

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110  
1210-0089

**2023**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

For calendar plan year 2023 or fiscal plan year beginning 07/01/2023 and ending 06/30/2024

- A** This return/report is for:
  - a multiemployer plan
  - a single-employer plan
  - a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
  - 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
  - special extension (enter description)
  - the DFVC program
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan <u>TEAMSTERS UNION LOCAL NO 92 HEALTH AND WELFARE FUND</u>	<b>1b</b> Three-digit plan number (PN) ▶ <u>501</u>
<b>2a</b> 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>TEAMSTERS UNION LOCAL NO 92</u>  <u>1127 9TH ST SW</u> <u>CANTON, OH 44707</u>	<b>1c</b> Effective date of plan <u>07/01/2001</u>  <b>2b</b> Employer Identification Number (EIN) <u>34-7133842</u>  <b>2c</b> Plan Sponsor's telephone number <u>330-453-0135</u>  <b>2d</b> Business code (see instructions) <u>813930</u>
<u>ALLYSON STONEKING</u> <u>1127 9TH ST SW</u> <u>CANTON, OH 44707</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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	04/14/2025	ALLYSON STONEKING
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2023)  
v. 230707

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	1059
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits ..... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	976
	<b>6a(2)</b>	1026
	<b>6b</b>	89
	<b>6c</b>	0
	<b>6d</b>	1115
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	<b>7</b>	10

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

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

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

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input checked="" 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
- (4)  **DCG** (Individual Plan Information) – Number Attached \_\_\_\_\_
- (5)  **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

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

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

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**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.

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**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 2023 Form M-1 annual report. If the plan was not required to file the 2023 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 \_\_\_\_\_

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**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

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>TEAMSTERS UNION LOCAL NO 92 HEALTH AND WELFARE FUND</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TEAMSTERS UNION LOCAL NO 92</b>		<b>D</b> Employer Identification Number (EIN) <b>34-7133842</b>	

**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  
**DEARBORN NATIONAL LIFE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>36-2598882</b>	<b>71129</b>	<b>MH785070</b>	<b>384</b>	<b>07/01/2023</b>	<b>06/30/2024</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year.....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	<b>7e(5)</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	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)
- |   |  |   |   |
|---|--|---|---|
| <b>a</b> <input type="checkbox"/> Health (other than dental or vision)                    | <b>b</b> <input type="checkbox"/> Dental               | <b>c</b> <input type="checkbox"/> Vision                    | <b>d</b> <input checked="" type="checkbox"/> Life insurance |
| <b>e</b> <input checked="" type="checkbox"/> Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> Long-term disability | <b>g</b> <input type="checkbox"/> Supplemental unemployment | <b>h</b> <input type="checkbox"/> Prescription drug         |
| <b>i</b> <input type="checkbox"/> Stop loss (large deductible)                            | <b>j</b> <input type="checkbox"/> HMO contract         | <b>k</b> <input type="checkbox"/> PPO contract              | <b>l</b> <input type="checkbox"/> Indemnity contract        |
| <b>m</b> <input checked="" type="checkbox"/> Other (specify) ▶ <b>ADD AND DEPSP</b>       |  |   |   |

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	<b>9a(1)</b>		
(2) Increase (decrease) in amount due but unpaid.....	<b>9a(2)</b>		
(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
(4) Earned ((1) + (2) - (3)).....		<b>9a(4)</b>	0
<b>b</b> Benefit charges (1) Claims paid.....	<b>9b(1)</b>		
(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
(3) Incurred claims (add (1) and (2)).....		<b>9b(3)</b>	0
(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>		
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies.....	<b>9c(1)(F)</b>		
(G) Other retention charges .....	<b>9c(1)(G)</b>		
(H) Total retention .....		<b>9c(1)(H)</b>	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.).....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	
(3) Other reserves.....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	
<b>10</b> Nonexperience-rated contracts:			
<b>a</b> Total premiums or subscription charges paid to carrier .....		<b>10a</b>	241742
<b>b</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 .....		<b>10b</b>	
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. ▶

**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

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023** and ending **06/30/2024**

<b>A</b> Name of plan <b>TEAMSTERS UNION LOCAL NO 92 HEALTH AND WELFARE FUND</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TEAMSTERS UNION LOCAL NO 92</b>		<b>D</b> Employer Identification Number (EIN) <b>34-7133842</b>	

**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  
**AULTCARE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>34-1624818</b>	<b>77216</b>	<b>A60000-A60076</b>	<b>456</b>	<b>07/01/2023</b>	<b>06/30/2024</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

<b>a</b> State the basis of premium rates ▶		
<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year.....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	
<b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies      (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
<b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		

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

<b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration      (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment      (4) <input type="checkbox"/> other ▶		
<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	<b>7c(6)</b>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	<b>7e(5)</b>	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	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:

<b>a</b> Premiums: (1) Amount received .....		<b>9a(1)</b>	
(2) Increase (decrease) in amount due but unpaid.....		<b>9a(2)</b>	
(3) Increase (decrease) in unearned premium reserve .....		<b>9a(3)</b>	
(4) Earned ((1) + (2) - (3)).....		<b>9a(4)</b>	0
<b>b</b> Benefit charges (1) Claims paid.....		<b>9b(1)</b>	
(2) Increase (decrease) in claim reserves .....		<b>9b(2)</b>	
(3) Incurred claims (add (1) and (2)).....		<b>9b(3)</b>	0
(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	<b>9c(1)(A)</b>		
(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
(D) Other expenses .....	<b>9c(1)(D)</b>		
(E) Taxes .....	<b>9c(1)(E)</b>		
(F) Charges for risks or other contingencies.....	<b>9c(1)(F)</b>		
(G) Other retention charges .....	<b>9c(1)(G)</b>		
(H) Total retention .....	<b>9c(1)(H)</b>		0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	
(3) Other reserves.....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	8927498
<b>b</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 .....	<b>10b</b>	

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. ▶

**SCHEDULE C  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Service Provider Information**

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

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

OMB No. 1210-0110

**2023**

**This Form is Open to Public Inspection.**

For calendar plan year 2023 or fiscal plan year beginning **07/01/2023**

and ending **06/30/2024**

**A** Name of plan

**TEAMSTERS UNION LOCAL NO 92 HEALTH AND WELFARE FUND**

**B** Three-digit

plan number (PN) ▶

**501**

**C** Plan sponsor's name as shown on line 2a of Form 5500

**TEAMSTERS UNION LOCAL NO 92**

**D** Employer Identification Number (EIN)

**34-7133842**

**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

**SEGAL SELECT INSURANCE SERVICES INC**

**46-0619194**

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

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

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

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**(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

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

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

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

ALLYSON STONEKING

34-1733842

(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?
30	EMPLOYEE	67639	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)

FAULKNER HOFFMAN AND PHILLIPS

34-1213174

(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	NONE	10200	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)

SWALLEN LAWHUN AND CO

34-1172572

(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	NONE	9350	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)

PARSONS RISK STRATEGIES, LLC

85-1042335

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	5700	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"/>

(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.

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

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

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

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

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

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

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> 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)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>▶ File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2023 or fiscal plan year beginning <b>07/01/2023</b> and ending <b>06/30/2024</b>			
<b>A</b> Name of plan <b>TEAMSTERS UNION LOCAL NO 92 HEALTH AND WELFARE FUND</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>B</b> Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;"><b>501</b></td> </tr> </table>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>		
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TEAMSTERS UNION LOCAL NO 92</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>D</b> Employer Identification Number (EIN) <b>34-7133842</b></td> </tr> </table>	<b>D</b> Employer Identification Number (EIN) <b>34-7133842</b>	
<b>D</b> Employer Identification Number (EIN) <b>34-7133842</b>			

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**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.

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>		
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	649817	865924
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	1633	653
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	948138	1001280
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>	0	6359
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	1599588	1874216
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>		
<b>h</b> Operating payables .....	<b>1h</b>	1325336	1557797
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>	0	6359
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	1325336	1564156
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	274252	310060

**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.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>		
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	9036071	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		9036071
<b>b Earnings on investments:</b>			
(1) Interest:			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>	47794	
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		
(2) Dividends: <b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		
(3) Rents .....	<b>2b(3)</b>		
(4) Net gain (loss) on sale of assets: <b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		
(5) Unrealized appreciation (depreciation) of assets: <b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(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)		
<b>c</b> Other income.....	2c		3000
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	2d		9086865

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)		
(2) To insurance carriers for the provision of benefits.....	2e(2)	8927498	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		8927498
<b>f</b> Corrective distributions (see instructions).....	2f		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	2g		
<b>h</b> Interest expense.....	2h		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	2i(1)	82395	
(2) Contract administrator fees.....	2i(2)		
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)	9350	
(5) Investment advisory and investment management fees.....	2i(5)		
(6) Bank or trust company trustee/custodial fees.....	2i(6)		
(7) Actuarial fees.....	2i(7)	5700	
(8) Legal fees.....	2i(8)	10200	
(9) Valuation/appraisal fees.....	2i(9)		
(10) Other trustee fees and expenses.....	2i(10)		
(11) Other expenses.....	2i(11)	15914	
(12) Total administrative expenses. Add lines 2i(1) through (11).....	2i(12)		123559
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	2j		9051057

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line 2j from line 2d.....	2k		35808
<b>l</b> Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan.....	2l(2)		

**Part III Accountant's Opinion**

**3** Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

**a** The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1)  Unmodified (2)  Qualified (3)  Disclaimer (4)  Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1)  DOL Regulation 2520.103-8 (2)  DOL Regulation 2520.103-12(d) (3)  neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: SWALLEN LAWHUN AND CO

(2) EIN: 34-1172572

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> 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.)		X	
<b>b</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.)		X	
<b>c</b> 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.)		X	
<b>d</b> 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.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> 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?		X	
<b>h</b> 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?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
<b>j</b> 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.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> 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.			

**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.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> PN(s)

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

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

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

AUDITED FINANCIAL STATEMENTS  
AND INDEPENDENT AUDITORS' REPORT

June 30, 2024 and 2023

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## Independent Auditors' Report

Trustees  
Teamsters Union Local 92 Health and Welfare Fund  
Canton, Ohio

### **Opinion**

We have audited the accompanying financial statements of Teamsters Union Local 92 Health and Welfare Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of plan benefit obligations as of June 30, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in plan benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of Teamsters Union Local 92 Health and Welfare Fund as of June 30, 2024 and 2023, and the changes in its net assets available for benefits and changes in its plan benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

### **Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Teamsters Union Local 92 Health and Welfare Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### **Responsibilities of Management for the Financial Statements**

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Teamsters Union Local 92 Health and Welfare Fund's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

### **Auditor's Responsibilities for the Audit of the Financial Statements**

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

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

- \* Exercise professional judgment and maintain professional skepticism throughout the audit.
- \* Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- \* Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Teamsters Union Local 92 Health and Welfare Fund's internal control. Accordingly, no such opinion is expressed.
- \* Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- \* Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Teamsters Union Local 92 Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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

*Swallen, Lawhead & Co.*

Certified Public Accountants

April 4, 2025

Canton, Ohio

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

June 30, 2024 and 2023

	<u>ASSETS</u>	<u>2024</u>	<u>2023</u>
<u>CURRENT ASSETS</u>			
Cash		\$ 1,001,280	\$ 948,138
Employer contributions receivable		865,924	649,817
Prepaid expenses		<u>653</u>	<u>1,633</u>
TOTAL CURRENT ASSETS		1,867,857	1,599,588
Operating lease right-of-use asset, net - NOTE F		<u>6,359</u>	<u>-</u>
TOTAL ASSETS		1,874,216	1,599,588
 <u>LIABILITIES</u> 			
<u>CURRENT LIABILITIES</u>			
Operating lease liability, current - NOTE F		2,299	-
Accounts payable and accrued expenses		<u>4,371</u>	<u>5,361</u>
TOTAL CURRENT LIABILITIES		6,670	5,361
Operating lease liability, long-term - NOTE F		<u>4,060</u>	<u>-</u>
TOTAL LIABILITIES		10,730	5,361
 <u>BENEFIT OBLIGATIONS</u> 			
Amounts payable to insurance companies		<u>1,553,426</u>	<u>1,319,975</u>
		<u>1,564,156</u>	<u>1,325,336</u>
NET ASSETS AVAILABLE FOR BENEFITS		<u>\$ 310,060</u>	<u>\$ 274,252</u>

The accompanying notes are an integral part of these financial statements.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

Years Ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<u>ADDITIONS TO NET ASSETS ATTRIBUTED TO:</u>		
<u>Other income</u>		
Interest	\$ 47,794	\$ 31,462
Miscellaneous - NOTE E	3,000	-
<u>Contributions</u>		
Employer	<u>9,036,071</u>	<u>8,600,900</u>
TOTAL ADDITIONS	9,086,865	8,632,362
<u>DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:</u>		
Insurance premiums	8,927,498	8,496,641
Administrative expenses	<u>123,559</u>	<u>113,268</u>
TOTAL DEDUCTIONS	<u>9,051,057</u>	<u>8,609,909</u>
INCREASE IN NET ASSETS	35,808	22,453
NET ASSETS AVAILABLE FOR BENEFITS AT BEGINNING OF YEAR	<u>274,252</u>	<u>251,799</u>
NET ASSETS AVAILABLE FOR BENEFITS AT END OF YEAR	<u>\$ 310,060</u>	<u>\$ 274,252</u>

The accompanying notes are an integral part of these financial statements.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

STATEMENTS OF PLAN BENEFIT OBLIGATIONS

Years Ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<u>AMOUNTS CURRENTLY PAYABLE</u>		
Amounts due to insurance companies	\$ 1,553,426	\$ 1,319,975
<u>POSTRETIREMENT BENEFIT OBLIGATIONS NET OF     AMOUNTS CURRENTLY PAYABLE</u>		
Retired participants	6,584,570	6,416,301
Other participants fully eligible for benefits	16,434,188	16,083,942
Participants not yet fully eligible for benefits	<u>24,844,257</u>	<u>22,096,328</u>
	<u>47,863,015</u>	<u>44,596,571</u>
 TOTAL BENEFIT OBLIGATIONS	 <u>\$49,416,441</u>	 <u>\$45,916,546</u>

The accompanying notes are an integral part of these financial statements.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN PLAN BENEFIT OBLIGATIONS

Years Ended June 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<u>AMOUNTS CURRENTLY PAYABLE</u>		
Balance at beginning of year	\$ 1,319,975	\$ 2,028,338
Insurance premiums paid	( 1,319,975)	( 2,028,338)
Amounts payable to insurance company	<u>1,553,426</u>	<u>1,319,975</u>
Balance at end of year	1,553,426	1,319,975
<u>POSTRETIREMENT BENEFIT OBLIGATIONS, NET OF</u> <u>AMOUNTS CURRENTLY PAYABLE</u>		
Balance at beginning of year	44,596,571	43,691,820
Increase (decrease) in postretirement benefits attributed to:		
Benefits earned net of benefits paid	408,855	( 368,000)
Actuarial (gain) loss	-	( 1,479,737)
Interest	2,857,589	2,752,488
Change in actuarial assumptions:		
Claims update	-	-
Retiree contributions updated	-	-
Mortality, trend, morbidity	<u>-</u>	<u>-</u>
Balance at end of year	<u>47,863,015</u>	<u>44,596,571</u>
PLANS TOTAL BENEFIT OBLIGATION AT END OF YEAR	<u>\$49,416,441</u>	<u>\$45,916,546</u>

The accompanying notes are an integral part of these financial statements.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE A - DESCRIPTION OF FUNDING POLICY

The Teamsters Union Local 92 Health and Welfare Fund (the Plan) is a fully insured multi employer health and welfare plan established to provide health and welfare benefits. The Plan, prior to July 1, 2005, was a self funding multi employer health and welfare plan. The following description of the Plan provides only general information. Participants should refer to the Plan agreement and summary plan descriptions for further information.

GENERAL

The Plan was created by an Agreement and Declaration of Trust between Teamsters Union Local 92 (the Union) and participating employers. The Union and the participating employers have the right to appoint an equal number of members to the Board of Trustees of the Plan. These trustees have the sole authority to administer the Plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

BENEFITS

The Plan provides health benefits (medical, hospital surgical, major medical, vision and dental), life insurance, disability benefits and death benefits to eligible participants and their beneficiaries and dependents. Eligibility is determined weekly by participating employers submitting contributions on behalf of employees. The Plan offers no hour banking for eligibility. Retired employees are eligible for similar benefits depending on the employer from whom they have retired.

Health claims of active and retired participants and their dependents and beneficiaries are provided under group insurance contracts with Aultcare (McKinley Life) which are non-experience rated. Death, accidental death and dismemberment, and short term disability benefits are covered by a group term policy with Fort Dearborn Life Insurance Company.

CONTRIBUTIONS

Contributions to the Plan are made by participating employers pursuant to collective bargaining agreements with the Union.

OTHER

The Board of Trustees have the right under the Plan to modify benefits, funding arrangements, and contribution rates. The Plan may be terminated at any time based on the provisions in the Plan's Declaration of Trust and ERISA.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

USE OF ESTIMATES

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

EMPLOYER CONTRIBUTIONS RECEIVABLE

Employer contributions receivable consists of contributions due for benefits earned in the current year.

POSTRETIREMENT BENEFITS

The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees service rendered to year end, reduced by the actuarial present value of contributions expected to be received in the future from Plan participants. Postretirement benefits include future benefits expected to be paid for 1) currently retired or terminated employees and their beneficiaries and dependents and 2) active employees and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing Plan assets. Prior to an active employee's full eligibility date, the postretirement benefit obligations is the portion of the expected postretirement benefit obligation that is attributed to that employee's service.

The actuarial preset value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claim-cost data to estimate future annual incurred claims cost per participation and to adjust such estimates for the time value of money.

ESTIMATED PENDING AND UNREPORTED CLAIMS

The liability for pending and reported claims includes the liability for claims reported and unpaid and estimates for claims incurred but not yet reported.

LEASES

The Plan calculates operating lease liabilities with a risk-free discount rate, using a comparable period with the lease term. All lease and non-lease components are combined for all leases.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE B - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - (Continued)

INCOME TAXES

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

NOTE C - POSTRETIREMENT BENEFIT OBLIGATION

The following actuarial methods and assumptions were used:

Demographic Data: Participant census as of June 30, 2023. Actual full valuation as of June 30, 2023.

Disability (%):	20	0.05%
	30	0.05%
	40	0.09%
	50	0.00%

Rationale: Adopted by Plan Sponsor with advice from the actuary to reasonably match plan experience.

Spouse Data: Retired Members - Actual Data  
Active Members - Male 80% Married with a 4 year offset  
- Female 65% Married with a 4 year offset

Expected Retirement Age:	<u>Age(s)</u>	<u>Retirement %</u>
	50-54	5%
	55-59	10%
	60-62	25%
	63-64	50%
	65 & Older	100%

Rationale: Adopted by Plan Sponsor with advice from the actuary to reasonably match plan experience.

Assumed Retirement Pension Eligibility: 55 years of age and 5 years of service.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE C - POSTRETIREMENT BENEFIT OBLIGATION - (Continued)

Mortality:                   Healthy - RP-2014 Blue Collar Mortality Projected with MP-2018.

                                  Disabled - RP-2014 Disabled Mortality Projected with MP-2018.

                                  Rationale: Based on the most recent mortality study by the Society of Actuaries.

Turnover - Sample Rates:	<u>Age</u>	<u>Male &amp; Females</u>
	20	5.44%
	30	3.70%
	40	1.13%
	50	0.00%

                                  Rationale: Adopted by Plan Sponsor with advice from the actuary to reasonably match plan experience.

Participation Rates at Retirement: 100.00%

Actuarial Cost Method:           Projected Unit Credit

Weighted-average Discount Rate: 6.25%

Trend (Society of Actuaries Getzen Model):

<u>Fiscal Year</u>	<u>Medical Trend</u>	<u>Fiscal Year</u>	<u>Medical Trend</u>
<u>Beginning</u>	<u>Rate</u>	<u>Beginning</u>	<u>Rate</u>
2020	7.50%	2049-2052	4.90%
2021	7.00%	2053-2057	4.80%
2022	6.50%	2058-2065	4.70%
2023	6.30%	2066	4.60%
2024	6.10%	2067	4.50%
2025	5.80%	2068	4.40%
2026	5.60%	2069-2070	4.30%
2027	5.40%	2071	4.20%
2028-2045	5.20%	2072+	4.00%

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE C - POSTRETIREMENT BENEFIT OBLIGATION - (Continued)

Monthly Average Cost actuarial rolled-up:

<u>Age</u>	Aultcare All Benefits			
	Retiree		Spouse	
	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
50	\$1,121	\$1,101	\$ 1,121	\$1,101
55	1,352	1,273	1,352	1,273
60	1,872	1,515	1,872	1,515
64	2,242	1,756	2,242	1,756
65	736	718	736	718
70	803	803	803	803
75	863	881	863	881

Medicare Part D: As of June 30, 2024, this report does not assume Medicare Part D subsidy or adjustments.

Retiree Contributions: Varies by Participating Employer, assumed not to change in the future. All retirees pay the same amount - \$257.25 per month, \$400 per month.

NOTE D - BENEFIT OBLIGATIONS

Health costs incurred by participants and their beneficiaries and dependents are covered by insurance contracts maintained by the Plan. It is the present intention of the Plan to continue obtaining insurance coverage for benefits. Insurance premiums for future years in respect of the Plan's postretirement benefit obligation will be funded by Sponsor contributions to the Plan in those later years.

The postretirement benefit obligation at June 30, 2024 and 2023, principally health benefits, relates to the following categories of participants (including their beneficiaries and dependents):

	<u>2024</u>	<u>2023</u>
Current retirees, beneficiaries and dependents	\$ 6,584,570	\$ 6,416,301
Actives - fully eligible for benefits	16,434,188	16,083,942
Actives - not yet fully eligible for benefits	<u>24,844,257</u>	<u>22,096,328</u>
	<u>\$47,863,015</u>	<u>\$44,596,571</u>

The weighted health care cost trend rate assumption (see Note C) has a significant effect on the amounts reported. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of June 30, 2024 and 2023, by \$11,167,567 and \$11,215,828, respectively.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

**NOTE E - RELATED PARTY TRANSACTIONS**

The Union is a participating employer in the Plan. The Plan has a lease agreement with the Union to rent office space in the Union building. The lease provided for monthly rental payments of \$110 through February 2024. In March 2024, the lease was renewed for a term of 36 months and the monthly rental payments were increased to \$210. Rental expense was \$1,720 and \$1,320 during the years ended June 30, 2024 and 2023, respectively. The Union is also reimbursed by the Plan for office supplies and utilities. These reimbursements were \$1,967 and \$1,992 during the years ended June 30, 2024 and 2023, respectively.

In July 2023, the Plan and the Union entered into a cost sharing agreement and agreed that the Union would reimburse the Plan \$250 per month related to administrative services provided by Plan personnel to the Union. This reimbursement is included in miscellaneous income.

**NOTE F - LEASES**

The Plan has a lease arrangement for office space. This lease has an original term of 3 years. The Plan's lease arrangement may contain both lease and non-lease components. The Plan has elected to combine and account for lease and non-lease components as a single lease component for its lease.

Payments under the Plan's lease arrangements are fixed. Lease costs associated with fixed payments on the Plan's operating lease were \$840 and \$-0- for the years ended June 30, 2024 and 2023, respectively. The Plan made \$840 and \$-0- of fixed cash payments related to operating leases for the years ended June 30, 2024 and 2023, respectively.

The following table shows right-of-use assets and lease liabilities, and the associated financial statement line items, as of June 30, 2024 and 2023:

<u>Lease-Related Assets and Liabilities</u>	<u>Financial Statement Line Items</u>	<u>2024</u>	<u>2023</u>
Right-of-use assets:			
Operating leases	Right-of-use asset, operating	\$ 6,359	\$ -
Total right-of-use assets		<u>\$ 6,359</u>	<u>\$ -</u>
Lease liabilities:			
Operating leases	Current liabilities	\$ 2,299	\$ -
	Long-term liabilities	<u>4,060</u>	<u>-</u>
Total lease liabilities		<u>\$ 6,359</u>	<u>\$ -</u>

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE F - LEASES - (Continued)

Operating lease liabilities maturities as of June 30, are as follows:

2025	\$	2,520
2026		2,520
2027		<u>1,680</u>
Total undiscounted liabilities		6,720
Less: imputed interest		<u>( 361)</u>
Total lease liabilities	\$	<u>6,359</u>

The remaining lease term related to the Plan's lease liabilities as of June 30, 2024 was 32 months. The discount rate related to the Plan's lease liabilities as of June 30, 2024 was 4.33%. The discount rate is generally based on estimates of the Plan's incremental borrowing rate, as the discount rate implicit in the Plan's lease cannot be readily determined.

NOTE G - EMPLOYEE BENEFIT PLANS

The Plan participates in the Teamster - National 401(k) Savings Plan. All full-time employees of the Plan are eligible to contribute. The Plan makes matching contributions on behalf of each eligible employee who is a participant in the Teamster - National 401(k) Savings Plan equal to 100% of such eligible employees elective deferral contribution along with an additional contribution of \$250 per month through December 2023. In January 2024, the additional contribution was increased to \$1,000 per month. The total contributions to the Teamster - National 401(k) Savings Plan were \$9,289 and \$4,897 for the years ended June 30, 2024 and 2023, respectively.

NOTE H - CONCENTRATIONS

At June 30, 2024 and 2023, and at times during the years then ended, the Plan had cash in banks in excess of Federally insured limits. At June 30, 2024 and 2023, the Plan had exposure of \$760,266 and \$703,945, respectively.

For the years ended June 30, 2024 and 2023, the Plan received 72.9% and 75.4% of its contributions from two and two employers, respectively. United Parcel Service accounted for 53.3% in 2024 and 56.2% in 2023, of the Plan's contributions. Dover Chemical accounted for 19.6% in 2024 and 19.2% in 2023, of the Plan's contributions.

TEAMSTERS UNION LOCAL 92  
HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

June 30, 2024 and 2023

NOTE I - SUBSEQUENT EVENTS

In preparing these financial statements, management of the Plan has evaluated events and transactions for potential recognition or disclosure through April 4, 2025, the date the financial statements were issued.