

Form 5500Department of the Treasury
Internal Revenue ServiceDepartment 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**2018****This Form is Open to Public Inspection****Part I Annual Report Identification Information**For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

- A** This return/report is for: 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.
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
- special extension (enter description)

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
	1c Effective date of plan <u>11/01/1984</u>
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) <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u> <u>1200 WESTLAKE AVENUE N, SUITE 1006</u> <u>SEATTLE, WA 98109</u>	2b Employer Identification Number (EIN) <u>93-0864012</u>
	2c Plan Sponsor's telephone number <u>503-224-0048</u>
	2d Business code (see instructions) <u>483000</u>

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	<u>Filed with authorized/valid electronic signature.</u>	<u>10/15/2019</u>	<u>MARINA SECCHITANO</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>10/15/2019</u>	<u>LEE EGLAND</u>
	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

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2018)
v. 171027

3a Plan administrator's name and address <input checked="" type="checkbox"/> 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	1839
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6a(1)	1727
	6a(2)	1575
	6b	113
	6c	0
	6d	1688
	6e	
	6f	
	6g	
	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 4C 4D 4E 4L

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> 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) **H** (Financial Information)
- (2) **I** (Financial Information – Small Plan)
- (3) 6 **A** (Insurance Information)
- (4) **C** (Service Provider Information)
- (5) **D** (DFE/Participating Plan Information)
- (6) **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2018 Form M-1 annual report. If the plan was not required to file the 2018 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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u>		B Three-digit plan number (PN) ▶ <u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u>		D Employer Identification Number (EIN) <u>93-0864012</u>

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 THE NORTHWEST

(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
<u>93-0798039</u>	<u>95540</u>	<u>2940</u>	<u>7</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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

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

(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
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	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	0
c Additions: (1) Contributions deposited during the year..... (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account..... (5) Other (specify below)	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	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..... (2) Administration charge made by carrier..... (3) Transferred to separate account..... (4) Other (specify below)	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	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** 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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		17299
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2018</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

<p>A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>B Three-digit plan number (PN) ▶ <u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>93-0864012</u></p>

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
<u>93-0242990</u>	<u>69019</u>	<u>645929</u>	<u>1657</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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).

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	0
c Additions: (1) Contributions deposited during the year..... (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account..... (5) Other (specify below)	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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..... (2) Administration charge made by carrier..... (3) Transferred to separate account..... (4) Other (specify below)	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions.....	7e(5)
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 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)	158338	
(2) Increase (decrease) in amount due but unpaid.....	9a(2)	1234	
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3)).....	9a(4)		159572
b Benefit charges (1) Claims paid.....	9b(1)	75000	
(2) Increase (decrease) in claim reserves.....	9b(2)	1110	
(3) Incurred claims (add (1) and (2)).....	9b(3)		76110
(4) Claims charged.....	9b(4)		76110
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)	20624	
(E) Taxes	9c(1)(E)	2886	
(F) Charges for risks or other contingencies.....	9c(1)(F)	12765	
(G) Other retention charges	9c(1)(G)	47187	
(H) Total retention.....	9c(1)(H)		83462
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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)		11853
(3) Other reserves.....	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....	9e		

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2018</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

<p>A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>B Three-digit plan number (PN) ▶ <u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>93-0864012</u></p>

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
<u>06-1041332</u>	<u>93440</u>	<u>402807</u>	<u>1525</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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	

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	0
c Additions: (1) Contributions deposited during the year..... (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account..... (5) Other (specify below)	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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..... (2) Administration charge made by carrier..... (3) Transferred to separate account..... (4) Other (specify below)	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions.....	7e(5)
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** 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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		2639355
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2018</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

<p>A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>B Three-digit plan number (PN) ▶ <u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>93-0864012</u></p>

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
<u>99-0040115</u>	<u>49948</u>	<u>52258</u>	<u>312</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	0
c Additions: (1) Contributions deposited during the year..... (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account..... (5) Other (specify below)	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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..... (2) Administration charge made by carrier..... (3) Transferred to separate account..... (4) Other (specify below)	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions.....	7e(5)
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)
- e** Temporary disability (accident and sickness)
- i** Stop loss (large deductible)
- m** Other (specify) ▶
- b** Dental
- f** Long-term disability
- j** HMO contract
- c** Vision
- g** Supplemental unemployment
- k** PPO contract
- d** Life insurance
- h** Prescription drug
- l** Indemnity contract

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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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		1382264
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2018</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

<p>A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>B Three-digit plan number (PN) ▶ <u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>93-0864012</u></p>

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
<u>94-1340523</u>	<u>60053</u>	<u>78</u>	<u>39</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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)	
	7e(2)	
	7e(3)	
	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** 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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		217340
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2018</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

<p>A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>B Three-digit plan number (PN) ▶ <u>501</u></p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u></p>	<p>D Employer Identification Number (EIN) <u>93-0864012</u></p>

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 HEALTLTH 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
<u>94-1340523</u>	<u>00000</u>	<u>18308</u>	<u>139</u>	<u>01/01/2018</u>	<u>12/31/2018</u>

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year.....	7b	
c Additions: (1) Contributions deposited during the year..... (2) Dividends and credits..... (3) Interest credited during the year..... (4) Transferred from separate account..... (5) Other (specify below)	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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..... (2) Administration charge made by carrier..... (3) Transferred to separate account..... (4) Other (specify below)	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions.....	7e(5)
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** 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 <input type="checkbox"/> paid in cash, or <input type="checkbox"/> 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		941855
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE C (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Service Provider Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2018</p> <hr/> <p>This Form is Open to Public Inspection.</p>
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For calendar plan year 2018 or fiscal plan year beginning **01/01/2018** and ending **12/31/2018**

<p>A Name of plan IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</p>	<p>B Three-digit plan number (PN) ▶ 501</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</p>	<p>D Employer Identification Number (EIN) 93-0864012</p>	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

- a** Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)..... Yes No
- b** If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

ISHARES	525 WASHINGTON BLVD SUITE 1405 JERSEY CITY, NJ 07310
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(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

MATTHEWS ASIA	PO BOX 9791 PROVIDENCE, RI 02940
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(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

(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	734987	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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	402848	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(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	102543	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

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	94876	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(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	87231	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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	78814	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

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	53558	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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	30966	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(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	18316	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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	9462	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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	6976	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

2018

This Form is Open to Public Inspection

For calendar plan year 2018 or fiscal plan year beginning 01/01/2018 and ending 12/31/2018

A Name of plan <u>IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>BD. OF TR. - IBU OF THE PACIFIC NATL HEALTH BENEFIT TRUST</u>	D Employer Identification Number (EIN) <u>93-0864012</u>	

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	2556408	4744759
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions.....	1b(1)	3931557	3506471
(2) Participant contributions.....	1b(2)		
(3) Other.....	1b(3)	2222697	1355767
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit).....	1c(1)	478853	143024
(2) U.S. Government securities	1c(2)	9179069	12676945
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	7640732	5072848
(B) All other.....	1c(3)(B)	3468430	1771505
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common.....	1c(4)(B)	4655800	3666532
(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)	3600190	3435465
(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	37733736 36373316
Liabilities			
g	Benefit claims payable	1g	3867000 3711997
h	Operating payables	1h	1000716 1116362
i	Acquisition indebtedness	1i	
j	Other liabilities	1j	319650 697657
k	Total liabilities (add all amounts in lines 1g through 1j)	1k	5187366 5526016
Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	32546370 30847300

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.

		(a) Amount	(b) Total
Income			
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers	2a(1)(A)	29840099
	(B) Participants	2a(1)(B)	232665
	(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)	30072764
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	6557
	(B) U.S. Government securities	2b(1)(B)	253654
	(C) Corporate debt instruments	2b(1)(C)	391329
	(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)	651540
(2)	Dividends: (A) Preferred stock	2b(2)(A)	
	(B) Common stock	2b(2)(B)	90084
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	82714
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)	172798
(3)	Rents	2b(3)	
(4)	Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	13915872
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	14212130
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)	-296258
(5)	Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)	
	(B) Other	2b(5)(B)	-517975
	(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)	-517975

		(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)		-438916
c Other income.....	2c		629
d Total income. Add all income amounts in column (b) and enter total	2d		29644582

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	23661295	
(2) To insurance carriers for the provision of benefits	2e(2)	5425559	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		29086854
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)	150688	
(2) Contract administrator fees.....	2i(2)	1328897	
(3) Investment advisory and management fees.....	2i(3)	94876	
(4) Other	2i(4)	173812	
(5) Total administrative expenses. Add lines 2i(1) through (4).....	2i(5)		1748273
j Total expenses. Add all expense amounts in column (b) and enter total	2j		30835127

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-1190545
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan.....	2l(2)		508525

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) Unqualified (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 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:

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.).....

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.)

	Yes	No	Amount
4a		X	
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 TRUST RETIREE HEALTH REIMBURSEMENT 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, 2018 AND 2017



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**INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
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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, 2018 and 2017, 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.

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

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, 2018 and 2017, 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 schedules of assets (held at end of year) and reportable transactions as of and for the year ended December 31, 2018, and schedules of administrative expenses for the years ended December 31, 2018 and 2017, 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

Bellevue, Washington
October 8, 2019

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2018 AND 2017

	2018	2017
ASSETS		
INVESTMENTS (at Fair Value)		
Short-Term Fund	\$ 143,024	\$ 478,853
U.S. Government Securities	12,676,945	9,179,069
Corporate Bonds	6,844,353	11,109,162
Common Stock	3,666,532	4,655,800
Mutual Funds	3,435,465	3,600,190
Total Investments at Fair Value	26,766,319	29,023,074
RECEIVABLES		
Employer Contributions	3,506,471	3,931,557
Accrued Interest and Dividends	172,285	190,334
Stop Loss Receivable	946,303	1,969,669
Other	237,179	62,694
Total Receivables	4,862,238	6,154,254
CASH	4,744,759	2,556,408
Total Assets	36,373,316	37,733,736
LIABILITIES		
ACCOUNTS PAYABLE	79,433	107,563
ASSETS HELD FOR RELATED PLAN	-	319,650
DUE TO RELATED PLAN	697,657	-
Total Liabilities	777,090	427,213
NET ASSETS AVAILABLE FOR BENEFITS	\$ 35,596,226	\$ 37,306,523

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, 2018 AND 2017**

	2018	2017
ADDITIONS:		
CONTRIBUTIONS		
Employers	\$ 29,840,099	\$ 30,215,156
Participants	232,665	273,123
Total Contributions	30,072,764	30,488,279
INVESTMENT INCOME (LOSS)		
Net Appreciation (Depreciation) in Fair Value of Investments	(1,253,149)	1,034,652
Interest and Dividends	824,338	843,923
Total Investment Income (Loss)	(428,811)	1,878,575
Less: Investment Expenses	(94,876)	(90,102)
Net Investment Income (Loss)	(523,687)	1,788,473
OTHER INCOME	629	8,818
Total Additions	29,549,706	32,285,570
DEDUCTIONS:		
COST OF BENEFITS		
Benefits Paid for Participants	23,687,246	22,164,854
Premiums	5,410,835	4,573,444
Total Cost of Benefits	29,098,081	26,738,298
ADMINISTRATIVE EXPENSES	1,653,397	1,544,256
Total Deductions	30,751,478	28,282,554
NET INCREASE (DECREASE)	(1,201,772)	4,003,016
TRANSFER TO RELATED PLAN	508,525	410,020
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of Year	37,306,523	33,713,527
End of Year	\$ 35,596,226	\$ 37,306,523

See accompanying Notes to Financial Statements.

**INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
STATEMENTS OF BENEFIT OBLIGATIONS
DECEMBER 31, 2018 AND 2017**

	<u>2018</u>	<u>2017</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Amounts Due Insurance Companies	\$ 1,036,929	\$ 893,153
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Lag Months Eligibility Coverage	3,956,951	4,250,000
Claims Payable and Incurred But Not Reported	3,711,997	3,867,000
Participants Individual Accounts	2,159,330	2,675,000
Participants Supplemental Accounts	936,000	859,000
Total	<u>10,764,278</u>	<u>11,651,000</u>
TOTAL BENEFIT OBLIGATIONS	<u>\$ 11,801,207</u>	<u>\$ 12,544,153</u>

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, 2018 AND 2017

	2018	2017
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS		
Balance at Beginning of Year	\$ 893,153	\$ 775,172
Increase in Amounts Due Insurance Companies	143,776	117,981
Balance at End of Year	1,036,929	893,153
 OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE		
AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Balance at Beginning of Year	11,651,000	9,350,000
Net Increase (Decrease) During the Year:		
Lag Months Eligibility Coverage	(293,049)	550,000
Claims Payable and Incurred But Not Reported	(155,003)	1,167,000
Participants Individual Accounts	(515,670)	425,000
Participants Supplemental Accounts	77,000	159,000
Balance at End of Year	10,764,278	11,651,000
 TOTAL BENEFIT OBLIGATIONS	\$ 11,801,207	\$ 12,544,153

See accompanying Notes to Financial Statements.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017

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 \$508,525 and \$410,020 in Employer contributions to the HRA Plan during 2018 and 2017, 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.

**INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017**

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:

<u>Participant Group</u>	<u>Retiree Contributions</u>
Pre 65 Retirees	In 2018, Retirees Contributed Approximately 74% (100% in 2017) 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.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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 \$3,221,927 and \$3,666,585 have been netted with benefits paid for participants in the accompanying statements of changes in net assets for the years ended December 31, 2018 and 2017, respectively.

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.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017

NOTE 3 PARTICIPANT'S INDIVIDUAL ACCOUNTS (CONTINUED)

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, 2018 and 2017.

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.

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017

NOTE 4 FAIR VALUE OF INVESTMENTS (CONTINUED)

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.

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

	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

	2017			
	Level 1	Level 2	Level 3	Total
Short-Term Fund	\$ 478,853	\$ -	\$ -	\$ 478,853
U.S. Government Securities	-	9,179,069	-	9,179,069
Corporate Bonds	-	11,109,162	-	11,109,162
Common Stock	4,655,800	-	-	4,655,800
Mutual Funds	3,600,190	-	-	3,600,190
Total Investment Assets at Fair Value	\$ 8,734,843	\$ 20,288,231	\$ -	\$ 29,023,074

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.

**INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017**

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 HRA Plan was established under the same Trust as the Plan. The Plan spun off the HRA Plan January 1, 2016. As of the years ended December 31, 2018 and 2017, the Plan held \$-0- and \$319,650 of HRA Plan assets, respectively. During the 2018 Plan year, the HRA Plan opened a bank account and accounted for it in their 2018 Plan records. This eliminated the assets held by the Health Plan for the HRA Plan at December 31, 2018.

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:

	2018	2017
Net Assets Available for Benefits per the Financial Statements	\$ 35,596,226	\$ 37,306,523
Less:		
Amounts Due Insurance Companies	1,036,929	893,153
Claims Payable and Incurred But Not Reported	3,711,997	3,867,000
Total	4,748,926	4,760,153
Net Assets Available for Benefits per Form 5500	\$ 30,847,300	\$ 32,546,370

INLANDBOATMEN'S UNION OF THE PACIFIC NATIONAL HEALTH BENEFIT PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2018 AND 2017

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, 2018.

Cost of Benefits Provided per the Financial Statements	\$ 29,098,081
Add: Amounts Payable at December 31, 2018	4,748,926
Less: Amounts Payable at December 31, 2017	<u>(4,760,153)</u>
Benefit Payments and Payments to Provide Benefits per Form 5500	<u>\$ 29,086,854</u>

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 8, 2019, 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, 2018, but have not yet been allocated and transferred to the related Plans. There were no amounts due from the Plan to the related Plans as of December 31, 2017.

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, 2018

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value	
Short-Term Fund:				
*	First America Prime Obligation Fund		\$ 143,024	\$ 143,024
U.S. Government Securities:				
	F H L M C GOLD PARTN CERT	4.000% due 07/01/25	\$ 5,842	\$ 5,844
	F H L M C M T N	3.750% due 03/27/19	271,227	250,770
	F H L M C M T N	2.375% due 01/13/22	276,221	273,906
	F H L M C DEB	1.250% due 08/01/19	223,081	223,128
	F N M A PARTN CERT	4.000% due 09/01/41	53,119	51,865
	F N M A PARTN CERT	5.500% due 07/01/38	5,394	5,374
	F N M A PARTN CERT	5.000% due 06/01/40	16,784	17,010
	F N M A PARTN CERT	4.000% due 11/01/40	30,406	30,746
	U S TREASURY NOTE	2.375% due 08/15/24	678,594	644,033
	U S TREASURY NOTE	2.250% due 11/15/25	1,297,463	1,271,309
	U S TREASURY NOTE	3.500% due 05/15/20	353,451	339,174
	U S TREASURY NOTE	2.625% due 08/15/20	823,331	821,156
	U S TREASURY NOTE	3.125% due 05/15/21	1,233,234	1,217,808
	U S TREASURY NOTE	2.125% due 08/15/21	863,426	842,265
	U S TREASURY NOTE	2.000% due 11/15/21	1,222,055	1,194,355
	U S TREASURY NOTE	2.000% due 02/15/22	979,997	951,432
	U S TREASURY NOTE	2.750% due 11/15/23	1,250,702	1,213,128
	U S TREASURY NOTE	2.125% due 05/15/25	1,295,758	1,265,069
	U S TREASURY NOTE	2.125% due 06/30/22	924,565	933,783
	U S TREASURY NOTE	2.375% due 01/31/23	1,103,748	1,124,790
	Total U.S. Government Securities		<u>\$ 12,908,398</u>	<u>\$ 12,676,945</u>
Corporate Bonds:				
	AMERICAN TOWER CORP	5.000% due 02/15/24	\$ 344,100	\$ 336,193
	BANK OF AMERICA CORP	5.700% due 01/24/22	458,632	423,948
	BOEING CAPITAL CORP	4.700% due 10/27/19	286,133	253,110
	BOSTON PROPERTIES LP	3.850% due 02/01/23	524,150	500,890
	BP CAPITAL	4.500% due 10/01/20	366,925	332,755
	CAPITAL ONE FINANCIAL CO	3.750% due 04/24/24	355,082	341,359
	CISCO SYSTEMS INC	3.625% due 03/04/24	497,696	458,946
	CONOCOPHILLIPS	4.950% due 03/15/26	329,349	321,042
	FEDEX CORP	4.000% due 01/15/24	406,612	409,648
	GENERAL MILLS INC	3.150% due 12/15/21	244,444	228,151
	GOLDMAN SACHS GROUP	4.000% due 03/03/24	204,120	197,354
	INTEL CORP	3.300% due 10/01/21	161,918	151,589
	INTEL CORP	3.700% due 07/29/25	209,170	201,746

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, 2018

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value	
<u>Corporate Bonds (Continued):</u>				
JP MORGAN CHASE CO	4.250% due 10/15/20	\$ 304,500	\$ 305,406	
MONDELEZ INTERNATIONAL	4.000% due 02/01/24	237,368	228,258	
MORGAN STANLEY	4.000% due 07/23/25	493,173	468,611	
NOVARTIS SECURITIES	5.125% due 02/10/19	371,283	365,734	
PORT OF NEWPORT OR	5.000% due 08/01/19	307,608	303,343	
UNION PACIFIC CORP	4.163% due 07/15/22	366,155	332,784	
VERIZON COMM INC	4.600% due 04/01/21	333,450	309,735	
WELLS FARGO	3.500% due 03/08/22	396,090	373,751	
Total Corporate Bonds		<u>\$ 7,197,957</u>	<u>\$ 6,844,353</u>	
<u>Common Stock:</u>				
AT&T INC		\$ 133,247	\$ 97,607	
ABBVIE INC		94,652	135,519	
ALLSTATE CORP		43,524	52,057	
ALPHABET INC CL A		64,656	135,845	
AMAZON CORP		40,108	30,039	
AMGEN INC		38,366	51,588	
ANALOG DEVICES INC		52,620	44,632	
APPLE INC		86,593	102,531	
BANK OF NEW YORK MELLON CORP		28,384	28,713	
BOEING CO		23,715	66,113	
CBS CORP		82,516	65,580	
CACI INTERNATIONAL INC CL A		40,158	40,328	
CHEVRON CORPORATION		52,824	60,922	
CISCO SYSTEMS INC		135,738	170,720	
CITIGROUP INC		73,442	64,554	
ELECTRONIC ARTS INC		25,229	26,040	
EMERSON ELECTRIC CO		75,340	60,348	
ENTERGY CORPORATION		39,237	45,617	
EXELON CORPORATION		44,357	44,198	
FACEBOOK INC A		39,108	33,428	
GAMING& LEISURE PROPE		50,497	47,496	
GENERAL DYNAMICS CORP		27,961	29,870	
GILEAD SCIENCES INC		82,470	69,431	
HOME DEPOT INC		29,498	87,628	
HONEYWELL INTERNATIONAL INC		77,795	89,842	
ILLINOIS TOOLS WORKSINC		57,181	72,213	
JP MORGAN CHASE CO		184,205	164,978	
JOHNSON JOHNSON		80,137	77,430	
KEYCORP		72,082	49,513	

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, 2018

(a)	(b)	(c)	(d)	(e)
Identity of Issue, Borrower Lessor, or Similar Party	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value	
<u>Common Stock (Continued):</u>				
ELI LILLY CO		\$ 48,106	\$ 62,489	
LYONDELLBASELL INDU CL A		35,801	34,927	
MARRIOT INTL		75,269	61,879	
MERCK CO INC		86,386	111,557	
MICROSOFT CORP		117,235	257,988	
MONDELEZ INTERNATIONAL W I		120,354	110,883	
OCCIDENTAL PETROLEUM CORPORATION		101,108	69,973	
PACKAGING CORP AMERICA		34,612	25,038	
PROCTER & GAMBLE CO		35,932	35,849	
PROGRESSIVE CORP		88,604	78,429	
RAYTHEON COMPANY		57,175	65,174	
SCHLUMBERGER LTD		32,447	32,472	
SUNTRUST BKS INC		31,347	41,361	
TJX COMPANIES INC		79,113	65,320	
THERMO FISHER SCIENTIFIC INC		95,584	132,036	
UNION PACIFIC CORP		58,891	49,763	
UNITEDHEALTH GROUP INC		47,200	115,841	
VERIZON COMMUNICATIONS INC		36,032	42,727	
VISA INC CLASS A SHARES		120,853	150,412	
XILINX INC		39,755	47,695	
ZOETIS INC		33,300	29,939	
Total Common Stock		<u>\$ 3,250,744</u>	<u>\$ 3,666,532</u>	
<u>Mutual Funds:</u>				
CONSUMER STAPLES SELECT ETF		\$ 78,668	\$ 73,123	
ISHARES CORE S P MID CAP		592,951	921,633	
ISHARES RUSSELL 2000		170,584	246,108	
ISHARES MSCI ACWI EX US		901,177	955,849	
METTHEWS PACIFIC TIGER FD		468,271	384,114	
VERSUS CAP RI EST		330,000	322,798	
VERSUS CAP MM REAL ESTATE I		520,000	531,840	
Total Mutual Funds		<u>\$ 3,061,651</u>	<u>\$ 3,435,465</u>	
Total Investment Assets		<u>\$ 26,561,774</u>	<u>\$ 26,766,319</u>	

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, 2018

(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	\$ 4,976,110	\$ -	\$ 4,976,110	\$ 4,976,110	\$ -
First American Inst Prime Oblig Fd Cl Z	Variable Rate	-	5,454,962	5,454,962	5,454,962	-

There were no category (i), (ii) or (iv) reportable transactions for the year ended December 31, 2018. 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, 2018 AND 2017
(SEE INDEPENDENT AUDITORS' REPORT)

	<u>2018</u>	<u>2017</u>
Administration and Claims Processing - Trust Administration Office	\$ 689,316	\$ 679,545
Administration and Claims Processing - Premera and Others	601,209	590,031
Admin and Other Expenses for Alaska Seafood Processors	39,092	41,810
Audit Fees	53,558	31,394
Bank Service Charges	30,966	24,172
Booklets, Mailings, and Printing	73,171	31,261
Consultant Fees	78,814	80,909
Fiduciary and Fidelity Insurance	34,008	5,454
Legal Fees	18,316	34,002
Meeting Expense	<u>34,947</u>	<u>25,678</u>
 Total Administrative Expenses	 <u>\$ 1,653,397</u>	 <u>\$ 1,544,256</u>

IBU of the Pacific Natl Health Benefit Trust

EIN 93-0864012

PN 501

FYE 12/31/2018

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 12/31/2018

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