

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: x-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; text-align: center;">2023</p> <hr/> <p style="text-align: center;">This Form is Open to Public Inspection</p>
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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: 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>IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND</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>IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND</u></p> <p><u>P.O. BOX 1449</u> <u>GOODLETTSVILLE, TN 37070-1449</u></p>	<p>1c Effective date of plan <u>07/08/1963</u></p> <p>2b Employer Identification Number (EIN) <u>62-0696127</u></p> <p>2c Plan Sponsor's telephone number <u>901-345-5825</u></p> <p>2d Business code (see instructions) <u>237990</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.	05/14/2025	DOUG IRWIN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	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	221
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)	183
	6a(2)	338
	6b	39
	6c	0
	6d	377
	6e	
	6f	
	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	46

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

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> General assets of the sponsor

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

a Pension Schedules	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> 3 </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 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND		D Employer Identification Number (EIN) 62-0696127

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

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	G3147 C4430	377	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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	(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) <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)	
	7c(6)	
(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)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
(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	40397
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 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND		B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND		D Employer Identification Number (EIN) 62-0696127	

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
HCC 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
35-1817054	92711		377	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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	(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)	
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 <input type="checkbox"/> Health (other than dental or vision) | b <input 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 checked="" 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	141629
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 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	D Employer Identification Number (EIN) 62-0696127

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

LABOR FIRST, LLC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1750191			39	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

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	(c) Amount	(d) Purpose	

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	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)	
	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	193031
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 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	D Employer Identification Number (EIN) 62-0696127	

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

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(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)

SOUTHERN BENEFIT ADMINISTRATORS

P.O. BOX 1449
GOODLETTSVILLE, TN 37070-1449

62-1116095

(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?
14 16 11	NONE	118512	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)

DANIELS, IRWIN & AYLOR

223 MADISON ST., 112
MADISON, TN 37115

62-1802605

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	13850	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)

CIGNA HEALTHCARE

1111 MARKET STREET
CHATTANOOGA, TN 37402

06-0303370

(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 31 38 49 50 56 62	NONE	178225	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" 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)

GODWIN MORRIS LAURENZI & BLOOMFIELD

P.O. BOX 3290
MEMPHIS, TN 38173

62-1371542

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	52025	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)

NEW SOUTH CAPITAL MANAGEMENT, LLC

999 S SHADY GROVE RD
901-761-5561
MEMPHIS, TN 31820

(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?
19 28	NONE	2669	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

3. If you reported on line 2 receipt of indirect compensation, other than eligible indirect compensation, by a service provider, and the service provider is a fiduciary or provides contract administrator, consulting, custodial, investment advisory, investment management, broker, or recordkeeping services, answer the following questions for (a) each source from whom the service provider received \$1,000 or more in indirect compensation and (b) each source for whom the service provider gave you a formula used to determine the indirect compensation instead of an amount or estimated amount of the indirect compensation. Complete as many entries as needed to report the required information for each source.

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTHCARE	12 13 31 38 49 50 56 62	
(d) Enter name and EIN (address) of source of indirect compensation CIGNA HEALTHCARE 1111 MARKET STREET CHATTANOOGA, TN 37402 06-0303370	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. SEE SCHEDULE ATTACHED	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)
(complete as many entries as needed)

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

SCHEDULE H (Form 5500) <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 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	D Employer Identification Number (EIN) 62-0696127

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	861522	33654
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	359998	858804
(2) Participant contributions	1b(2)	6211	5940
(3) Other	1b(3)	85406	121311
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	225401	3170366
(2) U.S. Government securities	1c(2)	824220	
(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)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	4063	5644

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	2366821	4195719
Liabilities			
g Benefit claims payable	1g	191623	258506
h Operating payables	1h	208208	578174
i Acquisition indebtedness	1i		
j Other liabilities	1j		
k Total liabilities (add all amounts in lines 1g through 1j)	1k	399831	836680
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1966990	3359039

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)	3819495	
(B) Participants	2a(1)(B)	263100	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		4082595
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	28604	
(B) U.S. Government securities	2b(1)(B)	18938	
(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)		
(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)		
(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)	1487209	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	1454413	
(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)		
c Other income.....	2c		323234
d Total income. Add all income amounts in column (b) and enter total.....	2d		4486167

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	2322933	
(2) To insurance carriers for the provision of benefits.....	2e(2)	375057	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3).....	2e(4)		2697990
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)	91200	
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)	13850	
(5) Investment advisory and investment management fees.....	2i(5)	2669	
(6) Bank or trust company trustee/custodial fees.....	2i(6)		
(7) Actuarial fees.....	2i(7)	7312	
(8) Legal fees.....	2i(8)	52025	
(9) Valuation/appraisal fees.....	2i(9)		
(10) Other trustee fees and expenses.....	2i(10)	399	
(11) Other expenses.....	2i(11)	228673	
(12) Total administrative expenses. Add lines 2i(1) through (11).....	2i(12)		396128
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		3094118

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		1392049
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: DANIELS, IRWIN & AYLOR, CPAS

(2) EIN: 62-1802605

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		400000
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.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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 _____.

**FINANCIAL STATEMENTS AND
REPORT OF INDEPENDENT
CERTIFIED PUBLIC ACCOUNTANTS**

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

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ORGANIZATION AND PURPOSE
IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND

JULY 31, 2024

Date of Agreement and Declaration of Trust

July 8, 1963

Office Location

Memphis, Tennessee

Officers and Trustees

James Cole	Chairman
Alison Smith	Secretary
Alan Barnhart	Trustee
Doug McCain	Trustee

Purpose of the Fund

To provide health and life insurance benefits to participants. The benefits provided by the Trustees are established to meet the objectives of the Fund and are consistent with the provisions of the Agreement and Declaration of Trust.



DANIELS, IRWIN & AYLOR

CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Ironworkers Local Union No. 167 Welfare Fund
Memphis, Tennessee

Opinion

We have audited the financial statements of the **Ironworkers Local Union No. 167 Welfare Fund**, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of plan's benefit obligations as of July 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in plan's benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and plan's benefit obligations of **Ironworkers Local Union No. 167 Welfare Fund** as of July 31, 2024 and 2023, and the changes in its net assets available for benefits and plan's benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). 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 **Ironworkers Local Union No. 167 Welfare Fund** and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about **Ironworkers Local Union No. 167 Welfare Fund's** ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that an audit conducted in accordance with GAAS 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 judgement made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgement 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 **Ironworkers Local Union No. 167 Welfare Fund's** internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgement, there are conditions or events, considered in the aggregate, that raise substantial doubt about **Ironworkers Local Union No. 167 Welfare Fund's** ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules for the years ended July 31, 2024 and 2023, together referred to as "supplemental information", are presented for the purpose of additional analyses and are not a required part of the financial statements, but are 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 audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are 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 schedules 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.

Daniels, Luwin & Aylor

Certified Public Accountants

March 28, 2025

STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31,

	<u>2024</u>	<u>2023</u>
<u>ASSETS</u>		
Investments, at fair value:		
Investment cash account	\$ 366	\$ 12,397
Money market fund	0	213,004
U.S. Government securities	0	824,220
	<hr/>	<hr/>
	366	1,049,621
Receivables:		
Employer contributions	858,804	359,998
Employee contributions	5,940	6,211
Accrued interest	0	7,407
Claims refunds	1,124	0
Formulary rebates	115,807	75,068
Late penalties	1,946	0
Stop loss insurance reimbursements	2,434	0
Subrogation Refunds	0	2,931
Prepaid expenses	5,644	4,063
Cash - sweeps to money market @ 5.03%	3,170,000	0
Cash	33,654	861,522
	<hr/>	<hr/>
Total assets	4,195,719	2,366,821
<u>LIABILITIES</u>		
Accounts payable and accrued expense	578,174	208,208
	<hr/>	<hr/>
NET ASSETS AVAILABLE FOR BENEFITS	\$ 3,617,545	\$ 2,158,613
	<hr/>	<hr/>

The accompanying notes are an integral part of this statement.

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND****FOR THE YEAR ENDED JULY 31,**

	<u>2024</u>	<u>2023</u>
Additions		
Employer contributions	\$ 3,819,495	\$ 2,146,075
Employee contributions	263,100	250,351
Investment income	47,542	27,231
Realized gains (losses) on sale of investments	14,906	(14,737)
Late penalties	6,577	0
	<hr/>	<hr/>
Total additions	4,151,620	2,408,920
Deductions		
Claims paid	2,256,050	1,339,450
Less: Claims refunds	1,741	1,605
Formulary rebates	271,697	131,146
Stop loss insurance reimbursements	43,219	0
Subrogation refunds	0	2,931
	<hr/>	<hr/>
Net claims paid	1,939,393	1,203,768
Medicare advantage prescription drug plan	193,031	160,520
Life insurance premiums	40,397	19,160
Stop loss insurance premiums	141,629	73,609
Administration fees	91,200	91,200
Consultation fees	20,000	20,000
Actuarial fees	7,312	0
Audit fees - annual audit	12,750	11,750
Audit fees - payroll audits	1,100	600
Legal fees	52,025	18,838
Investment management fees	2,669	2,607
Change Healthcare ACH fees	24	70
PCORI fee	1,017	923
Preferred provider fees	178,225	70,313
Printing and mailing	13,871	2,053
Administrator's meeting expense	254	1,743
Trustees' meeting expense	399	0
Bond expense	746	546
Fiduciary liability insurance	6,546	6,491
Cyber liability insurance	1,514	1,564
IFEBP membership dues	598	562
Bank charges	3,605	1,632
Credit card fees	2,273	1,407
	<hr/>	<hr/>
Total deductions	2,710,578	1,689,356

STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

FOR THE YEAR ENDED JULY 31,

	<u>2024</u>	<u>2023</u>
Net additions	\$ 1,441,042	\$ 719,564
Unrealized appreciation of assets	<u>17,890</u>	<u>13,526</u>
Net increase in assets for the year	1,458,932	733,090
Net assets available for benefits at beginning of year	<u>2,158,613</u>	<u>1,425,523</u>
NET ASSETS AVAILABLE FOR BENEFITS AT END OF YEAR	<u><u>\$ 3,617,545</u></u>	<u><u>\$ 2,158,613</u></u>

The accompanying notes are an integral part of this statement.

STATEMENT OF PLAN'S BENEFIT OBLIGATIONS

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31,

	<u>2024</u>	<u>2023</u>
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Estimated health claims payable	\$ 40,062	\$ 47,850
Other obligations for current benefit coverage, at present value of estimated amounts:		
Estimated health claims incurred, but not reported	218,444	143,773
Accumulated eligibility	836,826	556,160
	<u>1,055,270</u>	<u>699,933</u>
Total obligations other than postretirement benefit obligations	<u>1,095,332</u>	<u>747,783</u>
Postretirement benefit obligations:		
Current retirees	2,124,918	2,086,481
Other participants fully eligible for benefits	1,182,752	1,203,514
Other participants not yet fully eligible for benefits	1,797,146	2,124,444
Total postretirement benefit obligations	<u>5,104,816</u>	<u>5,414,439</u>
Total benefit obligations	<u>\$ 6,200,148</u>	<u>\$ 6,162,222</u>

The accompanying notes are an integral part of this statement.

STATEMENT OF CHANGES IN PLAN'S BENEFIT OBLIGATIONS

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

FOR THE YEAR ENDED JULY 31,

	<u>2024</u>	<u>2023</u>
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Balance at beginning of year	\$ 47,850	\$ 16,334
Claims reported and approved for payment	2,248,262	1,370,966
Claims paid	<u>(2,256,050)</u>	<u>(1,339,450)</u>
Balance at end of year	<u>40,062</u>	<u>47,850</u>
Other obligations for current benefit coverage, at present value of estimated amounts:		
Balance at beginning of year	699,933	677,694
Increase (decrease) in estimated health claims incurred, but not reported	74,671	(25,870)
Increase in accumulated eligibility	<u>280,666</u>	<u>48,109</u>
Balance at end of year	<u>1,055,270</u>	<u>699,933</u>
Postretirement benefit obligations:		
Balance at beginning of year	5,414,439	5,487,657
Increase (decrease) during year attributable to:		
Plan amendments	0	0
Changes in actuarial assumptions	22,181	(183,231)
Benefits earned and other changes	(338,913)	214,600
Interest	284,258	233,225
Estimated net benefits paid	<u>(277,149)</u>	<u>(337,812)</u>
Balance at end of year	<u>5,104,816</u>	<u>5,414,439</u>
Total benefit obligations	<u><u>\$ 6,200,148</u></u>	<u><u>\$ 6,162,222</u></u>

The accompanying notes are an integral part of this statement.

NOTES TO THE FINANCIAL STATEMENTS
IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND

JULY 31, 2024

NOTE 1 - DESCRIPTION OF THE PLAN

The following description of the **Ironworkers Local Union No. 167 Welfare Fund** provides only general information. Participants should refer to the Plan Document for a complete description of the Plan's provisions, copies of which may be obtained from the Plan sponsor.

1. **General** - The Fund was established July 8, 1963, as a result of a collective bargaining agreement between the Union and various employers to provide health benefits for eligible participants. It is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Fund is financed by employer contributions as specified in the collective bargaining agreement, employee contributions and earnings from investments. The Board of Trustees is responsible for all aspects of the administration and operation of the Plan. Plan assets are held in a voluntary employees' beneficiary association (VEBA) trust.
2. **Benefits** - The Fund provides health and life insurance benefits to plan participants. Please refer to the Plan Document for a complete description of the rules of eligibility and benefits payable under the Plan. The Plan also provides continuation of certain benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

All health benefits are self-insured. The claims for self-insured benefits are processed by the Plan's third-party claims processor under an administrative services only (ASO) arrangement. The claims processor pays claims directly to or on behalf of participants from the bank account of the Plan's VEBA trust. Despite the Plan's utilization of a third-party claim's processor, ultimate responsibility for payments to providers and participants is retained by the Plan.

The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes rebates to the Plan based on the Plan's actual utilization pattern of specific drugs.

Life insurance benefits are purchased for active and retired participants from The Union Labor Life Insurance Company. The benefit amount is \$20,000 for all active and retired participants. However, for participants who are 65 years old or older, but under age 70, this amount is reduced to \$13,000. Participants who are 70 years old or older have a \$10,000 benefit.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 1 - DESCRIPTION OF THE PLAN (CONTINUED)

2. **Benefits (continued)** - The Fund has secured stop loss insurance coverage that reimburses the Fund for claims totaling in excess of \$250,000 per participant per contract year with an accumulating deductible of \$101,225.
3. **Contributions/Funding policy** - Each month, the employers of the participants make contributions to the Fund based on the collective bargaining agreement. The collective bargaining agreement currently provides for contributions of \$6.13 per hour worked by participants and \$6.22 per hour worked by TVA participants.

Under certain conditions active participants who have less than the required contributions made to the Fund on their behalf and retired participants may make self-contributions to the Fund in order to continue their eligibility. Please refer to the Plan Document for a complete description of the rules of eligibility.

The costs of the postretirement benefits are shared by the Plan's participating employers and retirees. In addition to deductibles and co-payments, the retiree contribution rate as of July 31, 2024, was \$501.67 per month for continuing coverage.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNT POLICIES

- A. **Basis of accounting** - The accompanying financial statements have been prepared using the accrual basis of accounting.
- B. **Cash and cash equivalents** - Cash and cash equivalents include all short-term highly liquid investments that have original maturities of three months or less, including the Fund's liquid sweep account with Regions Bank.
- C. **Use of estimates** - The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein; and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.
- D. **Payment of benefits** - Claims payments, life and stop loss insurance premiums are recorded when paid.
- E. **Administrative expenses** - The Plan's expenses are paid by the Plan.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

- F. **Stop loss** - Premiums for stop loss insurance are included in premium payments in the accompanying Statement of Changes in Net Assets Available for Benefits. Stop loss insurance reimbursements totaling \$43,219 and \$0 were received for the years ended July 31, 2024 and 2023.
- G. **Formulary rebates** - Rebates due from the Plan's PBM are recorded when earned. Rebates due as of the financial statement date have been reported as a receivable. Pharmacy rebates totaling \$271,697 and \$131,146 are shown on the accompanying Statement of Changes in Net Assets Available for Benefits for the years ended July 31, 2024 and 2023, respectively.
- H. **Investment valuation and income recognition** - The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by its investment advisors and custodians. See Note 8 for discussion of fair value measurements.
- Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on an accrual basis. Dividends are recorded on the ex-dividend date. Realized gains and losses include the Plan's gains and losses on investments sold during the year. Unrealized gains and losses include the Plan's gains and losses on investments held during the year and as of the year end.
- I. **Postretirement benefit obligation** - A postretirement benefit obligation has been recognized for retiree medical benefits for eligible participants and their dependents upon retirement. The postretirement benefit obligation represents the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to employee service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current retirees of the Plan. The obligation represents the amounts that are to be funded by contributions from the Plan's participating employers and from existing plan assets. 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 the participating employers.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

I. **Postretirement benefit obligation (continued)** - 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 rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an independent actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims 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.

For measurement purposes, the medical and drug trend rates shown below were assumed for the indicated years (the self-payment trend rates equal the medical and drug trend rates shown below combined). These assumptions are consistent with those used to measure the benefit obligation at July 31, 2023.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported as benefit obligations in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of July 31, 2024 and 2023, by \$529,572 and \$709,551, respectively.

MEDICAL TREND RATES			MEDICAL TREND RATES		
<u>Year Ending</u>	<u>Pre-65</u>	<u>Post-65</u>	<u>Year Ending</u>	<u>Pre-65</u>	<u>Post-65</u>
2025	7.90%	7.90%	2033	5.70%	5.70%
2026	7.40%	7.40%	2034	5.50%	5.50%
2027	6.80%	6.80%	2035	5.20%	5.20%
2028	6.20%	6.20%	2036	4.90%	4.90%
2029	6.10%	6.10%	2037	4.60%	4.60%
2030	6.00%	6.00%	2038	4.30%	4.30%
2031	5.90%	5.90%	2039	4.10%	4.10%
2032	5.80%	5.80%	2040+	4.00%	4.00%

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

I. Postretirement benefit obligation (continued) -

DRUG TREND RATES		DRUG TREND RATES	
Year Ending	Rate	Year Ending	Rate
2025	9.00%	2033	5.80%
2026	8.00%	2034	5.60%
2027	7.00%	2035	5.30%
2028	6.40%	2036	5.00%
2029	6.30%	2037	4.70%
2030	6.20%	2038	4.40%
2031	6.10%	2039	4.10%
2032	5.90%	2040+	4.00%

The following were other significant assumptions used in the valuations as of July 31, 2024 and July 31, 2023:

Discount rate: 5.25% - 2024; 5.25% - 2023.

Retirement Rates:

Age	Less than 34 yrs Rate	At least 34 yrs Rate
<55	0%	25%
55	5%	25%
56	15%	25%
57-58	20%	25%
59	30%	50%
60-61	75%	75%
62+	100%	100%

Mortality: 2024 - 105% of the PRI-2012 Blue Collar Mortality Table for employees and healthy annuitants for males, and 110% for females, projected forward using the MP-2021 Projection Scale; **2023** - 105% of the PRI-2012 Blue Collar Mortality Table for employees and healthy annuitants for males, and 95% for females, projected forward using the MP-2021 Projection Scale.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

I. Postretirement benefit obligation (continued) -

Administrative expenses: 5% addition to claims costs.

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 the postretirement benefit obligation. Please refer to the actuarial report for a complete description of all assumptions.

- J. Claims incurred, but not reported and accumulated eligibility -** All health benefits are self-funded. Provision for liability has been recorded for 1) an estimate of those claims incurred and unpaid or unreported and 2) an estimate of future benefits based on participants' accumulated eligibility. These estimates have been provided by the Fund's benefit consultant. The estimate for claims incurred and unpaid or unreported is calculated by taking the Fund's historical average time lag in months between the time a claim is incurred and reported, multiplied by the Fund's historical average claims per month adjusted for inflation. The estimate of the liability of future benefits based on accumulated eligibility is derived by multiplying each eligible individual's historical average monthly cost adjusted for inflation by the number of months the individual will be eligible after the fiscal year's end. Estimated health claims incurred by retired participants, but not reported at year-end are included with active participants' estimated health claims incurred, but not reported. These amounts are paid by the Plan only if claims are submitted and approved for payment.

For measurement purposes at July 31, 2024, an 8.0% annual rate of increase in the per capita cost of covered health care benefits was assumed for 2024 and to remain at that level thereafter. The assumptions used to measure the benefit obligation at July 31, 2023, were 8.0% and to remain at that level thereafter.

- K. Subsequent events -** The Plan has evaluated subsequent events through March 28, 2025, the date the financial statements were available to be issued.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 3 - PRIORITIES UPON TERMINATION

The Board of Trustees has the right to modify the benefits provided to, and the contributions required of, participants and to terminate the Plan subject to the provisions of ERISA. It is the intent of the Trustees to continue the Fund in full force and effect. Termination shall not permit any part of the Fund to be used for or diverted to purposes other than for the exclusive benefit of the employees or their eligible dependents. In the event the Fund terminates, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants. Participants should refer to the Agreement and Declaration of Trust for a complete description of the Plan's termination provisions.

NOTE 4 - INCOME TAX STATUS

The VEBA trust funding benefits of the Plan received an exemption letter from the Internal Revenue Service dated August 27, 1975, stating that the trust is tax-exempt under the provisions of Section 501(c)9 of the Internal Revenue Code (IRC). However, as a result of the Plan's funding policy, from time to time the Trust may be subject to income taxes. No federal or state income taxes have been recorded in the years ended July 31, 2024 or 2023 for unrelated business taxable income.

In addition, the Plan and the Trust are required to operate in conformity with the IRC to maintain tax-exempt status of the Trust. The Plan has been amended since receiving the determination letter. However, the plan administrator believes that the Plan is being operated in compliance with the applicable requirements of the Internal Revenue Code and, therefore, believes that the related Trust is tax-exempt. Therefore, no provision for income taxes has been included in the Plan's financial statements.

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

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 5 - EMPLOYER CONTRIBUTIONS RECEIVABLE

Employer contributions receivable represents the total of employers' contribution reports that were applicable to the periods prior to August 1st which were received during a period of time following the close of the year. These amounts do not reflect any amounts due from employers who are contractually liable to the Fund that have failed to file the required reports of covered workers in their employ during the period under review.

NOTE 6 - EMPLOYEE CONTRIBUTIONS RECEIVABLE

Employee contributions receivable represents the total of participants' self-payments that were applicable to the periods prior to August 1st which were received during a period of time following the close of the year.

NOTE 7 - INVESTMENTS

The Fund's investment portfolio as of July 31, 2024 consisted of:

	Fair Value at 07/31/23	Net Investments Purchased (Sold)	Net Appreciation (Depreciation) in Fair Value	Fair Value at 07/31/24
Investment cash account	\$ 12,397	\$ (12,031)	\$ 0	\$ 366
Money market fund	213,004	(213,004)	0	0
U.S. Government securities	<u>824,220</u>	<u>(842,110)</u>	<u>17,890</u>	<u>0</u>
	<u>\$1,049,621</u>	<u>\$ (1,067,145)</u>	<u>\$ 17,890</u>	<u>\$ 366</u>

Please note a change in interest rates could affect the value of plan assets.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 8 - FAIR VALUE MEASUREMENTS

The Fund's investments are reported at fair value in the accompanying statement of net assets available for benefits. The methods used to measure fair value may produce an amount that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Fund 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 framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 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;
- 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.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 8 - FAIR VALUE MEASUREMENTS (CONTINUED)

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 maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at July 31, 2024 and 2023.

Money market fund: Valued at the net asset value (NAV) of shares held by the Plan at year end. The underlying assets are traded in active markets.

U.S. Government securities: Valued at the closing price reported in the active market in which the individual securities are traded.

As of July 31, 2024 and 2023, all plan investments were valued under **Level 1** of the fair value hierarchy outlined above.

NOTE 9 - RECONCILIATION OF THE FINANCIAL STATEMENTS TO THE FORM 5500

The following is a reconciliation of realized gains and losses per the financial statements to the Form 5500:

	<u>Year Ended</u> <u>7/31/24</u>	<u>Year Ended</u> <u>7/31/23</u>
Realized gains (losses) per the financial statements	\$ 14,906	\$(14,737)
Conversion from historical cost to revalued cost required by Form 5500	<u>17,890</u>	<u>13,257</u>
Realized gains (losses) per the Form 5500	<u>\$ 32,796</u>	<u>\$ (1,480)</u>

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

**NOTE 9 - RECONCILIATION OF THE FINANCIAL STATEMENTS TO THE FORM 5500
(CONTINUED)**

The following is a reconciliation of unrealized gains and losses per the financial statements to the Form 5500:

	<u>Year Ended 7/31/24</u>	<u>Year Ended 7/31/23</u>
Unrealized gains per the financial statements	\$ 17,890	\$ 13,526
Conversion from historical cost to revalued cost required by Form 5500	<u>(17,890)</u>	<u>(13,257)</u>
Unrealized gains per the Form 5500	<u>\$ 0</u>	<u>\$ 269</u>

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

	<u>07/31/24</u>	<u>07/31/23</u>
Net assets available for benefits per the financial statements	\$3,617,545	\$2,158,613
Benefit obligations currently payable:		
Health claims reported, but not paid	(40,062)	(47,850)
Health claims incurred, but not reported	<u>(218,444)</u>	<u>(143,773)</u>
Net assets available for benefits per the Form 5500	<u>\$3,359,039</u>	<u>\$1,966,990</u>

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

**NOTE 9 - RECONCILIATION OF THE FINANCIAL STATEMENTS TO THE FORM 5500
(CONTINUED)**

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

	<u>Year Ended 07/31/24</u>
Benefits paid to and for participants per the financial statements	\$2,256,050
Add: Amounts currently payable at end of year	258,506
Less: Amounts currently payable at beginning of year	<u>(191,623)</u>
Benefits paid to and for participants per the Form 5500	<u>\$2,322,933</u>

Claims that have been processed and approved for payment at year-end, but not paid and claims incurred, but not reported are not considered liabilities under GAAP and, therefore, are not presented as liabilities or claims paid in the accompanying financial statements, but are recorded on the Form 5500 as liabilities.

NOTE 10 - PLAN AMENDMENTS

Effective August 1, 2023, the Trustees amended the Plan to add a wellness benefit for children through the age of 12 with no annual deductible, a \$25 copayment per visit and paid at 100%, as well as a routine immunizations and inoculations benefit with no annual deductible, paid at 100% for charges incurred at a public health facility and at 80% for charges incurred with a participating PPO provider.

NOTE 11 - SUBSEQUENT PLAN AMENDMENTS

Effective October 1, 2024, the trustees approved the transition of the Pharmacy Benefit Manager from Express Scripts to Sav-Rx.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 11 - SUBSEQUENT PLAN AMENDMENTS (CONTINUED)

At their September 25, 2024 meeting, the Trustees amended the Fund's "Participant Privacy Policies and Procedures" to comply with the provisions of a Final Rule issued by the Department of Health and Human Services.

NOTE 12 - RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the value of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

The value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Ironworkers Local Union No. 167 is a local union doing business in the Memphis Tennessee Area. Consequently, concentration of the employers contributing to the Welfare Fund in the Memphis Tennessee Area subjects the Fund to the risks associated with the economy in this area.

NOTE 13 - CONCENTRATION RISK

During the year, The State Group Industrial (45.5%), Ideal Contracting (8.4%), Williams Erection Company (7.1%), and Walbridge Equipment (5.1%) contributed 66.1% of all contributions made to the Plan. A withdrawal by these employers would have a significant impact upon the Plan.

NOTES TO THE FINANCIAL STATEMENTS (CONTINUED)

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

NOTE 14 - RELATED-PARTY AND PARTY-IN-INTEREST TRANSACTIONS

As described in Note 2, the Plan paid all expenses related to operations and investment activity to various service providers. These transactions are party-in-interest transactions under ERISA. Of note, Southern Benefit Administrators, Inc., is the Plan's claims payer and third-party administrator; CIGNA is the Plan's PPO provider; Raymond James is the Plan's investment custodian; NewSouth Capital Management is the Plan's investment manager; and Regions is the custodian of the Plan's general, claims, and escrow checking accounts, as well as the money market sweep account.

SUPPLEMENTAL INFORMATION

SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

JULY 31, 2024

	<u>Par Value/ Shares</u>	<u>Cost</u>	<u>Fair Value</u>
<u>Investment Cash Account</u>			
Raymond James Bank		\$ 366	\$ 366
		<hr/> <hr/>	<hr/> <hr/>

**SCHEDULE OF INVESTMENT ASSETS REQUIRED TO BE REPORTED
BOTH ACQUIRED AND DISPOSED OF WITHIN THE PLAN YEAR**

**IRONWORKERS LOCAL UNION NO. 167
WELFARE FUND**

FOR THE YEAR ENDED JULY 31, 2024

	<u>Par Value/ Shares</u>	<u>Cost</u>	<u>Proceeds</u>
None			

SCHEDULE OF REPORTABLE TRANSACTIONS

IRONWORKERS LOCAL UNION NO. 167

WELFARE FUND

FOR THE YEAR ENDED JULY 31, 2024

<u>Name</u>	<u>Description</u>	<u>Purchase Price</u>	<u>Selling Price</u>	<u>Cost of Asset</u>	<u>Current Value at Time of Sale</u>	<u>Net Gain or Loss</u>
<u>U.S. Government Securities</u>						
Federal National Mortgage Assoc.	2.875% Matures 09-12-23	\$	\$ 155,000	\$ 159,663	\$ 155,000	\$ (4,663)
Federal National Mortgage Assoc.	2.500% Matures 02-05-24		250,015	259,210	250,015	(9,195)
Federal National Mortgage Assoc.	2.625% Matures 09-06-24		224,225	218,183	224,225	6,042
Federal Home Loan Mortgage Corp.	0.375% Matures 09-23-25		213,925	205,055	213,925	8,870
Federal National Mortgage Assoc.	2.125% Matures 04-24-26	163,844	168,068	163,844	168,068	4,224
Federal National Mortgage Assoc.	0.750% Matures 10-08-27	150,992	156,852	150,992	156,852	5,860
Federal Home Loan Banks	4.000% Matures 06-30-28	172,678	174,478	172,678	174,478	1,800
Federal Home Loan Banks	3.250% Matures 11-16-28	142,680	144,647	142,680	144,647	1,967

Note: This information is required for and reported on Schedule H Form 5500.

SCHEDULE OF EMPLOYER CONTRIBUTIONS

IRONWORKERS LOCAL UNION NO. 167

WELFARE FUND

FOR THE YEAR ENDED JULY 31,

	<u>2024</u>	<u>2023</u>
American Fence and Supply	\$ 57,058	\$ 16,828
Aristeo Construction	99,588	0
Atlanta Steel Erectors	15,300	0
Barnhart Crane & Rigging	301,328	283,349
Bristol Steel	50,747	84,790
CMF Group	114,038	0
Central Industrial	13,011	0
CitySteel	16,621	149,561
Collins & Hermann	309	705
Corona Stud & Deck	27,304	19,184
Day & Zimmermann	274,872	0
Duncan Machinery	14,007	13,587
DuraServ	143,566	3,825
Durr Systems	97,223	0
Enerfab Power & Industrial	3,741	0
G&L Corporation	356	324
GENESYS	5,388	0
G-UB-MK Constructors	0	6,879
Glasco	0	600
Glass Design	0	3,427
H&R Industrial	241	0
Harris Steel	14,694	34,866

SCHEDULE OF EMPLOYER CONTRIBUTIONS

IRONWORKERS LOCAL UNION NO. 167

WELFARE FUND

FOR THE YEAR ENDED JULY 31,

	<u>2024</u>	<u>2023</u>
Henkels & McCoy	\$ 0	\$ 11,019
Ideal Contracting	547,588	1,242,342
IronMan Steel Erectors	0	507
Ironworkers Local Union No. 167	24,467	20,008
Ironworkers Local Union No. 167 Training Fund	22,881	10,667
KLS Contractors	0	4,644
KVM Door Systems	588	0
Kiewit Power Constructors	46,349	70,013
Lee Machinery Movers	2,207	0
Lesco Design & Manufacturing	136,331	0
Midwest Steel	299,967	147,254
Morris-Shea Bridge	0	4,883
Morsey Constructors	6,334	0
NR Windows	0	2,487
Patton Tully Marine	1,221	33,199
Precision Iron Works	0	2,400
RMF Nooter	53,328	46,059
R. Clark & Sons	3,611	0
Red Cedar Steel	16,482	256,672
Roy Blackwell Enterprises	0	5,612
STEVENS Engineers & Constructors	92,219	0
Sarus Industrial	24,767	24,225

SCHEDULE OF EMPLOYER CONTRIBUTIONS

IRONWORKERS LOCAL UNION NO. 167

WELFARE FUND

FOR THE YEAR ENDED JULY 31,

	<u>2024</u>	<u>2023</u>
Service Electric	\$ 3,147	\$ 14,095
Southern Steel & Concrete	68,648	105,598
Superior Steel Erectors	10,167	4,080
The Boldt Company	9,662	0
The L.E. Myers Company	1,020	15,404
The State Group Industrial	2,979,313	0
Total Steel Services	0	749
Trade-Mark Industrial	4,600	0
Tri-State Ironworks, Inc.	144,799	174,656
United Rebar	241	0
Vulcan Industrial	5,494	0
Walbridge Equipment	332,566	298,659
Wenger Corporation	0	3,030
Williams Erection Company	<u>465,841</u>	<u>0</u>
	6,553,230	3,116,187
Add: Reciprocal Contributions Received	106,094	129,981
Less: Reciprocal Contributions Disbursed	<u>(2,839,829)</u>	<u>(1,100,093)</u>
	<u>\$ 3,819,495</u>	<u>\$ 2,146,075</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 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2023</div> 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 multiple-employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.)
B This return/report is:	<input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here	<input checked="" type="checkbox"/> the DFVC program
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <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"/>

Part II Basic Plan Information—enter all requested information					
1a Name of plan IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND	<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 colspan="2">1c Effective date of plan 07/08/1963</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan 07/08/1963	
1b Three-digit plan number (PN) ▶	501				
1c Effective date of plan 07/08/1963					
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) IRONWORKERS LOCAL UNION NO. 167 WELFARE FUND P.O. BOX 1449 GOODLETTSVILLE TN 37070-1449	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">2b Employer Identification Number (EIN) **-***6127</td> </tr> <tr> <td>2c Plan Sponsor's telephone number 901-345-5825</td> </tr> <tr> <td>2d Business code (see instructions) 237990</td> </tr> </table>	2b Employer Identification Number (EIN) **-***6127	2c Plan Sponsor's telephone number 901-345-5825	2d Business code (see instructions) 237990	
2b Employer Identification Number (EIN) **-***6127					
2c Plan Sponsor's telephone number 901-345-5825					
2d Business code (see instructions) 237990					

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"/> <i>James R Cole</i> Signature of plan administrator <i>Chairman</i>	4-8-25 Date	<i>James R Cole</i> Chairman Enter name of individual signing as plan administrator
SIGN HERE	<input checked="" type="checkbox"/> <i>James R Cole / Alison Smit</i> Signature of employer/plan sponsor <i>SECRETARY</i>	4/8/2025 Date	<i>Alison Smit</i> Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">5</td> <td style="text-align: right;">221</td> </tr> </table>	5	221																															
5	221																																	
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).	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"></td> <td style="width:15%;"></td> <td style="width:80%;"></td> </tr> <tr> <td>6a(1)</td> <td>Total number of active participants at the beginning of the plan year</td> <td style="text-align: right;">183</td> </tr> <tr> <td>6a(2)</td> <td>Total number of active participants at the end of the plan year</td> <td style="text-align: right;">338</td> </tr> <tr> <td>6b</td> <td>Retired or separated participants receiving benefits</td> <td style="text-align: right;">39</td> </tr> <tr> <td>6c</td> <td>Other retired or separated participants entitled to future benefits</td> <td style="text-align: right;">0</td> </tr> <tr> <td>6d</td> <td>Subtotal. Add lines 6a(2), 6b, and 6c</td> <td style="text-align: right;">377</td> </tr> <tr> <td>6e</td> <td>Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.</td> <td></td> </tr> <tr> <td>6f</td> <td>Total. Add lines 6d and 6e</td> <td></td> </tr> <tr> <td>6g(1)</td> <td>Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</td> <td></td> </tr> <tr> <td>6g(2)</td> <td>Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</td> <td></td> </tr> <tr> <td>6h</td> <td>Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested</td> <td></td> </tr> </table>				6a(1)	Total number of active participants at the beginning of the plan year	183	6a(2)	Total number of active participants at the end of the plan year	338	6b	Retired or separated participants receiving benefits	39	6c	Other retired or separated participants entitled to future benefits	0	6d	Subtotal. Add lines 6a(2), 6b, and 6c	377	6e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6f	Total. Add lines 6d and 6e		6g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		6g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	
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7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;">7</td> <td style="text-align: right;">46</td> </tr> </table>	7	46																															
7	46																																	

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

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	(1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor

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

a Pension Schedules

- (1) R (Retirement Plan Information)
- (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) DCG (Individual Plan Information) - Number Attached _____
- (5) MEP (Multiple-Employer Retirement Plan Information)

b General Schedules

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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 _____

SERVICE PROVIDER INFORMATION APPLICABLE TO:
Cigna Health and Life Insurance Company ("Cigna")



2001 CALDWELL DRIVE
ATTN: ALISHA HESTER
GOODLETTSVILLE, TN 37072

Account Number : 3220903

For plan year beginning August 1, 2023 and ending July 31, 2024

Part I Service Provider Information

1. Information on Persons receiving Only Eligible Indirect Compensation:

- (a) Check "No"
- (b) Not applicable

2. Information on Other Service Providers Receiving Direct or Indirect Compensation:

- (a) Cigna Health and Life Insurance Company ("Cigna")
Contract Identification Number: 59-1031071
NAIC Code: 67369

- (b) Service Code(s):
12 Claims Processing 38 Participant communications 50 Direct payments from the Plan
13 Contract Administrator 49 Other Services 56 Non-monetary compensation
31 Named fiduciary (if indicated in ASO Agreement) 62 Float Revenue

- (c) Cigna provides claim administration and related Services Pursuant to an Administrative Services Agreement.

- (d) Direct compensation paid by the plan:

	<u>Amount Paid</u>
Medical Fees	\$ 178,225
Dental Fees	See attached Dental Sch C, if applicable

- (e) Check "Yes." Cigna received indirect compensation.
- (f) Check "Yes", see appendix for eligible indirect compensation calculation.
- (g) See Appendix for indirect compensation calculation.
- (h) Check "Yes." See Appendix included with this reporting.

3. For information regarding each source of indirect compensation (a) of \$1,000 or more and (b) each source of indirect compensation for which Cigna provided a formula refer to:

- (a) Reference Appendix for information on eligible indirect compensation including formulas
- (b) Reference Appendix for information on indirect compensation including formulas

Part II Service Providers Who Fail or Refuse to Provide Information

4. Do not identify Cigna in this section as information for completion of Schedule C is provided in this documentation.

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: If you have elected not to receive identifiable health information, this report complies with your election. Nevertheless, please note that you may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

"Cigna" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

SERVICE PROVIDER INFORMATION APPLICABLE
Cigna Health and Life Insurance Company ("Cigna")
FOOTNOTE DOCUMENT

2001 CALDWELL DRIVE
ATTN: ALISHA HESTER
GOODLETTSVILLE, TN 37072

Account Number 3220903

For plan year beginning August 1, 2023 and ending July 31, 2024

Part 1, line 2d: Amount reflects payments at the time this report is prepared. Other direct compensation may be due, but not yet paid.

Part 1, line 2d: May include prior year commissions not previously reported.

The following amounts were paid to your broker(s) /consultant(s) during the contract year:

Commissions: \$0

Service/General Agent Fees: \$0

Contact your broker/consultant for further details.

◆ Appendix refers to subscriber and membership information for your plan that is available at the Cigna Access Employer Portal at www.cignaaccess.com. Go to the report titled, Subscriber and Membership Reporting.

◆ In addition, Cigna enters into compensation programs under which certain brokers/ consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, is funded from our general overhead, and is not required to be reported on Schedule C. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent/ broker for specific information about their participation.

◆ If you have a Cigna administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor.

**APPENDIX FOR SERVICE PROVIDER INFORMATION REGARDING SOURCES OF INDIRECT
COMPENSATION EXCLUDING ELIGIBLE INDIRECT COMPENSATION TO BE REPORTED ON
SCHEDULE C PART I, LINE 3**

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
CareCore d/b/a eviCore, 400 Buckwalter Place Blvd, Bluffton, SC 29910 EIN - 141831391
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Indirect compensation received by Cigna from CareCore to help defray Cigna's cost for implementation and maintenance of it's agreement with CareCore.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.27 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2016 in all plans that have purchased PHS+ (excluding Shared Administration Repricing "SAR") administered by Cigna.)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
American Specialty Health (ASH), 10221 Wateridge Cir 201, San Diego, CA 92121 EIN - 330571188
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Indirect compensation received by Cigna from this vendor to defray Cigna's infrastructure and other cost to implement and administer on an ongoing basis the expanded access to the covered chiropractic, physical therapy, a occupational therapy provider network/discounts. Your plan participants may have received covered services through vendor's network.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.04 per participant. (Determined by dividing total

compensation received by the number of participants as of July 1, 2016 in all plans insured/administered by Cigna.
(including Shared Administration Repricing OAP plans)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

(a) Service provider name: Cigna

(b) Service codes:

12 Claims Processing	38 Participant communications	50 Direct payments from the plan
13 Contract Administrator	49 Other Services	56 Non-monetary compensation
31 Named fiduciary - (if indicated in ASO agreement)		62 Float Revenue

(c) Amount of indirect compensation:

\$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:

Castlight Health, 121 Spear St 3rd floor, San Francisco, CA 94105 EIN - 261989091

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Indirect compensation received by Cigna from this vendor (i) to defray Cigna's cost for the infrastructure changes re facilitate implementation of this vendor's customer transparency and engagement services; (ii) as reimbursement fo providing the vendor Cigna derived Center of Excellence (COE) and Cigna Designation (CCD) Information; (iii) as reir for making available customer access to cost estimate information, and (iv) as reimbursed for access to client paid c

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.08 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2016 in all plans that utilized this vendor. (excluding Shared Administration Repricing "SAR")

Effective Date 01/01/2016

Cancel Date: 01/01/9999

(a) Service provider name: Cigna

(b) Service codes:

12 Claims Processing	38 Participant communications	50 Direct payments from the plan
13 Contract Administrator	49 Other Services	56 Non-monetary compensation
31 Named fiduciary - (if indicated in ASO agreement)		62 Float Revenue

(c) Amount of indirect compensation:

\$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:

MedSolutions d/b/a eviCore, Inc, 730 Cool Springs Blvd. #800, Franklin, TN 37067 EIN - 621615395

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:

Indirect compensation received by Cigna from MedSolutions, Inc as consideration for contracting with MedSolutions for access to certain Cigna contracted HI-Tech Radiology services providers. Your plan participants may have received covered services arranged by MedSolutions.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.64 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2016 in all plans, including Shared Administration Repricing plans insured/administered by Cigna.)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
MedSolutions d/b/a eviCore, Inc, 730 Cool Springs Blvd. #800, Franklin, TN 37067 EIN - 205953092
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Indirect compensation received by Cigna from MedSolutions, Inc as consideration for contracting with Cigna from this vendor to defray Cigna's cost for infrastructure changes required to utilize this vendor's Musculoskeletal Management Program.
Your plan participants may have received covered services arranged by MedSolutions.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.23 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2016 in all plans, including Shared Administration Repricing plans insured/administered by Cigna.)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Stratose (formally Coalition America (Medical)), Two Concourse Parkway, Suite 300, Atlanta, GA 30328
EIN - 261790538
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Indirect compensation received by Cigna from this vendor to defray Cigna's cost

for the infrastructure changes required to utilize this vendor's medical provider network/discounts.
Your plan participants may have received covered services arranged through this vendor's network.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.05 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2016 in all plans, including Shared Administration Repricing plans insured/administered by Cigna.)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Vision Service Plan "VSP", 333 Quality Drive, Rancho Cordova, CA 96670, EIN - 061227840
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
NOTE: The following is not applicable to your plan if your Cigna administered plan did not include benefits for vision services through VSP.

Vendor for Vision Services - Indirect compensation received by Cigna from this vendor for Cigna's expenses associated with administering plans with vision benefits.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from this vendor of approximately \$0.63 per participant. (Determined by dividing total compensation received by the number of Vision Service Plan participants in participating plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid.) (excluding Shared Administration Repricing plans)

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Refer to Sagamore Network Hospital listing below *

- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Network hospitals listed below have contracted with Sagamore Health Network (an affiliate of Cigna) to pay network administration fees.

Indirect Compensation Formula/Estimate:

For calendar year 2016, Cigna received indirect compensation from these hospitals of approximately \$0.11 per participant. (Determined by dividing total indirect compensation received by the number of participants in all plans, including Shared Administration Repricing plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid to these hospitals.)

Hospital name

* Bloomington Hospital, P. O. Box 1149, Bloomington, IN 47402, TIN = 351720796
 Bloomington Hospital of Orange County, 642 W. Hospital Road, Paoli, IN 47454, TIN = 352090919
 Clark Memorial Hospital, 1220 Missouri Avenue, Jeffersonville, IN 47130, TIN = 350944638
 Daviess Community Hospital, P. O. Box 32, Washington, IN 47501, TIN = 356001322
 Gibson General Hospital, 1808 Sherman Drive, Princeton, IN 47670, TIN = 350877575
 Good Samaritan Hospital, 520 S. Seventh Street, Vincennes, IN 47591-1098, TIN = 356001532
 Goshen General Hospital, P. O. Box 139, Goshen, IN 46527-0139, TIN = 356001540
 Greene County General Hospital, RR#1, Box 1000, Linton, IN 47441-9457, TIN = 356001492
 Home Hospital/Lafayette Home Hospital, P. O. Box 310, Mishawaka, IN 46546-0310, TIN = 352056396
 Jasper County Hospital, 1104 E. Grace Street, Rennselaer, IN 47978, TIN = 351404051
 Margaret Mary Community Hospital, P. O. Box 226, Batesville, IN 47006-8953, TIN = 356067049
 Meadows Hospital, 3600 N. Prow Road, Bloomington, IN 47404, TIN = 351858510
 Monroe Hospital, 4011 S. Monroe Medical Park Blvd., Bloomington, IN 47403, TIN = 202069733
 Oaklawn Psychiatric Center, P. O. Box 809, Goshen, IN 46527, TIN 351070041
 Starke Memorial Hospital (Principal Knox LLC), P. O. Box 339, Knox, IN 46534-0339, TIN = 621763056
 Pulaski Memorial Hospital, P. O. Box 279, Winamac, IN 46996, TIN = 351097674
 St. Elizabeth Medical Center, P. O. Box 310, Mishawaka, IN 46546-0310, TIN = 352056396
 St. Joseph Regional Medical Center -Plymouth, P. O. Box 1935, South Bend, IN 46634, TIN = 351142669
 St. Joseph Regional Medical Center -South Bend, P. O. Box 1935, South Bend, IN 46634, TIN = 350868157
 St. Mary's Medical Center, 3700 Washington Ave, Evansville, IN 47750, TIN = 350869065
 St. Mary's Warrick Hospital, P.O. Box 2408, Indianapolis, IN 46206, TIN = 351343019
 White County Memorial Hospital, 720 South 6th St., Monticello, IN 47960, TIN = 351140233
 Woodlawn Hospital, 1400 E. 9th St., Rochester, IN 46975, TIN = 351171815

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: Cigna
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
 \$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:

Bank of America (Lockbox), 540 West Madison Street, Chicago, IL 60661

- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of claim overpayment recovery
Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2016, \$0.01 per participant with the average annual rate of the earnings credit at .42%.

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
CitiBank NA, One Penns Way, New Castle, DE 19720
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna.
Applicable to all self-funded plans utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2016, \$0.41 per participant with the average annual rate of the earnings credit at .62%.

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
CitiBank NA (Omnibus), One Penns Way, New Castle, DE 19720
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna.
Applicable to all self-funded plans for Cigna Behavioral Health utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2016, \$0.01 per participant with the average annual rate of the earnings credit at .62%.

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: Cigna
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Deutsche Bank, 60 Wall St., New York, NY 10005-2836
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of disbursing claim refunds.
Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2016, \$0.00 per participant with the average annual rate of the earnings credit at .17%.

Effective Date 01/01/2016

Cancel Date: 01/01/9999

-
- (a) Service provider name: Cigna
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Fifth Third Bancorp, 38 Fountain Square Plaza, Cincinnati, OH 45202
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of disbursing claim refunds.
Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2016, \$0.01 per participant with the average annual rate of the earnings credit at .28%.

Effective Date

Cancel Date:

01/01/2016

01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
JPMorgan Chase, 3 Chase Metro Tech Center, 5th Floor, Brooklyn, NY 11245
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
**Earnings credits on daily fund balances associated with bank accounts utilized in claim administration by Cigna.
Applicable to all self-funded plans utilizing JPMorgan Chase services.**

Eligible Indirect Compensation Formula/Estimate:
**For calendar year 2016, \$0.43 per participant with the average annual
rate of the earnings credit at .44%.**

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
JPMorgan Chase, HSA Operations, 10420 Highland Manor Dr., 4th Floor, Tampa, FL 33610-9128
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
**Variable earnings credit on cash balances in individual plan participants' Health Savings Accounts at JPMorgan Chase
Applicable only to plans administered by Cigna that make available Health Savings Accounts to plan participants.**

Eligible Indirect Compensation Formula/Estimate:
**For calendar year 2016, \$0.03 per participant with the average annual
rate of the earnings credit at .01%.**

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:

12 Claims Processing	38 Participant communications	50 Direct payments from the plan
13 Contract Administrator	49 Other Services	56 Non-monetary compensation
31 Named fiduciary - (if indicated in ASO agreement)		62 Float Revenue

- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
HSA Bank, P.O.Box 939, Sheboygan, WI 53082-0939 (replaces JPMorgan Chase, HSA operations)
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Variable earnings credit on cash balances in individual plan participants' Health Savings Accounts at JPMorgan Chase
Applicable only to plans administered by Cigna that make available Health Savings Accounts to plan participants.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2016, \$0.48 per participant with the average annual rate of the earnings credit at .01%.

Effective Date 01/01/2016

Cancel Date: 01/01/9999

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|--|-------------------------------|----------------------------------|
| 12 Claims Processing | 38 Participant communications | 50 Direct payments from the plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (if indicated in ASO agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation:
\$0 (see formula/estimate provided below)
- (d) Name and EIN (address) of source of indirect compensation:
Cigna Healthy Rewards Vendors
Luxottica (Cole Managed Vision (EyeMed) and Cole National) 4000 Luxottica Place, Mason, OH 45040
Amplifon USA, Inc. (formally HearPo Corp Sonus), 5000 Cheshire Parkway N, Plymouth, MN 55446
Gaiam 833 W South Boulder Rd., Louisville, CO 80027-2452
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Volume based marketing fees paid by vendors participating in the Cigna Healthy Rewards program which offers plan discounts on various services. Applicable to your plan if your plan participants have a Cigna ID card and access to myCigna.com or other authorized portals.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2016, \$0.01 PMPY (this formula is based upon total compensation received from Healthy Reward Vendors across Cigna companies' entire insured and self-insured book

Effective Date 01/01/2016

Cancel Date: 01/01/9999

010265500 Ironworkers Local Union No. 167

62-0696127

FYE: 7/31/2024

Federal Statements

Ironworkers Local Union No. 167 Welfare Fund Plan: 501

Plan transactions in excess of 5% of plan assets

<u>Name</u>		<u>Purchase Price</u>	<u>Selling Price</u>	<u>Lease Rental</u>	<u>Expenses</u>	<u>Cost of Asset</u>	<u>Current Value</u>	<u>Net Gain or Loss</u>
	<u>Description</u>							
FEDERAL NATIONAL MORTGAGE A	2.875% DUE 09-12-23	\$	\$ 155,000	\$	\$	\$ 159,663	\$ 155,000	\$ -4,663
FEDERAL NATIONAL MORTGAGE A	2.500% DUE 02-05-24		250,015			259,210	250,015	-9,195
FEDERAL NATIONAL MORTGAGE A	2.625% DUE 09-06-24		224,225			218,183	224,225	6,042
FEDERAL HOME LOAN MORTGAGE	0.375% DUE 09-23-25		213,925			205,055	213,925	8,870
FEDERAL NATIONAL MORTGAGE A	2.125% DUE 04-24-26	163,844	168,068			163,844	168,068	4,224
FEDERAL NATIONAL MORTGAGE A	0.750% DUE 10-08-27	150,992	156,852			150,992	156,852	5,860
FEDERAL HOME LOAN BANKS	4.000% DUE 06-30-28	172,678	174,478			172,678	174,478	1,800
FEDERAL HOME LOAN BANKS	3.250% DUE 11-16-28	142,680	144,647			142,680	144,647	1,967

010265500 Ironworkers Local Union No. 167

62-0696127

Federal Statements

FYE: 7/31/2024

Ironworkers Local Union No. 167 Welfare Fund Plan: 501

Assets Held for Investment

<u>Party in Interest</u>	<u>Identity</u>	<u>Description</u>	<u>Cost</u>	<u>Current Value</u>
	RAYMOND JAMES BANK	INVESTMENT CASH ACCO	\$ 366	\$ 366