIANS, PLLC	**c** EIN-PN	91-2018691-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SAMARITAN CENTER OF PUGET SOUND	**c** EIN-PN	91-1268538-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SAMARITAN HEALTHCARE	**c** EIN-PN	91-6001698-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SKAGIT COUNTY PUBLIC HOSPITAL DIST 304	**c** EIN-PN	81-6223939-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SKAGIT REGIONAL HEALTH	**c** EIN-PN	56-2392010-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SKYLINE HEALTH	**c** EIN-PN	91-6000960-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	SUMMIT PACIFIC MEDICAL CENTER	**c** EIN-PN	91-1158307-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	TACOMA PIERCE COUNTY BLOOD BANK	**c** EIN-PN	91-0657805-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	THREE RIVERS HOSPITAL	**c** EIN-PN	91-6001009-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	TUMWATER FAMILY PRACTICE CLINIC	**c** EIN-PN	91-1400290-501

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	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WASHINGTON EMERGENCY CARE PHYSICIANS, INC.	**c** EIN-PN	91-0877393-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WASHINGTON RURAL HEALTH COLLABORATIVE	**c** EIN-PN	90-0195254-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WASHINGTON STATE HOSPITAL ASSOCIATION	**c** EIN-PN	91-0584257-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WESTSIDE PEDIATRIC CLINIC PC	**c** EIN-PN	93-1129829-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WHITMAN HOSPITAL AND MEDICAL CLINICS	**c** EIN-PN	91-1451777-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	WILLAPA HARBOR HOSPITAL	**c** EIN-PN	91-6002007-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	YAKIMA UROLOGY ASSOCIATES, PLLC	**c** EIN-PN	91-1689156-501
a Plan name	WESTERN HEALTHCARE INSURANCE TRUST		
b Name of plan sponsor	YELM FAMILY MEDICINE, PLLC	**c** EIN-PN	91-1325323-501
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	

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
WESTERN HEALTHCARE INSURANCE TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, WESTERN HEALTHCARE INSURANCE TRUST

D Employer Identification Number (EIN)
90-1075780

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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	188225	95535
(2) Participant contributions	1b(2)	4710	717
(3) Other	1b(3)	757634	1147307
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	970544	652780
(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)	6999794	7674357
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(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	8920907	9570696
Liabilities			
g Benefit claims payable	1g	887574	724726
h Operating payables	1h	90055	14161
i Acquisition indebtedness	1i		
j Other liabilities	1j	103316	127164
k Total liabilities (add all amounts in lines 1g through1j)	1k	1080945	866051
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	7839962	8704645

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)	9991415	
(B) Participants	2a(1)(B)	11483	
(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)		10002898
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	13426	
(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)	2499	
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		15925
(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)	230993	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		230993
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	1011087	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	952222	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		58865
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	397878	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		397878

		(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		15612
d Total income. Add all **income** amounts in column (b) and enter total	2d		10722171
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)	9121183	
(3) Other	2e(3)	26004	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		9147187
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)	185367	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	22400	
(5) Investment advisory and investment management fees	2i(5)	14531	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	17117	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	28609	
(11) Other expenses	2i(11)	442277	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		710301
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		9857488
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		864683
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) [X] 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)** [X] 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: 20-8149084

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.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
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.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k			
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
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 _____.

Western Healthcare Insurance Trust

Financial Statements and Independent Auditors' Report

December 31, 2024 and 2023

Anastasi | Moore | Martin
Certified Public Accountants & Consultants PLLC

Western Healthcare Insurance Trust

December 31, 2024 and 2023

Table of Contents

INDEPENDENT AUDITORS' REPORT

Board of Trustees
Western Healthcare Insurance Trust
Mukilteo, Washington

Opinion on the 2024 Financial Statements

We have audited the accompanying financial statements of the Western Healthcare Insurance Trust (the Trust), 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 Trust 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 Trust 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 Trust as of December 31, 2023, were audited by other auditors whose report, dated October 14, 2024, expressed an unmodified opinion on those statements.

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 Trust's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the 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 Trust's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Trust's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets held for investment and reportable transactions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

Anastasi, Moore & Martin, PLLC

Spokane, Washington
October 9, 2025

Western Healthcare Insurance Trust

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
ASSETS:		
Cash and cash equivalents	$ 630,768	$ 947,273
Investments, at fair value	7,696,369	7,023,065
Employer and participant contributions receivable	96,252	192,935
Contract experience surpluses	611,452	348,261
Call deposit held at insurer	470,000	403,000
Claims fluctuation reserve	50,249	-
Prepaid expenses	15,606	6,373
Total assets	9,570,696	8,920,907
LIABILITIES:		
Checks written in excess of deposits	27,449	23,290
Accounts payable and accrued expenses	14,161	90,055
Unearned employer and participant contributions	99,715	80,026
Contract experience deficit	260,056	-
Total liabilities	401,381	193,371
NET ASSETS AVAILABLE FOR BENEFITS	$ 9,169,315	$ 8,727,536

See accompanying notes to financial statements.

Western Healthcare Insurance Trust

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
ADDITIONS:		
Employer and participant contributions, net	$ 10,002,898	$ 9,811,439
Investment income:		
Net appreciation in fair value	456,743	579,703
Interest and dividends	249,071	197,678
	705,814	777,381
Less investment expenses	(14,531)	(12,722)
Net investment income	691,283	764,659
Total additions	10,694,181	10,576,098
DEDUCTIONS:		
Insurance premiums paid, net	9,570,091	8,808,102
Cost of administration:		
Accounting and audit fees	22,400	21,750
Administration fees	161,617	169,133
Broker commissions	297,274	316,453
Consulting fees	66,000	66,000
Insurance and bonding	12,608	12,218
Legal fees	17,117	28,811
Meetings and conferences	28,609	27,318
Member services fees	60,000	60,000
Postage and printing	645	658
Program communication fees	23,750	23,700
Website, technology, and maintenance	5,750	750
Total deductions	10,265,861	9,534,893
NET OPERATING INCREASE BEFORE INCOME TAXES	428,320	1,041,205
Income tax refund	13,459	-
NET INCREASE	441,779	1,041,205
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year	8,727,536	7,686,331
End of year	$ 9,169,315	$ 8,727,536

See accompanying notes to financial statements.

Western Healthcare Insurance Trust

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Premiums due to insurers	$ 464,670	$ 887,574

See accompanying notes to financial statements.

Western Healthcare Insurance Trust

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Balance, beginning of year	$ 887,574	$ 1,705,435
Insurance premiums approved for payment	9,147,187	7,990,241
Insurance premiums paid	(9,570,091)	(8,808,102)
Balance, end of year	$ 464,670	$ 887,574

See accompanying notes to financial statements.

Western Healthcare Insurance Trust

Notes to Financial Statements

Western Healthcare Insurance Trust
Notes to Financial Statements

Note 1 – Description of the Trust

The Western Healthcare Insurance Trust (the Trust) was established on May 31, 1976. The Trust 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 Trust 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 Trust are described as follows: dental, vision, basic life, supplemental life, accidental death and dismemberment, disability, and employee assistance benefits.

Participation in the Trust is limited to any employer in the health care industry that is one of the following: 1) a member of the Washington State Hospital Association and located in the state of Washington, 2) a public hospital district in the Pacific Northwest (including Alaska), 3) a hospital or health care clinic in the Pacific Northwest (including Alaska), or 4) an employer located in the Pacific Northwest (including Alaska) and working primarily in the areas of: scientific research related to healthcare, pharmaceutical and medicine manufacturing, or medical equipment and supplies manufacturing. Participation in the Trust is subject to approval by the Board of Trustees.

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

The Trust is administered by the Board of Trustees with the assistance of Vimly Benefit Solutions, Inc., a contract administration organization; Brown & Brown Insurance Services, Inc. dba DiMartino Associates (DiMartino Associates), a benefits consulting services firm; and The Wagner Law Group, a legal services firm. Communication services are provided by Washington Hospital Services, Inc. The Trust is marketed to employers by various insurance brokers, including DiMartino Associates.

Note 2 – Summary of Significant Accounting Policies

a. **Basis of accounting** – The accompanying financial statements of the Trust 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 Board of Trustees to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates.

c. **Investment valuation and income recognition** – The Trust'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.

Note 2 – Summary of Significant Accounting Policies (Continued)

d. **Investment valuation and income recognition (continued)** – Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Trust's gains and losses on investments bought and sold as well as held during the year. See Note 6 for a further discussion of fair value measurements.

e. **Contributions** – Employer and participant contributions are recognized as the Trust becomes obligated for the payment of insurance premiums. Therefore, contributions received after December 31 for premiums paid before the beginning of the subsequent year are recognized as contributions receivable. On the other hand, contributions received before December 31 for premiums to be paid in the subsequent year are recognized as unearned.

f. **Contract experience surpluses/deficits** – Certain benefits are provided through experience rated insurance contracts with Delta Dental of Washington (DDW) and Standard Insurance Company (Standard). As part of the provisions of the contracts, DDW and Standard may retain experience surpluses or deficits from one contract year to the next to assist in the mitigation of the effects of negative experience. Experience surpluses are the property of the Trust and are not refundable to any participating employer. (See Note 7)

g. **Call deposit held at insurer** – As part of the provisions of an experience rated insurance contract, DDW retains funds as a call deposit for a group of four tax-exempt employers. Annual changes to the account are a result of contract negotiations between the Trust and DDW. As such, the call deposit is recognized as an asset of the Trust. (See Notes 7 and 8)

h. **Claims fluctuation reserve account** – As part of the provisions of the experience rated insurance contracts with Standard, the insurance provider retains funds as a claims fluctuation reserve account. Standard credits the reserve account for interest earned. Any other changes to the account are a result of contract negotiations between the Trust and Standard. If the contracts with Standard were terminated, any funds in the reserve account would be refunded to the Trust after the contract experience results were settled. As such, the reserve account is recognized as an asset of the Trust. (See Note 9)

i. **Claim reserves** – As part of the provisions of the experience rated insurance contracts with DDW and Standard, funds are retained as reserves to pay future claims and expenses of the Trust. In the event the contracts were terminated, any excess funds remaining in these reserves would be refunded to the Trust 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, claim reserves held by DDW totaled $207,000 and $189,000, respectively; claim reserves held by Standard totaled $2,622,022 and $3,205,992, respectively.

j. **Payment of insurance premiums** – Insurance premiums are recognized when paid.

k. **Reclassification**s – Certain amounts in the 2023 financial statements have been reclassified for comparative purposes to conform with the 2024 presentation with no effect on previously reported net assets available for benefits.

Note 2 – Summary of Significant Accounting Policies (Continued)

l. **Subsequent events** – Subsequent events have been evaluated through October 9, 2025, which is the date the financial statements were available to be issued.

Note 3 – Income Tax Status

The Trust was originally established to qualify as a tax-exempt organization under Section 501(c)(9) of the Internal Revenue Code (IRC). Effective January 1, 2013, the Trust relinquished its tax-exempt status and, as such, beginning with the tax year ended December 31, 2013, was treated as a complex trust, taxable pursuant to the IRC. For the tax years ended December 31, 2024 and 2023, the Trust's qualified tax deductions exceeded the Trust's taxable income.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Trust and recognize a tax liability (or asset) if the Trust has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service.

The trust administrator has analyzed the tax positions taken by the Trust 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. The Trust is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Note 4 – Priorities Upon Termination

The Trust may be terminated at any time by action of the Board of Trustees. Upon the termination of the Trust, the Board of Trustees will wind up the affairs of the Trust. Where the termination occurs as a result of a merger, any and all monies and assets remaining in the Trust, after payment of expenses, will be transferred to the successor plan. With respect to any other termination, any and all monies and assets remaining in the Trust (after the payment of expenses) will be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted. In no event will any of the remaining monies or assets be paid to or be recoverable by any participating employer or paid in cash to participating employees, unless such disposition is required by applicable laws.

Note 5 – Risks and Uncertainties

The Plan provides for investment in a variety of investment securities. In general, investment securities are exposed to various risks such as interest rate, market, and credit risk. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of the investment securities will occur in the near term and that such changes could materially affect participants' account balances and the amounts reported in the statements of net assets available for benefits.

Note 5 – Risks and Uncertainties (Continued)

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

The Plan maintains its cash balances in a high credit quality financial institution. Accounts at this institution are insured by the Federal Deposit Insurance Corporation up to $250,000 through December 31, 2024, at which time the insured coverage amount may be changed. At times, such cash balances may be in excess of the insurance limit.

The Trust 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 Trust.

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 Trust 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.

Note 6 – Fair Value Measurements (Continued)

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

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

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

Level 3 – The Trust 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 Trust believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

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

	As of December 31, 2024			
	Level 1	Level 2	Level 3	Total
Short-term funds	$ 22,012	$ -	$ -	$ 22,012
Mutual and exchange traded funds	7,674,357	-	-	7,674,357
	$ 7,696,369	$ -	$ -	$ 7,696,369

	As of December 31, 2023			
	Level 1	Level 2	Level 3	Total
Short-term funds	$ 23,271	$ -	$ -	$ 23,271
Mutual and exchange traded funds	6,999,794	-	-	6,999,794
	$ 7,023,065	$ -	$ -	$ 7,023,065

The Trust's net appreciation in fair value of investments consisted of the following:

	December 31,	
	2024	2023
Realized gains (losses) from the sale of investments	$ 58,865	$ (212,907)
Unrealized gains from investments	397,878	792,610
	$ 456,743	$ 579,703

Note 7 – Contract Experience Surpluses/Deficits

Experience surpluses are the property of the Trust and are not refundable to any participating employer, regardless of whether the employer's premiums are experience rated or not. Experience deficits are the obligation of the Trust.

Delta Dental of Washington (Experience Rated Employer Group) – The contract between DDW and the Trust is experience rated for a group of four tax-exempt employers. (The remaining employers participating in the DDW plan are not individually experience-rated.) Once the accounting for the contract year is finalized, any experience surpluses are refunded and any experience deficits become a contract experience deficit obligation of the Trust.

Additionally, once the accounting for the contract year is finalized, the Trust and DDW negotiate a call deposit held by DDW. In the event the contract with DDW is terminated, the maximum obligation of the Trust is the premiums paid plus the negotiated call deposit for that particular contract year.

Net experience surpluses for the contract year ended December 31, 2022, totaled $256,642. The surplus was refunded to the Trust in April 2023. Additionally, as a result of the 2022 net experience surpluses, the call deposit was reduced and DDW refunded $107,000 in April 2023. For the year ended December 31, 2023, the call deposit was $403,000.

Net experience surpluses for the contract year ended December 31, 2023, totaled $300,511. DDW retained $67,000 to cover the increase in the call deposit. DDW refunded to the Trust the remaining $233,511 of the surplus in May 2024. For the year ended December 31, 2024, the call deposit was $470,000.

Net experience deficits for the contract year ended December 31, 2024, totaled $260,056. DDW gave credit for the decrease in the call deposit of $44,000, plus an additional $9,400. The Trust remitted $206,656 to DDW in July of 2025. For the year ending December 31, 2025, the call deposit is $426,000.

Standard Insurance Company (Standard) – Effective March 1, 2008, the Trust entered into experience rated contracts with Standard for life and long-term disability with no individual employer experience rating. All experience rating is based on the claims experience of the entire Trust pool of employers participating in the plan. As such, cumulative net experience surpluses are recognized as trust assets, whereas cumulative net experience deficits are recognized as trust liabilities. Additionally, the Trust and Standard agreed that, in order for the Trust to receive a distribution, the net position of both the life and long-term disability contracts must be positive.

Experience surpluses for the year ended December 31, 2024, were $611,452. Since there was no prior deficit balance carried forward, the accumulated experience surplus also totaled $611,452 as of December 31, 2024.

Experience surpluses for the year ended December 31, 2023, were $950,974. The surpluses for the year ended December 31, 2023, eliminated the Trust's related accumulated experience deficit and created an accumulated experience surplus totaling $47,750 as of December 31, 2023.

Note 8 – Call Deposit Held at Insurer

The activity and balance of the call deposit held at DDW during the contract years are summarized as follows:

	Years Ended December 31,	
	2024	2023
Balance, beginning of year	$ 403,000	$ 510,000
Refunded to Trust	-	(107,000)
Trust payment to increase the balance	67,000	-
Balance, end of year	$ 470,000	$ 403,000

The Trust and DDW have negotiated to decrease the call amount to $426,000 for the year ended December 31, 2025.

Note 9 – Claims Fluctuation Reserve Account

As of December 31, 2023, an experience surplus of $47,750 was available with Standard and was subsequently deposited into the claims fluctuation reserve during the contract year ended December 31, 2024. During 2024, the account earned $2,499 in interest. As a result, the balance in the claims fluctuation reserve as of December 31, 2024 was $50,249.

There was no activity in the claims fluctuation reserve account for the contract year ended December 31, 2023, and the reserve maintained a zero balance throughout that period.

Note 10 – 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:

	As of December 31,	
	2024	2023
Net assets available for benefits per the financial statements	$ 9,169,315	$ 8,727,536
Premiums due to insurers	(464,670)	(887,574)
Net assets available for benefits per Schedule H of Form 5500	$ 8,704,645	$ 7,839,962

Note 10 – Reconciliation of Financial Statements to Form 5500 (Continued)

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	$ 9,570,091	$ 8,808,102
Less payments to First Choice Health EAP	(26,004)	(25,565)
Add premiums due to insurers, end of year	464,670	887,574
Add contract experience deficits, end of the year	260,056	-
Less premiums due to insurers, beginning of year	(887,574)	(802,211)
Less contact experience deficits, beginning of year	-	(903,224)
Insurance premiums paid to insurance carriers per Schedule H of Form 5500	$ 9,381,239	$ 7,964,676

For the years ended December 31, 2024 and 2023, other payments to provide benefits per Schedule H of Form 5500 consisted of payments to First Choice Health Employee Assistance Program (First Choice Health EAP) for employee assistance benefits. Such payments totaled $26,004 and $25,565, respectively.

Western Healthcare Insurance Trust

Supplemental Information

Western Healthcare Insurance Trust

Form 5500, Schedule H – Part IV, Line 4i EIN: 90-1075780 PN: 501

December 31, 2024

Assets Held for Investment				
(a)	(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment	(d) Cost	(e) Current Value
	SHORT-TERM FUNDS			
*	Charles Schwab & Co., Inc.		$ 22,012	$ 22,012
	MUTUAL AND EXCHANGE TRADED FUNDS:			
	Invesco NASDAQ 100 ETF	1,178 shares	181,059	247,948
	iShares 7-10 Year Treasury Bond ETF	5,264 shares	492,556	486,739
	iShares 10-20 Year Treasury Bond ETF	3,967 shares	467,568	394,912
	iShares Core S&P Mid-Cap ETF	3,697 shares	242,015	230,402
	iShares iBox Investment Grd Corp Bd ETF	8,191 shares	1,027,628	875,137
	iShares MBS ETF	14,702 shares	1,338,107	1,347,893
*	Payden Strategic Income Fund	128,163 shares	1,314,328	1,225,244
*	Schwab S&P 500 Index Fund	31,750 shares	2,074,440	2,866,082
	Total mutual and exchange traded funds		7,137,701	7,674,357
			$ 7,159,713	$ 7,696,369

* Party-in-interest transaction, not a prohibited transaction.

Western Healthcare Insurance Trust

Form 5500, Schedule H - Part IV, Line 4j EIN: 90-1075780 PN: 501

Year Ended December 31, 2024

Reportable Transactions

(a) Identity of Party Involved	(b) Description of Assets	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain
Category (i) -- A Single Transaction in Excess of 5% of Plan Assets:						
iShares Core S&P Mid-Cap ETF	Exchange-traded fund	$ 287,961	$ -	$ 287,961	$ 287,961	$ -
iShares Core S&P Mid-Cap ETF	Exchange-traded fund	-	216,796	204,251	216,796	12,545
Schwab S&P 500 Index Fund	Mutual fund	308,949	-	308,949	308,949	-
Schwab S&P 500 Index Fund	Mutual fund	-	291,000	240,922	291,000	50,078

Western Healthcare Insurance Trust

Form 5500, Schedule H – Part IV, Line 4i EIN: 90-1075780 PN: 501

December 31, 2024

Assets Held for Investment				
(a)	(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment	(d) Cost	(e) Current Value
	SHORT-TERM FUNDS			
*	Charles Schwab & Co., Inc.		$ 22,012	$ 22,012
	MUTUAL AND EXCHANGE TRADED FUNDS:			
	Invesco NASDAQ 100 ETF	1,178 shares	181,059	247,948
	iShares 7-10 Year Treasury Bond ETF	5,264 shares	492,556	486,739
	iShares 10-20 Year Treasury Bond ETF	3,967 shares	467,568	394,912
	iShares Core S&P Mid-Cap ETF	3,697 shares	242,015	230,402
	iShares iBox Investment Grd Corp Bd ETF	8,191 shares	1,027,628	875,137
	iShares MBS ETF	14,702 shares	1,338,107	1,347,893
*	Payden Strategic Income Fund	128,163 shares	1,314,328	1,225,244
*	Schwab S&P 500 Index Fund	31,750 shares	2,074,440	2,866,082
	Total mutual and exchange traded funds		7,137,701	7,674,357
			$ 7,159,713	$ 7,696,369

* Party-in-interest transaction, not a prohibited transaction.

Western Healthcare Insurance Trust

Form 5500, Schedule H - Part IV, Line 4j EIN: 90-1075780 PN: 501

Year Ended December 31, 2024

Reportable Transactions

(a) Identity of Party Involved	(b) Description of Assets	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain
Category (i) -- A Single Transaction in Excess of 5% of Plan Assets:						
iShares Core S&P Mid-Cap ETF	Exchange-traded fund	$ 287,961	$ -	$ 287,961	$ 287,961	$ -
iShares Core S&P Mid-Cap ETF	Exchange-traded fund	-	216,796	204,251	216,796	12,545
Schwab S&P 500 Index Fund	Mutual fund	308,949	-	308,949	308,949	-
Schwab S&P 500 Index Fund	Mutual fund	-	291,000	240,922	291,000	50,078