

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2023

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 08/01/2023 and ending 07/31/2024

- A This return/report is for: [X] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension... E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here... []

Part II Basic Plan Information—enter all requested information

1a Name of plan: ROOFERS HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 08/06/1959
2a Plan sponsor's name (employer, if for a single-employer plan): BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
2b Employer Identification Number (EIN): 94-6074642
2c Plan Sponsor's telephone number: 408-288-4420
2d Business code (see instructions): 238100

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2023) v. 230707

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	1948
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1862
	6a(2)	2043
	6b	84
	6c	0
	6d	2127
	6e	
	6f	2127
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	115

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

9a Plan funding arrangement (check all that apply)	9b 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	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>5</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> 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 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 _____

**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 **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE		D Employer Identification Number (EIN) 94-6074642

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 INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1340523	00000	8527	2487	08/01/2023	07/31/2024

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	

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year..... **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

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

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

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits **7c(2)**
 (3) Interest credited during the year **7c(3)**
 (4) Transferred from separate account..... **7c(4)**
 (5) Other (specify below) **7c(5)**
 ▶

(6) Total additions **7c(6)** 0

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier **7e(2)**
 (3) Transferred to separate account..... **7e(3)**
 (4) Other (specify below) **7e(4)**
 ▶

(5) Total deductions **7e(5)** 0

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f** 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)
b	Benefit charges (1) Claims paid.....	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2)).....		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies.....	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <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	18598407
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. ▶

**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 **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6074642

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

1 Coverage Information:

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1632821	N/A	12004422	1998	08/01/2023	07/31/2024

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	

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year..... **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

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

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

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits **7c(2)**
 (3) Interest credited during the year **7c(3)**
 (4) Transferred from separate account..... **7c(4)**
 (5) Other (specify below) **7c(5)**
 ▶

(6) Total additions **7c(6)** 0

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier **7e(2)**
 (3) Transferred to separate account..... **7e(3)**
 (4) Other (specify below) **7e(4)**
 ▶

(5) Total deductions **7e(5)** 0

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f** 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)	151546	
	(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)		151546
b	Benefit charges (1) Claims paid.....	9b(1)	124793	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2)).....	9b(3)		124793
	(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)	26753	
	(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)		26753
	(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	
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 A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">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 style="font-size: large;">2023</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

<p>A Name of plan ROOFERS HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE</p>	<p>D Employer Identification Number (EIN) 94-6074642</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
THE UNION LABOR 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
13-1423090	69744	SL10284	1132	08/01/2023	07/31/2024

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.

<p>(a) Total amount of commissions paid 172153</p>	<p>(b) Total amount of fees paid</p>
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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
STEALTH PARTNER GROUP **18700 N HAYDEN RD STE 405**
SCOTTSDALE, AZ 85255

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
172153			3

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

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

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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) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f 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)

a 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 Balance at the end of the previous year	7b	
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	
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)
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)
b Benefit charges (1) Claims paid.....	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2)).....		9b(3)
(4) Claims charged		9b(4)
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies.....	9c(1)(F)	
(G) Other retention charges.....	9c(1)(G)	
(H) Total retention		9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were <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	3443052
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. ▶

**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 **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6074642

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

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL OF CALIFORNIA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1461312	N/A	16014	1953	08/01/2023	07/31/2024

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
---	--------------------------------------

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

c Premiums due but unpaid at the end of the year..... **6c**

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. **6d**
 Specify nature of costs ▶

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

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

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

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

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

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits **7c(2)**
 (3) Interest credited during the year **7c(3)**
 (4) Transferred from separate account..... **7c(4)**
 (5) Other (specify below) **7c(5)**
 ▶

(6) Total additions **7c(6)** 0

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier **7e(2)**
 (3) Transferred to separate account..... **7e(3)**
 (4) Other (specify below) **7e(4)**
 ▶

(5) Total deductions **7e(5)** 0

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**) **7f** 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 <input type="checkbox"/> Health (other than dental or vision) | b <input checked="" type="checkbox"/> Dental | c <input type="checkbox"/> Vision | d <input type="checkbox"/> Life insurance |
| e <input type="checkbox"/> Temporary disability (accident and sickness) | f <input type="checkbox"/> Long-term disability | g <input type="checkbox"/> Supplemental unemployment | h <input type="checkbox"/> Prescription drug |
| i <input type="checkbox"/> Stop loss (large deductible) | j <input type="checkbox"/> HMO contract | k <input type="checkbox"/> PPO contract | l <input type="checkbox"/> Indemnity contract |
| m <input type="checkbox"/> Other (specify) ▶ | | | |

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3)).....		9a(4)
b Benefit charges (1) Claims paid.....	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2)).....		9b(3)
(4) Claims charged		9b(4)
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies.....	9c(1)(F)	
(G) Other retention charges.....	9c(1)(G)	
(H) Total retention		9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were <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	1009759
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. ▶

**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 **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE		D Employer Identification Number (EIN) 94-6074642

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
SUN LIFE ASSURANCE COMPANY OF CANADA

(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
38-1082080	80802	245775	2117	08/01/2023	07/31/2024

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	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	
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)
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) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid.....	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3)).....	9a(4)	
b Benefit charges (1) Claims paid.....	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2)).....	9b(3)	
(4) Claims charged	9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies.....	9c(1)(F)	
(G) Other retention charges	9c(1)(G)	
(H) Total retention	9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <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	130621
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. ▶

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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.	<small>OMB No. 1210-0110</small> 2023 This Form is Open to Public Inspection.
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6074642	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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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)

UNITED ADMINISTRATIVE SERVICES

94-1749354

(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?
13 50	NONE	582436	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)

ANTHEM BLUE CROSS LIFE & HEALTH INS

95-4331852

(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 15 49 50 62	NONE	301626	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

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	110304	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)

MILLER KAPLAN ARASE LLP

95-2036255

(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	77929	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)

MCMORGAN & COMPANY LLC

52-2334338

(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?
27 50	NONE	53445	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)

BEAT IT! PROGRAM INC

77-0111619

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	44348	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)

SALTZMAN & JOHNSON

94-2376174

(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	29038	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)

AMERICAN HEALTH HOLDING, INC

31-1368946

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	27265	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)

INEICH & COMPANY, LLP

56-2552172

(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	22877	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)

COMPLIANCE AUDIT SERVICES

94-3134229

(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	14080	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)

NEYHART, ANDERSON, FLYNN & GRSBOLL

94-2576729

(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	12963	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)

HINGE HEALTH INC

81-1884841

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	11940	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"/>

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: INEICH & COMPANY, LLP	b EIN: 56-2552172
c Position: AUDITOR	
d Address: 950 TOWER LN STE 780 FOSTER CITY, CA 94404	e Telephone: 650-573-8007

Explanation: **TERMINATED AND REPLACED AS PART OF THE COMPETITIVE BIDDING PROCESS.**

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) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	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 2023 This Form is Open to Public Inspection
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For calendar plan year 2023 or fiscal plan year beginning **08/01/2023** and ending **07/31/2024**

A Name of plan ROOFERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6074642	

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.

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	4815846	9012966
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	4065218	4052744
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	1021558	773253
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	10677387	11048353
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	15023179	16096450
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	61170	0

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(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	35664358	40983766
Liabilities			
g Benefit claims payable	1g	6811392	13252530
h Operating payables	1h	127197	145632
i Acquisition indebtedness	1i		
j Other liabilities	1j	8726179	0
k Total liabilities (add all amounts in lines 1g through 1j)	1k	15664768	13398162
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	19999590	27585604

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	37384895	
(B) Participants	2a(1)(B)	1031588	
(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)		38416483
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	37328	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		37328
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	580504	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts.....	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts.....	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities.....	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		561241
c Other income	2c		2243550
d Total income. Add all income amounts in column (b) and enter total	2d		41839106

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	11792678	
(2) To insurance carriers for the provision of benefits.....	2e(2)	20958749	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		32751427
f Corrective distributions (see instructions).....	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances.....	2i(1)		
(2) Contract administrator fees.....	2i(2)	582436	
(3) Recordkeeping fees.....	2i(3)	92009	
(4) IQPA audit fees.....	2i(4)	22877	
(5) Investment advisory and investment management fees	2i(5)	53445	
(6) Bank or trust company trustee/custodial fees	2i(6)	2531	
(7) Actuarial fees	2i(7)	4500	
(8) Legal fees	2i(8)	45601	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	698266	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1501665
j Total expenses. Add all expense amounts in column (b) and enter total	2j		34253092

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		7586014
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) 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: MILLER KAPLAN ARASE LLP

(2) EIN: 95-2036255

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		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.)		X	
e Was this plan covered by a fidelity bond?	X		1565000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		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?		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?		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.)	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.)		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?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
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.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND

FINANCIAL STATEMENTS

JULY 31, 2024 AND 2023



INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Bay Area Roofers Health and Welfare Trust Fund
6800 Santa Teresa Boulevard, Suite 100
San Jose, California 95119

Members of the Board:

Opinion

We have audited the accompanying financial statements of Bay Area Roofers Health and Welfare Trust Fund (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), which comprise the statements of net assets available for benefits and of benefit obligations as of July 31, 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the year ended July 31, 2024, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of July 31, 2024, and the changes in its net assets available for benefits and benefit obligations for the year ended July 31, 2024, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan'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 the Plan'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 the Plan'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.

Prior Period Financial Statements

The financial statements of the Plan as of July 31, 2023, were audited by a predecessor auditor whose report dated April 30, 2024, expressed an unmodified opinion on those statements.

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

Burbank, California

April 29, 2025

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	July 31, 2024	July 31, 2023
ASSETS		
CASH	\$ 19,989,038	\$ 15,493,233
INVESTMENTS - AT FAIR VALUE		
Short Term Investment Funds	\$ 72,281	\$ 76,932
Mutual Funds	3,826,978	4,586,357
Exchanged Traded Funds	<u>12,269,472</u>	<u>10,359,890</u>
TOTAL CASH AND INVESTMENTS	36,157,769	30,516,412
RECEIVABLES		
Employer Contributions	4,052,744	4,065,218
Stop Loss Reimbursements and Rx Rebates	<u>743,781</u>	<u>1,021,558</u>
TOTAL RECEIVABLES	4,796,525	5,086,776
PREPAID EXPENSES	<u>29,472</u>	<u>61,170</u>
TOTAL ASSETS	40,983,766	35,664,358
LIABILITIES		
Accounts Payable	107,205	91,340
Due to Other Trusts	<u>38,427</u>	<u>35,857</u>
TOTAL LIABILITIES	<u>145,632</u>	<u>127,197</u>
NET ASSETS AVAILABLE FOR BENEFITS	40,838,134	35,537,161
MEMORANDUM:		
Health Reimbursement Accounts ("HRA")	10,033,165	8,608,310
Benefit Obligations Other Than Postretirement Benefit Obligations	<u>13,252,530</u>	<u>15,537,570</u>
Excess of Net Assets Available For Benefits Over HRA and Benefit Obligations Other Than Postretirement Benefit Obligations	<u><u>\$ 17,552,439</u></u>	<u><u>\$ 11,391,281</u></u>

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

	August 1, 2023 to July 31, 2024		August 1, 2022 to July 31, 2023	
ADDITIONS				
CONTRIBUTIONS				
Employer Contributions	\$ 37,384,895		\$ 34,201,512	
Participant Contributions	259,158		222,115	
Retiree Contributions	<u>772,430</u>	\$ 38,416,483	<u>781,156</u>	\$ 35,204,783
NET INVESTMENT INCOME (LOSS)				
Interest and Dividends	617,931		640,970	
Net Appreciation (Depreciation) of Investments	561,241		(712,321)	
Less: Investment Expenses	<u>(53,445)</u>	<u>1,125,727</u>	<u>(55,197)</u>	<u>(126,548)</u>
TOTAL ADDITIONS		39,542,210		35,078,235
DEDUCTIONS				
BENEFITS PAID				
Premiums	20,993,983		20,631,027	
Claims	12,924,449		14,020,560	
HRA Claims	1,118,035		1,191,843	
Benefits Processing Fees	598,268		560,989	
Less:				
Stop Loss Reimbursements and Rx Rebates	<u>(2,243,451)</u>	<u>33,391,284</u>	<u>(2,150,208)</u>	<u>34,254,211</u>
EXPENSES				
Actuary Fees	4,500		4,500	
Administrative Fees	368,885		355,162	
Audit Fees	22,877		21,801	
Bank Charges	2,531		5,827	
Claims Review Fees	27,265		-	
Conference and Meetings	14,125		5,213	
Consulting Fees	110,304		58,183	
Insurance	39,610		45,428	
Legal Fees	45,601		98,008	
Printing, Postage and Telephone Expenses	115,148		119,461	
Payroll Audit Fees	92,009		34,264	
Excise Taxes	<u>7,098</u>	<u>849,953</u>	<u>6,324</u>	<u>754,171</u>
TOTAL DEDUCTIONS		34,241,237		35,008,382
NET INCREASE FOR THE YEAR		5,300,973		69,853
NET ASSETS AVAILABLE FOR BENEFITS				
Balance, Beginning of Year		<u>35,537,161</u>		<u>35,467,308</u>
Balance, End of Year		<u><u>\$ 40,838,134</u></u>		<u><u>\$ 35,537,161</u></u>

(Attached notes are an integral part of this statement)

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
STATEMENTS OF BENEFIT OBLIGATIONS

	July 31, 2024	July 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Premiums Payable	\$ 2,276,822	\$ 2,312,056
Claims Payable	64,108	1,999,335
	2,340,930	4,311,391
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Claims Incurred But Not Reported	1,751,600	2,500,000
Reserve Bank Liability	9,160,000	8,726,179
	10,911,600	11,226,179
TOTAL OBLIGATIONS OTHER THAN POST-RETIREMENT BENEFIT OBLIGATIONS	13,252,530	15,537,570
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Current Retirees	3,020,272	3,079,068
Other Participants Fully Eligible for Benefits	2,982,285	(64,345)
Other Participants Not Yet Fully Eligible for Benefits	5,163,868	(364,543)
	11,166,425	2,650,180
PLAN'S TOTAL BENEFIT OBLIGATIONS	\$ 24,418,955	\$ 18,187,750

* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

	August 1, 2023 to July 31, 2024	August 1, 2022 to July 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Premiums Payable at Beginning of Year	\$ 2,312,056	\$ 1,939,557
Premiums for Participants Eligible for Coverage During the Year	20,958,749	21,003,526
Premiums Paid	(20,993,983)	(20,631,027)
Premiums Payable at End of Year	2,276,822	2,312,056
Claims Payable at Beginning of Year	1,999,335	2,874,310
Claims Reported and Approved for Payment	10,462,074	12,748,210
Claims Paid	(12,397,301)	(13,623,185)
Claims Payable at End of Year	64,108	1,999,335
Premiums and Claims Payable at End of Year	2,340,930	4,311,391
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Balance at Beginning of Year	11,226,179	12,024,876
Net Change During the Year:		
Claims Incurred But Not Reported	(748,400)	(1,600,000)
Reserve Bank Liability	433,821	801,303
Balance at End of Year	10,911,600	11,226,179
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	13,252,530	15,537,570
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Balance at Beginning of Year	2,650,180	2,516,624
Net Changes During the Year:		
Actuarial assumptions	1,371,709	-
Actuarial experience	589,982	248,500
Benefits accumulated during the year	72,590	-
Benefits Paid (Including expenses)	(548,918)	(253,358)
Expected claim costs and premiums assumption	(1,459,710)	-
Interest	145,760	138,414
Method Change	8,344,832	-
	11,166,425	2,650,180
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	\$ 24,418,955	\$ 18,187,750

* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND

NOTES TO FINANCIAL STATEMENTS

JULY 31, 2024 AND 2023

NOTE 1 - DESCRIPTION OF THE PLAN

The Bay Area Roofers Health and Welfare Trust Fund (the "Plan") is a multiemployer welfare benefit plan established on August 6, 1959 for the purpose of providing health care benefits to eligible participants covered by collective bargaining agreements between the Associated Roofing Contractors of the Bay Area Counties, Inc. and Roofers Locals Union No. 40, 81, and 95 of the United Union of Roofers, Waterproofers, and Allied Workers, AFL-CIO, as well as various independent employers signatory to the agreements located throughout Northern California. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan documents include detailed rules for each situation. Participants should refer to the Plan agreement and any amendments regarding specific provisions of the Plan.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

The financial statements are recorded on the accrual basis of accounting.

B. Estimates

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

C. Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to July 31. Postretirement benefits include future benefits expected to be paid to or 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. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation was determined by actuaries and is the amount that results from applying actuarial assumptions to historical benefit cost data to estimate future annual incurred benefit costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

The significant actuarial assumptions and methods used at July 31, 2024 (2023) were: (a) interest rate: 5.25% (5.50%) per annum, (b) Mortality – PRI-2012 Private Retirement Plans Mortality Table with Blue Collar adjustment for "Employee", "Healthy Annuitant" sex distinct projected to valuation date using MP-2021 (Mortality – Healthy: the RP-2000 Table projected to 2022 for Blue Collar Males and Females & Disabled: the RP-2000 Table projected to 2022 for Blue Collar Males and Females set forward five year), (c) Retirement Age: 100% assumed to retire at age 65, (d) Expenses – included in assumed costs of benefits (6.0% of benefits), (e) Medical Inflation – has been updated to this year's Getzen model, and (f) other assumptions and methods for retirement rates, mix of type of retiree coverage, trend rates and per capita cost assumption.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
NOTES TO FINANCIAL STATEMENTS
JULY 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

C. Postretirement Benefits (Continued)

The health care cost trend rate and retiree contribution trend rate have a significant effect on the postretirement benefit obligations. A 1% increase in the health care cost trend rate would increase the net postretirement benefit obligation as of July 31, 2024 and 2023 by \$3,901,568 and \$775,364, respectively.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of postretirement benefit obligations.

D. Employer Contributions

Employer contributions, including HRA contributions, as reported are contributions made at a fixed rate per hour worked during the year. Contributions receivable is estimated based on contributions received subsequent to the end of the year. No allowance is provided for uncollectible accounts.

E. Payroll Audit Program

Remittance reports were accepted as submitted, without examination or verification of employers' payroll records. The system of internal control provides for examination of employers' records under a separate payroll compliance program.

F. Tax-Exempt Status

The Plan has received tax-exempt status from the federal government under Internal Revenue Code Section 501(c)(9) and the state of California under Revenue and Taxation Code Section 23701i. Therefore, no provision for federal or state income tax is made.

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

G. Risks and Uncertainties

Benefit obligations are reported based on certain assumptions pertaining to health care inflation rates and participant demographics which are subject to change. Due to uncertainties inherent in the estimation and assumption 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.

Plan investments are exposed to various risks such as interest rate, market fluctuations and credit risk. Due to the level of risk associated with investments, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
NOTES TO FINANCIAL STATEMENTS
JULY 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

H. Reclassifications

Certain amounts reported in the July 31, 2023 financial statements have been reclassified to conform to the current year presentation. The reclassifications had no effect on the previously reported net assets available for benefits.

NOTE 3 - ELIGIBILITY

In order for participants to become covered initially, they must accumulate an initial reserve of 480 units (one hour is equal to one unit) of service is accumulated and continues if the participant maintains an accumulation of at least 120 units, as adjusted monthly for benefit coverage and hours of service. The monthly charge for benefit coverage results in a 120-unit, reduction in the participant's accumulated units.

Participants may accumulate units sufficient to provide a maximum of six months eligibility. The estimated liability is based on accumulated units and an estimated premium rate. Participants who lose eligibility as a result of inadequate unit accumulations (less than 120 units) may continue eligibility by making monthly self-payments at rates designated by the Board of Trustees. Similarly, retirees may continue their eligibility by making monthly self-payments at rates designated by the Board of Trustees.

NOTE 4 - HEALTH REIMBURSEMENT ACCOUNTS (HRA)

The Plan provides health reimbursement arrangement (HRA) benefits for employees earning hours under collective bargaining agreements of Roofers Local Union No. 81.

Additional contributions, specifically to fund these HRA benefits are provided as part of the Local 81 employer contributions. Participants may be reimbursed for eligible out of pocket health benefits, up to their individual account balance.

The following reflects the activity in the HRA accounts:

	August 1, 2023 to July 31, 2024	August 1, 2022 to July 31, 2023
Beginning Balance	\$ 8,608,310	\$ 7,750,843
Add: Contributions	2,334,242	2,224,520
Net Investment Income (Loss)	330,026	(56,043)
Less: Benefits	(1,118,035)	(1,191,843)
Fees and Expenses	(121,378)	(119,167)
Ending Balance	\$ 10,033,165	\$ 8,608,310

NOTE 5 - CONCENTRATION OF CREDIT RISK

During the year ended July 31, 2024, the Plan maintained its bank accounts in excess of the Federal Deposit Insurance Corporation (FDIC) insurance limit of \$250,000 per bank. The amount in excess of the limit was subject to risk if the financial institution did not perform. The Plan has not incurred any losses on the uninsured balances.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
NOTES TO FINANCIAL STATEMENTS
JULY 31, 2024 AND 2023

NOTE 6 - INVESTMENT VALUATION AND INCOME RECOGNITION

FASB ASC 820 provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

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

Level 2 – Inputs to the valuation methodology include:

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

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. There have been no changes in the methodologies used at July 31, 2024 and 2023.

The following is a description of the valuation methodologies used for assets measured at fair value:

Level 1 investments include short term investment funds, mutual funds and exchange traded funds valued at quoted market price.

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

The following tables summarize the Plan's investments at July 31 based on the inputs used to value them:

	July 31, 2024			
	Level 1	Level 2	Level 3	Total
Short Term Investment Funds	\$ 72,281	\$ -	\$ -	\$ 72,281
Mutual Funds	3,826,978	-	-	3,826,978
Exchanged Traded Funds	12,269,472	-	-	12,269,472
	<u>\$ 16,168,731</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 16,168,731</u>

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
NOTES TO FINANCIAL STATEMENTS
JULY 31, 2024 AND 2023

NOTE 6 - INVESTMENT VALUATION AND INCOME RECOGNITION (Continued)

	July 31, 2023			Total
	Level 1	Level 2	Level 3	
Short Term Investment Funds	\$ 76,932	\$ -	\$ -	\$ 76,932
Mutual Funds	4,586,357	-	-	4,586,357
Exchanged Traded Funds	10,359,890	-	-	10,359,890
	<u>\$ 15,023,179</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 15,023,179</u>

Purchases and sales of securities are recorded on the trade date. Interest, dividends and realized gains and losses on sales of investments are reported on the accrual basis. Realized gain or loss from the sale of investments and unrealized appreciation or depreciation in the fair value of investments are reported as net appreciation of investments.

NOTE 7 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500

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

	July 31, 2024	July 31, 2023
Net Assets Available for Benefits Per the Financial Statements	\$ 40,838,134	\$ 35,537,161
Total Benefit Obligations Other Than Postretirement Benefit Obligations	<u>13,252,530</u>	<u>15,537,570</u>
Net Assets Per the Form 5500	<u>\$ 27,585,604</u>	<u>\$ 19,999,591</u>

The following is a reconciliation of net benefits paid per the financial statements to the Form 5500:

	August 1, 2023 to July 31, 2024
Net Benefits Per the Financial Statements	\$ 33,391,284
Add: Total Benefit Obligations Other Than Postretirement Benefit Obligations at July 31, 2024	13,252,530
(Less): Total Benefit Obligations Other Than Postretirement Benefit Obligations at July 31, 2023	<u>(15,537,570)</u>
Total Benefits Per the Form 5500	<u>\$ 31,106,244</u>

Amounts currently payable to or for participants, dependents, and beneficiaries are reported on the Form 5500 for benefits that have been earned prior to July 31, but not yet paid as of that date.

NOTE 8 - PRIORITIES UPON TERMINATION

It is the intent of the Board of Trustees to continue the Plan in full force and effect; however, the Plan may be terminated at any time by the Board of Trustees by an instrument in writing executed by mutual consent, subject to the provisions of the plan document. Upon termination, any monies remaining in the Plan after the payment of all expenses and obligations of the Plan, shall be paid or used for the continuance of one or more benefits in accordance with the provisions of this Plan until such Plan is exhausted. No assets of the Plan may revert to the signatory employers or be used for purposes other than for the exclusive benefit of the Plan's participants.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND

NOTES TO FINANCIAL STATEMENTS

JULY 31, 2024 AND 2023

NOTE 9 - SUBSEQUENT EVENTS

Management has evaluated subsequent events through April 29, 2025, the date on which the financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosures in these financial statements.

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND

FORM 5500

SCHEDULE H - LINE 4

E.I.N. 94-6074642; PLAN NO. 501

SUPPLEMENTAL SCHEDULE REQUIRED BY
THE DEPARTMENT OF LABOR



Independent Auditor's Report on Supplemental
Schedule Required by the Department of Labor

Board of Trustees
Bay Area Roofers Health and Welfare Trust Fund
6800 Santa Teresa Boulevard, Suite 100
San Jose, California 95119

Members of the Board:

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) as of July 31, 2024 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

Miller Kaplan Arase LLP
MILLER KAPLAN ARASE LLP
Burbank, California
April 29, 2025

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6074642; PLAN NO. 501
JULY 31, 2024

<u>Face Value</u>	<u>Short Term Investment Funds</u>	<u>Fair Value</u>	<u>Cost</u>
\$ 72,281	Fidelity Government Cash Reserves	\$ 72,281	\$ 72,281
<u>No. of Shares</u>	<u>Mutual Funds</u>		
23,311	BlackRock Global Equity Market Neutral Fund	\$ 326,348	\$ 300,702
184,755	BlackRock Strategic Income Opportunities Portfolio	1,755,172	1,765,106
45,402	BlackRock Systematic Multi-Strategy Fund	469,906	458,350
21,173	BlackRock Tactical Opportunities Fund	297,689	294,750
33,355	Campbell Systematic Macro Fund	326,883	323,513
26,102	JPMorgan U.S. Equity Fund	650,980	561,158
	<u>TOTALS - MUTUAL FUNDS</u>	<u>\$ 3,826,978</u>	<u>\$ 3,703,579</u>
	<u>Exchanged Traded Funds</u>		
77,153	iShares Core Total USD Bond Market	\$ 3,558,277	\$ 3,799,962
15,145	iShares Flexible Income Active	800,713	787,842
5,794	iShares MSCI EAFE Value	319,854	277,000
1,869	iShares MSCI USA Quality Factor	320,980	248,850
10,284	iShares US Equity Factor Rotation Active	486,121	471,016
34,836	SPDR Portfolio Long Term Treasury	979,232	1,176,251
643	Vanguard S&P 500	325,216	263,637
74,525	Vanguard Total Bond Market Index Fund	5,479,079	6,227,611
	<u>TOTALS - EXCHANGED TRADED FUNDS</u>	<u>\$ 12,269,472</u>	<u>\$ 13,252,169</u>
	<u>TOTALS - INVESTMENTS</u>	<u>\$ 16,168,731</u>	<u>\$ 17,028,029</u>

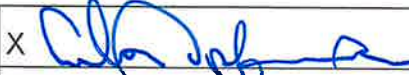

Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the 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
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Part I Annual Report Identification Information	
For calendar plan year 2023 or fiscal plan year beginning <u>08/01/2023</u> and ending <u>07/31/2024</u>	
A This return/report is for: <input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a single-employer plan B This return/report is: <input type="checkbox"/> the first return/report <input type="checkbox"/> an amended return/report C If the plan is a collectively-bargained plan, check here <input checked="" type="checkbox"/> D Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> special extension (enter description) E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here <input type="checkbox"/>	<input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the final return/report <input type="checkbox"/> a short plan year return/report (less than 12 months) <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program

Part II Basic Plan Information - enter all requested information											
1a Name of plan ROOFERS HEALTH AND WELFARE PLAN 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) BOARD OF TRUSTEES, BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND C/O UNITED ADMINISTRATIVE SERVICES 6800 SANTA TERESA BLVD STE 100 SAN JOSE, CA 95119	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">08/06/1959</td> </tr> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">94-6074642</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">408-288-4420</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">238100</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan	08/06/1959	2b Employer Identification Number (EIN)	94-6074642	2c Plan Sponsor's telephone number	408-288-4420	2d Business code (see instructions)	238100
1b Three-digit plan number (PN) ▶	501										
1c Effective date of plan	08/06/1959										
2b Employer Identification Number (EIN)	94-6074642										
2c Plan Sponsor's telephone number	408-288-4420										
2d Business code (see instructions)	238100										

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	<input checked="" type="checkbox"/> 	5-6-25	Carlos Opfermann
	Signature of Union Trustee	Date	Enter name of individual signing as Union Trustee
SIGN HERE	<input checked="" type="checkbox"/> 	05/06/25	Manuel De Santiago III
	Signature of Employer Trustee	Date	Enter name of individual signing as Employer Trustee
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 (2023) v. 230728

BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6074642; PLAN NO. 501
JULY 31, 2024

<u>Face Value</u>	<u>Short Term Investment Funds</u>	<u>Fair Value</u>	<u>Cost</u>
\$ 72,281	Fidelity Government Cash Reserves	\$ 72,281	\$ 72,281
<u>No. of Shares</u>	<u>Mutual Funds</u>		
23,311	BlackRock Global Equity Market Neutral Fund	\$ 326,348	\$ 300,702
184,755	BlackRock Strategic Income Opportunities Portfolio	1,755,172	1,765,106
45,402	BlackRock Systematic Multi-Strategy Fund	469,906	458,350
21,173	BlackRock Tactical Opportunities Fund	297,689	294,750
33,355	Campbell Systematic Macro Fund	326,883	323,513
26,102	JPMorgan U.S. Equity Fund	650,980	561,158
	<u>TOTALS - MUTUAL FUNDS</u>	<u>\$ 3,826,978</u>	<u>\$ 3,703,579</u>
	<u>Exchanged Traded Funds</u>		
77,153	iShares Core Total USD Bond Market	\$ 3,558,277	\$ 3,799,962
15,145	iShares Flexible Income Active	800,713	787,842
5,794	iShares MSCI EAFE Value	319,854	277,000
1,869	iShares MSCI USA Quality Factor	320,980	248,850
10,284	iShares US Equity Factor Rotation Active	486,121	471,016
34,836	SPDR Portfolio Long Term Treasury	979,232	1,176,251
643	Vanguard S&P 500	325,216	263,637
74,525	Vanguard Total Bond Market Index Fund	5,479,079	6,227,611
	<u>TOTALS - EXCHANGED TRADED FUNDS</u>	<u>\$ 12,269,472</u>	<u>\$ 13,252,169</u>
	<u>TOTALS - INVESTMENTS</u>	<u>\$ 16,168,731</u>	<u>\$ 17,028,029</u>