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

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
- [X] a DFE (specify) G

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

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

D Check box if filing under:
- [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
OMNITRADE HEALTH TRUST ARRANGEMENT

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2011

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

P.O. BOX 75449
SEATTLE, WA 98175

2b Employer Identification Number (EIN)
27-6838771

2c Plan Sponsor's telephone number
425-771-7359

2d Business code (see instructions)
525100

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2026	JOHN SCATES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2026	JOHN SCATES
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [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

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	4294
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)**	4294
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	5168
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5168
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan 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 4B 4D 4E 4F 4H 4Q 4T

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 12
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [X] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... [X] 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.) ..... [X] 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 177037659

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

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL OF WASHINGTON

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
91-0621480	47341	352 776 777 ETC	3285	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	**(b)** Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	1689903
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

2025

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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
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
PREMERA BLUE CROSS

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
91-0499247	47570	100000055	1126	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	**(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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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	9428067		
(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)	9428067
b Benefit charges (1) Claims paid	9b(1)	10841623		
(2) Increase (decrease) in claim reserves	9b(2)	751698		
(3) Incurred claims (add (1) and (2))			9b(3)	11593321
(4) Claims charged			9b(4)	10785395
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)	1246552		
(E) Taxes	9c(1)(E)	204374		
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	1450926
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [X] credited.)			9c(2)	-2808254
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	1607698
(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	790655
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
PREMERA BLUE CROSS

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
91-0499247	47570	200000021	1259	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	**(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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	7e(2)			
	(3) Transferred to separate account	7e(3)			
	(4) Other (specify below)	7e(4)			
	▶				
	(5) Total deductions			7e(5)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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** [X] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [X] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	15692018	
	(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)	15692018
b	Benefit charges (1) Claims paid	9b(1)	16422630	
	(2) Increase (decrease) in claim reserves	9b(2)	-157398	
	(3) Incurred claims (add (1) and (2))		9b(3)	16265232
	(4) Claims charged		9b(4)	16096054
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)	1638680	
	(E) Taxes	9c(1)(E)	333590	
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention		9c(1)(H)	1972270
	(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [X] credited.)		9c(2)	-2376306
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
	(2) Claim reserves		9d(2)	2242602
	(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	987498
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
VISION SERVICE PLAN

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
23-7089668	53031	12032443	2631	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	**(b)** Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] 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	274682
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	151567	2469	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	(b) Total amount of fees paid
0	2831

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	2831	ADDITIONAL COMPENSATION	3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] 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) ▶ ACCIDENTAL DEATH & DISMEMBERMENT

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	161787
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	151568	77	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	(b) Total amount of fees paid
0	629

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] Life insurance
- **e** [ ] 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) ▶ ACCIDENTAL DEATH & DISMEMBERMENT

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	35917
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	934370	116	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	(b) Total amount of fees paid
0	634

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [X] 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	36216
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	934420	116	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	(b) Total amount of fees paid
0	630

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] 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**	36021
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
MODA HEALTH PLAN, 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
93-0438772	47098	100000057-61	1986	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	**(b)** Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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	18460183
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0438772	54941	100000057-61	1171	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	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	605930
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

(a) Name of insurance carrier
MODA HEALTH PLAN, 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
93-0438772	47098	10030794 ET AL	167	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	**(b)** Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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	405651
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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

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

1 Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
93-0438772	54941	10031515	25	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	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	8179
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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan	**B** Three-digit plan number (PN) ▶	
OMNITRADE HEALTH TRUST ARRANGEMENT		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
OMNITRADE HEALTH TRUST	27-6838771	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions).. . . . . ☐ Yes ☒ No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

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

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

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

ABD INSURANCE & FINANCIAL SERVICES,

27-0673528

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 16 22 23 49 50 53 61 70	NONE	1567459	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

VIMLY BENEFIT SOLUTIONS, INC

91-1603312

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 13 15 36 38 50 64	NONE	570862	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ASSOCIATED INDUSTRIES MANAGEMENT SE

91-1485366

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 13 15 36 38 50 64	NONE	542382	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)

ACRISURE LLC DBA RISQ CONSULTI

26-3554645

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	224093	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DAVIS WRIGHT TREMAINE, LLP

91-0839480

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 29 50	NONE	207936	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE BALDWIN GROUP MID-ATLANTIC, LLC

54-0654623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	196886	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)

PARKER SMITH & FEEK INSURANCE, LLC

87-2544519

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	182286	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ACRISURE NW PARTNERS INSURANCE SERV

92-1242214

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	157479	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WILSON ALBERS AN ALERA GROUP AGENCY

82-3775054

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	145876	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

DIGITAL INSURANCE, INC.

58-2522668

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	142490	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

GALLAGHER BENEFIT SERVICES

36-4291971

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	120389	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ALASKA EMPLOYEE BENEFITS, INC

71-0869170

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	108602	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)

AURORA NATIONAL INSURANCE

82-1257465

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	99090	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BTG AND ASSOCIATES DBA BTG BENEFITS

84-3131974

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	94193	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

HUB INTERNATIONAL NORTHWEST, LLC

91-2036015

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	89812	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)

PAYNEWEST INSURANCE, A MARSH & MCLE

36-1436000

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	86776	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

B & F INSURANCE, LLC

35-2384961

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	83301	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JOHN B. SCATES

4565 FLYING GOAT AVE NE B240
BAINBRIDGE ISLAND, WA 98110

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
20 50	NONE	82152	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MARSH USA, INC. DBA MARSH & MC

26-3237575

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	75060	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BENEFIT DESIGN SERVICES, LLC

27-3460566

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	69238	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEA-MOUNTAIN INSURANCE BROKERS

91-1375220

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	52977	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

INSURANCE OFFICE OF AMERICA, INC.

59-2472656

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	40994	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BENEFIT SOLUTIONS NORTHWEST LLC

84-4089157

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	37267	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ANASTASI, MOORE & MARTIN, PLLC

20-8149084

(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	37000	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)

ASSUREDPARTNERS OF WA DBA FORTUNE

45-2712335

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	33656	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ARMFIELD, HARRISON & THOMAS TECH

54-0654623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	32977	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MADDOCK & ASSOCIATES, LLC

83-2655931

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	31450	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)

WESTLEY PRICE INSURANCE, LLC

87-4625895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	27422	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ADVOCATE, INC. DBA NAVA BENEFITS

32-0616585

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	26220	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

GREGORY A MYHRE

12931 STEPHENSON ST.
ANCHORAGE, AK 99515

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	24620	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)

WHITFIELDS DBA LEAVITT GROUP BEN

91-1366133

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	23023	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TRUEBENEFITS, LLC

91-2034415

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	21787	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CURALINC LLC

33-1206383

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 14 50	NONE	21786	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ALLIANT INSURANCE SERVICES, INC

33-0785439

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	21759	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DAVE TUTTLE INSURANCE, INC

1764 W LAKE LUCILLE DR
WASILLA, AK 99654

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	20938	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

STEVENSON INSURANCE AGENCY, LLC

88-1229056

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	17921	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)

TERRIL LEWIS & WILKE INSURANCE

91-1137671

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	15475	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WALTERS & ASSOCIATES INSURANCE, INC

92-0084414

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	14252	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LOCKTON COMPANIES

20-3354970

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	13704	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)

CUMMINGS, FRASER, & ASSOCIATES, LLC

68-0609841

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12561	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MITCHELL REED & SCHMITTEN INSURANCE

91-1745509

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12488	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PILKEY-HOPPING & EKBERG, INC.

91-1050022

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12461	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

KIBBLE & PRENTICE HOLDING CO DBA US

91-1176315

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	12056	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

NICHOLSON & ASSOCIATES INSURANCE

91-1991902

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	11320	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

FEJES & ASSOCIATES, INC.

86-0877658

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	10336	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)

BENEFIT CONSULTING SERVICES, LLC

PO BOX 2088
ISSAQUAH, WA 98027-0093

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	9924	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TINA GONSALVES

2455 VIA SONOMA, UNIT C
PALM SPRINGS, CA 92264

(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	9000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

USI INSURANCE SERVICES NATIONAL

56-1882208

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	8677	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

COORDINATED BENEFITS - THE SIMMONS

27-1158624

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	8450	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PCF INSURANCE OF THE WEST, LLC

82-1368960

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	7866	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ASD INSURANCE AND FINANCIAL SERVICE

31-1746517

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	7445	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)

PROSYNC INSURANCE SERVICES, LLC

83-0541257

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	6813	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PRO BENEFITS OF WASHINGTON, LLC

82-3618758

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	5594	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

IMPACT CG, LLC

87-2379951

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	5313	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)

ESSENTIAL BENEFITS, LLC

45-5125484

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	5298	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

VAULT INSURANCE & INVESTMENTS, LLC

26-3980956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 50 53	NONE	5224	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
(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a Name:

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 D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection.

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

Part I **Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)**
(Complete as many entries as needed to report all interests in DFEs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	907 ELECTRIC INC.	**c** EIN-PN	82-5095105-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	A&A ROOFING	**c** EIN-PN	92-0032279-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AAA SEPTIC LLC	**c** EIN-PN	87-0746339-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	A-ALPHA BIO	**c** EIN-PN	82-3070666-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ABACUS BIOSCIENCE	**c** EIN-PN	81-0544756-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ACE ACADEMY	**c** EIN-PN	81-2983424-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ADVANCED CELLULAR DYNAMICS, INC.	**c** EIN-PN	83-1611949-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AGLIETTI OFFRET & WOOFTER LLC	**c** EIN-PN	82-5130244-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AK LEASING, INC.	**c** EIN-PN	26-4818914-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AK NEURODIAGNOSTICS SPECIALISTS LLC	**c** EIN-PN	88-0615248-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AK RADIATION ONCOLOGY SPECIALISTS INC	**c** EIN-PN	20-3533934-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AK WINDOW CLEANERS LLC	**c** EIN-PN	47-3392190-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA BILLING SERVICES	**c** EIN-PN	92-0166134-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA CENTER FOR PEDIATRICS	**c** EIN-PN	92-0132089-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA CENTER FOR THE BLIND & VISUALLY IMPAIRED	**c** EIN-PN	92-0108817-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA COMMERCIAL FISHING & AGRICULTURE BANK	**c** EIN-PN	92-0073648-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA ENERGY METALS DEVELOPMENT CORP	**c** EIN-PN	42-1759222-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA EXECUTIVE SEARCH INC	**c** EIN-PN	92-0081458-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA FUEL SERVICES LLC	**c** EIN-PN	36-4782074-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA PERMANENT CAPITAL MGMT CO	**c** EIN-PN	92-0139234-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA PREMIER AUCTIONS & APPRAISALS LLC	**c** EIN-PN	82-4029092-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA REMOTE IMAGING LLC	**c** EIN-PN	84-2666304-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SAFETY ALLIANCE	**c** EIN-PN	92-0170234-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SHOULDER & ORTHOPAEDIC INSTITUTE	**c** EIN-PN	85-0738158-501

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA SPRING & PERFORMANCE INC	**c** EIN-PN	26-2659231-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKA WOMENS CANCER CARE	**c** EIN-PN	80-0722946-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALASKAN RESIDENTIAL RESCUE	**c** EIN-PN	93-1490006-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALL CLASSICAL MEDIA INC	**c** EIN-PN	93-1042868-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALL PRO ALASKA	**c** EIN-PN	92-0170261-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALLIANCE PARTITION SYSTEMS	**c** EIN-PN	80-0516178-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALSC ARCHITECTS, P.S.	**c** EIN-PN	91-0890436-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ALUTIIQ HERITAGE FOUNDATION	**c** EIN-PN	92-0150422-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AMPED ELECTRIC INC	**c** EIN-PN	20-5131487-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ANCHORAGE BARIATRICS LLC	**c** EIN-PN	81-1634305-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ANCHORAGE COMMUNITY DEV AUTHORITY	**c** EIN-PN	92-0102697-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ANCHORAGE DOWNTOWN PARTNERSHIP	**c** EIN-PN	92-0157658-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ANCHORAGE HOME BUILDERS ASSOCIATION	**c** EIN-PN	51-0173290-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ANCHORAGE PRINTING INC	**c** EIN-PN	92-0085472-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	APEX CUSTOM BUILDERS, LLC	**c** EIN-PN	84-3849572-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ARCHON BIOSCIENCES	**c** EIN-PN	92-1879724-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ARCTIC FOUNDATIONS INC.	**c** EIN-PN	92-0044919-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ARCTIV DESIGN MECHANICAL, LLC	**c** EIN-PN	99-1344745-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ARETE FAMILY CARE LLC	**c** EIN-PN	86-3599685-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ARSENAL ENTERPRISES, INC.	**c** EIN-PN	91-1783009-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ART PRIMO	**c** EIN-PN	20-5166073-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ASSOCIATED SERVICE COMPANIES INTERNATIONAL LLC	**c** EIN-PN	20-3515127-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ATMOSPHERE TECHNOLOGIES, IND DBA ETHOSPHERE TECHNOLOGIES	**c** EIN-PN	99-1920812-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ATOSSA THERAPEUTICS, INC.	**c** EIN-PN	26-4753208-501

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AURORA LAUNCH SERVICES	**c** EIN-PN	82-3393700-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AURORA STORES LLC	**c** EIN-PN	88-1759150-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AVM BIOTECHNOLOGY, INC.	**c** EIN-PN	92-1634578-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	AXIS ARCHITECTURE + DESIGN	**c** EIN-PN	94-3410939-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	B&C TRUCKING, INC.	**c** EIN-PN	91-1818925-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BAIR CONSTRUCTION, INC.	**c** EIN-PN	91-1603978-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BAKER EXCAVATING LLC	**c** EIN-PN	83-3668132-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BALUSTER DISCOVERY, LLC	**c** EIN-PN	20-8034690-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BANYAN, LLC	**c** EIN-PN	20-1552040-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BARTEE CO. CONSTRUCTION LLC	**c** EIN-PN	87-0842023-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BARTOW ASSOCIATES INC	**c** EIN-PN	92-0161790-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BATTGENIE, INC.	**c** EIN-PN	82-3541103-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BC EXCAVATING	**c** EIN-PN	27-1432653-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BEADEDSTREAM INC.	**c** EIN-PN	87-0804934-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BEAR TRAIL LODGE	**c** EIN-PN	26-2461348-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BERHOLZ & GRAHAM T & C	**c** EIN-PN	91-1821502-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BHAG LLC DBA FLORCRAFT CARPET ONE	**c** EIN-PN	46-4180422-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BICKNELL INC	**c** EIN-PN	92-0139552-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BIRCHWOOD RECREATION & SHOOTING PARK	**c** EIN-PN	92-6004399-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BLACK GALLINA CONSULTING, LLC	**c** EIN-PN	83-1364343-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BLACKTHORNE CONSULTING, LLC	**c** EIN-PN	84-4397401-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BLAZE BIOSCIENCE INC.	**c** EIN-PN	27-4410926-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BONUM THERAPEUTICS, INC.	**c** EIN-PN	87-2883314-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BORARCHITECTURE, PLLC	**c** EIN-PN	91-1662670-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BOREALIS BASECAMP	**c** EIN-PN	82-3273133-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BOYNTON OFFICE SYSTEMS	**c** EIN-PN	92-0162313-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BRAINSPACE, INC.	**c** EIN-PN	86-1755179-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BREAKWATER THERAPEUTICS	**c** EIN-PN	33-3553132-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BROADWAY ALASKA ENTERPRISE	**c** EIN-PN	92-0170093-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BROOKS HOMES INC	**c** EIN-PN	91-1642433-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BROWN'S ELECTRICAL SUPPLY INC	**c** EIN-PN	92-0074068-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BRUCE DEES & ASSOCIATES, LLC	**c** EIN-PN	91-2147699-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BRUNO INVESTMENTS	**c** EIN-PN	84-2804578-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BUILDING TRANSPARENCY	**c** EIN-PN	84-2727715-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BULL TROUT, LLC	**c** EIN-PN	84-3105300-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	BURKHART CROFT ARCHITECTS LLC	**c** EIN-PN	86-1108928-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	C&T FIRE PROTECTION INC.	**c** EIN-PN	47-1314262-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CALICO ENERGY SERVICES	**c** EIN-PN	27-1606271-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CANCER RESEARCH AND BIOSTATISTICS	**c** EIN-PN	31-1828539-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CARLETTI ARCHITECTS	**c** EIN-PN	91-1805618-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CARR & FAMILY ADMINISTRATION LLC	**c** EIN-PN	82-0675278-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CARUS CRUISE, INC.	**c** EIN-PN	61-1754040-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CASCADE INDUSTRIAL & HYDRAULIC LLC	**c** EIN-PN	91-2000508-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CASCADE LUMBER, INC.	**c** EIN-PN	91-1276475-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CASCADIA DRUG DEVELOPMENT GROUP	**c** EIN-PN	81-4588886-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CASIUM INC	**c** EIN-PN	99-2418691-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CASTO'S INLAND CONSTRUCTION GROUP, LLC	**c** EIN-PN	27-1566712-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CB GROWTH PARTNERS LLC	**c** EIN-PN	84-4198154-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CHRISTIAN VETERINARY MISSION	**c** EIN-PN	85-2465430-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CHUGACH BEVERAGES LLC	**c** EIN-PN	92-0156470-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CIRRO BIO INC.	**c** EIN-PN	92-3489670-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CLEAN ENERGY TRANSITION INSTITUTE	**c** EIN-PN	83-0644369-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CLOUDENGAGE	**c** EIN-PN	46-3505425-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CMES ROBOTICS, INC.	**c** EIN-PN	86-1424976-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COLD SPOT FEEDS, INC.	**c** EIN-PN	87-0803237-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COMMERCIAL CONTRACTORS INC.	**c** EIN-PN	92-0035013-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COMMUNITY SERVICES OF MOSES LAKE, INC.	**c** EIN-PN	91-0664984-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CONSOLIDATED CONTRACTING AND ENGINEERING	**c** EIN-PN	45-2801311-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CONTANGO ORE	**c** EIN-PN	27-3431051-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COPACINO + FUJIKADO, LLC	**c** EIN-PN	91-1875614-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COPPER RIVER AUTO PARTS DBA NAPA	**c** EIN-PN	81-2587938-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CORVUS DESIGN INC	**c** EIN-PN	26-2906074-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	COUFFLEY HOMES SERVICES	**c** EIN-PN	87-2127321-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CREATORSAGI INC.	**c** EIN-PN	99-0592549-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CROSSROADS COUNSELING AND TRAINING SERVICES	**c** EIN-PN	92-0159057-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CULTIVAR FARMS	**c** EIN-PN	47-2107654-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	CYCLONE SERVICES, LLC	**c** EIN-PN	84-2260064-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DC 907 DIESELS INC	**c** EIN-PN	81-4794300-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DEFENDERMATE SYSTEMS INC.	**c** EIN-PN	33-1267454-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DELIGHT LABS	**c** EIN-PN	45-4039339-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DENALI CONCRETE INC	**c** EIN-PN	92-0167703-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DEVERRA THERAPUTICS	**c** EIN-PN	47-5261773-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DIBBLE ENGINEERS INC	**c** EIN-PN	20-0396839-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DIRTY BOYS LLC	**c** EIN-PN	88-3891167-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DKS, INC.	**c** EIN-PN	91-1161010-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DOCNEXUS CO	**c** EIN-PN	88-3081341-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DOOR SYSTEMS OF ALASKA INC	**c** EIN-PN	92-0173130-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DREAMWORKS CABINETRY LLC	**c** EIN-PN	92-0177119-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DURA-SHINE CLEAN	**c** EIN-PN	27-0502696-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	DYNAMIC METALS, INC.	**c** EIN-PN	81-0881602-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	EARTH SOLUTIONS NORTHWEST, LLC	**c** EIN-PN	32-0139742-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ELASTIXAI INC	**c** EIN-PN	33-3696132-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	EMERALD AUTOMATION, LLC	**c** EIN-PN	20-1225432-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ENCORE ELECTRIC LLC	**c** EIN-PN	46-4176438-501

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ENDURANCE ENERGY SYSTEMS, INC.	**c** EIN-PN	33-2679226-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ENVIRONMENTAL HEALTH SCIENCES ALASKA INC	**c** EIN-PN	92-0120819-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	EP ROOFING INC	**c** EIN-PN	20-8817906-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	EVERGREEN RENEWABLES, INC.	**c** EIN-PN	87-3323912-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	EXSELON	**c** EIN-PN	20-5848284-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	F & F FOUNDATIONS, INC.	**c** EIN-PN	91-1618351-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FAR NORTH GEN SURGERY & SURGICAL ONCOLOGY	**c** EIN-PN	46-5203728-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FARWEST FABRICATION	**c** EIN-PN	91-1593253-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FARWEST PAINT MANUFACTURING CO.	**c** EIN-PN	91-0216910-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FELIX GOLD ALASKA OPERATIONS INC	**c** EIN-PN	88-0877412-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FICKLIN CONSTRUCTION LLC	**c** EIN-PN	45-4583041-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FINPILOT INC.	**c** EIN-PN	92-3590522-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FIRE & FLOOD SERVICES INC.	**c** EIN-PN	82-0563359-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FIRST RATE FINANCIAL LLC	**c** EIN-PN	20-3009026-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FISCHER BROS EXCAVATION LLC	**c** EIN-PN	75-3145378-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FOM TECHNOLOGIES INC	**c** EIN-PN	86-1382286-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FOX ENERGY SERVICES LLC	**c** EIN-PN	85-3046539-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FOX ISLAND MUTUAL WATER ASSOC	**c** EIN-PN	91-1031720-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FOX TIRE SERVICE LLC DBA AK TIRE & RIM	**c** EIN-PN	20-5628296-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FR BELL & ASSOCIATES INC	**c** EIN-PN	92-0128211-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FRAMERS INVENTORY	**c** EIN-PN	93-1096576-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	FUNL TECHNOLOGIES, INC.	**c** EIN-PN	85-2290939-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	G.E. GORDON, INC.	**c** EIN-PN	91-1750624-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GAGE TREE SERVICE	**c** EIN-PN	61-1212258-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GAPPS	**c** EIN-PN	81-4625437-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GEMATEG	**c** EIN-PN	83-1795906-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GENERAL BUILDERS SUPPLY, INC.	**c** EIN-PN	91-1196010-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GENERATIVE CAPITAL, LLC	**c** EIN-PN	99-4762797-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GENESIS ADVANCED TECHNOLOGIES	**c** EIN-PN	20-4205465-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GLYPH LANGUAGE SERVICES	**c** EIN-PN	73-1630914-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GRANGER PAINTING, LLC	**c** EIN-PN	45-0606450-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GRANITE CITY ALASKA INC	**c** EIN-PN	20-3518674-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GRAYLING CONSTRUCTION	**c** EIN-PN	91-1841964-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GREAT ALASKAN HOLIDAYS INC	**c** EIN-PN	92-0165766-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GREATER FAIRBANKS CHAMBER OF COMMERCE	**c** EIN-PN	92-0006532-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GRITTON BUILDING CO., INC.	**c** EIN-PN	45-5135092-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	GUMSHOE.AI INC	**c** EIN-PN	33-2677444-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	H20 2U LLC	**c** EIN-PN	06-1784743-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HAPPY POTATO INC.	**c** EIN-PN	93-4536160-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HAPPY SKEETER INC DBA B&J SPORTING GOODS	**c** EIN-PN	83-2770812-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HAPPY TAILS INC MIDNIGHT SUN ANIMAL HOSP	**c** EIN-PN	27-3044674-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HARRIS SAND & GRAVEL INC	**c** EIN-PN	92-0056819-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HARTILL'S MOUNTAIN SAW & TRACTOR LLC	**c** EIN-PN	26-1573711-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HASCO INC	**c** EIN-PN	92-0020430-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HEADSET, INC.	**c** EIN-PN	47-4361329-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HEARTLAND, LLC	**c** EIN-PN	91-1876752-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HINKLE PROPERTIES	**c** EIN-PN	91-1759781-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HISTONE THERAPEUTICS CORP	**c** EIN-PN	86-3543907-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOALOHA ROBOTICS OPERATING INC	**c** EIN-PN	33-2672932-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOCHSTATTER ELECTRIC, INC.	**c** EIN-PN	91-1004291-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOGBACK DEVELOPMENT COMPANY	**c** EIN-PN	46-4807555-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOMEOSTASIS SYSTEMS CORP.	**c** EIN-PN	88-1551006-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOMER SCIENTIFIC HOLDINGS, INC.	**c** EIN-PN	83-0634981-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOUSE OF STILES LLC	**c** EIN-PN	83-1598469-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOUSEAMP, INC.	**c** EIN-PN	83-4556628-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	HOYLU, INC.	**c** EIN-PN	81-4444699-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	IGNYTE BIO	**c** EIN-PN	87-3594710-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	IMAGINOMIX, LLC	**c** EIN-PN	82-4558990-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	IMPACT BIOENERGY, INC.	**c** EIN-PN	46-4310848-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	IMPORT AUTO BODY DBA COLLISION MASTERS	**c** EIN-PN	92-0127484-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	IMPORTERS FORWARDING	**c** EIN-PN	91-1169518-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INFINITE HEATING & COOLING, LLC	**c** EIN-PN	47-5520506-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTELLIGENT ENERGY SYSTEMS	**c** EIN-PN	26-0684716-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTERIOR AIDS ASSOCIATION	**c** EIN-PN	92-0127274-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTERIOR AUTO BODY & REPAIR	**c** EIN-PN	20-4578990-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTERIOR EXCAVATING & TRUCKING INC.	**c** EIN-PN	92-0163995-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTERIOR REGION EMS COUNCIL INC	**c** EIN-PN	92-0072567-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	INTERIOR WEATHERIZATION INC	**c** EIN-PN	92-0112206-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	J S CONTRACTING, INC.	**c** EIN-PN	91-1683839-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	J.C. HAWKINS INC.	**c** EIN-PN	34-1980747-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JERMAIN DUNNAGAN & OWENS PC	**c** EIN-PN	92-0116216-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JOHNSON RIVER ENTERPRISES	**c** EIN-PN	92-0166208-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JOHNSTON ENGINEERING PLLC	**c** EIN-PN	47-5222481-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JOON CARE MEDICAL CORPORATION	**c** EIN-PN	87-0929469-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JOSEPH MIRCI DMD DBA PENINSULA FAMILY DENTAL	**c** EIN-PN	93-1557973-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JR TRANSPORTATION, INC.	**c** EIN-PN	47-1825274-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JSA CIVIL, LLC	**c** EIN-PN	87-1588415-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JUNEAU ECONOMIC DEVELOPMENT COUNCIL	**c** EIN-PN	94-3053042-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	JVO SQUARED, LLC	**c** EIN-PN	84-2201211-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KAZIA THERAPEUTICS	**c** EIN-PN	80-0911755-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KCL EXCAVATING, INC.	**c** EIN-PN	81-2004766-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KELLEY & CANTERBURY LLC	**c** EIN-PN	92-0159079-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KINEA BIO	**c** EIN-PN	85-2529139-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KINTER ELECTRIC, INC.	**c** EIN-PN	46-0506111-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KODIAK REGIONAL AQUACULTURE ASSOC	**c** EIN-PN	91-0115279-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KRISCO AQUATECH POOLS & SPAS	**c** EIN-PN	91-1166117-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KUBOTA VISION, INC.	**c** EIN-PN	81-3239491-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	KYOTO FUSIONEERING AMERICA	**c** EIN-PN	92-0458353-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LABELS & LISTS, INC.	**c** EIN-PN	91-1319158-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LANDTEK ENTERPRISES, INC.	**c** EIN-PN	68-0617724-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LANKTREE LAND SURVEYING, INC.	**c** EIN-PN	45-5446952-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LAST FRONTIER MOTOR SPORTS DBA THE OUTPOST	**c** EIN-PN	92-0172630-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LEGACY DETAIL LLC	**c** EIN-PN	92-3639250-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LEGATA, INC.	**c** EIN-PN	99-4181050-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LEONABIO	**c** EIN-PN	45-3368487-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LIFE SCIENCE WASHINGTON	**c** EIN-PN	91-1453398-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LODESTAR MARKETING GROUP	**c** EIN-PN	26-0809006-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LOKEN CONSTRUCTION LLC	**c** EIN-PN	48-1305701-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LOWE CONSULTING, INC.	**c** EIN-PN	81-0957677-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LUMRUN NETWORK INC	**c** EIN-PN	33-4199638-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	LYSSN.IO, INC.	**c** EIN-PN	83-3320512-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	M&M CONSTRUCTORS	**c** EIN-PN	83-0611888-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	M2C1 INTERNATIONAL LLC	**c** EIN-PN	20-1643155-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAGNA LLC	**c** EIN-PN	81-1199831-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAIN EVENT SERVIES LLC	**c** EIN-PN	81-4371112-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAIN LINE, INC.	**c** EIN-PN	91-1680271-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAK3 CONSTRUCTION LLC	**c** EIN-PN	99-1018973-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MALARVX, INC.	**c** EIN-PN	45-5021055-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MARINE EXCHANGE OF ALASKA	**c** EIN-PN	92-0173630-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MARK MORRIS INC.	**c** EIN-PN	91-1986650-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MARKOS INC.	**c** EIN-PN	99-3788234-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MARTIN ENGINEERING INC	**c** EIN-PN	54-2164523-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAXIMAL LEARNING, INC.	**c** EIN-PN	60-5208813-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MAXVAX BIOTECHNOLOGY	**c** EIN-PN	88-2376159-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MCKENNA BROTHERS PAVING INC	**c** EIN-PN	91-1828761-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MECHANICAL SPECIALISTS INC	**c** EIN-PN	43-1978111-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MERIDIAN MANAGEMENT INC.	**c** EIN-PN	92-0165158-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MERIDIAN SYSTEMS INC.	**c** EIN-PN	27-1583554-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	METAL EMPIRE MANUFACTURING	**c** EIN-PN	82-5511704-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	METHOD LLC	**c** EIN-PN	74-3234505-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MH ELECTRIC, INC.	**c** EIN-PN	20-2381114-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MICHELSOHN & DAUGHTER CONSTRUCTION INC.	**c** EIN-PN	92-0141583-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MODELREMODEL LLC	**c** EIN-PN	02-0673639-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MOH FINANCIAL LLC DBA MARIETTA HALL CFP	**c** EIN-PN	99-3981907-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MONOD BIO	**c** EIN-PN	86-2512911-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MONOLITHIC POWER SYSTEMS	**c** EIN-PN	91-2109960-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MONTEGO, LLC	**c** EIN-PN	20-3957634-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MONTYCLOUD, INC.	**c** EIN-PN	82-5212662-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MORAIR MEDTECH, LLC	**c** EIN-PN	84-1779484-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MORRIS THOMPSON CULTURAL VISITORS CENTER	**c** EIN-PN	20-1113317-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MOSEIAN FARMS OF ALASKA INC.	**c** EIN-PN	92-0081726-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MOTORCYCLE TIMES INC.	**c** EIN-PN	92-0098392-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MOUNTAIN VIEW TRUCKING	**c** EIN-PN	46-3435646-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MRT INC DBA SIGNATURE LAND SERVICES	**c** EIN-PN	92-0146992-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	MTNT LTD	**c** EIN-PN	92-0060313-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NATIONAL METERING & TECHNICAL SERVICES, LLC	**c** EIN-PN	27-2390637-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NEIGHBORS CONSTRUCTION	**c** EIN-PN	20-5017408-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NEPPEL ELECTRICAL & CONTROLS, LLC	**c** EIN-PN	91-2109585-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NETACQUIRE CORPORATION	**c** EIN-PN	91-1596849-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NEURALWATT CORPORATION	**c** EIN-PN	33-3443639-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NEW COURSE	**c** EIN-PN	27-1971697-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NEWTON PARK, LLC	**c** EIN-PN	81-3433355-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NICK SARRIMANOLIS MD LLC	**c** EIN-PN	04-3775917-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NORTHERN ECONOMICS INC	**c** EIN-PN	92-0162195-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NORTHERN LIGHTS DEVELOPMENT INC	**c** EIN-PN	92-0144640-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NORTHSTAR SUPPLY LLC	**c** EIN-PN	82-0959561-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NORTHWEST HEAVY DUTY	**c** EIN-PN	47-4045863-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	NW CUTTING-EDGE MASONRY	**c** EIN-PN	47-5221638-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OCO LLC	**c** EIN-PN	81-4780656-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ODB HOLDINGS LLC	**c** EIN-PN	85-4257653-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OFFICIAL TECHNOLOGIES INC	**c** EIN-PN	93-3776569-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OLYMPIC MOUNTAIN PRODUCTS	**c** EIN-PN	91-1073888-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OMNI ELECTRIC GROUP LLC	**c** EIN-PN	86-1920823-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ONTRADE INC	**c** EIN-PN	99-1967926-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ORCA WAVE, LLC	**c** EIN-PN	91-2173724-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ORUTSARARMIUT TRADITIONAL NATIVE COUNCIL	**c** EIN-PN	92-0074128-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OSG DOZING, INC.	**c** EIN-PN	56-2433453-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OTTO TRIP, INC.	**c** EIN-PN	99-2376412-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	OVERLAND AI, INC.	**c** EIN-PN	88-4401693-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PACIFIC AIR CONTROL, INC.	**c** EIN-PN	91-0987825-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PACIFIC PROPANE NW, LLC	**c** EIN-PN	86-3620734-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PARAGON DISTRIBUTING LLC	**c** EIN-PN	20-1424585-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PAUG VIK INC LTD	**c** EIN-PN	92-0047081-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PEAK HEALTH DENTRISTRY LLC	**c** EIN-PN	47-1184326-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PETERKIN DISTRIBUTORS INC.	**c** EIN-PN	92-0048259-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PHINNEY BISCHOFF	**c** EIN-PN	91-1267748-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PINNACLE PLUMBING & HEATING	**c** EIN-PN	20-0678939-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PIPELINE SAFETY TRUST	**c** EIN-PN	56-2369975-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	POLLARD WIRELINE INC	**c** EIN-PN	92-0170650-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	POMRANING EXCAVATION LLC	**c** EIN-PN	26-4752670-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	POWER DISTRIBUTING	**c** EIN-PN	91-0922570-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	POWER FIX LLC	**c** EIN-PN	81-4659806-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRECISION IMAGE ANALYSIS	**c** EIN-PN	46-1048686-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRECLINICAL GPS	**c** EIN-PN	06-7665113-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRESAGE BIOSCIENCES	**c** EIN-PN	26-3690569-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRICE FORD, INC.	**c** EIN-PN	91-1699072-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRISM WORLDWIDE LLC	**c** EIN-PN	83-4114259-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRIZM CONSULTING, INC.	**c** EIN-PN	99-4455155-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PRO ELECTRICAL SVCS	**c** EIN-PN	47-5117385-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PROBUILD CONSTRUCTION LLC	**c** EIN-PN	84-1901576-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PTP HOLDINGS LLC	**c** EIN-PN	47-4982185-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PUGET SOUND QUALITY SPECIALIST, INC.	**c** EIN-PN	27-3037553-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	PURE & PRESSED JUICE CO	**c** EIN-PN	83-2420729-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	QUALITY CONTROLS INC	**c** EIN-PN	26-1335541-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	QUESTIVA.COM INC.	**c** EIN-PN	91-1880371-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	R. MUNN FARMS, LLC	**c** EIN-PN	91-1720199-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RADICAL INC.	**c** EIN-PN	88-3174460-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RARECYTE, INC.	**c** EIN-PN	27-0860840-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RC ENTERPRISES INC	**c** EIN-PN	92-0156805-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RCRVS OREGON LLC DBA RIVER CITY RV	**c** EIN-PN	87-2878704-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RECON LLC	**c** EIN-PN	75-3090858-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	REDLINE SERVICES GROUP	**c** EIN-PN	82-2691274-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	REDPOINT, INC.	**c** EIN-PN	36-5042504-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	REED TRUCKING & EXCAVATING, INC.	**c** EIN-PN	91-1938552-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RELIANCE UTILITY CONSTRUCTION LLC	**c** EIN-PN	88-2085880-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	REMOTE ALASKA SOLUTIONS INC	**c** EIN-PN	45-4509607-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RENT A CAN TOILET CO INC	**c** EIN-PN	92-0093054-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	REPAIRING ALASKA LLC	**c** EIN-PN	82-3324420-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ROBINSON & WARD PC	**c** EIN-PN	92-0176403-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ROCKETSHIP MARKETING LLC	**c** EIN-PN	39-2358905-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RODARTE CONSTRUCTION, INC.	**c** EIN-PN	91-1016627-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ROLLUDA ARCHITECTS, INC.	**c** EIN-PN	45-0487361-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ROY BRILEY INC	**c** EIN-PN	27-1583554-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RURAL ENERGY ENTERPRISES	**c** EIN-PN	92-0130133-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RUSTAIR INC	**c** EIN-PN	92-0132311-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RUSTY BRADEEN TRUCKING, INC.	**c** EIN-PN	91-1609115-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	RYAN SNIDER PAINTLESS DENT REPAIR, LLC	**c** EIN-PN	71-1008413-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	S&P CERTIFIED CAR CARE	**c** EIN-PN	26-2527087-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	S.W. FRANCK LLC	**c** EIN-PN	33-2236669-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SAGE & STONE, LLC	**c** EIN-PN	47-4354810-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SANCTUART II ALH	**c** EIN-PN	20-8157991-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEALEVEL PROPERTIES	**c** EIN-PN	45-3578432-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEAPRO	**c** EIN-PN	92-0139334-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEATTLE CONSTRUCTION RESOURCES	**c** EIN-PN	91-1452233-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEATTLE GALVANIZING	**c** EIN-PN	20-2875388-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEATTLE SHOWER DOOR LLC	**c** EIN-PN	83-2279632-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEAVIEW COMMUNITY SERVICES	**c** EIN-PN	92-0043803-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEI NW GREEN, LLC	**c** EIN-PN	93-4914246-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SEINERGY	**c** EIN-PN	46-1456684-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SELKIRK PHARMA, INC.	**c** EIN-PN	82-0831982-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SHARC ENERGY	**c** EIN-PN	32-0676410-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SHIFLETT'S, INC.	**c** EIN-PN	91-0957388-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SIDING SOLUTIONS LLC	**c** EIN-PN	90-1209503-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SIMPLY SOMETHING INC.	**c** EIN-PN	65-1229150-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SINARD AUTOMOTIVE INC	**c** EIN-PN	47-0851783-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SINGLETTO, INC.	**c** EIN-PN	85-2799793-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SLABJACK NW LLC	**c** EIN-PN	20-5050153-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SM STEMPER ARCHITECTS	**c** EIN-PN	91-2005611-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SMILE BREAK	**c** EIN-PN	99-3332706-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SMULTEA ENVIRONMENT SCIENCE	**c** EIN-PN	27-1661548-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SNAPLINC CONSULTING, LLC	**c** EIN-PN	82-4612620-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SNBL USA	**c** EIN-PN	54-1595945-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SOUND PHARMACEUTICALS, INC.	**c** EIN-PN	91-2135919-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPALDING DENTAL LLC	**c** EIN-PN	46-2447195-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPECIALTY IMPORTS INC	**c** EIN-PN	92-0074411-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPERNAK & SON LLC	**c** EIN-PN	47-3732688-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPINELL HOMES INC.	**c** EIN-PN	92-0120043-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPOKANE ELECTRIC LLC	**c** EIN-PN	39-3268199-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPOKANE REGIONAL BROADBAND DEVELOPMENT AUTHORITY BROADLINC	**c** EIN-PN	92-2660984-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SPRING VALLEY DEVELOPERS LLC	**c** EIN-PN	47-4318800-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	STAR EQUITY MANAGEMENT, LLC	**c** EIN-PN	45-0492821-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	STARFISH NEUROSCIENCE, INC.	**c** EIN-PN	87-2081594-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	STATELY CLOUD, INC.	**c** EIN-PN	93-2572996-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	STEINHAUER PROPERTIES, INC.	**c** EIN-PN	91-1731331-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SUMMIT WINDOWS & DOORS, INC.	**c** EIN-PN	92-0133038-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SUNSHINE RAE MOTORS	**c** EIN-PN	92-0171298-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SYSTEMS INTERFACE, INC.	**c** EIN-PN	91-1271056-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	SYSTIMMUNE, INC.	**c** EIN-PN	46-5743763-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	T & T TRUCKING INC.	**c** EIN-PN	91-0719450-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TAGBOARD INC.	**c** EIN-PN	45-2545444-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TAIGA MINING COMPANY	**c** EIN-PN	92-0133571-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TANANA ADVENTURE SPORTS LLC	**c** EIN-PN	26-0018850-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TEAM MECHANICAL INC.	**c** EIN-PN	91-1782324-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TEAM ROOFING NORTHWEST, LLC	**c** EIN-PN	84-4396097-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TEKNOLOGIZE, LLC	**c** EIN-PN	45-2967757-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TERRACLEAR INC	**c** EIN-PN	82-3691924-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TERRAVISTA NW, LLC	**c** EIN-PN	47-4216346-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TERSULI CONSTRUCTION	**c** EIN-PN	26-4835842-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TETHER, INC.	**c** EIN-PN	26-2265778-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	THE AUTOMATED PARKING COMPANY	**c** EIN-PN	83-4392894-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	THE METALSMITHS, INC.	**c** EIN-PN	91-0958362-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	THE PRATOR ORGANIZATION LLC	**c** EIN-PN	83-2774931-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	THE SAMSON HARDWARE COMPANY	**c** EIN-PN	92-0279122-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	THINK OFFICE LLC	**c** EIN-PN	27-0474541-501

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TOOL & TRADE CONSTRUCTION	**c** EIN-PN	84-4110387-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TOP POD, INC.	**c** EIN-PN	47-2906228-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TOPSIDE CONSTRUCTION INC	**c** EIN-PN	91-1703554-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TRANSITION COMPOSITES ENGINEERING, INC.	**c** EIN-PN	26-1752683-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TRAPPERS CREEK INC	**c** EIN-PN	92-0124989-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TREINEN ASSOCIATES, INC.	**c** EIN-PN	91-2180560-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TSCM LLC	**c** EIN-PN	46-4283059-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TSIGONIS COMPANIES INC	**c** EIN-PN	92-0170506-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TTC CONSTRUCTION, INC.	**c** EIN-PN	46-2635149-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TTT ENVIRONMENTAL LLC	**c** EIN-PN	71-0939336-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TWIGS GIFTS INC.	**c** EIN-PN	82-3635911-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	TWO RAVENS, LLC	**c** EIN-PN	92-2756445-501

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ULTRABAC SOFTWARE	**c** EIN-PN	91-1178250-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	VALIDAR INC	**c** EIN-PN	42-1733270-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	VALLEY PAINT CENTER INC	**c** EIN-PN	92-0176332-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	VAN BELLE EXCAVATING, LLC	**c** EIN-PN	27-0720919-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	VEGA CLOUD, INC.	**c** EIN-PN	83-2611695-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	VIOLETT	**c** EIN-PN	85-3808849-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WALLNER EXCAVATION	**c** EIN-PN	92-0153624-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WAMARITIME LLC	**c** EIN-PN	93-2885038-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WASHINGTON WATER HEATERS, HEATING & AIR, INC.	**c** EIN-PN	87-4376706-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WAVEWORKS TECHNOLOGIES, IC.	**c** EIN-PN	93-3398116-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WAYFINDER BIOSCIENCES, INC.	**c** EIN-PN	86-1515703-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WESTERN COMMERCIAL PROPERTIES INC	**c** EIN-PN	92-0041695-501

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

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

a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WITHROW CONSTRUCTION	**c** EIN-PN	91-1407077-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WOOD HARBINGER, INC.	**c** EIN-PN	91-1088312-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	WOSTMANN ASSOCIATES	**c** EIN-PN	92-0123560-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	Y & B POSTAL COMPANY INC.	**c** EIN-PN	34-2059386-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	YAKIMA VALLEY TRANSPORTATION, LLC	**c** EIN-PN	82-2524191-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	YODER, INC.	**c** EIN-PN	91-1220788-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	YOR LABS, INC.	**c** EIN-PN	81-2647569-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	Z TRANSMISSION AND AUTO REPAIR LLC	**c** EIN-PN	81-0826596-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ZEPHER FLIGHT LABORATORIES INC	**c** EIN-PN	84-3153325-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ZILA BIOWORKS, SPC	**c** EIN-PN	86-2177088-501
a Plan name	OMNITRADE HEALTH TRUST ARRANGEMENT		
b Name of plan sponsor	ZIPBIO INC.	**c** EIN-PN	92-3023932-501
a Plan name			
b Name of plan sponsor		**c** EIN-PN	

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
OMNITRADE HEALTH TRUST ARRANGEMENT

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OMNITRADE HEALTH TRUST

D Employer Identification Number (EIN)
27-6838771

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1143346	1123713
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	95935	81647
(2) Participant contributions	1b(2)	1728	476
(3) Other	1b(3)	8490	43367
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	256591	257748
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	1506090	1506951
Liabilities			
1g Benefit claims payable	1g	156348	229866
1h Operating payables	1h	173655	201000
1i Acquisition indebtedness	1i		
1j Other liabilities	1j	652215	361150
1k Total liabilities (add all amounts in lines 1g through1j)	1k	982218	792016
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	523872	714935

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)	53628549	
(B) Participants	2a(1)(B)	505617	
(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)		54134166
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	8500	
(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)		8500
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		9598
d Total income. Add all **income** amounts in column (b) and enter total	2d		54152264
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	48364235	
(3) Other	2e(3)	21786	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		48386021
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)	1113244	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	37600	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	809	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	205926	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	82152	
(11) Other expenses	2i(11)	4135449	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		5575180
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		53961201
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		191063
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: WAYPOINT PARTNERS, PLLC **(2)** EIN: 20-8149084

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

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

Part IV Compliance Questions

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

During the plan year:

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

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [ ] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

Omnitrade Health Trust Arrangement

Financial Statements and Independent Auditors' Report

December 31, 2025 and 2024

WAYPOINT PARTNERS PLLC

Omnitrade Health Trust Arrangement

December 31, 2025 and 2024

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WAYPOINT PARTNERS PLLC | CERTIFIED PUBLIC ACCOUNTANTS & CONSULTANTS

INDEPENDENT AUDITORS' REPORT

Trustee
Omnitrade Health Trust Arrangement
Seattle, Washington

Opinion

We have audited the accompanying financial statements of the Omnitrade Health Trust Arrangement (the Arrangement), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Arrangement as of December 31, 2025 and 2024, and the changes in its net assets available for benefits and of changes in benefit obligations for the years then ended 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Arrangement and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our 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 the Arrangement's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

Supplemental Schedule Required by ERISA

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

The information has been subjected to the auditing procedures applied in the 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 generally accepted auditing standards.

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

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

Waypoint Partners, PLLC

Spokane, Washington
October 14, 2026

Omnitrade Health Trust Arrangement

Statement of Net Assets Available for Benefits

December 31, 2025 and 2024

	2025	2024
ASSETS:		
Cash	$ 1,123,713	$ 1,143,346
Investments	257,748	256,591
Employer contributions receivable	81,647	95,935
Participant contributions receivable	476	1,728
Prepaid expenses	43,367	8,490
Total assets	1,506,951	1,506,090
LIABILITIES:		
Accounts payable and accrued expenses	201,000	173,655
Unearned employer contributions	344,524	635,781
Unearned participant contributions	16,626	16,434
Total liabilities	562,150	825,870
NET ASSETS AVAILABLE FOR BENEFITS	$ 944,801	$ 680,220

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statement of Changes in Net Assets Available for Benefits

Years Ended December 31, 2025 and 2024

	2025	2024
ADDITIONS:		
Employer contributions, net	$ 53,628,549	$ 54,236,030
Participant contributions, net	505,617	458,814
Employer late fees	9,598	14,799
Interest income	8,500	10,749
Total additions	54,152,264	54,720,392
DEDUCTIONS:		
Insurance premiums paid, net	48,312,503	48,950,486
Cost of administration:		
Accounting and audit fees	37,600	38,200
Administrative fees	1,113,244	1,086,739
Bank service charges	809	1,768
Consultant fees	1,445,483	1,486,072
Insurance and bonding	15,899	12,747
Insurance broker commissions	2,656,914	2,785,735
Legal fees	205,926	153,587
Promotional services	9,000	4,450
Supplies, postage, and printing	6,566	6,278
Trustee fees	82,152	83,078
Website and maintenance	1,587	1,498
Total deductions	53,887,683	54,610,638
CHANGE IN NET ASSETS AVAILABLE FOR BENEFITS	264,581	109,754
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year	680,220	570,466
End of year	$ 944,801	$ 680,220

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statement of Benefit Obligations

December 31, 2025 and 2024

	2025	2024
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Premiums due to insurers	$ 229,866	$ 156,348

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Statement of Changes in Benefit Obligations

Years Ended December 31, 2025 and 2024

	2025	2024
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Balance, beginning of year	$ 156,348	$ 200,862
Insurance premiums approved for payment	48,386,021	48,905,972
Insurance premiums paid	(48,312,503)	(48,950,486)
Balance, end of year	$ 229,866	$ 156,348

See accompanying notes to financial statements.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 1 – Description of the Arrangement

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

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

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

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

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

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

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

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 2 – Summary of Significant Accounting Policies

a. **Basis of accounting** – The accompanying financial statements of the Arrangement are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

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

c. **Investment valuation** – The Arrangement's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 6 for a discussion of fair value measurements.

d. **Contract experience surpluses/deficits** – Certain benefits are provided through experience rated insurance contracts with Premera Blue Cross (Premera). As part of the provisions of the contracts, experience surpluses will be refunded to the Arrangement whereas experience deficits of ongoing contracts will be funded by the Arrangement. If the contracts with Premera were terminated, all eligible claims would be paid by the carrier, and any contract deficits would remain unfunded by the Arrangement. The Arrangement recognizes contract experience surpluses as assets and contract experience deficits as obligations. As of the contract years ended December 31, 2025 and 2024, the Arrangement recognized no contract experience surpluses or deficits.

e. **Rate stabilization reserves** – As part of the experience rated insurance contracts, the insurance provider may retain funds as rate stabilization reserves to assist in the mitigation of significant rate adjustments. The insurance provider may credit the reserves for interest earned. Any other changes to the reserves are a result of contract negotiations between the Arrangement and the insurance provider. If a contract was terminated, any funds in the reserves would be refunded to the Arrangement after the contract's experience results were settled. The reserves are recognized as assets of the Arrangement. As of the contract years ended December 31, 2025 and 2024, Premera held no rate stabilization reserves.

f. **Claim reserves** – As part of the provisions of the experience rated contracts with Premera, funds are retained, as reserves, to pay future claims and expenses of the Arrangement. In the event the contracts with Premera are terminated, any excess funds remaining in these reserves will be refunded to the Arrangement after all claims associated with the insurance provider are settled. These reserves are not recognized as assets on the financial statements, as the amounts of future claims and refunds cannot be determined. As of the contract years ended December 31, 2025 and 2024, the claim reserves held by Premera totaled $3,850,000 and $3,256,000, respectively.

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

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

i. **Subsequent events** – Subsequent events have been evaluated through October 14, 2026, which is the date the financial statements were available to be issued.

Omnitrade Health Trust Arrangement

Notes to Financial Statements

Note 3 – Income Tax Status

The trust established under the Plan to hold the assets of the Arrangement is qualified as a tax-exempt organization under Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the net investment income of the trust is exempt from income taxes. The Omnitrade Health Trust obtained its latest tax determination letter from the Internal Revenue Service (IRS) with an effective date of exemption of September 1, 2010. In the letter, the IRS stated that the Omnitrade Health Trust, as then designed, was in compliance with the applicable requirements of the IRC. The Omnitrade Health Trust's Trust Agreement has been amended and restated since the receipt of the tax determination letter. The other trusts are unfunded and have not applied for tax determination letters. The Trustee and legal counsel believe the trusts and related Arrangement are designed and have been operated through December 31, 2025, in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Arrangement and recognize a tax liability (or asset) if the Arrangement has taken an uncertain position that more likely than not would not be substantiated upon examination by the IRS. The plan administrator has analyzed the tax positions taken by the Arrangement, and has concluded that as of December 31, 2025 and 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements.

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

Note 4 – Priorities Upon Termination

The Trust may be amended and/or terminated by resolution adopted by the Trustee(s). However, no such resolution can divert the Trust assets or any part thereof to a purpose other than as set forth in the Trust Agreement, or relieve the Trustee(s) from liability for acts in violation of the standard of care, or modify the limitation of rights to Trust fund in place, per the current Trust Agreement. Notice of any amendment or modification will be promptly forwarded to the Trustee(s), to each member company, and to any insurer, and on request a copy will be furnished to any such person.

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

Note 5 – Risks and Uncertainties

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

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

Note 5 – Risks and Uncertainties (Continued)

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

The Arrangement maintains its cash balances in various high credit quality financial institutions. Accounts at these institutions are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 per depositor, per insured bank, through December 31, 2025, at which time the insured coverage amount may be changed. To mitigate concentration risk and ensure full FDIC insurance coverage, the Arrangement utilizes sweep accounts and participates in the IntraFi Cash Service network. Through this network, funds are distributed across multiple partner banks to help ensure that no single deposit exceeds the insured threshold. However, at times, other cash balances may be in excess of the insurance limit.

Note 6 – Fair Value Measurements

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

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

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

Level 2 – Inputs to the valuation methodology include:

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

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

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

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

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

Note 6 – Fair Value Measurements (Continued)

Level 2 – The Arrangement has no investments that are classified as Level 2 at December 31, 2025 or 2024.

Level 3 – The Arrangement has no investments that are classified as Level 3 at December 31, 2025 or 2024.

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

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

	December 31, 2025			
	Level 1	Level 2	Level 3	Total
Short-term funds	$ 257,748	$ -	$ -	$ 257,748

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

Note 7 – Related-party Transactions

Related party contributions

During the years ended December 31, 2025 and 2024, employer contributions from Life Science Washington, one of the three endorsing sponsors of the Arrangement, totaled $186,170 and $195,012, respectively.

Dues and fees forwarded to related parties

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

	December 31,	
	2025	2024
Life Science Washington	$ 253,924	$ 280,276
CleanTech Alliance Washington	278,257	315,516
Associated Industries of the Inland Northwest	214,641	184,629

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

	December 31,	
	2025	2024
Life Science Washington	$ 2,379	$ (559)
CleanTech Alliance Washington	811	530
Associated Industries of the Inland Northwest	(1,287)	-

Note 8 – Reconciliation of Financial Statements to Form 5500

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

	December 31,	
	2025	2024
Net assets available for benefits per the financial statements	$ 944,801	$ 680,220
Premiums due to insurers	(229,866)	(156,348)
Net assets available for benefits per Schedule H of Form 5500	$ 714,935	$ 523,872

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

	Years Ended December 31,	
	2025	2024
Insurance premiums paid, net	$ 48,312,503	$ 48,950,486
Less payments to Wellspring Family Services EAP	-	(22,619)
Less payments to CuraLinc LLC	(21,786)	(2,337)
Add premiums due to insurers, end of year	229,866	156,348
Less premiums due to insurers, beginning of year	(156,348)	(200,862)
Insurance premiums paid to insurance carriers per Schedule H of Form 5500	48,364,235	48,881,016

For the year ended December 31, 2025, other payments to provide benefits per Schedule H of Form 5500 consisted of payments totaling $21,786 to CuraLinc LLC for employee assistance program (EAP)

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

Omnitrade Health Trust Arrangement

Supplemental Information

Omnitrade Health Trust Arrangement

Form 5500, Schedule H - Part IV, Line 4i

EIN: 2706838771 PN: 501

December 31, 2025

Assets Held for Investment

(a) Identity of Issue	(b) Description of Investment	(c) Cost	(d) Current Value
SHORT-TERM FUNDS:			
BankUnited	Deposit account	$ 2	$ 2
First Horizon Bank	Deposit account	10,657	10,657
Merchants Bank of India	Deposit account	247,089	247,089
		$ 257,748	$ 257,748

Omnitrade Health Trust Arrangement

Form 5500, Schedule H - Part IV, Line 4i

EIN: 2706838771 PN: 501

December 31, 2025

Assets Held for Investment

(a) Identity of Issue	(b) Description of Investment	(c) Cost	(d) Current Value
SHORT-TERM FUNDS:			
BankUnited	Deposit account	$ 2	$ 2
First Horizon Bank	Deposit account	10,657	10,657
Merchants Bank of India	Deposit account	247,089	247,089
		$ 257,748	$ 257,748