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 06/01/2024 and ending 05/31/2025

A This return/report is for:
- [X] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

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

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [X]

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

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, UNITEHERE NORTHWEST HEALTH TRUST FUND

2323 EASTLAKE AVENUE EAST
SEATTLE, WA 98102

2b Employer Identification Number (EIN) 91-0590441

2c Plan Sponsor's telephone number 206-329-4900

2d Business code (see instructions) 721110

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.	03/13/2026	ERIK VAN ROSSUM
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	03/13/2026	DOUG RIGONI
	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**	2469
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)**	2467
a(2) Total number of active participants at the end of the plan year	**6a(2)**	2603
b Retired or separated participants receiving benefits	**6b**	2
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2605
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**	27

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

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

4A 4B 4D 4E 4F 4Q

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(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 6
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code_____

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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	SL 10280	2491	06/01/2024	05/31/2025

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	

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	(c) Amount	**(d)** Purpose	

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] 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	1502018
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			10b	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	FLX965893	2654	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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**	27062
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.**

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OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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	WA78	151	06/01/2024	05/31/2025

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

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	(c) Amount	**(d)** Purpose	

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [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)**	73448		
(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)**	73448
b Benefit charges (1) Claims paid	**9b(1)**	72378		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	72378
(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)**	8079		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**	1285		
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	9364
(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**	
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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	OK 967473	2654	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)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] 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**	8242
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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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
AMERITAS LIFE INSURANCE CORP

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
47-0098400	61301	010-301736	2120	06/01/2024	05/31/2025

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [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**	43011
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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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
LIFE INSURANCE COMPANY OF NORTH AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1503749	65498	LK 963775	2370	06/01/2024	05/31/2025

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [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)**			
(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**	162859
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 06/01/2024 and ending 05/31/2025

A Name of plan	**B** Three-digit plan number (PN) ▶
UNITEHERE NORTHWEST HEALTH TRUST FUND	501

C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND	91-0590441

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).. . . . . [X] 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	
FIDELITY INVESTMENTS	245 SUMMER STREET BOSTON, MA 02210

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
DODGE & COX	555 CALIFORNIA STREET, 40TH FLOOR SAN FRANCISCO, CA 94104

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
JP MORGAN ASSET MANAGEMENT	270 PARK AVENUE NEW YORK, NY 10017

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation	
PGIM FIXED INCOME	655 BROAD STREET NEWARK, NJ 07102

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

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

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

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

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

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

NORTHWEST ADMINISTRATORS, INC.

91-0680697

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 12 13 15 50	NONE	1264022	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

AETNA

06-6033492

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	743832	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VERA WHOLE HEALTH, INC

20-8906429

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	600071	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

WITHUMSMITH+BROWN, PC

22-2027092

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	122415	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BROWN & BROWN INSURANCE SERVICES IN

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?
16 23 50 53	NONE	102000	Yes [X] No [ ]	Yes [ ] No [X]	39927	Yes [ ] No [X]

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

UNITE HERE LOCAL 8

91-0968179

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	PARTICIPATING LOCAL	72786	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 NETWORK, INC.

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?
49 50 53	NONE	60665	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WEINBERG, ROGERS & ROSENFELD

94-2458080

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	48077	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BANK OF AMERICA, NA

94-1687665

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 50	NONE	36445	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

US BANK N.A.

31-0841368

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 51 62 68	NONE	29650	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [ ]

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

KRISTIN MANWARING INSURANCE

20-4650764

(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 23 50	NONE	24000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

RBC WEALTH MANAGEMENT

41-1416330

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	22917	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)

SERVICE PRINTING COMPANY, INC.

91-0830372

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	15036	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

AUKEMA & ASSOCIATES, IN

94-1701048

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 17 50	NONE	5122	Yes [ ] No [X]	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
BROWN & BROWN INSURANCE SERVICES IN	53	6199

(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.
AETNA 06-6033492	INSURANCE COMMISSIONS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
BROWN & BROWN INSURANCE SERVICES IN	53	3799

(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.
AMERITAS 47-0098400	INSURANCE COMMISSIONS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
BROWN & BROWN INSURANCE SERVICES IN	53	29928

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ULLICO 1325 FOURTH AVENUE, SUITE 1705 SEATTLE, WA 98101	INSURANCE COMMISSION

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)

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 06/01/2024 and ending 05/31/2025

A Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES, UNITEHERE NORTHWEST HEALTH TRUST FUND

D Employer Identification Number (EIN)
91-0590441

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	-436761	-90741
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3199418	3284700
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	436519	1219439
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	4599111	4111136
(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)	90584279	100158309
(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	98382566	108682843
Liabilities			
g Benefit claims payable	1g	6401870	8792000
h Operating payables	1h	139763	297327
i Acquisition indebtedness	1i		
j Other liabilities	1j	82174	34922
k Total liabilities (add all amounts in lines 1g through1j)	1k	6623807	9124249
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	91758759	99558594

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)	37243853	
(B) Participants	2a(1)(B)	97933	
(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)		37341786
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	19154	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		19154
(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)	3771517	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		3771517
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(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)		2360763
c Other income	2c		2520619
d Total income. Add all **income** amounts in column (b) and enter total	2d		46013839
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	33281767	
(2) To insurance carriers for the provision of benefits	2e(2)	1740621	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		35022388
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)	2071358	
(3) Recordkeeping fees	2i(3)	92303	
(4) IQPA audit fees	2i(4)	30160	
(5) Investment advisory and investment management fees	2i(5)	22917	
(6) Bank or trust company trustee/custodial fees	2i(6)	66095	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	48077	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	14048	
(11) Other expenses	2i(11)	846658	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		3191616
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		38214004
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		7799835
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: WITHUMSMITH+BROWN, PC **(2)** EIN: 22-2027092

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**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**	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**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**		X	
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 [X] 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 _____.

UniteHERE Northwest Health Trust Fund
Financial Statements
May 31, 2025 and 2024
With Independent Auditor's Reports

withum
ADVISORY TAX AUDIT

UniteHERE Northwest Health Trust Fund
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May 31, 2025 and 2024

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ADVISORY TAX AUDIT

Independent Auditor's Report

To the Trustees and Participants of
UniteHERE Northwest Health Trust Fund:

Opinion

We have audited the financial statements of UniteHERE Northwest Health Trust Fund, 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 as of May 31, 2025 and 2024 and the related statements of changes in net assets available for benefits for the years then ended and the statements of benefit obligations as of May 31, 2025 and 2024 and the related statements of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits as of May 31, 2025 and 2024 and the changes in net assets available for benefits for the years then ended and the benefit obligations as of May 31, 2025 and 2024 and the changes in benefit obligations for the years then ended, of UniteHERE Northwest Health Trust Fund in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about UniteHERE Northwest Health Trust Fund's ability to continue as a going concern for at least one year following the date that 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.

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Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, 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 GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of UniteHERE Northwest Health Trust Fund'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 UniteHERE Northwest Health Trust Fund's ability to continue as a going concern for a reasonable period of time.

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

Withum Smith + Brown, PC

March 12, 2026

UniteHERE Northwest Health Trust Fund
Statements of Net Assets Available for Benefits
May 31, 2025 and 2024

	2025	2024
Assets		
Cash	$ 4,020,395	$ 4,162,350
Investments at fair value		
Mutual funds	90,235,741	81,534,438
Short-term investment fund	9,922,568	9,049,841
Total investments at fair value	100,158,309	90,584,279
Receivables		
Employer contributions	3,284,700	3,199,418
Formulary rebates	315,000	210,045
Stop-loss refunds	866,684	183,841
Accrued interest and dividends	35,243	41,339
Total receivables	4,501,627	3,634,643
Prepaid expenses	2,512	1,294
Total assets	108,682,843	98,382,566
Liabilities		
Accounts payable and accrued expenses	297,327	139,763
Due to related parties	34,922	82,174
Total liabilities	332,249	221,937
Net assets available for benefits	$ 108,350,594	$ 98,160,629

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

UniteHERE Northwest Health Trust Fund
Statements of Changes in Net Assets Available for Benefits
Years Ended May 31, 2025 and 2024

	2025	2024
Additions		
Investment income, net		
Net appreciation in fair value of investments	$ 2,360,763	$ 1,000,229
Interest and dividends	3,790,671	3,303,975
Investment expenses	(52,567)	(52,656)
Total investment income, net	6,098,867	4,251,548
Employer contributions	37,243,853	31,695,391
COBRA contributions	97,933	85,887
Stop-loss refunds	1,724,432	356,914
Other income	796,187	582,963
Total additions	45,961,272	36,972,703
Deductions		
Cost of benefits		
Group medical insurance premiums	1,740,621	1,603,595
Medical benefits	25,899,026	17,586,836
Prescription drug benefits	3,459,095	2,860,148
Dental benefits	1,526,141	1,265,921
Disability benefits	7,375	17,234
Total cost of benefits	32,632,258	23,333,734
Administrative expenses	3,139,049	2,410,701
Total deductions	35,771,307	25,744,435
Net change in net assets available for benefits	10,189,965	11,228,268
Net assets available for benefits		
Beginning of year	98,160,629	86,932,361
End of year	$ 108,350,594	$ 98,160,629

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

UniteHERE Northwest Health Trust Fund
Statements of Benefit Obligations
May 31, 2025 and 2024

	2025	2024
Amounts currently payable		
Claims payable and incurred but not reported	$ 8,792,000	$ 6,401,870
Other benefit obligations for current benefit coverage - at present value of estimated amounts, net of amounts currently payable		
Accumulated eligibility credits	5,691,000	4,160,000
Total benefit obligations	$ 14,483,000	$ 10,561,870

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

UniteHERE Northwest Health Trust Fund
Statements of Changes in Benefit Obligations
Years Ended May 31, 2025 and 2024

	2025	2024
Amounts currently payable		
Balance at beginning of year	$ 6,401,870	$ 3,826,884
Increase during the year attributable to changes in claims payable and incurred but not reported	2,390,130	2,574,986
Balance at end of year	8,792,000	6,401,870
Postemployment benefit obligations, net of amounts currently payable		
Balance at beginning of year	4,160,000	3,567,000
Increase during the year attributable to changes in accumulated eligibility credits	1,531,000	593,000
Balance at end of year	5,691,000	4,160,000
Total benefit obligations at end of year	$ 14,483,000	$ 10,561,870

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

1. Description of Plan

The following description of the UniteHERE Northwest Health Trust Fund (the "Plan") provides only general information. Participants should refer to the Plan agreement for a more complete description of the Plan's provisions.

General
The Plan is a multiemployer defined benefit health and welfare plan that was established in 1976 as a result of collective bargaining agreements ("CBA") with participating employers in Washington and Oregon.

Administration
Administration of the Plan is the responsibility of the Board of Trustees (the "Trustees") and is governed by a joint board consisting of equal representation from the participating employers and various unions.

Benefits
The Plan provides health care, death, weekly disability, dental, hearing, vision, and accidental death and dismemberment benefits for eligible participants and their dependents.

Eligibility
To initially become eligible for benefits, participants must be employed by one or more contributing employers and must have completed the number of hours of employment as specified by their industry classification for which contributions are made on their behalf.

General eligibility rules under the Plan are as follows:

Participants and their dependents may become eligible for benefits under the Plan if they satisfy one of the two following conditions:

1. The participant works as an employee in a collective bargaining unit for which the employer has entered into a collective bargaining agreement; or

2. The participant is not an employee in such a collective bargaining unit, but works as an employee for an employer in employment covered by a special agreement.

If condition (1) is satisfied, a participant can become eligible for benefits in accordance with Eligibility Rule A or Eligibility Rule B, which are described below, depending on the number of hours worked per month.

If condition (2) is satisfied, a participant can become eligible for benefits only in accordance with the terms of a special agreement.

Under Eligibility Rule A, eligibility is authorized by the Plan for individuals who work a minimum of 65 or 80 hours per month, depending on the actual number of hours established by the employer and the union in the collective bargaining agreement or established in a special agreement.

Under Eligibility Rule B, eligibility is authorized by the Plan for individuals who work a minimum number of hours per month (but not less than 30 hours per month) established by the employer and the union in the collective bargaining agreement. Not all collective bargaining agreements provide for eligibility under Eligibility Rule B. Individuals eligible under Eligibility Rule B are not eligible for vision benefits, hearing benefits or dental benefits, and dependents are not eligible for any benefits under the Plan.

A participant will become eligible for benefits on the first day of the second calendar month following three consecutive months during which they have worked required hours in each month and for which the employer has paid all required employer contributions on a participant’s behalf. In addition, there may be a probationary period established by the collective bargaining agreement. A participant must be actively at work on that day for coverage to begin as scheduled. If they are not at work on that day, coverage will not begin until returning to active work.

For full coverage to begin, a participant may be required to elect whether to make employee contributions through payroll deductions, as outlined in the collective bargaining agreement.

If a participant does not elect to make an employee contribution, the participant and their dependents will be eligible for vision and life benefits only. A participant will not be able to change the election until the beginning of the next collective bargaining agreement.

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

In July 2020, the Board of Trustees approved a five-year pilot program for early retiree coverage. The program would allow participants who have met the service requirements to retire prior to age 65 and to maintain health coverage until they are eligible for Medicare. To be eligible for coverage under the proposed early retiree health coverage program, enrollees must be at least age 55, be retired, have a minimum of twenty (20) years of service in the health plan or the equivalent number of months (240), and have first exhausted their eighteen (18) months of continuation coverage under COBRA. If the enrollee meets these requirements, coverage would then run from the end of their COBRA coverage to the month in which their eligibility for Medicare begins. The cost of coverage will be the same as for COBRA coverage. If, at the end of the five-year pilot period, the program is terminated, any current enrollees would remain covered until they are eligible for Medicare. The Plan's consultant has advised the Board of Trustees that, because contributions from participants fund 100% of the cost of retiree benefits, the Plan has no obligation for postretirement benefits.

Stop-Loss Coverage
Certain self-funded medical benefits are paid under the terms of a stop-loss insurance policy. If the claims paid on behalf of an eligible participant exceed the deductible during the policy year, the carrier will reimburse the Plan for the excess in accordance with the terms of the stop-loss insurance arrangement. The deductible for the policy years ended May 31, 2025 and 2024 was $350,000. During the years ended May 31, 2025 and 2024, the Plan received stop-loss refunds of $1,724,432 and $356,914, respectively.

2. Summary of Accounting Policies

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

Use of Estimates
The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Investment Valuation and Income Recognition
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. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by the investment advisers, custodians and insurance company, as applicable. See Note 6 for discussion of fair value measurements.

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 (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Employer Contributions and Related Receivables
Employers are required to make monthly contributions based on the number of hours worked multiplied by a participant's hourly contribution rate.

Employer contributions due but not paid at year-end are recorded as employer contributions receivable. Management has evaluated contributions receivable and believes all amounts are fully collectible. Therefore, an estimate for current expected credit losses is not provided.

The collectability of contributions due as a result of payroll audits is uncertain. In determining the amount of the allowance as of the financial statement date, management developed a loss rate based on management's historical collection experience, adjusted for management's expectations about current and future economic conditions. At May 31, 2025, management believes its historical loss rate is a reasonable and supportive forecast for current and future economic and industry conditions.

Payment of Benefits
Premiums paid are recorded as group medical insurance premiums in the statements of changes in net assets available for benefits. Claim payments are recorded when submitted to the Plan by the third-party claims processor for reimbursement.

Benefit Obligations
Claims payable and incurred but not reported and accumulated eligibility credits were estimated by the Plan based on historical claims experience data. The Plan has no obligation to provide benefits to retirees; therefore, post-retirement benefit obligations are not recorded on the financial statements.

Administrative Expenses
Expenses incurred in connection with the general administration of the Plan are recorded as deductions in the accompanying statements of changes in net assets available for benefits. Certain investment-related expenses are included in net appreciation or depreciation in fair value of investments.

Subsequent Events
Subsequent events were evaluated through March 12, 2026, the date the financial statements were available to be issued.

3. Plan Termination

Although the Trustees have not expressed intent to discontinue the Plan, they may do so at any time subject to the provisions of ERISA and the terms of the CBA. In the event of Plan termination, the assets of the Plan would continue to be used to pay reasonable administrative expenses and to distribute and apply remaining surplus as the Trustees so determine, until no assets remain. Termination shall not permit any part of the Plan to be used for, or diverted to, purposes other than the exclusive benefit of the participants.

4. Tax Status

The Plan obtained its latest exemption letter, dated October 27, 1986, in which the Internal Revenue Service stated that the Plan was qualified under Section 501(c)(9) of the Internal Revenue Code and, therefore, is not subject to tax under present income tax laws. The Plan has been amended since receiving the exemption letter. However, the Plan's administrator and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, they believe that the Plan was qualified and the related trust was tax exempt as of the financial statement date.

Plan management is required to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

5. Funding Policy

The Plan is financed by employer and participant contributions and from members electing COBRA coverage. The monthly employer contribution rate is specified in the collective bargaining agreements. The rate for COBRA coverage is determined by the Board of Trustees. Employer contributions include participant contributions, which are deducted from participant wages on certain employees who have not been separately identified in the statements of changes in net assets available for benefits.

6. Fair Value Measurements

The framework for measuring fair value 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) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820, *Fair Value Measurement*, are described as follows:

Level 1 - Inputs to the valuation technique are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 - Inputs to the valuation technique 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;
- 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 technique are unobservable and significant to the fair value measurement.

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

Following is a description of the valuation techniques used for assets measured at fair value. There have been no changes in the techniques used at May 31, 2025 and 2024.

Short-term investment fund: The fair value of the short-term investment fund, which is not actively traded, is based on cost, which approximates fair value of the underlying investments (Level 2).

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

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of May 31, 2025 and 2024:

	May 31, 2025			
	Level 1	**Level 2**	**Level 3**	**Total**
Short-term investment fund	$ -	$ 9,922,568	$ -	$ 9,922,568
Mutual funds	90,235,741	-	-	90,235,741
Total investments at fair value	$ 90,235,741	$ 9,922,568	$ -	$ 100,158,309

	May 31, 2024			
	Level 1	**Level 2**	**Level 3**	**Total**
Short-term investment fund	$ -	$ 9,049,841	$ -	$ 9,049,841
Mutual funds	81,534,438	-	-	81,534,438
Total investments at fair value	$ 81,534,438	$ 9,049,841	$ -	$ 90,584,279

7. Concentrations

The Plan has significant cash balances at financial institutions insured by the Federal Deposit Insurance Corporation, which throughout the year regularly exceed the federally insured limit of $250,000. Any loss incurred or lack of access to such funds could have a significant adverse impact on the Plan's financial condition, results of operations, and cash flows. As of May 31, 2025 and 2024, the Plan's cash accounts exceeded federally insured limits by approximately $3,770,395 and $3,912,350, respectively.

8. Risks and Uncertainties

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

9. Related-Party and Party In Interest Transactions

The Plan has two related organizations, UniteHERE Local Union 8 (“Local Union 8”) and UniteHERE Northwest Pension Trust Fund (the “Pension Plan”). The Pension Plan merged into the Western UNITE HERE and Employers Pension Fund effective December 31, 2023. The Plan and the Pension Plan (collectively, the “trust funds”) retain a trust coordinator who provides information and assistance to the trust funds’ participants. The trust funds have entered into an agreement with Local Union 8 to allow the trust coordinator to maintain an office at Local Union 8 and have Local Union 8 serve as the payroll agent for the trust funds. The trust funds reimburse Local Union 8 for salary, payroll taxes, fringe benefits, parking, telephone and postage associated with the trust coordinator. For the years ended May 31, 2025 and 2024, reimbursements paid by the Plan for these expenses totaled $72,786 and $64,268, respectively.

The Plan shares common trustees and certain expenses, including travel, conference fees and trust coordinator expenses, with the Pension Plan. In addition, contributions from employers are remitted to a lockbox account held by the Plan. These contributions are reconciled and the portion belonging to the Pension Plan is transferred on a periodic basis.

As of May 31, 2025 and 2024, the net amounts due from the Plan to the Pension Plan totaled $34,922 and $82,174, respectively.

10. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements at May 31, 2025 and 2024, to Form 5500:

	2025	2024
Net assets available for benefits per the financial statement	$ 108,350,594	$ 98,160,629
Benefit obligations currently payable	(8,792,000)	(6,401,870)
Net assets available for benefits per Form 5500	$ 99,558,594	$ 91,758,759

The following is a reconciliation of benefits paid to or for participants per the financial statements for the years ended May 31, 2025 and 2024, to Form 5500:

	2025	2024
Benefits paid to or for participants per the financial statements	$ 32,632,258	$ 23,333,734
Add: Amounts currently payable at end of year	8,792,000	6,401,870
Less: Amounts currently payable at beginning of year	(6,401,870)	(3,826,884)
Benefits paid to or for participants per Form 5500	$ 35,022,388	$ 25,908,720

11. Restricted Net Assets

On January 24, 2019, the Board of Trustees approved segregating approximately three months' worth of reserves ($8.4 million) to explore the idea of the Plan establishing a health clinic. During the year ended May 31, 2024, the Plan began using these reserves to launch a partnership with Vera Clinic. During the years ended May 31, 2025 and 2024, the plan used $615,142 and $135,000, and the remaining reserve amounts as of May 31, 2025 and 2024 were $7,649,858 and $8,265,000, respectively. These restricted assets are included in the total net assets of the Plan.

12. Operating expenses

The Plan recorded the following expenses for the years ended May 31, 2025 and 2024:

	2025	2024
Administrative expenses		
Claims processing fees	$ 1,553,194	$ 1,433,705
Vera clinic fees	600,071	135,000
Plan administrative expenses	518,789	441,278
Consulting fees	126,000	126,000
Audit and accounting fees	122,463	64,542
Cost containment and member assistance services	60,665	63,947
Legal fees	48,077	47,237
Bank fees	36,445	33,324
Printing, postage and other expenses	31,702	16,313
Insurance expenses	18,661	10,457
Meeting expenses	14,048	13,620
PCORI fee	8,059	9,388
Regulatory compliance project	875	15,890
Total administrative expenses	$ 3,139,049	$ 2,410,701

Supplementary Information

withum
ADVISORY TAX AUDIT

Report on Supplemental Information Required by the Department of Labor's Rules and Regulations for Reporting and Disclosure Under the Employee Retirement Income Security Act of 1974 ("ERISA")

Independent Auditor's Report

To the Board of Trustees of
UniteHERE Northwest Health Trust Fund:

We have audited the financial statements of UniteHERE Northwest Health Trust Fund as of and for the years ended May 31, 2025 and 2024, and have issued our report thereon dated March 12, 2026, which contained an unmodified opinion on those financial statements.

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules, Schedule H, Line 4i - Schedule of Assets (Held at End of Year) and Schedule H, Line 4j - Schedule of Reportable Transactions as of and for the year ended May 31, 2025 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 ("DOL") 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 auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying supplemental 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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

WithumSmith+Brown, PC

March 12, 2026

UniteHERE Northwest Health Trust Fund
Schedule H, Line 4i - Schedule of Assets (Held at End of Year)
EIN: 91-0590441 Plan Number: 501
May 31, 2025

(b) Identity of Issue, Borrower, Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	(d) Cost	(e) Current Value
First Am Govt Ob Fd Cl Z	Short-term investment fund	$ 9,922,568	$ 9,922,568
American Eupac Fund Class R6	Mutual fund - equity	989,000	1,047,248
Fidelity Total Market Index Fund	Mutual fund - equity	9,730,309	12,254,914
Dodge Cox Income	Mutual fund - fixed income	19,002,051	19,823,881
Fidelity US Bond Index	Mutual fund - fixed income	18,836,627	17,384,255
Jpmorgan Core Bond Fund Class R6	Mutual fund - fixed income	19,547,477	19,807,434
Pgim Total Return Bond Cl R6	Mutual fund - fixed income	21,669,241	19,918,009
Total investments		$ 99,697,273	$ 100,158,309

See Independent Auditor's Report on Supplementary Information.

UniteHERE Northwest Health Trust Fund
Schedule H, Line 4i - Schedule of Reportable Transactions
EIN: 91-0590441 Plan Number: 501
Year Ended May 31, 2025

(a)	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(e) Lease Rental	(f) Expenses	(g) Cost	(h) Current Value	(i) Net Gain/(Loss)
	See attached.	$ -	$ -	$ -	$ -	$ 19,096,859	$ 18,890,290	$ (206,569)

See Independent Auditor's Report on Supplementary Information.

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
	BEGINNING MARKET VALUE				**90,625,748.49**		
	COMPARATIVE VALUE (5%)				**4,531,287.42**		

CATEGORY 1 - SINGLE TRANSACTION EXCEEDS 5% OF VALUE
NO TRANSACTIONS QUALIFIED FOR THIS SECTION

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

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

Issue: 316146356 - Fidelity US Bond Index

06/18/2024 6746036207	B	27,016.521	10.2900		- 278,000	278,000
07/18/2024 6746036207	B	2,613.746	10.3300		- 27,000	27,000
09/18/2024 6746036207	B	26,217.228	10.6800		- 280,000	280,000
10/18/2024 6746036207	B	18,529.131	10.4700		- 194,000	194,000
11/19/2024 6746036207	B	26,893.204	10.3000		- 277,000	277,000
12/20/2024 6746036207	B	2,834.800	10.2300		- 29,000	29,000
01/21/2025 6746036207	B	684.262	10.2300		- 7,000	7,000
02/20/2025 6746036207	B	1,265.823	10.2700		- 13,000	13,000
	Total For Buys			**0**	**1,105,000**	**1,105,000**	**0**

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
06/30/2024 6746036207	R	5,046.461	10.2000		- 51,474	51,474	
07/31/2024 6746036207	R	5,156.159	10.4000		- 53,624	53,624	
08/31/2024 6746036207	R	5,136.994	10.5200		- 54,041	54,041	
09/30/2024 6746036207	R	4,999.467	10.6400		- 53,194	53,194	
10/31/2024 6746036207	R	5,391.183	10.3400		- 55,745	55,745	
11/30/2024 6746036207	R	5,311.179	10.4200		- 55,342	55,342	
12/01/2024 6746036207	R	5,727.275	10.2200		- 58,533	58,533	
01/31/2025 6746036207	R	5,779.993	10.2400		- 59,187	59,187	
02/28/2025 6746036207	R	5,304.491	10.4400		- 55,379	55,379	
03/31/2025 6746036207	R	5,780.125	10.4100		- 60,171	60,171	
04/30/2025 6746036207	R	5,644.392	10.4200		- 58,815	58,815	
05/31/2025 6746036207	R	5,185.847	10.3100		- 53,466	53,466	
Total For Reinvestments				**0**	**668,971**	**668,971**	**0**
08/20/2024 6746036207	S	- 10,879.849	10.5700		115,000	122,126	- 7,126

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
03/20/2025 6746036207	S	- 17,098.943	10.4100		178,000	191,147	- 13,147
04/17/2025 6746036207	S	- 9,514.563	10.3000		98,000	106,340	- 8,340
04/30/2025 6746036207	S	- 235,220.729	10.4200		2,451,000	2,628,956	- 177,956
Total For Sells				**0**	**2,842,000**	**3,048,569**	**- 206,569**
Total Fidelity US Bond Index				**0**	**4,615,971**	**4,822,540**	**- 206,569**
Issue: 31846V567 - First Am Govt Ob Fd Cl Z							
06/04/2024 6746036200	B	41,338.620	1.0000		- 41,339	41,339	
06/04/2024 6746036207	B	131.850	1.0000		- 132	132	
06/07/2024 6746036200	B	1,200,000.000	1.0000		- 1,200,000	1,200,000	
06/18/2024 6746036207	B	1,005,000.000	1.0000		- 1,005,000	1,005,000	
06/21/2024 6746036200	B	131.850	1.0000		- 132	132	
07/02/2024 6746036200	B	40,950.150	1.0000		- 40,950	40,950	
07/02/2024 6746036207	B	285.970	1.0000		- 286	286	
07/19/2024 6746036207	B	105,000.000	1.0000		- 105,000	105,000	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
07/22/2024 6746036200	B	105,285.970	1.0000		- 105,286	105,286	
08/02/2024 6746036200	B	41,161.190	1.0000		- 41,161	41,161	
08/02/2024 6746036207	B	45.530	1.0000		- 46	46	
08/21/2024 6746036207	B	110,000.000	1.0000		- 110,000	110,000	
08/22/2024 6746036200	B	110,045.530	1.0000		- 110,046	110,046	
09/04/2024 6746036200	B	41,722.520	1.0000		- 41,723	41,723	
09/04/2024 6746036207	B	15.700	1.0000		- 16	16	
09/09/2024 6746036200	B	1,400,000.000	1.0000		- 1,400,000	1,400,000	
09/18/2024 6746036207	B	1,129,000.000	1.0000		- 1,129,000	1,129,000	
09/23/2024 6746036200	B	15.700	1.0000		- 16	16	
10/02/2024 6746036200	B	41,811.490	1.0000		- 41,811	41,811	
10/02/2024 6746036207	B	159.410	1.0000		- 159	159	
10/18/2024 6746036207	B	142,000.000	1.0000		- 142,000	142,000	
10/22/2024 6746036200	B	159.410	1.0000		- 159	159	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
11/04/2024 6746036200	B	39,736.580	1.0000		- 39,737	39,737	
11/04/2024 6746036207	B	55.720	1.0000		- 56	56	
11/12/2024 6746036200	B	867,000.000	1.0000		- 867,000	867,000	
11/20/2024 6746036207	B	55.720	1.0000		- 56	56	
11/22/2024 6746036200	B	55.720	1.0000		- 56	56	
12/03/2024 6746036200	B	37,703.460	1.0000		- 37,703	37,703	
12/03/2024 6746036207	B	.130	1.0000				
12/20/2024 6746036200	B	44.220	1.0000		- 44	44	
12/23/2024 6746036200	B	32,000.130	1.0000		- 32,000	32,000	
12/23/2024 6746036207	B	32,000.000	1.0000		- 32,000	32,000	
01/03/2025 6746036200	B	37,077.220	1.0000		- 37,077	37,077	
01/21/2025 6746036207	B	206,000.000	1.0000		- 206,000	206,000	
02/04/2025 6746036200	B	35,646.640	1.0000		- 35,647	35,647	
02/04/2025 6746036207	B	24.040	1.0000		- 24	24	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
02/21/2025 6746036207	B	192,000.000	1.0000		- 192,000	192,000	
02/25/2025 6746036200	B	192,024.040	1.0000		- 192,024	192,024	
03/04/2025 6746036200	B	31,770.690	1.0000		- 31,771	31,771	
03/04/2025 6746036207	B	89.330	1.0000		- 89	89	
03/20/2025 6746036207	B	36,000.000	1.0000		- 36,000	36,000	
03/24/2025 6746036200	B	89.330	1.0000		- 89	89	
04/02/2025 6746036200	B	35,596.770	1.0000		- 35,597	35,597	
04/02/2025 6746036207	B	4.350	1.0000		- 4	4	
04/17/2025 6746036207	B	114,000.000	1.0000		- 114,000	114,000	
05/01/2025 6746036200	B	68,000.000	1.0000		- 68,000	68,000	
05/01/2025 6746036207	B	68,000.000	1.0000		- 68,000	68,000	
05/02/2025 6746036200	B	34,235.260	1.0000		- 34,235	34,235	
05/02/2025 6746036207	B	52.520	1.0000		- 53	53	
Total For Buys				**0**	**7,573,524**	**7,573,524**	**0**

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
06/18/2024 6746036200	S	- 1,005,000.000	1.0000		1,005,000	1,005,000	
06/20/2024 6746036207	S	- 1,005,000.000	1.0000		1,005,000	1,005,000	
06/21/2024 6746036207	S	- 131.850	1.0000		132	132	
06/26/2024 6746036200	S	- 6,784.390	1.0000		6,784	6,784	
07/22/2024 6746036207	S	- 105,285.970	1.0000		105,286	105,286	
08/22/2024 6746036207	S	- 110,045.530	1.0000		110,046	110,046	
09/18/2024 6746036200	S	- 1,129,000.000	1.0000		1,129,000	1,129,000	
09/19/2024 6746036207	S	- 1,129,000.000	1.0000		1,129,000	1,129,000	
09/23/2024 6746036207	S	- 15.700	1.0000		16	16	
09/26/2024 6746036200	S	- 7,203.060	1.0000		7,203	7,203	
10/18/2024 6746036200	S	- 142,000.000	1.0000		142,000	142,000	
10/21/2024 6746036207	S	- 142,000.000	1.0000		142,000	142,000	
10/22/2024 6746036207	S	- 159.410	1.0000		159	159	
11/20/2024 6746036200	S	- 900,000.000	1.0000		900,000	900,000	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
11/20/2024 6746036207	S	- 55.720	1.0000		56	56	
11/22/2024 6746036207	S	- 55.720	1.0000		56	56	
12/23/2024 6746036207	S	- 32,000.130	1.0000		32,000	32,000	
12/26/2024 6746036200	S	- 7,440.230	1.0000		7,440	7,440	
01/21/2025 6746036200	S	- 206,000.000	1.0000		206,000	206,000	
01/22/2025 6746036207	S	- 206,000.000	1.0000		206,000	206,000	
02/25/2025 6746036207	S	- 192,024.040	1.0000		192,024	192,024	
03/20/2025 6746036200	S	- 36,000.000	1.0000		36,000	36,000	
03/21/2025 6746036207	S	- 36,000.000	1.0000		36,000	36,000	
03/24/2025 6746036207	S	- 89.330	1.0000		89	89	
03/26/2025 6746036200	S	- 7,504.100	1.0000		7,504	7,504	
04/17/2025 6746036200	S	- 114,000.000	1.0000		114,000	114,000	
04/21/2025 6746036207	S	- 114,000.000	1.0000		114,000	114,000	
05/01/2025 6746036207	S	- 68,000.000	1.0000		68,000	68,000	

FORM 5500 - REPORTABLE TRANSACTION SCHEDULE (continued)

DATE	BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
	Total For Sells			**0**	**6,700,795**	**6,700,795**	**0**
	Total First Am Govt Ob Fd Cl Z			**0**	**14,274,319**	**14,274,319**	**0**
	GRAND TOTAL			**0**	**18,890,290**	**19,096,859**	**- 206,569**

CATEGORY 4 - SINGLE TRANSACTION WITH ONE BROKER EXCEEDS 5% OF VALUE

NO TRANSACTIONS QUALIFIED FOR THIS SECTION

UNITEHERE NORTHWEST HEALTH TRUST FUND

EIN 91-0590441
Plan No. 501
Plan Year Ended May 31, 2025

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

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

UNITEHERE NORTHWEST HEALTH TRUST FUND

EIN 91-0590441
Plan No. 501
Plan Year Ended May 31, 2025

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

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

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 06/01/2024 and ending 05/31/2025

A This return/report is for:
- [X] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ___

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

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [X]

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
UNITEHERE NORTHWEST HEALTH TRUST FUND

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, UNITEHERE
NORTHWEST HEALTH TRUST FUND

2323 EASTLAKE AVENUE EAST

SEATTLE WA 98102

2b Employer Identification Number (EIN) 91-0590441

2c Plan Sponsor's telephone number (206)329-4900

2d Business code (see instructions) 721110

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	Signed by: Erik Van Rossum 505178990DA24A0...	3/13/2026 | 1:27 PM PDT	ERIK VAN ROSSUM
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	DocuSigned by: Doug Rigoni B7181E90E8914D0...	3/13/2026 | 1:31 PM PDT	DOUG RIGONI
	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:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		

5	Total number of participants at the beginning of the plan year	**5**	2,469
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)**	2,467
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	2,603
b	Retired or separated participants receiving benefits	**6b**	2
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2,605
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**	27

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

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

4A 4B 4D 4E 4F 4Q

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(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 6
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

ACCIDENTAL DEATH AND DISMEMBERMENT

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_____

Printing Specialties and Paper Products Joint Employer and Union Health and Welfare Fund

EIN 95-6035137
Plan No. 501
Plan Year Ended January 31, 2025

Form 5500, Schedule H, Part III
Financial Statements used to formulate IQPA's opinion

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