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

2019

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

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

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 11/01/1984

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)
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

1200 WESTLAKE AVENUE N, SUITE 1006
SEATTLE, WA 98109

2b Employer Identification Number (EIN)
93-0864012

2c Plan Sponsor's telephone number
503-224-0048

2d Business code (see instructions)
483000

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.	10/14/2020	MARINA SECCHITANO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/12/2020	LEE EGLAND
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	1688
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)**	1575
a(2) Total number of active participants at the end of the plan year	**6a(2)**	1501
b Retired or separated participants receiving benefits	**6b**	123
c Other retired or separated participants entitled to future benefits	**6c**	0
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	1624
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
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**	21

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

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

4A 4B 4D 4E 4L

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

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

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2019 Form M-1 annual report. If the plan was not required to file the 2019 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
93-0242990	69019	645929	1515	01/01/2019	12/31/2019

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

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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

(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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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(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**	0
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**	0
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**	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

e [ ] Temporary disability (accident and sickness) **f** [ ] Long-term disability **g** [ ] Supplemental unemployment **h** [ ] Prescription drug

i [ ] Stop loss (large deductible) **j** [ ] HMO contract **k** [ ] PPO contract **l** [ ] Indemnity contract

m [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	130722		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	10520		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	141242
b Benefit charges (1) Claims paid	**9b(1)**	15000		
(2) Increase (decrease) in claim reserves	**9b(2)**	-1013		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	13987
(4) Claims charged			**9b(4)**	13987
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)**	17553		
(E) Taxes	**9c(1)(E)**	2553		
(F) Charges for risks or other contingencies	**9c(1)(F)**	11300		
(G) Other retention charges	**9c(1)(G)**	95849		
(H) Total retention			**9c(1)(H)**	127255
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	32276
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	10840
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 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

2019

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For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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
HM LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1041332	93440	402807	1457	01/01/2019	12/31/2019

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

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	

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	0
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**	0
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**	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	0
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)**	0
(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)**	0
(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**	2999265
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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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
HAWAII MEDICAL SERVICE ASSOCIATION

(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
99-0040115	49948	52258	244	01/01/2019	12/31/2019

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

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	

(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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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**	0
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**	0
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**	0

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** [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** [X] 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)**	0
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)**	0
(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)**	0
(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**	1498134
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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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
KAISER FOUNDATION HEALTH PLAN OF HAWAII

(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
94-1340523	60053	78	41	01/01/2019	12/31/2019

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

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**	0
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**	0
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**	0

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** [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** [X] 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)**	0
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)**	0
(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)**	0
(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**	212840
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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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
KAISER FOUNDATION HEATLTH 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
94-1340523	00000	18308	169	01/01/2019	12/31/2019

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	33

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

MILLIMAN AGENCY INC
650 CALIFORNIA ST FL 17
SAN FRANCISCO, CA 94108

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	33	BROKERAGE	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**	0
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**	0
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**	0

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** [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** [X] 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)**	0
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)**	0
(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)**	0
(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**	1349536
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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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

1 Coverage Information:

(a) Name of insurance carrier
STANDARD INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
93-0242990	69019	144184	1452	10/01/2018	09/30/2019

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

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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

(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		
	(c) Amount	**(d)** Purpose	**(e)** Organization code

(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**	0
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**	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	15077		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**	2877		
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	17954
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**	72		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	72
(4) Claims charged			**9b(4)**	72
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)**	5345		
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**	1438		
(G) Other retention charges	**9c(1)(G)**	11099		
(H) Total retention			**9c(1)(H)**	17882
(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)**	3305
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. 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 C (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Service Provider Information

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

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

OMB No. 1210-0110

2019

This Form is Open to Public Inspection.

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

ISHARES
525 WASHINGTON BLVD
SUITE 1405
JERSEY CITY, NJ 07310

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

MATTHEWS ASIA
PO BOX 9791
PROVIDENCE, RI 02940

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

SSGA FUNDS MANAGEMENT, INC
1 IRON STREET
BOSTON, MA 02210

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

VERSUS CAPITAL
5555 DTC PARKWAY, SUITE 330
GREENWOOD VILLAGE, CO 80111

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

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

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

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

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

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

BENESYS

5331 SW MACADAM AVE #220
PORTLAND, OR 97239

(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 13 14 15 36 38 49 50 64 65 99	NONE	700675	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PREMERA BLUECROSS

91-0499247

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50 62	NONE	377950	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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

FERGUSON WELLMAN CAPITAL MANAGEMENT

93-0064698

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 51	NONE	92786	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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)

MILLIMAN INC

91-0675641

(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 50	NONE	69411	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INNOVATIVE CARE MANAGEMENT

15 82ND DR
#180
GLADSTONE, OR 97027

(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 50	NONE	68041	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MODA HEALTH PLAN INC.

93-0989307

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	55516	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)

US BANK N.A.

31-0841368

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 19 50 51 52	PARTY-IN-INTEREST	41306	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

CLIFTONLARSONALLEN LLP

41-0746749

(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	26686	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BROWNSTEIN RASK

93-0589000

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	10359	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)

EDGEWATER SEATTLE

2411 ALASKAN WAY
SEATTLE, WA 98121

(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	NONE	6224	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE BENSON HOTEL

309 SW BROADWAY
PORTLAND, OR 97205

(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	NONE	5997	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 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

2019

This Form is Open to Public Inspection

For calendar plan year 2019 or fiscal plan year beginning 01/01/2019 and ending 12/31/2019

A Name of plan
IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST

D Employer Identification Number (EIN)
93-0864012

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	4744759	6610446
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3506471	3602731
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	1355767	302234
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	143024	159903
(2) U.S. Government securities	1c(2)	12676945	14921070
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	5072848	4086520
(B) All other	1c(3)(B)	1771505	2712332
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	3666532	4427950
(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)	3435465	3953045
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	36373316	40776231
	Liabilities			
g	Benefit claims payable	1g	3711997	2911946
h	Operating payables	1h	1116362	1134654
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	697657	205477
k	Total liabilities (add all amounts in lines 1g through1j)	1k	5526016	4252077
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	30847300	36524154

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)	30074626	
	(B) Participants	2a(1)(B)	361525	
	(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)		30436151
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	7208	
	(B) U.S. Government securities	2b(1)(B)	307129	
	(C) Corporate debt instruments	2b(1)(C)	274224	
	(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)		588561
	(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)	90786	
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	102700	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		193486
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	4806645	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	4647769	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		158876
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)	1521038	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		1521038

		(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)		527815
c Other income	2c		15560
d Total income. Add all **income** amounts in column (b) and enter total	2d		33441487
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	19544786	
(2) To insurance carriers for the provision of benefits	2e(2)	6200337	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		25745123
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: **(1)** Professional fees	2i(1)	106456	
(2) Contract administrator fees	2i(2)	1203565	
(3) Investment advisory and management fees	2i(3)	92786	
(4) Other	2i(4)	131753	
(5) Total administrative expenses. Add lines **2i(1)** through **(4)**	2i(5)		1534560
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		27279683
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		6161804
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		484950

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 Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103-8 and/or 103-12(d)? [ ] Yes [X] No

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: CLIFTONLARSONALLEN LLP **(2)** EIN: 41-0746749

d The opinion of an independent qualified public accountant is **not attached** because:

(1) [ ] This form is filed for a CCT, PSA, 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.

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	4b		X	

			Yes	No	Amount
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e	Was this plan covered by a fidelity bond?	4e	X		500000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j	Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked, and see instructions for format requirements.)	4j	X		
k	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l	Has the plan failed to provide any benefit when due under the plan?	4l		X	
m	If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m		X	
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)
IBU OF THE PACIFIC NATL HEALTH BENEFIT TURST RETIREE HEALTH REIMBURSMENT ARRANGEMENT	93-0864012	502

5c If the plan is a defined benefit plan, is it covered under the PBGC insurance program (See ERISA section 4021.)? ☐ Yes ☒ No ☐ Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year_____. (See instructions.)

INLANDBOATMEN'S UNION OF THE PACIFIC
NATIONAL HEALTH BENEFIT PLAN

FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION

YEARS ENDED DECEMBER 31, 2019 AND 2018

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
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CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT

Board of Trustees
Inlandboatmen's Union of the Pacific
National Health Benefit Plan
Seattle, Washington

Report on the Financial Statements

We have audited the accompanying financial statements of the Inlandboatmen's Union of the Pacific National Health Benefit Plan (the Plan), which comprise the statements of net assets available for benefits and statements of benefit obligations as of December 31, 2019 and 2018, 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 financials.

Board of Trustees' Responsibility for the Financial Statements

The Board of Trustees is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements 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 Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by the Board of Trustees, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the Plan as of December 31, 2019 and 2018, and the changes in financial status for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) and schedule of reportable transactions as of and for the year ended December 31, 2019, and schedules of administrative expenses for the years ended December 31, 2019 and 2018 are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental schedules of assets (held at end of year) and reportable transactions are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's Board of Trustees 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 auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Bellevue, Washington
October 6, 2020

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2019 AND 2018

	2019	2018
ASSETS		
INVESTMENTS (at Fair Value)		
Short-Term Fund	$ 159,903	$ 143,024
U.S. Government Securities	14,921,070	12,676,945
Corporate Bonds	6,798,852	6,844,353
Common Stock	4,427,950	3,666,532
Mutual Funds	3,953,045	3,435,465
Total Investments at Fair Value	30,260,820	26,766,319
RECEIVABLES		
Employer Contributions	3,602,731	3,506,471
Accrued Interest and Dividends	172,374	172,285
Stop Loss Receivable	93,661	946,303
Due from Retiree Plan	6,578	-
Other	29,621	237,179
Total Receivables	3,904,965	4,862,238
CASH	6,610,446	4,744,759
Total Assets	40,776,231	36,373,316
LIABILITIES		
ACCOUNTS PAYABLE	98,598	79,433
DUE TO RELATED PLAN	84,887	697,657
OTHER LIABILITIES	120,590	-
Total Liabilities	304,075	777,090
NET ASSETS AVAILABLE FOR BENEFITS	$ 40,472,156	$ 35,596,226

See accompanying Notes to Financial Statements.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
ADDITIONS:		
CONTRIBUTIONS		
Employers	$ 30,074,626	$ 29,840,099
Participants	361,525	232,665
Total Contributions	30,436,151	30,072,764
INVESTMENT INCOME (LOSS)		
Net Appreciation (Depreciation) in Fair Value of Investments	2,207,729	(1,253,149)
Interest and Dividends	782,047	824,338
Total Investment Income (Loss)	2,989,776	(428,811)
Less: Investment Expenses	(92,786)	(94,876)
Net Investment Income (Loss)	2,896,990	(523,687)
OTHER INCOME	15,560	629
Total Additions	33,348,701	29,549,706
DEDUCTIONS:		
COST OF BENEFITS		
Benefits Paid for Participants	20,344,837	23,687,246
Premiums	6,201,210	5,410,835
Total Cost of Benefits	26,546,047	29,098,081
ADMINISTRATIVE EXPENSES	1,441,774	1,653,397
Total Deductions	27,987,821	30,751,478
NET INCREASE (DECREASE)	5,360,880	(1,201,772)
TRANSFER TO RELATED PLAN	484,950	508,525
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of Year	35,596,226	37,306,523
End of Year	$ 40,472,156	$ 35,596,226

See accompanying Notes to Financial Statements.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF BENEFIT OBLIGATIONS
DECEMBER 31, 2019 AND 2018

	2019	2018
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Amounts Due Insurance Companies	$ 1,036,056	$ 1,036,929
Claims Payable and Incurred But Not Reported	2,911,946	3,711,997
Total	3,948,002	4,748,926
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Lag Months Eligibility Coverage	3,737,250	3,956,951
Participants Individual Accounts	1,532,000	2,159,330
Participants Supplemental Accounts	1,099,783	936,000
Total	6,369,033	7,052,281
TOTAL BENEFIT OBLIGATIONS	$ 10,317,035	$ 11,801,207

See accompanying Notes to Financial Statements.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS
YEARS ENDED DECEMBER 31, 2019 AND 2018

	2019	2018
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Balance at Beginning of Year	$ 881,926	$ 893,153
Increase (Decrease) in Amounts Due Insurance Companies	(873)	143,776
Decrease in Claims Payable and Incurred But Not Reported	(800,051)	(155,003)
Balance at End of Year	81,002	881,926
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Balance at Beginning of Year	10,919,281	11,651,000
Net Increase (Decrease) During the Year:		
Lag Months Eligibility Coverage	(219,701)	(293,049)
Participants Individual Accounts	(627,330)	(515,670)
Participants Supplemental Accounts	163,783	77,000
Balance at End of Year	10,236,033	10,919,281
TOTAL BENEFIT OBLIGATIONS	$ 10,317,035	11,801,207

See accompanying Notes to Financial Statements.

NOTE 1 DESCRIPTION OF PLAN

The following description of the Inlandboatmen's Union of the Pacific National Health Benefit Plan (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The Plan is maintained pursuant to the terms of collective bargaining agreements between participating employers and the Inlandboatmen's Union of the Pacific, Marine Division of I.L.W.U., and other employers who have signed joinder agreements with the Plan, all of whom have been accepted by the Board of Trustees. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Benefits

The Plan provides medical, dental, vision, and prescription drug benefits for active participants and their dependents and death and time loss benefits for active participants. The Plan provides medical and prescription drug benefits for retired participants and their dependents who are not eligible for Medicare. The Plan also offers HMO options. Benefits are provided to all active participants who have sufficient credits in their individual reserve accounts to pay for a month of coverage. The Plan also has an agreement to provide coverage for All Alaska Longshore Health and Welfare Trust Fund eligible participants and their dependents.

The Plan provides dental, vision, death, and accidental death and dismemberment benefits for certain employees who work in the seafood processing industry in Alaska.

The Plan has a Retiree Health Reimbursement Arrangement (HRA Plan), available to Medicare eligible retirees and their Medicare eligible dependents. The Plan contributed $484,950 and $508,525 in Employer contributions to the HRA Plan during 2019 and 2018, respectively.

Contributions

The Plan provides that participating Employers make monthly or bi-monthly contributions to the Plan of a specified amount as specified in the collective bargaining agreement or joinder agreement to provide health benefits for participants. Participants generally only contribute to extend their coverage under the Plan in accordance with the provisions of COBRA or to extend their coverage under the Plan as retirees.

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Contributions (Continued)

The cost of the postretirement benefit plan coverage is shared by the Plan's participating Employers and retirees. In addition to deductibles and co-payments, contributions in the current year and prior year were as follows:

Participant Group	Retiree Contributions
Pre 65 Retirees	In 2019, Retirees Contributed Approximately 77% (74% in 2018) of the Estimated Annual Cost of Providing their Postretirement Benefits.
Post 65 Retirees	Retirees over 65 do not Contribute to the Cost of Providing their Postretirement Benefits.

Post 65 retirees are covered by the HRA Plan.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

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

Investment Valuation and Income Recognition

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements. Purchases and sales are recorded on a trade-date basis. Interest income is recorded on an accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Plan Benefits

The Plan's obligation for premiums due insurance carriers is accrued based upon eligibility earned during the year as they relate to the eligibility formula of the Plan. The Plan's obligation for lag month eligibility coverage is estimated based on actual claims paid for the first two months subsequent to year-end. The obligation for claims payable and claims incurred but not reported is estimated based on prior claims experience and actual lag patterns of the Plan. The liability for participants' individual and supplemental accounts (i.e., accumulated eligibility credits) is based on the number of months of future coverage earned and estimated benefit costs per eligible participant.

Stop Loss

Premiums for stop loss insurance are included in premium payments in the accompanying statements of changes in net assets available for benefits. Stop loss refunds totaling $767,498 and $3,221,927 have been netted with benefits paid for participants in the accompanying statements of changes in net assets for the years ended December 31, 2019 and 2018, respectively.

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan's Board of Trustees to make estimates and assumptions that affect the reported amount of assets, liabilities, benefit obligations, and changes therein, and disclosure of contingent assets and liabilities. Actual results could vary from the estimates that were used.

NOTE 3 PARTICIPANT'S INDIVIDUAL ACCOUNTS

Each participant will have established on his or her behalf an individual account whereby Employer contributions will be credited. At the end of each month, an amount will be deducted from the individual account to provide future coverage. The amount to be deducted for coverage may be changed from time to time by the Board of Trustees. As long as the participant maintains a balance sufficient to provide the deduction, his or her coverage will remain in force.

One time per Plan year, a participant may transfer contributions from the participant's individual account into his or her supplemental account, provided there is at least one month of coverage remaining in his or her individual account.

The balance of the supplemental account is to be limited to $3,000 and the funds can only be utilized under two conditions:

a. To reimburse the participant and dependents for any portion of a medical expense not covered by the Plan or other group insurance up to the balance in his or her account.

b. In the event the participant's individual account is insufficient to provide coverage, the administrator of the Plan will withdraw funds to keep his or her Plan coverage in force unless otherwise instructed by the participant.

The Plan's supplemental account requirements include that in addition to the participant being required to have at least one month of coverage remaining in his or her individual account, the participant also must have health and welfare plan coverage through a plan offered by the Board of Trustees in the month the transfer from the participant's individual account to the participant's supplemental account is scheduled to occur.

The Plan has the ability for participants to opt out and forfeit the money in his or her supplemental account by completing an opt-out form. Should a participant opt-out, the money forfeited will go to the Trust and not the participant.

NOTE 4 FAIR VALUE OF INVESTMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy 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 Plan has the ability to access.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, such as:

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

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

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

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques 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 measured at fair value. There have been no changes in the methodologies used at December 31, 2019 and 2018.

Short-Term Funds: Valued at the closing price reported on the active market on which the individual funds are traded.

U.S. Government Securities and Corporate Bonds: Valued using the latest bid price or using valuations based on a matrix system which considers such factors as security prices, yields, maturities, and ratings.

Common Stock: Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual Funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the SEC. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

NOTE 4 FAIR VALUE OF INVESTMENTS (CONTINUED)

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31:

	2019			
	Level 1	Level 2	Level 3	Total
Short-Term Fund	$ 159,903	$ -	$ -	$ 159,903
U.S. Government Securities	-	14,921,070	-	14,921,070
Corporate Bonds	-	6,798,852	-	6,798,852
Common Stock	4,427,950	-	-	4,427,950
Mutual Funds	3,953,045	-	-	3,953,045
Total Investment Assets at Fair Value	$ 8,540,898	$ 21,719,922	$ -	$ 30,260,820

	2018			
	Level 1	Level 2	Level 3	Total
Short-Term Fund	$ 143,024	$ -	$ -	$ 143,024
U.S. Government Securities	-	12,676,945	-	12,676,945
Corporate Bonds	-	6,844,353	-	6,844,353
Common Stock	3,666,532	-	-	3,666,532
Mutual Funds	3,435,465	-	-	3,435,465
Total Investment Assets at Fair Value	$ 7,245,021	$ 19,521,298	$ -	$ 26,766,319

NOTE 5 TAX STATUS

The Trust established under the Plan to hold the Plan's assets is qualified pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) and, accordingly, the Trust's net investment income is exempt from income taxes. The Plan has obtained a favorable tax determination letter from the Internal Revenue Service (IRS) and the Plan's Board of Trustees believes that the Plan, as amended, continues to qualify and to operate as designed.

Accounting principles generally accepted in the United States of America require the Plan's Board of Trustees to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 6 PLAN TERMINATION

Although it has not expressed any intent to do so, the Board of Trustees has the right under the Plan to terminate the Trust.

In any event, the Trust shall be automatically terminated upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Plan; provided, however, that such termination shall not result from the expiration of all collective bargaining agreements so long as any employer continues to have a legal obligation to continue to make contributions to the Plan, or continues during contract negotiations to voluntarily contribute to the Plan without the union's objection, and provided the Plan is permitted by law to receive such contributions.

Upon the termination of the Trust, the Board of Trustees shall wind up the affairs of the Trust and Plan. In the event of any termination, any and all monies and assets remaining in the Trust, after the payment of expenses, shall be used for the payment of benefits in accordance with the purposes of the Plan, until such monies and assets have been exhausted, unless some other disposition is required by law.

In no event shall any of the remaining monies or assets be paid to or be recoverable by any participating employer, employer association, or labor organization.

NOTE 7 PARTY-IN-INTEREST TRANSACTIONS

The Plan pays expenses related to Plan operations and investment activity to various service providers. These transactions are party-in-interest transactions under ERISA.

NOTE 8 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Form 5500 as of December 31:

	2019	2018
Net Assets Available for Benefits per the Financial Statements	$ 40,472,156	$ 35,596,226
Less:		
Amounts Due Insurance Companies	1,036,056	1,036,929
Claims Payable and Incurred But Not Reported	2,911,946	$ 3,711,997
Total	3,948,002	4,748,926
Net Assets Available for Benefits per Form 5500	$ 36,524,154	$ 30,847,300

NOTE 8 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (CONTINUED)

The following is a reconciliation of the cost of benefits provided per the financial statements to Form 5500 for the year ended December 31, 2019.

Cost of Benefits Provided per the Financial Statements	$ 26,546,047
Add: Amounts Payable at December 31, 2019	3,948,002
Less: Amounts Payable at December 31, 2018	(4,748,926)
Benefit Payments and Payments to Provide Benefits per Form 5500	$ 25,745,123

NOTE 9 RISKS AND UNCERTAINTIES

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

The estimate for claims payable and incurred but not reported is based on prior claims experience and actual lag patterns of the Plan. The estimate for participants' individual and supplemental accounts is based on the number of months of future coverage earned and estimated benefit costs per eligible participant. The estimate for accumulated eligibility credits is based on certain assumptions pertaining to health care trends and inflation rates. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

NOTE 10 SUBSEQUENT EVENTS

The Board of Trustees has evaluated subsequent events through October 6, 2020, the date the financial statements were available to be issued.

NOTE 11 RELATED PARTY TRANSACTION

Contributions for the IBU Pension Plan, IBU 401(k) Plan, and the IBU HRA Plan are remitted to the Plan and then allocated and transferred to the respective related Plans. The amount due to the related Plans represents cash deposits that have been made into the Plan as of December 31, 2019, but have not yet been allocated and transferred to the related Plans. There were amounts due of $84,887 and $697,657 for the years ended December 31, 2019 and 2018, respectively.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
E.I.N. 93-0864012 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)
DECEMBER 31, 2019

(a)	(b) Identity of Issue, Borrower Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Short-Term Fund:			
*	First America Prime US Treasury MM Fund		$ 159,903	$ 159,903
	U.S. Government Securities:			
	F H L M C GOLD PARTN CERT	4.000% due 07/01/25	$ 4,346	$ 4,422
	F H L M C M T N	2.375% due 01/13/22	276,221	279,241
	F N M A PARTN CERT	4.000% due 09/01/41	44,937	45,758
	F N M A PARTN CERT	5.500% due 07/01/38	4,808	5,027
	F N M A PARTN CERT	5.000% due 06/01/40	13,969	14,605
	F N M A PARTN CERT	4.000% due 11/01/40	26,022	27,453
	U S TREASURY NOTE	2.375% due 08/15/24	678,594	669,910
	U S TREASURY NOTE	2.250% due 11/15/25	1,297,463	1,335,399
	U S TREASURY NOTE	3.125% due 05/15/21	1,079,080	1,071,452
	U S TREASURY NOTE	2.125% due 08/15/21	863,426	857,106
	U S TREASURY NOTE	2.000% due 11/15/21	1,222,055	1,219,547
	U S TREASURY NOTE	2.000% due 02/15/22	976,997	973,222
	U S TREASURY NOTE	2.750% due 11/15/23	1,250,702	1,248,984
	U S TREASURY NOTE	2.125% due 05/15/25	1,295,758	1,326,819
	U S TREASURY NOTE	2.125% due 06/30/22	924,565	957,474
	U S TREASURY NOTE	2.375% due 01/31/23	1,248,594	1,244,772
	U S TREASURY NOTE	1.625% due 08/15/29	1,312,340	1,267,448
	U S TREASURY NOTE	2.375% due 01/31/23	1,103,748	1,155,649
	U S TREASURY NOTE	2.625% due 01/31/26	1,186,025	1,216,782
	Total U.S. Government Securities		$ 14,809,650	$ 14,921,070
	Corporate Bonds:			
	AMERICAN TOWER CORP	5.000% due 02/15/24	$ 344,100	$ 357,458
	BANK OF AMERICA CORP	5.700% due 01/24/22	458,632	429,284
	BOSTON PROPERTIES LP	3.850% due 02/01/23	524,150	523,945
	CAPITAL ONE FINANCIAL CO	3.750% due 04/24/24	355,082	368,627
	CISCO SYSTEMS INC	3.625% due 03/04/24	497,696	481,131
	COMCAST CORP	4.150% due 10/15/28	279,958	281,585
	CONOCOPHILLIPS	4.950% due 03/15/26	329,349	345,240
	FEDEX CORP	4.000% due 01/15/24	406,612	428,060
	GENERAL MILLS INC	3.150% due 12/15/21	244,444	235,159
	GOLDMAN SACHS GROUP	4.000% due 03/03/24	204,120	213,128
	INTEL CORP	3.300% due 10/01/21	161,918	154,154
	INTEL CORP	3.700% due 07/29/25	209,170	216,344

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
E.I.N. 93-0864012 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)
DECEMBER 31, 2019

(a)	(b) Identity of Issue, Borrower Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Corporate Bonds (Continued):			
	JP MORGAN CHASE CO	3.300% due 04/01/26	$ 315,756	$ 315,795
	MONDELEZ INTERNATIONAL	4.000% due 02/01/24	237,368	239,609
	MORGAN STANLEY	4.000% due 07/23/25	493,173	513,979
	STARBUCKS CORP	3.550% due 8/15/2029	324,717	325,452
	UNION PACIFIC CORP	4.163% due 07/15/22	366,155	341,582
	VERIZON COMM INC	4.600% due 04/01/21	333,450	310,101
	WELLS FARGO	3.500% due 03/08/22	396,090	387,266
	BP CAPITAL PLC	4.500& due 10/01/20	366,925	330,954
	Total Corporate Bonds		$ 6,848,864	$ 6,798,852
	Common Stock:			
	AT&T INC		$ 75,974	$ 76,206
	ABBVIE INC		41,269	52,239
	ALLSTATE CORP		43,524	70,844
	ALPHABET INC CL A		87,952	190,193
	AMAZON CORP		40,108	36,957
	AMEREM CORP		41,642	41,472
	AMGEN INC		38,366	63,884
	ANALOG DEVICES INC		108,687	117,652
	APPLE INC		66,610	146,825
	AVERY DENNISON CORP		29,760	35,321
	BOEING CO		23,715	66,781
	BROADCOM INC		41,569	47,603
	CACI INTERNATIONAL INC CL A		40,158	69,997
	CELANESE CORP		27,209	30,780
	CHEVRON CORPORATION		44,335	56,640
	CISCO SYSTEMS INC		36,863	51,317
	CITIGROUP INC		67,519	91,075
	DIGITAL REALITY TRUST INC		66,045	74,239
	WALT DISNEY CO INC		59,115	65,084
	ELECTRONIC ARTS INC		65,835	82,783
	EMERSON ELECTRIC CO		64,151	65,584
	ENTERGY CORPORATION		39,237	63,494
	EXXON MOBIL CORP		59,280	53,033
	FACEBOOK INC A		80,272	101,599
	FIDELITY NATL INFO SVCS INC		67,073	76,500
	GAMING& LEISURE PROPE		41,566	52,091
	GILEAD SCIENCES INC		44,579	38,988
	HOME DEPOT INC		15,617	58,963
	HONEYWELL INTERNATIONAL INC		68,643	106,200
	ILLINOIS TOOLS WORKSINC		41,296	48,500
	JP MORGAN CHASE CO		167,856	214,676
	JOHNSON JOHNSON		37,397	40,844
	KEYCORP		65,627	61,723

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
E.I.N. 93-0864012 PLAN NO. 501
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)
DECEMBER 31, 2019

(a)	(b) Identity of Issue, Borrower Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Common Stock (Continued):			
	MARRIOT INTL		$ 60,743	$ 69,658
	MCDONALDS CORP		55,428	55,331
	MERCK CO INC		64,115	92,769
	MICROSOFT CORP		93,696	320,131
	MONDELEZ INTERNATIONAL W I		43,015	54,529
	MOTORALA SOLUTIONS		42,959	41,896
	NEXTERA ENERGY INC		33,444	43,589
	NIKE INC		41,629	48,629
	PHILIP MORRIS		82,527	89,345
	PROCTER & GAMBLE CO		72,126	96,173
	PROGRESSIVE CORP		42,256	44,882
	RAYTHEON COMPANY		49,103	80,205
	STRYKER CORP		33,426	37,789
	TJX COMPANIES INC		67,192	75,715
	THERMO FISHER SCIENTIFIC INC		58,322	116,953
	TRUIST FINL CORP		26,361	50,294
	UNION PACIFIC CORP		47,440	52,429
	UNITEDHEALTH GROUP INC		46,584	77,905
	VERIZON COMMUNICATIONS INC		99,022	114,204
	VISA INC CLASS A SHARES		106,012	187,900
	VOYA		47,844	46,345
	ZOETIS INC		69,392	103,233
	MEDTRONIC PLC		39,890	41,977
	SCHLUMBERGER LTD		32,447	36,180
	Total Common Stock		$ 3,193,822	$ 4,427,950
	Mutual Funds:			
	CONSUMER STAPLES SELECT ETF		$ 66,660	$ 76,836
	ISHARES CORE S P MID CAP		592,951	1,142,301
	ISHARES RUSSELL 2000		170,584	304,501
	ISHARES MSCI ACWI EX US		1,311,723	1,548,754
	VERSUS CAP MM REAL ESTATE I		520,000	542,534
	VERUS CAP RI		330,000	338,119
	Total Mutual Funds		$ 2,991,918	$ 3,953,045
	Total Investment Assets		$ 28,004,157	$ 30,260,820

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
E.I.N. 93-0864012 PLAN NO. 501
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS
YEAR ENDED DECEMBER 31, 2019

(a) Identity of Party Involved	(b) Description of Assets (Include Interest Rate and Maturity in Case of a Loan)	#	(c) Purchase Price	(d) Selling Price	(g) Cost of Assets	(h) Current Value of Assets on Transaction Date	(i) Net Gain or (Loss)
Category (iii) - A Series of Transactions in Excess of 5% of Plan Assets							
First American Inst Prime Oblig Fd Cl Z	Variable Rate		$ 4,237,297	$ -	$ 4,237,297	$ 4,237,297	$ -
First American Inst Prime Oblig Fd Cl Z	Variable Rate		-	4,220,418	4,220,418	4,220,418	-

There were no category (i), (ii) or (iv) reportable transactions for the year ended December 31, 2019.
Columns (e) and (f) are omitted because they are not applicable.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
SCHEDULES OF ADMINISTRATIVE EXPENSES
YEARS ENDED DECEMBER 31, 2019 AND 2018
(SEE INDEPENDENT AUDITORS' REPORT)

	2019	2018
Administration and Claims Processing - Trust Administration Office	$ 660,299	$ 689,316
Administration and Claims Processing - Premera and Others	505,796	601,209
Admin and Other Expenses for Alaska Seafood Processors	38,203	39,092
Audit Fees	26,686	53,558
Bank Service Charges	41,306	30,966
Booklets, Mailings, and Printing	38,298	73,171
Consultant Fees	69,411	78,814
Fiduciary and Fidelity Insurance	34,362	34,008
Legal Fees	10,359	18,316
Meeting Expense	17,054	34,947
Total Administrative Expenses	$ 1,441,774	$ 1,653,397

IBU of the Pacific Natl Health Benefit Trust

EIN 93-0864012 PN 501 FYE 12/31/2019

Schedule H, Line 4j – Schedule of Reportable Transactions - included in the Accountant's audit report attachment.

IBU of the Pacific Natl Health Benefit Trust

EIN 93-0864012 PN 501 FYE 12/31/2019

Schedule H, Line 4i – Schedule of Assets (Held at End of Year) - included in the Accountant's audit report attachment.