

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 2025 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan ORENCO SYSTEMS INC. MEDICAL AND DENTAL PLAN
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 09/01/1995
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) ORENCO SYSTEMS INC. 814 AIRWAY AVENUE SUTHERLIN, OR 97479
2b	Employer Identification Number (EIN) 93-0781063
2c	Plan Sponsor's telephone number 541-459-4449
2d	Business code (see instructions) 326100

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.	07/13/2026	TIM WILLHOFT
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 299
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 299 6a(2) 270 6b 0 6c 0 6d 270 6e 6f 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 0

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

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

4A 4D 4E

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 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 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025		
A Name of plan ORENCO SYSTEMS INC. MEDICAL AND DENTAL PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ORENCO SYSTEMS INC.	D Employer Identification Number (EIN) 93-0781063	

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

(a) Name of insurance carrier PACIFICSOURCE HEALTH PLANS					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0245545	54976	G0020307	471	01/01/2025	12/31/2025

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 43829	(b) Total amount of fees paid 4170
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
USI INSURANCE SERVICES LLC	975 OAK STREET, SUITE 900 EUGENE, OR 97401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
43829	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
USI INSURANCE SERVICES LLC	100 SUMMIT LAKE DRIVE, SUITE 400 VALHALLA, NY 10595

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	4170	RETENTION BONUS	3

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

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

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	3514490
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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



Authorization to Electronically Sign and EFile Health and Welfare Form 5500

I hereby authorize any employee of Ascensus' Wrangle Team ("Wrangle") to electronically sign and transmit the Health and Welfare (H&W) Form 5500 on my behalf through EFAST 2.

I further understand the following in granting this authority:

I, the Plan Administrator/Plan Sponsor and signer, have the final responsibility for the information reported in the H&W Form 5500, and by signing below I acknowledge that I have reviewed and accepted the information as accurate and correct.

I am providing to Wrangle a PDF copy of the first three pages of the Form 5500 with signature(s) and date. These signed copies are required per Department of Labor (DOL) rules and will be attached to the H&W Form 5500 when transmitted.

Ascensus, LLC and the Wrangle Team are not liable for and do not have a duty to indemnify or hold the Plan Administrator/Plan Sponsor harmless from any penalties, damages, incidental charges or consequential damages imposed or caused as a result of the transmission of the H&W Form 5500 on my behalf. Wrangle is merely providing an option to me that will make the filing process easier should I elect this option. Ascensus LLC, the Wrangle Team and its employees shall not be deemed an administrator or other fiduciary with respect to any plan. I understand that I do have the option to obtain signing credentials and to directly submit the H&W Form 5500 to the DOL electronically.

I will also sign and keep a copy of the completed H&W Form 5500 in my files, per ERISA.

An electronic image of my signature will be included with the rest of the H&W Form 5500 posted by the DOL on the internet for public disclosure.

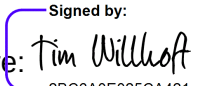
By the signature below, I am acknowledging that I am the person responsible for the H&W Form 5500 for the entity listed below and am authorizing Wrangle to submit this H&W Form 5500.

I may revoke or change authorization at any time by written notification to Wrangle.

Company/Entity Name: ORENCO SYSTEMS INC.

Plan Administrator Name: Tim Willhoft

Please print your name clearly or type in from your computer.

Plan Administrator Signature: 
Signed by: 2BC6A0E025CA421...

Date: 7/13/2026

Note: A copy of this authorization must be kept in your records.

Failure to follow these instructions and complete this form in its entirety, including signature, will delay transmission of the 5500.

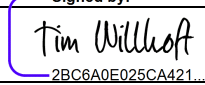
Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the 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 2025 This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A	This return/report is for: ☐ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☒ a single-employer plan ☐ a DFE (specify) _____ ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☐
D	Check box if filing under: ☐ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan ORENCO SYSTEMS INC. MEDICAL AND DENTAL PLAN
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 09/01/1995
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) ORENCO SYSTEMS INC. 814 AIRWAY AVENUE SUTHERLIN, OR 97479
2b	Employer Identification Number (EIN) 93-0781063
2c	Plan Sponsor's telephone number 541-459-4449
2d	Business code (see instructions) 326100

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:  2BC6A0E025CA421...	7/13/2026	Tim Willhoft
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☒ Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5 299
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 299 6a(2) 270 6b 0 6c 0 6d 270 6e 6f 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7

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

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

4A 4D 4E

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☒ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☒ General assets of the sponsor
--	--

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

a Pension Schedules

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

b General Schedules

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

Part III

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 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 2025 This Form is Open to Public Inspection
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For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025	
A Name of plan ORENCO SYSTEMS INC. MEDICAL AND DENTAL PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 ORENCO SYSTEMS INC.	D Employer Identification Number (EIN) 93-0781063

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

(a) Name of insurance carrier PACIFICSOURCE HEALTH PLANS					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0245545	54976	G0020307	471	01/01/2025	12/31/2025

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 43829	(b) Total amount of fees paid 4170
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
USI INSURANCE SERVICES LLC	975 OAK STREET, SUITE 900 EUGENE, OR 97401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
43829			3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	
USI INSURANCE SERVICES LLC	100 SUMMIT LAKE DRIVE, SUITE 400 VALHALLA, NY 10595

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	4170	RETENTION BONUS	3

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

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

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

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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

Part II		Investment and Annuity Contract Information	
Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.			
4		Current value of plan's interest under this contract in the general account at year end	4
5		Current value of plan's interest under this contract in separate accounts at year end	5
6 Contracts With Allocated Funds:			
a State the basis of premium rates ▶			
b		Premiums paid to carrier	6b
c		Premiums due but unpaid at the end of the year	6c
d		If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d
e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶			
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐			
7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)			
a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶			
b		Balance at the end of the previous year	7b
c		Additions: (1) Contributions deposited during the year	7c(1)
		(2) Dividends and credits	7c(2)
		(3) Interest credited during the year	7c(3)
		(4) Transferred from separate account	7c(4)
		(5) Other (specify below)	7c(5)
		▶	
		(6) Total additions	7c(6)
d		Total of balance and additions (add lines 7b and 7c(6)).	7d
e		Deductions:	
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
		(2) Administration charge made by carrier	7e(2)
		(3) Transferred to separate account	7e(3)
		(4) Other (specify below)	7e(4)
		▶	
		(5) Total deductions	7e(5)
f		Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f

Part III

Welfare Benefit Contract Information

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

8

Benefit and contract type (check all applicable boxes)

a☒ Health (other than dental or vision)

b☒ Dental

c☒ Vision

d☐ Life insurance

e☐ Temporary disability (accident and sickness)

f☐ Long-term disability

g☐ Supplemental unemployment

h☒ Prescription drug

i☐ Stop loss (large deductible)

j☐ HMO contract

k☐ PPO contract

l☐ Indemnity contract

m☐ Other (specify) ▶

9

Experience-rated contracts:

a

Premiums: (1) Amount received

9a(1)

(2) Increase (decrease) in amount due but unpaid

9a(2)

(3) Increase (decrease) in unearned premium reserve

9a(3)

(4) Earned ((1) + (2) - (3))

9a(4)

b

Benefit charges (1) Claims paid

9b(1)

(2) Increase (decrease) in claim reserves

9b(2)

(3) Incurred claims (add (1) and (2))

9b(3)

(4) Claims charged

9b(4)

c

Remainder of premium: (1) Retention charges (on an accrual basis) --

(A) Commissions

9c(1)(A)

(B) Administrative service or other fees

9c(1)(B)

(C) Other specific acquisition costs

9c(1)(C)

(D) Other expenses

9c(1)(D)

(E) Taxes

9c(1)(E)

(F) Charges for risks or other contingencies

9c(1)(F)

(G) Other retention charges

9c(1)(G)

(H) Total retention

9c(1)(H)

(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

9c(2)

d

Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement

9d(1)

(2) Claim reserves

9d(2)

(3) Other reserves

9d(3)

e

Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)

9e

10

Nonexperience-rated contracts:

a

Total premiums or subscription charges paid to carrier

10a

3514490

b

If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.

10b

Specify nature of costs.

Part IV

Provision of Information

11

Did the insurance company fail to provide any information necessary to complete Schedule A?

☐ Yes

☒ No

12

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

Carriers' Schedules

Initial
TW

I have reviewed the Carrier Schedules.

The following document(s) are the Schedules from the Carrier(s) of the Plan Sponsor's ERISA Plan.

These documents represent a snap shot taken on the last day of the policy period per the Carriers' systems. The data was copied and placed into the Plan Sponsor's 5500 report.

Please note: If the data was altered in any way, the liability of the data will no longer rest on the Carrier; instead, it would rest upon the Plan Sponsor/Plan Administrator.

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April 1, 2026

Orenco Systems Inc
814 Airway Ave
Sutherlin, OR 97479

We are providing you with the following information regarding your health/dental plan with PacificSource Health Plans pursuant to ERISA section 103(a)(2). You may be required to file a Form 5500 for this Plan and the following is the information to be included on Schedule A:

Insurance carrier: PacificSource Health Plans

EIN: 93-0245545 **NAIC code:** 54976

Contract #: G0020307

Persons covered at end of policy period:	Employees	270
	Dependents	201

Policy period: 01/01/2025 - 12/31/2025

Commission paid during policy period:

Mark Quinney
Kibble and Prentice Holding Co dba USI Ins Svcs NW
975 Oak St Ste 900
Eugene, OR 97401
\$ 43,829

New Group/Retention Bonus paid during policy period:

Kibble and Prentice Holding Co dba USI Ins Svcs NW
100 Summit Lake Dr Ste 400
Valhalla, NY 10595
\$ 4,170

Experience rated contracts: N/A

Nonexperience-rated contracts:	Premiums	\$	3,514,490
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Please contact the Quality Control Department at QCBusinessAnalysts@pacificsource.com if you have any questions regarding this information. We appreciate the opportunity to be of service to you.

Self-Insured Benefit

FSA / HRA

A Schedule A will not be included in the 5500 as the benefit was self-insured. A Schedule A is only to report fully insured benefits.

We did include the appropriate benefit code for the benefit and checked general assets for funding.

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Self-Insured Benefit

FSA

A Schedule A will not be included in the 5500 as the FSA benefit is self-insured. A Schedule A is only to report fully insured benefits.

We did include the appropriate benefit code (4A) for the benefit and checked general assets for funding.

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The Summary Annual Report...SAR

Initial
TW

I have reviewed the SAR.

The Summary Annual Report, also known by its acronym, the SAR, is, generally speaking, a one-page summary of the ERISA Plan's Form 5500 report. ERISA mandates for the SAR to be distributed to Plan Participants within two months from the Form 5500's due date (the SAR is not required to be issued if the plan is 100% self-funded such as a Health FSA plan).

The SAR's purpose is to inform the Plan Participants of the carriers and the policies included within the Form 5500 report. Additionally, funding is noted as well as the financials including the total premium spent and the claim total, if applicable.

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SUMMARY ANNUAL REPORT

For Orenco Systems Inc. Medical and Dental Plan

This is a summary of the annual report of the Orenco Systems Inc. Medical And Dental Plan, EIN 93-0781063, Plan No. 501, for period 01/01/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with Pacificsource Health Plans to pay Medical, Dental and Vision claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were \$3,514,490.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Orenco Systems Inc. at 814 Airway Avenue, Sutherlin, OR, 97479 or by telephone at 541-459-4449.

You also have the legally protected right to examine the annual report at the main office of the plan (Orenco Systems Inc., 814 Airway Avenue, Sutherlin, OR, 97479) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site www.efast.dol.gov.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no

person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)