

<p style="text-align: center;">Form 5500</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: small;">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).</p> <p style="text-align: center;">▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold; text-align: center;">2024</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

<p>1a Name of plan <u>LINDAR CORPORATION WELFARE BENEFIT PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>LINDAR CORPORATION</u></p> <p><u>7789 HASTINGS RD</u> <u>BAXTER, MN 56425-8467</u></p>	<p>1c Effective date of plan <u>02/01/2000</u></p> <p>2b Employer Identification Number (EIN) <u>41-1752658</u></p> <p>2c Plan Sponsor's telephone number <u>218-829-3457</u></p> <p>2d Business code (see instructions) <u>326100</u></p>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	05/13/2025	STEVE LUND
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	05/13/2025	STEVE LUND
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <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	179
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)	179
	6a(2)	166
	6b	
	6c	
	6d	166
	6e	
	6f	166
	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	

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 4H 4F 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 type="checkbox"/> Trust	(3) <input type="checkbox"/> Trust
(4) <input checked="" 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 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>2</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input 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 2024 Form M-1 annual report. If the plan was not required to file the 2024 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 _____

(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	

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)**

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)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** 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	
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

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan LINDAR CORPORATION WELFARE BENEFIT PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LINDAR CORPORATION		D Employer Identification Number (EIN) 41-1752658

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

UNITED OF OMAHA 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
47-0322111	69868	G000CFCF	166	01/01/2024	01/01/2025

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

(a) Total amount of commissions paid 34679	(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

DATTILO CONSULTING, INC.

**1711 LAKE DR W
CHANHASSEN, MN 55317**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
34679			3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
	(6) Total additions			
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	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	

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	
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. ▶

Blue Cross and Blue Shield of Minnesota

P.O. Box 64560
St. Paul, MN 55164-0560



4/24/2025

Lindar Corporation
7789 HASTINGS RD
BAXTER, MN 56425

Client Number: 296288

Dear Employer,

Attached is the health care coverage information you need to prepare your IRS Schedule A or C (Form 5500), if applicable. This information is provided in compliance with the Employee Retirement Income Security Act of 1974, pursuant to ERISA Section 103 (a) (2).

Blue Cross and Blue Shield of Minnesota certifies the accuracy and completeness of this information. If you have questions call your Blue Cross and Blue Shield of Minnesota Account Manager.

Sincerely,

Blue Cross and Blue Shield of Minnesota
Kimberly Engstrom
(651) 662-8000
(800) 382-2000

ERISA (Form 5500) Information

Lindar Corporation
Date: April 24, 2025

Funding Type: Self Insured
Client Number: 296288
Plan Year: 1/1/2024 - 12/31/2024
Paid Through Date: 12/31/2024
Approximate Number of Persons Covered at the End of the Plan Year: Contracts 110
Members 155

General Information for Schedule A & C

Name of Contract Administrator: BCBSMN, Inc, d.b.a. Blue Cross and Blue Shield of Minnesota
EIN: 41-0984460
NAIC Code: 55026
Official Plan Position: Insurance Carrier

Enrollment Information

	<u>Contracts</u>	<u>Dependents</u>
Medical:	110	45
Dental:	120	73
Vision:	93	58

Schedule A - Health Plan Premium

	<u>Amount</u>
Medical:	\$304,044.10
Dental:	\$51,781.11
Vision:	\$10,521.75

Schedule A - Agent/Broker Commissions & Incentive Payments

Agency: DATTILO CONSULTING INC

	<u>Amount</u>	<u>Service Codes</u>
Fees & Commissions Paid by Plan:	\$22,882.00	22, 53
Agent/Broker Incentive Payments:	\$0.00	55

Schedule C - Payments Received by BCBSMN

	<u>Amount</u>	<u>Service Codes</u>
<u>Direct Compensation</u>		
Administrative Fees & Other ¹ :	\$32,037.39	12, 13, 15, 99
<u>Indirect Compensation</u>		
Subrogation Fees ² :	\$0.00	12, 13, 29
Pharmacy Administrative Fees ³ :	\$247,569.92	12, 13, 15, 99

Schedule C - Payments Made by BCBSMN

	<u>Amount</u>	<u>Service Codes</u>
<u>Indirect Compensation</u>		
BlueCard Fees ⁴ :	\$573.42	12, 13, 15
Retail Pharmacy Transaction Fees ⁵ :	\$5,306.58	12, 13, 15
Retail Pharmacy Dispensing Fees ⁶ :	\$482.25	99
Payment Integrity Vendor Fees ⁷ :	\$7,935.92	12, 13, 15
Nonparticipating Provider Negotiation Fees ⁸ :	\$0.00	12, 13, 15

¹ This amount includes ad hoc and ancillary fees, health and wellness program fees, direct secondary claim review fees, fixed BlueCard fees, and out-of-network cost savings program fees.

² Please refer to attached Indirect Compensation Disclosure document for additional details on Subrogation Fees.

³ Please refer to attached Indirect Compensation Disclosure document for additional details on Pharmacy Administrative Fees (estimates only).

⁴ Amount paid to Blue Card Host Plans for Access, AEA, National VBP Fees, and Global Core Program Fees. Please refer to attached Indirect Compensation Disclosure document for additional details.

⁵ Amount paid to Prime Therapeutics, Inc. for pharmacy claim processing services (estimates only).

⁶ Claim amounts include a retail network pharmacy dispensing fee. Retail network pharmacy dispensing fees paid to and dispersed by Prime Therapeutics, Inc.

⁷ Please refer to attached Indirect Compensation Disclosure document for additional details on Payment Integrity.

⁸ Please refer to attached Indirect Compensation Disclosure document for additional details on the Nonparticipating Provider Negotiation Fees.

Blue Cross and Blue Shield of Minnesota and Blue Plus Clients

INDIRECT COMPENSATION DISCLOSURES

A. BLUECARD® PROGRAM

One of the benefits your employees and their dependents (“members”) receive is access to healthcare services outside the geographic area Blue Cross and Blue Shield of Minnesota (“Blue Cross”) serves under the BlueCard Program. Typically, in that situation, members obtain care from healthcare providers that have a contractual agreement with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the “Host Blue”). Within that arrangement, Blue Cross is referred to as the “Home Blue.” The BlueCard Program is established and operated pursuant to policies established and enforced by the Blue Cross and Blue Shield Association.

The Department of Labor has amended its regulations governing the Form 5500 annual reporting and disclosure requirements. A plan sponsor’s reporting requirements for a self-funded plan on Schedule C are significantly streamlined for “eligible indirect compensation” about which a service provider has shared certain information. As such, below is a list of eligible indirect compensation that has been received in connection with the BlueCard Program. Note that the fees and compensation subject to disclosure under the Department of Labor rules include amounts that are not necessarily passed on to you or your members. The financial terms of the BlueCard Program, and additional details about the BlueCard Program, are described in your administrative service agreement.

1. BlueCard Access Fees: Access Fees are charged on a per-claim basis and are charged as a percentage of the savings that a Host Blue passes along to the Home Blue by virtue of its relationships with healthcare providers. These fees are paid by the Home Blue to the Host Blue. These fees are charged for making the Host Blue’s provider network available to your members. The actual BlueCard Access Fees charged in connection with your plan for the 2017 Plan Year reporting period are set forth in the accompanying “Schedule C Data Report.” Those amounts were passed by Blue Cross to Host Blues in accordance with the following formulae:

Standard BlueCard Claims (Indemnity and <1,000 EPO/PPO Contract holders & Travelers (HMO/POS)) – 4.51% (2017) 4.30% (2018) of savings (maximum = \$2,000 per claim)

Reduced EPO & PPO, Non-Medicare Prime BlueCard Claims:

- 1,000 – 9,999 Contract holders 2.52% (2017) 2.40% (2018) of savings (maximum = \$2,000 per claim)
 - 10,000 – 49,999 Contract holders 2.33% (2017) 2.22% (2018) of savings (maximum = \$2,000 per claim)
2. BlueCard Access Fees may not apply in cases where your members receive services from providers located in a service area in which Blue Cross has negotiated a per-claim access fee in lieu of the BlueCard Access Fee and BlueCard Administrative Expense Allowance. For 2017, such fees were up to \$31.41 per claim.

3. BlueCard Administrative Expense Allowance (AEA):

The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Blue Cross for administrative services that the Host Blue provides in processing claims for Employer's Members. The AEA fees charged directly to your ERISA Plan in connection with your members' claims are specified in your administrative service agreement. The actual AEA Fees charged in connection with your plan for the 2017 Plan Year reporting period are set forth in the accompanying "Schedule C Data Report." Those amounts were passed by Blue Cross to Host Blues in accordance with the following formulae.

Standard BlueCard Claims (Indemnity and <1,000 EPO/PPO enrolled contract holders & Travelers (HMO/POS)):

Institutional \$11.00 per claim
Professional \$5.00 per claim

Reduced EPO & PPO, Non-Medicare Prime BlueCard Claims (1,000 – 49,999 enrolled contract holders)

Institutional \$9.75 per claim
Professional \$4.00 per claim

4. Use of Estimated or Average Pricing by Host Blues: As described in your administrative service agreement, some Host Blues use estimated or average prices to determine the negotiated price that is made available to us when plan participants access the Host Blue's participating provider network. This may result in a difference (positive or negative) between the price you pay on a specific claim and the actual amount paid to the provider by the Host Blue.

The following describes the formula used for determining an estimated or average price:

Estimated: A percentage is used to modify the claim price for covered services. This percentage (either positive or negative) allows Host Blues to incorporate adjustments and actuarial projections prospectively into the final price. The percentage is determined by figuring the aggregate cost to the Host Blue over a look-back period less any initial payments made to providers divided by the total of payments initially made to providers. The aggregate cost in the numerator includes all provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, other non-claim transactions and any positive or negative balance in the variance account. The percentage is then actuarially adjusted for anticipated changes in claims expenses for the prospective period.

Average: An average price is determined for a defined category of provider (e.g., institutional, professional, etc.) of a Host Blue in a given geographic area. The average is determined as follows:

Total amount paid to such providers over a look-back period, including initial payments as well as applicable claim and non-claim related transactions, which may include but are not limited to provider retrospective settlements, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, performance-related bonuses or incentives, interest, etc., and any positive or negative balance in the variance account divided by the total amount of such providers' corresponding charges for covered services over the same look-back period (claims for non-covered services are not included in the calculation)

This result is an average price that is applied to each claim for the defined category of provider of the Host Blue in the geographic area and presented as the negotiated price.

Although use of these pricing methods may result in a difference (positive or negative) between the price you pay and the amount actually paid to the provider, the price used to determine your payment is a final price. Any positive or negative differences are accounted for in a variance account held by the Host Blue. Host Blues may prospectively increase or reduce estimated or average prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from you.

Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices.

5. Blue Cross Blue Shield Global Core Program: The Blue Cross Blue Shield Global Core Program (formally known as BlueCard Worldwide) provides members with access to an international network of inpatient, outpatient and professional providers. Blue Cross Blue Shield Global Core assists Blue Cross and Blue Shield members traveling or living outside of the United States to obtain medical care services. The current fees charged for international Claims processed through Blue Cross Blue Shield Global Core are disclosed below:

- | | | |
|-----|---|-------------------|
| (a) | Institutional Claims (inpatient and outpatient), up to: | \$17.00 per Claim |
| (b) | Professional Claims, up to: | \$4.75 per Claim |
| (c) | Member-payable Claims paid by Home Licensees in U.S. currency, up to: | \$3.75 per Claim |

B. PHARMACY ADMINISTRATIVE FEES

Blue Cross may implement pricing strategies and may receive pharmacy admin fees attributable to the Plan via Prime Therapeutics LLC for rebates, traditional pricing, or other pricing strategies. The sum of the admin fees retained by Blue Cross attributable to the Plan is the amount on the report.

C. COST SAVINGS PROGRAM

Blue Cross may implement various services on your behalf aimed at generating savings on Claims. Services may include, but are not limited to, fee negotiations with non-participating providers, and arrangements with participating non-network providers. When so implemented, Blue Cross and its vendor will retain up to thirty percent (30%) in exchange for this service.

D. COORDINATION OF BENEFIT AND SUBROGATION SERVICES

Blue Cross will remit to you any subrogation recovery made on behalf of the Plan, net of all costs and expenses including legal fees. Blue Cross will be entitled to retain up to thirty (30%) of its net subrogation, workers' compensation intervention, or other legal recoveries made on behalf of the Plan.

E. PAYMENT INTEGRITY SHARED SAVINGS PROGRAM

Blue Cross' Payment Integrity Program ("Payment Integrity") identifies savings to the Plan through pre-payment and post-payment recovery efforts. In the event a recovery is made, Blue Cross will retain a percentage of recoveries for pre-payment correction and post-payment recovery services.

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**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**LINDAR CORP
BAXTER, MN**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000CFCF **Data for Period:** 01-01-2024 to 01-01-2025
Legacy Group ID: GLTD0CFCF
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Long Term Disability Insured	166

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
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INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums 35,276

Memo Items: Benefit Charges – Claims Paid 0
 Administrative Service Fees 0

Group Office: MINNEAPOLIS



**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**LINDAR CORP
BAXTER, MN**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000CFCF **Data for Period:** 01-01-2024 to 01-01-2025
Legacy Group ID: GLUG0CFCF
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Life & AD&D	166

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
DATTILO CONSULTING INC 1711 LAKE DR W CHANHASSEN, MN 55317	4,013		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	20,066
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: MINNEAPOLIS



**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**LINDAR CORP
BAXTER, MN**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000CFCF **Data for Period:** 01-01-2024 to 01-01-2025
Legacy Group ID: GUC 0CFCF
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
ShortTerm Disability Voluntary	132

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
DATTILO CONSULTING INC 1711 LAKE DR W CHANHASSEN, MN 55317	9,341		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	46,705
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: MINNEAPOLIS



**SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION
INFORMATION FOR COMPLETION OF PART I**

**LINDAR CORP
BAXTER, MN**

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868
EIN Number: 47-0322111
Group Identification Number: G000CFCF **Data for Period:** 01-01-2024 to 01-01-2025
Legacy Group ID: GVTL0CFCF
Type of Contract: NON-RETENTION

Benefits Provided	Persons Covered
Life & AD&D Voluntary	92

Name of Each Recipient	Amount of Commission Paid	Amount of Service Fees Paid or Other Fees	Purpose for Which Paid	Organization Type
DATTILO CONSULTING INC 1711 LAKE DR W CHANHASSEN, MN 55317	21,325		Agent or Broker of Record	3

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums	75,089
Memo Items: Benefit Charges – Claims Paid	0
Administrative Service Fees	0

Group Office: MINNEAPOLIS

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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [X] a single-employer plan [] a DFE (specify)
B This return/report is: [] the first return/report [] the final return/report [] an amended return/report [] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. []
D Check box if filing under: [] Form 5558 [] automatic extension [] the DFVC program [] special extension (enter description)
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 LINDAR CORPORATION WELFARE BENEFIT PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 02/01/2000
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) LINDAR CORPORATION
7789 HASTINGS RD BAXTER, MN 56425-8467
7789 HASTINGS RD BAXTER, MN 56425-8467
2b Employer Identification Number (EIN) 41-1752658
2c Plan Sponsor's telephone number 218-829-3457
2d Business code (see instructions) 326100

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, Date, and Name. Row 1: Steve Lund, 5/13/2025, Steve Lund. Row 2: Steve Lund, 5/13/2025, Steve Lund. Row 3: Empty.

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

Form 5500 (2024) v. 240311