

<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; font-weight: bold; text-align: center;">2023</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

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>4TH DISTRICT IBEW HEALTH 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>JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND</u></p> <p><u>AMERICAN BENEFIT CORPORATION</u> <u>9200 US ROUTE 60</u> <u>ONA, WV 25545</u></p>	<p>1c Effective date of plan <u>02/01/1965</u></p> <p>2b Employer Identification Number (EIN) <u>31-6068797</u></p> <p>2c Plan Sponsor's telephone number <u>304-525-0331</u></p> <p>2d Business code (see instructions) <u>238210</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.	06/11/2025	JESSICA MORRISON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	06/11/2025	JESSICA MORRISON
	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

<p>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p>AMERICAN BENEFIT CORPORATION</p> <p>9200 US ROUTE 60 ONA, WV 25545</p>	<p>3b Administrator's EIN 55-0671859</p> <p>3c Administrator's telephone number 304-525-0331</p>
<p>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:</p> <p>a Sponsor's name</p> <p>c Plan Name</p>	<p>4b EIN</p> <p>4d PN</p>
<p>5 Total number of participants at the beginning of the plan year</p>	<p>5 6513</p>
<p>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).</p> <p>a(1) Total number of active participants at the beginning of the plan year</p> <p>a(2) Total number of active participants at the end of the plan year</p> <p>b Retired or separated participants receiving benefits</p> <p>c Other retired or separated participants entitled to future benefits</p> <p>d Subtotal. Add lines 6a(2), 6b, and 6c</p> <p>e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits</p> <p>f Total. Add lines 6d and 6e</p> <p>g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p> <p>g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p> <p>h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested</p>	<p>6a(1) 4141</p> <p>6a(2) 4747</p> <p>6b 2319</p> <p>6c</p> <p>6d 7066</p> <p>6e</p> <p>6f</p> <p>6g(1)</p> <p>6g(2)</p> <p>6h</p>
<p>7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)</p>	<p>7 293</p>

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
4A 4B 4D 4E 4F

<p>9a Plan funding arrangement (check all that apply)</p> <p>(1) <input checked="" type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>	<p>9b Plan benefit arrangement (check all that apply)</p> <p>(1) <input checked="" type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input checked="" type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<p>a Pension Schedules</p> <p>(1) <input type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p> <p>(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____</p> <p>(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)</p>	<p>b General Schedules</p> <p>(1) <input checked="" type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information – Small Plan)</p> <p>(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u> 2 </u></p> <p>(4) <input checked="" type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p>
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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 **10/01/2023** and ending **09/30/2024**

A Name of plan 4TH DISTRICT IBEW HEALTH FUND		B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND		D Employer Identification Number (EIN) 31-6068797	

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
METROPOLITAN 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
13-5581829	65978	0117888	4534		03/31/2024

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 0	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

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) **▶ AD&D INSURANCE**

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	291082
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 **10/01/2023** and ending **09/30/2024**

A Name of plan 4TH DISTRICT IBEW HEALTH FUND		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND		D Employer Identification Number (EIN) 31-6068797

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

1 Coverage Information:

(a) Name of insurance carrier

VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1227840	39616	30055894	5313	01/01/2024	12/31/2024

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 0	(b) Total amount of fees paid 154147
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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	
	142430	CLAIMS PAID	

(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	
	11717	ADMINISTRATIVE FEES	

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))			7d	
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	

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

- 8** Benefit and contract type (check all applicable boxes)
- | | | | |
|--|--|---|--|
| a <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 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
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 **10/01/2023** and ending **09/30/2024**

A Name of plan 4TH DISTRICT IBEW HEALTH FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND	D Employer Identification Number (EIN) 31-6068797	

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

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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)

AMERICAN BENEFIT CORPORATION

9200 US ROUTE 60
ONA, WV 25545

55-0672859

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 12 50	NONE	2531374	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)

HIGHMARK WEST VIRGINIA

614 MARKET STREET
PARKERSBURG, WV 26102

55-0624615

(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 50	NONE	786186	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

THE SEGAL COMPANY

333 W 34TH STREET
NEW YORK, NY 10001

13-2646110

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 50	NONE	382647	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

PART D ADVISORS

17199 N LAUREL PARK DR STE 400
LIVONIA, MI 48152

85-3689655

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	331253	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AMERICAN HEALTH HOLDING

PO BOX 360142
PITTSBURGH, PA 15250

31-1368946

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50	NONE	290297	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)

COMMUNITY INSURANCE CO DBA ANTHEM

3350 PEACHTREE ROAD POB 30302-445
ATLANTA, GA 30326

31-1440175

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 12 50	NONE	241816	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LYRA HEALTH, INC.

270 EAST LANE
BURLINGAME, CA 94010

47-2935915

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50	NONE	190023	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JOHNSON PRINTING COMPANY

4136 GREEN VALLEY ROAD
HUNTINGTON, WV 25701

55-0726948

(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?
36 50	NONE	161110	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)

DELTA DENTAL

PO BOX 30416
LANSING, MI 48909

31-0685339

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 12 50	NONE	143363	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LEDBETTER PARTNERS

5078 WOOSTER ROAD, SUITE 400
CINCINNATI, OH 45226

03-0599899

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	82937	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)

NATIONAL REAL ESTATE ADVISORS

900 7TH ST NW
WASHINGTON DC, DC 20001

26-3437991

(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?
28 50	NONE	54791	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)

KEY BANK

P.O. BOX 93885
CLEVELAND, OH 44101

34-0797057

(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?
21 50	NONE	52653	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

HARRIS HARDIN & COMPANY

404 NINTH STREET
HUNTINGTON, WV 25723

55-0756523

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	52315	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)

MEDICAL REVIEW INSTITUTE

PO BOX 35145
SEATTLE, WA 98124

87-0515201

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	43316	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)

SEGAL SELECT INSURANCE COMPANY

333 W 34TH STREET
NEW YORK, NY 10001

13-2646110

(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?
22 50	NONE	27433	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

WESTERN ASSET MANAGEMENT

620 8TH AVE
NEW YORK, NY 10018

(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?
28 50	NONE	26982	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)

SEGAL ROGERS CASEY

333 W 34TH STREET
NEW YORK, NY 10001

13-2646110

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	22500	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)

GRAY, GRIFFITH & MAYS. A.C.

707 VIRGINIA STREET EAST, SUITE 400
CHARLESTON, WV 25301

55-0621482

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	20915	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

NORTHERN TRUST COMPANY

181 W MADISON
CHICAGO, IL 60603

26-6411809

(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?
28 50	NONE	20457	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)

HYATT REGENCY COLUMBUS

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	11300	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)

JP MORGAN

270 PARK AVENUE
NEW YORK, NY 10017

13-3200244

(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?
28 50	NONE	10086	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

JOHN DASCOLI

2442 KANAWHA BLVD E
CHARLESTON, WV 25311

20-5780253

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	5446	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 <hr/> 2023 This Form is Open to Public Inspection.
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For calendar plan year 2023 or fiscal plan year beginning 10/01/2023 and ending 09/30/2024

A Name of plan <u>4TH DISTRICT IBEW HEALTH FUND</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND</u>	D Employer Identification Number (EIN) <u>31-6068797</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE: NORTHERN TRUST COMPANY

b Name of sponsor of entity listed in (a): THE NORTHERN TRUST COMPANY

c EIN-PN <u>26-6411809-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>25762837</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: WESTERN ASSET

b Name of sponsor of entity listed in (a): WESTERN ASSET

c EIN-PN <u>95-2705767-001</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>11778611</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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.	<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 10/01/2023 and ending 09/30/2024			
A Name of plan 4TH DISTRICT IBEW HEALTH FUND	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">B Three-digit plan number (PN) ►</td> <td style="width:20%; text-align: center;">501</td> </tr> </table>	B Three-digit plan number (PN) ►	501
B Three-digit plan number (PN) ►	501		
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES OF 4TH DISTRICT IBEW HEALTH FUND	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">D Employer Identification Number (EIN) 31-6068797</td> </tr> </table>	D Employer Identification Number (EIN) 31-6068797	
D Employer Identification Number (EIN) 31-6068797			

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	1143662	835124
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	9512942	11989300
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	975510	6420
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	12004757	11117497
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)	4865794	4487704
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	18830398	25762837
(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)	7716928	11778611
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	37349454	52128397
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

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	92399445	118105890
Liabilities			
g Benefit claims payable	1g	10526700	11956700
h Operating payables	1h	3702630	3480951
i Acquisition indebtedness	1i		
j Other liabilities	1j	23676056	29181112
k Total liabilities (add all amounts in lines 1g through 1j)	1k	37905386	44618763
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	54494059	73487127

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)	89776460	
(B) Participants	2a(1)(B)	8707112	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		98483572
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	550978	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		550978
(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)	2373884	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		2373884
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds	2b(4)(A)	900678	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	889371	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		11307
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	2690172	
(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)		5582315
(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		
d Total income. Add all income amounts in column (b) and enter total	2d		109692228

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	84577139	
(2) To insurance carriers for the provision of benefits.....	2e(2)	413801	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		84990940
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)	3615678	
(3) Recordkeeping fees.....	2i(3)		
(4) IQPA audit fees.....	2i(4)	20915	
(5) Investment advisory and investment management fees	2i(5)	234907	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	452983	
(8) Legal fees	2i(8)	88383	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	1295354	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		5708220
j Total expenses. Add all expense amounts in column (b) and enter total	2j		90699160

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		18993068
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: GRAY, GRIFFITH & MAYS, A.C.

(2) EIN: 55-0621482

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		3000000
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.		X	

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 _____.

4TH DISTRICT IBEW HEALTH FUND

FINANCIAL STATEMENTS AND
INDEPENDENT AUDITOR'S REPORT

September 30, 2024 and 2023

4TH DISTRICT IBEW HEALTH FUND

FINANCIAL STATEMENTS AND INDEPENDENT AUDITOR'S REPORT
September 30, 2024 and 2023

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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees
4th District IBEW Health Fund
% American Benefit Corporation
9200 US Route 60
Ona, WV 25545

Opinion

We have audited the financial statements of the 4TH District IBEW Health Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and the statements of benefit obligations as of September 30, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, information regarding the Plan's net assets available for benefits as of September 30, 2024 and 2023, and the changes in its net assets available for benefits for the years then ended, and the accumulated plan benefits as of September 30, 2024 and 2023 and the changes in its accumulated plan benefits 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 the Plan 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 the Plan's ability to continue as a going concern for one year after the date that the financial statements are 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 judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

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

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

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 of assets held at end of year and schedule of reportable transactions, referred to as "supplemental information," are presented for the purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the 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.

Gray, Griffith & Mays, a.c.

June 11, 2025
Charleston, West Virginia

4th District IBEW Health Fund

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<u>ASSETS</u>		
Investments, at fair value:		
Money market funds	\$ 11,117,497	\$ 12,004,757
Mutual funds	52,128,397	37,349,454
Private commingled funds	11,778,611	7,716,928
Commingled real estate funds	4,487,704	4,865,794
Collective investment funds	<u>25,762,837</u>	<u>18,830,398</u>
	<u>105,275,046</u>	<u>80,767,331</u>
Receivables:		
Participating employers' contributions	9,848,193	7,796,116
Reciprocity receivable	2,141,107	1,716,826
Accrued interest and dividends	6,420	55,662
Medicare drug subsidy	<u>-</u>	<u>919,848</u>
	<u>11,995,720</u>	<u>10,488,452</u>
Cash	<u>835,124</u>	<u>1,143,662</u>
Total assets	<u>\$ 118,105,890</u>	<u>\$ 92,399,445</u>
<u>LIABILITIES</u>		
Accounts payable	\$ 259,357	\$ 95,680
Reciprocity payable	3,221,594	3,606,950
Unearned premiums received from employee self-contributions for future coverage	<u>311,112</u>	<u>303,656</u>
	<u>3,792,063</u>	<u>4,006,286</u>
Net assets available for benefits	<u>\$ 114,313,827</u>	<u>\$ 88,393,159</u>

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

4th District IBEW Health Fund

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

For the years ended September 30, 2024 and 2023

	2024	2023
ADDITIONS TO NET ASSETS ATTRIBUTED TO:		
Contributions:		
Participating employers	\$ 89,776,460	\$ 75,539,797
Participants	<u>8,707,112</u>	<u>9,290,927</u>
	<u>98,483,572</u>	<u>84,830,724</u>
Investment income:		
Net appreciation in fair value of investments	8,283,794	1,096,489
Interest and dividends	<u>2,924,862</u>	<u>2,478,017</u>
	11,208,656	3,574,506
Less: investment expenses	<u>(234,907)</u>	<u>(207,499)</u>
	<u>10,973,749</u>	<u>3,367,007</u>
Medicare drug subsidy	<u>-</u>	<u>919,848</u>
Total additions	<u>109,457,321</u>	<u>89,117,579</u>
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:		
Benefits paid to / for participants:		
Health care	66,944,342	54,893,015
Prescription drug plan	<u>10,705,197</u>	<u>8,690,904</u>
	77,649,539	63,583,919
Transition care program	105,750	139,425
Group life insurance premiums	<u>308,051</u>	<u>290,226</u>
	78,063,340	64,013,570
Administrative expenses:		
Administration	1,912,183	1,638,815
Claims administration – Anthem	241,816	1,646,282
Claims administration – Highmark	786,186	-
Dental administration – Delta Dental	143,363	127,320
HRA administration	532,130	505,113
Medical review	43,316	19,294
Pre-certifications/case management	529,184	427,276
Actuarial and consulting	452,983	666,198
Audit of fund	20,915	23,512
Audits of employers	56,675	55,939
Dependent audit	331,253	70,272
Dues	2,295	1,360
Fiduciary responsibility insurance	16,737	42,489
Cyber insurance	10,815	-
Legal	88,383	102,032
Postage and printing	264,725	187,130
Reciprocal transfer systems	4,880	3,380
Seminars and meetings	35,269	18,386
Telephone	<u>205</u>	<u>753</u>
Total administrative expenses	<u>5,473,313</u>	<u>5,535,551</u>

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

4th District IBEW Health Fund

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

For the years ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Total deductions	<u>83,536,653</u>	<u>69,549,121</u>
Net increase	25,920,668	19,568,458
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year	<u>88,393,159</u>	<u>68,824,701</u>
End of year	<u><u>\$ 114,313,827</u></u>	<u><u>\$ 88,393,159</u></u>

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

4th District IBEW Health Fund

STATEMENTS OF BENEFIT OBLIGATIONS
For the years ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS AND OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS:		
Health claims payable and incurred but not reported	\$ 11,956,700	\$ 10,526,700
Benefits based on participant's accumulated eligibility	<u>28,870,000</u>	<u>23,372,400</u>
Total obligations other than post-retirement benefit obligations	<u>40,826,700</u>	<u>33,899,100</u>
POSTRETIREMENT BENEFIT OBLIGATIONS:		
Current retirees	21,505,024	2,801,448
Other participants fully eligible for benefits	24,635,060	23,649,426
Other participants not yet fully eligible for benefits	<u>31,741,163</u>	<u>26,105,205</u>
	<u>77,881,247</u>	<u>52,556,079</u>
Plan's total benefit obligations	<u>\$ 118,707,947</u>	<u>\$ 86,455,179</u>

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

4th District IBEW Health Fund

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

For the years ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS AND OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS:		
Balance at beginning of year	\$ 33,899,100	\$ 29,756,400
Claims reported and approved for payment and net change in claims incurred but not reported	79,079,539	67,167,419
Net change in benefits based on participants accumulated eligibility	5,497,600	559,200
Claims paid	<u>(77,649,539)</u>	<u>(63,583,919)</u>
Balance at end of year	<u>40,826,700</u>	<u>33,899,100</u>
POSTRETIREMENT BENEFIT OBLIGATIONS:		
Balance at beginning of year	52,556,079	95,937,005
Increase (decrease) during the year attributable to:		
Plan amendments	(19,458,390)	-
Benefits earned net of benefits paid	3,299,506	4,868,998
Actuarial experience loss	11,433,355	-
Changes in actuarial assumptions	<u>30,050,697</u>	<u>(48,249,924)</u>
Balance at end of year	<u>77,881,247</u>	<u>52,556,079</u>
Plan's total benefit obligations at end of year	<u>\$ 118,707,947</u>	<u>\$ 86,455,179</u>

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

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

1 – DESCRIPTION OF PLAN

The following description of the 4th District IBEW Health Fund (the Plan) provides only general information. Participants should refer to the Plan's governing documents for a more complete description of the Plan's provisions.

General – The Plan, formerly the Outside Electrical Welfare Fund, provides health and other benefits covering eligible participants who have worked or are working for any of the contributing employers as established by the collective bargaining agreement by and between several employers' associations and various local unions in the IBEW Fourth District. The Plan and related trust were established on February 1, 1965. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Benefits – The Plan provides health benefits (hospital, surgical, major medical, dental, vision, prescription drug and disability) and life insurance covering eligible persons. The basic qualifying requirements state that participants will become eligible for benefits following the crediting of at least the required contribution.

The Plan is primarily self-insured for providing health benefits to participants and their beneficiaries with the exception of life and accidental death and dismemberment coverage, which is underwritten by an insurance provider. American Benefit Corporation processes and pays health benefit claims.

Contributions – Contributions to the Plan are made by participating employers based on the negotiated contribution rates set forth in collective bargaining agreements. In addition, participants may qualify to self-pay in order to continue receiving benefits. In general, if the balance in a participant's contribution account is less than the required contribution, the participant will be permitted to make self-contributions to the Plan in order to maintain eligibility.

Other – The Plan's board of trustees, as Sponsor, has the right under the Plan to modify the benefits provided to participants. The Plan may be terminated by the board of trustees or the bargaining parties, subject to the provisions of ERISA.

Effective October 1, 2020, a participant may make up to 15 consecutive full self-contributions to purchase coverage if their dollar bank balance is zero. The total number of consecutive months allowed under self-contributions and COBRA continuation coverage combined is 18 months.

Effective March 1, 2021, regular retiree medical coverage has been updated for non-Medicare-eligible retirees. When an employee retires, but before they turn age 65, they can access any credits in their HRA, but are not able to contribute any new amounts to that account. The out-of-pocket maximum for medical plan is \$3,000 for individual and \$6,000 for family for in-network and \$9,500 for both individual and family out-of-network. The out-of-pocket maximum for prescription drugs is \$4,600 for individual and \$9,200 for family for in-network.

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

Effective April 1, 2021, the eligibility coverage was updated as follows. In order to qualify for retiree coverage as a formerly covered participant who is unable to meet the eligibility requirements for covered participants because they accepted a position with the IBEW, NECA, or similar affiliated entity and became covered as a participant under another group health plan, the participant must: 1) notify the board of trustees, in writing that you have accepted a qualifying position and request coverage under the Plan to be terminated; 2) maintain continuous coverage with the affiliated entity through the final date of retirement; 3) promptly notify the board of trustees, in writing that they have retired from the industry and wish to resume participation in the Plan; and 4) upon the return to the Plan, any Dollar Bank balance available at the time Plan coverage was initially terminated will be restored.

Effective October 1, 2022, the diagnosis and treatment services for those with Autism was added to the list of covered preventative services.

Effective October 1, 2023, the plan was amended to modify dependent's ability to continue coverage. Previously, dependents could continue coverage as long as self-payments were made. Under this amendment, in order for the dependents to qualify, the covered participant must 1) be at least 57 ½ 2) have been eligible for the Plan for at least 48 of the most recent 60 benefit months (or 96 of the most recent 120 benefit months and 3) be eligible for the plan at the time of death.

2 – SUMMARY OF ACCOUNTING POLICIES

Date of Management's Review – Subsequent events were evaluated through the date of the independent auditor's report, which is the date the financial statements were available to be issued.

Basis of Accounting – The financial statements of the Plan are prepared using the accrual method of accounting.

Estimates – The preparation of financial statements in conformity with generally accepted accounting principles requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures, such as the reported amounts of assets, liabilities, benefit obligations and changes therein, health claims payable and incurred but not reported, participants' accumulated eligibility, claims payable, and disclosure of contingent assets and liabilities. Accordingly, actual results may differ from those estimates.

Valuation of Investments – Investments are stated at fair value. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date.

Postretirement Benefits – The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees' service rendered to the date of the financial statements and reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. 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

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

and their beneficiaries and dependents after retirement from service with the participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing Plan assets. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an 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.

The more significant assumptions underlying the September 30, 2024 and 2023 actuarial valuations are as follows:

	2024	2023
Discount rate:	4.75%	5.50%
Health trend rates:		
Non-Medicare Medical & Prescription Drugs	8.00% graded to 4.50% over 12 years	7.50% graded to 4.50% over 12 years
Medicare Medical & Prescription Drugs	8.00% graded to 4.50% over 12 years	7.50% graded to 4.50% over 11 years
Dental & Vision	4%	4%
PPO Fees	3%	3%
Administrative expense increase rate	3%	3%
Retiree contribution increase rate	Equal to medical and prescription drug trend	Equal to medical and prescription drug trend
Postretirement mortality rates	Pri-2012 Blue Collar Headcount-weighted Annuitant Mortality Table, projected generationally from 2012 with Scale MP-2021	Pri-2012 Blue Collar Headcount-weighted Annuitant Mortality Table, projected generationally from 2012 with Scale MP-2021

The foregoing actuarial 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.

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

The changes in the postretirement benefit obligation as of September 30, 2024 and are summarized as follows:

Changes in postretirement benefit obligation for 2024 – While a plan amendment decreased obligations by \$19,458,390, valuation assumption changes increased obligations by \$30,050,697. This was primarily the result of updating the valuation-year per capita health costs. Other changes include updating the retiree contribution rates, updating trend rates on per capita health costs and retiree contribution rates, and decreasing the discount rate from 5.50% to 4.75%. The discount rate is reset each year based on the rates of return on high-quality fixed income investments currently available as of the valuation measurement date whose cash flows match the timing and amount of expected benefit payments. Also, an actuarial experience loss increased obligations by \$11,433,355. This was the result of gains and losses due to demographic changes. In total, the obligations increased by \$25,325,168.

Changes in postretirement benefit obligation for 2023 – Valuation assumption changes decreased obligations by \$48,249,924. This was primarily the result of updating the valuation-year per capita health costs. Other changes include updating the retiree contribution rates, updating trend rates on per capita health costs and retiree contribution rates, and increasing the discount rate increased from 5.25% to 5.50%. The discount rate is reset each year based on the rates of return on high-quality fixed income investments currently available as of the valuation measurement date whose cash flows match the timing and amount of expected benefit payments.

Other Plan Benefits – Plan obligations at September 30 for health claims incurred by active participants but not reported at that date, for accumulated eligibility of participants, and for future disability payments to members considered permanently disabled at September 30 are estimated by the Plan's actuary in accordance with accepted actuarial principles. Such estimated amounts are reported in the accompanying statement of the Plan's benefit obligations at present value. Health claims incurred by retired participants but not reported at year-end are included in the postretirement benefit obligation.

Allowance for Doubtful Accounts – The Plan's administration has evaluated employer contributions receivable and has determined that an allowance for doubtful accounts was not necessary as all amounts are deemed to be fully collectible.

3 – FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1) and the lowest priority to unobservable inputs (level 3). The three levels of the fair value hierarchy 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.

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

Level 2—Inputs to the valuation methodology include:

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

If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

Level 3—Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques 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 September 30, 2024 and 2023.

Mutual Funds – Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Private Commingled Funds – Valued at the daily closing price as reported by the fund. Private commingled funds held by the Plan are registered with the Securities and Exchange Commission. The private commingled funds held by the Plan are deemed to be actively traded.

Commingled Real Estate Funds – Valued based upon property appraisals of the underlying assets. Values are estimated based on the price that would be received to sell an asset in an orderly transaction between marketplace participants at the measurement date. Investments without a public market are valued based on assumptions made and valuation techniques, such as discounted cash flow analysis, prevailing market capitalization rates, and analysis of recent comparable sales transactions.

Collective Investment Trust: – Valued at NAV. The NAV, as provided by the Custodian, is used as a practical expedient to estimate fair value. The NAV is based on the fair value of the underlying investments held by the fund less its liabilities.

Money Market Funds: – Fair value is based on amortized cost or original cost-plus accrued interest.

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

The following tables sets forth, by level within the fair value hierarchy, the Plan's investments at fair value as of September 30, 2024 and 2023:

	Fair Value Measurements at Reporting Date Using:			
	Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)	Fair Value
September 30, 2024				
Money market funds	\$ -	\$ 11,117,497	\$ -	\$ 11,117,497
Mutual funds	52,128,397	-	-	52,128,397
Private commingled funds	-	11,778,611	-	11,778,611
Commingled real estate funds	-	-	4,487,704	4,487,704
Total assets in the FV hierarchy	52,128,397	22,896,108	4,487,704	79,512,209
Investments measured at NAV				
Collective investment funds	-	-	-	25,762,837
Total Investments	<u>\$52,128,397</u>	<u>\$22,896,108</u>	<u>\$4,487,704</u>	<u>\$105,275,046</u>
September 30, 2023				
Money market funds	\$ -	\$ 12,004,757	\$ -	\$ 12,004,757
Mutual funds	37,349,454	-	-	37,349,454
Private commingled funds	-	7,716,928	-	7,716,928
Commingled real estate funds	-	-	4,865,794	4,865,794
Total assets in the FV hierarchy	37,349,454	19,721,685	4,865,794	61,936,933
Investments measured at NAV				
Collective investment funds	-	-	-	18,830,398
Total Investments	<u>\$37,349,454</u>	<u>\$19,721,685</u>	<u>\$4,865,794</u>	<u>\$80,767,331</u>

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

A reconciliation of assets using level 3 inputs as of September 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Beginning Balance	\$ 4,865,794	\$ 5,460,593
Investment income	81,500	108,110
Realized gain or loss	83,038	(30,874)
Unrealized gain or loss	<u>(542,628)</u>	<u>(672,035)</u>
	<u>\$ 4,487,704</u>	<u>\$ 4,865,794</u>

The following table summarizes investments for which fair value is measured using the net asset value per share practical expedient as of September 30, 2024 and 2023:

<u>September 30, 2024</u>	<u>Fair Value</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
Collective investment funds	<u>\$25,762,837</u>	Daily	None

<u>September 30, 2023</u>	<u>Fair Value</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
Collective investment funds	<u>\$18,830,398</u>	Daily	None

4 – CASH

At times during the year, the Plan has cash on deposit at a financial institution in excess of the maximum amount insured by the Federal Deposit Insurance Corporation.

5 – BENEFIT OBLIGATIONS

The Plan's postretirement benefit obligation is an actuarially calculated estimate of the amount required to fund postretirement benefits under the current plan rules. These benefits are not guaranteed or vested and the Plan's board of trustees, as Sponsor, has the right under the Plan to modify the benefits provided to participants.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of September 30, 2024 and 2023, by \$8,942,524 and \$5,912,236, respectively.

4TH District IBEW Health Fund**NOTES TO FINANCIAL STATEMENTS**

September 30, 2024 and 2023

6 – RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the accompanying financial statements to the Schedule H of the Form 5500 at September 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 114,313,827	\$ 88,393,159
Total benefit obligations other than postretirement benefit obligations	<u>(40,826,700)</u>	<u>(33,899,100)</u>
Net assets available for benefits per the Form 5500	<u>\$ 73,487,127</u>	<u>\$ 54,494,059</u>

The following is a reconciliation of benefits paid to participants per the accompanying financial statements to the Schedule H of the Form 5500 for the years ended September 30, 2024 and 2023:

	<u>2024</u>	<u>2023</u>
Total benefits paid per the financial statements	\$ 78,063,340	\$ 64,013,570
Add: Total benefit obligations other than postretirement benefit obligations at end of year	40,826,700	33,899,100
Less: Total benefit obligations other than postretirement benefit obligations at beginning of year	<u>(33,899,100)</u>	<u>(29,756,400)</u>
Total benefits paid per the Form 5500	<u>\$ 84,990,940</u>	<u>\$ 68,156,270</u>

7 – TAX STATUS

The trust established under the Plan to hold the Plan's assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code, as a tax-exempt organization. The Plan sponsor believes that the Plan, as amended, qualifies, and is operating in accordance with the applicable provisions of the Internal Revenue Code.

4TH District IBEW Health Fund

NOTES TO FINANCIAL STATEMENTS

September 30, 2024 and 2023

8 – 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 values of investment securities will occur in the near term and those changes could materially affect the amounts reported in the statement of net assets available for benefits.

The actuarial present 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.

All of the revenue and receivables shown on the financial statements are from electrical services. The Plan's ability to collect contributions and enter into contracts could be affected by fluctuations in the electrical service industry and the overall economy.

9 – PARTY IN INTEREST TRANSACTIONS

Parties-in-interest are defined under DOL regulations as any fiduciary of the Plan, any party rendering service to the Plan, the Plan Sponsor, and certain others. American Benefit Corporation, Inc. is the third-party administrator and bookkeeper. The Segal Group, Inc. is the actuary for the Plan. Segal Marco Advisors provide investment advisory services for the Plan. Ledbetter Partners LLC is the legal counsel to the Plan. Gray Griffith and Mays, A.C. is the independent auditor and Harris, Hardin & Company is the payroll auditor of the Plan. Key Bank is the custodian of the assets owned by the Plan. The Plan utilizes Highmark, Delta Dental, VSP Insurance Company, and SAV-Rx. to administer, respectively, health claims, dental claims, vision claims, and prescription drug claims for its participants. The Plan purchases life insurance for its covered members through MetLife.

10 – SUBSEQUENT EVENTS

The Plan's management has evaluated events and transactions occurring after September 30, 2024 through the date of the Auditor's Report, which is the date the financial statements were available to be issued.

SUPPLEMENTAL SCHEDULES

4th District IBEW Health Fund

Schedule H, line 4i - Schedule of Assets Held at End of Year

EIN: 31-6068797

PN: 501

September 30, 2024

(a)	(b)	(d)	(e)
Identity of Issue, Borrower, lessor or similar party	Description of investment include maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
<u>Mutual Funds</u>			
*	Baird Intermediate Bond Fund	\$ 17,253,511	\$ 17,729,278
	Moderate Duration Inst Fund	<u>25,304,802</u>	<u>34,399,119</u>
	Total mutual funds	42,558,313	52,128,397
<u>Private Commingled Funds</u>			
	Total Return Unconstrained (TRU) Bond	<u>10,450,457</u>	<u>11,778,611</u>
<u>Commingled Real Estate Funds</u>			
*	Indure Build-to-Core Fund	<u>1,400,015</u>	<u>4,487,704</u>
<u>Money Market Funds</u>			
*	Federated Government Obligations Institutional Shares	1,231	1,231
	Qualified Federated Govt Obligations	<u>11,116,266</u>	<u>11,116,266</u>
		11,117,497	11,117,497
<u>Collective Investment Funds</u>			
*	MFB NTGI- QM Common Daily	<u>17,219,924</u>	<u>25,762,837</u>
	Total investments	<u><u>\$ 82,746,206</u></u>	<u><u>\$ 105,275,046</u></u>

* Represents a party-in-interest.

See independent auditor's report.

4th District IBEW Health Fund

Schedule H, line 4j – Schedule of Reportable Transactions

EIN: 31-6068797

PN: 501

September 30, 2024

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of party Involved	Description of asset	Purchase Price	Selling Price	Cost of Asset	Current value of asset on transaction date	Net Gain/(Loss)
Single Transactions Exceeding 5%						
JP Morgan	JP Morgan Intermediate Bond Trust/High Yield	\$ -	\$ 11,714,795	\$ 13,179,101	\$ 11,714,795	\$ (1,464,306)
Aggregate Transactions Exceeding 5%						
Baird	Baird Intermediate Bond Fund	13,083,779	-	13,083,779	13,083,779	-
Pimco	Money Market Funds	7,000,000	-	7,000,000	7,000,000	-
Victory	Money Market Funds	99,094,310	-	99,094,310	99,094,310	-
Victory	Money Market Funds	-	97,275,930	97,275,930	97,275,930	-
	Purchases for	<u>\$ 119,178,089</u>				
	Sale for		<u>\$ 108,990,725</u>			
	Issue aggregate total			<u>\$ 229,633,120</u>	<u>\$ 228,168,814</u>	
	Net Gain					<u>\$ (1,464,306)</u>

See independent auditor's report.

4th District IBEW Health Fund

SCHEDULE OF ASSETS OVER OPERATING LIABILITIES, CLAIMS LIABILITIES AND ESTIMATED FUTURE BENEFIT LIABILITIES BASED ON PARTICIPANT ACCUMULATED ELIGIBILITY

September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<u>ASSETS</u>		
Investments, at fair value:		
Money market funds	\$ 11,117,497	\$ 12,004,757
Mutual funds	52,128,397	37,349,454
Private commingled funds	11,778,611	7,716,928
Commingled real estate funds	4,487,704	4,865,794
Collective investment funds	<u>25,762,837</u>	<u>18,830,398</u>
	<u>105,275,046</u>	<u>80,767,331</u>
Receivables:		
Participating employers' contributions	9,848,193	7,796,116
Reciprocity receivable	2,141,107	1,716,826
Accrued interest and dividends	6,420	55,662
Medicare drug subsidy	-	919,848
	<u>11,995,720</u>	<u>10,488,452</u>
Cash	<u>835,124</u>	<u>1,143,662</u>
Total assets	<u>\$ 118,105,890</u>	<u>\$ 92,399,445</u>
Operating liabilities:		
Accounts payable	\$ 259,357	\$ 95,680
Reciprocity payable	3,221,594	3,606,950
Unearned premiums received from employee self-contributions for future coverage	<u>311,112</u>	<u>303,656</u>
	<u>3,792,063</u>	<u>4,006,286</u>
Claims liabilities:		
Health claims payable and claims incurred but not reported	11,956,700	10,526,700
Estimated future benefit liabilities based on participant's eligibility:		
Accumulated eligibility credits	<u>28,870,000</u>	<u>23,372,400</u>
	<u>40,826,700</u>	<u>33,899,100</u>
	<u>44,618,763</u>	<u>37,905,386</u>
Total assets over operating liabilities, claims liabilities and estimated future benefit liabilities based on participant's eligibility	<u>\$ 73,487,127</u>	<u>\$ 54,494,059</u>

See independent auditor's report.

4th District IBEW Health Fund

SCHEDULE OF CHANGES IN ASSETS, OPERATING LIABILITIES, CLAIMS
LIABILITIES AND ESTIMATED FUTURE BENEFIT LIABILITIES BASED ON PARTICIPANT
ACCUMULATED ELIGIBILITY
For the Years Ended September 30, 2024 and 2023

	2024	2023
ADDITIONS TO NET ASSETS ATTRIBUTED TO:		
Contributions:		
Participating employers	\$ 89,776,460	\$ 75,539,797
Participants	<u>8,707,112</u>	<u>9,290,927</u>
	<u>98,483,572</u>	<u>84,830,724</u>
Investment income:		
Net appreciation in fair value of investments	8,283,794	1,096,489
Interest and dividends	<u>2,924,862</u>	<u>2,478,017</u>
	11,208,656	3,574,506
Less: investment expenses	<u>(234,907)</u>	<u>(207,499)</u>
	<u>10,973,749</u>	<u>3,367,007</u>
Medicare drug subsidy	<u>-</u>	<u>919,848</u>
Total additions	<u>109,457,321</u>	<u>89,117,579</u>
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO:		
Benefits paid to / for participants:		
Health care	66,944,342	54,893,015
Prescription drug plan	<u>10,705,197</u>	<u>8,690,904</u>
	77,649,539	63,583,919
Transition care program	105,750	139,425
Group life insurance premiums	<u>308,051</u>	<u>290,226</u>
	78,063,340	64,013,570
Subtractions from liabilities for:		
Health claims	1,430,000	3,583,500
Participants' accumulated eligibility	<u>5,497,600</u>	<u>559,200</u>
	<u>6,927,600</u>	<u>4,142,700</u>
	<u>84,990,940</u>	<u>68,156,270</u>

See independent auditor's report.

4th District IBEW Health Fund

SCHEDULE OF CHANGES IN ASSETS, OPERATING LIABILITIES, CLAIMS LIABILITIES AND ESTIMATED FUTURE BENEFIT LIABILITIES BASED ON PARTICIPANT ACCUMULATED ELIGIBILITY

For the Years Ended September 30, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Administrative expenses:		
Administration	1,912,183	1,638,815
Claims administration - Anthem	241,816	1,646,282
Claims administration - Highmark	786,186	-
Dental administration - Delta Dental	143,363	127,320
HRA administration	532,130	505,113
Medical review	43,316	19,294
Pre-certifications / case management	529,184	427,276
Actuarial and consulting	452,983	666,198
Audit of fund	20,915	23,512
Audits of employers	56,675	55,939
Dependent audit	331,253	70,272
Dues	2,295	1,360
Fiduciary responsibility insurance	16,737	42,489
Cyber insurance	10,815	-
Legal	88,383	102,032
Postage and printing	264,725	187,130
Reciprocal transfer systems	4,880	3,380
Seminars and meetings	35,269	18,386
Telephone	205	753
	<u>5,473,313</u>	<u>5,535,551</u>
Total deductions	<u>90,464,253</u>	<u>73,691,821</u>
Net increase	18,993,068	15,425,758
Total assets over operating liabilities, claims liabilities and estimated future benefit liabilities based on participant's eligibility as of the beginning of the year	<u>54,494,059</u>	<u>39,068,301</u>
Total assets over operating liabilities, claims liabilities and estimated future benefit liabilities based on participant's eligibility as of the end of the year	<u>\$73,487,127</u>	<u>\$ 54,494,059</u>

See independent auditor's report.

4th District IBEW Health Fund

Schedule H, line 4i - Schedule of Assets Held at End of Year

EIN: 31-6068797

PN: 501

September 30, 2024

(a)	(b)	(d)	(e)
Identity of Issue, Borrower, lessor or similar party	Description of investment include maturity date, rate of interest, collateral, par or maturity value	Cost	Current Value
<u>Mutual Funds</u>			
*	Baird Intermediate Bond Fund	\$ 17,253,511	\$ 17,729,278
	Moderate Duration Inst Fund	<u>25,304,802</u>	<u>34,399,119</u>
	Total mutual funds	<u>42,558,313</u>	<u>52,128,397</u>
<u>Private Commingled Funds</u>			
	Total Return Unconstrained (TRU) Bond	<u>10,450,457</u>	<u>11,778,611</u>
<u>Commingled Real Estate Funds</u>			
*	Indure Build-to-Core Fund	<u>1,400,015</u>	<u>4,487,704</u>
<u>Money Market Funds</u>			
*	Federated Government Obligations Institutional Shares	1,231	1,231
	Qualified Federated Govt Obligations	<u>11,116,266</u>	<u>11,116,266</u>
		<u>11,117,497</u>	<u>11,117,497</u>
<u>Collective Investment Funds</u>			
*	MFB NTGI- QM Common Daily	<u>17,219,924</u>	<u>25,762,837</u>
	Total investments	<u><u>\$ 82,746,206</u></u>	<u><u>\$ 105,275,046</u></u>

* Represents a party-in-interest.

See independent auditor's report.

4th District IBEW Health Fund

Schedule H, line 4j – Schedule of Reportable Transactions

EIN: 31-6068797

PN: 501

September 30, 2024

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of party Involved	Description of asset	Purchase Price	Selling Price	Cost of Asset	Current value of asset on transaction date	Net Gain/(Loss)
Single Transactions Exceeding 5%						
JP Morgan	JP Morgan Intermediate Bond Trust/High Yield	\$ -	\$ 11,714,795	\$ 13,179,101	\$ 11,714,795	\$ (1,464,306)
Aggregate Transactions Exceeding 5%						
Baird	Baird Intermediate Bond Fund	13,083,779	-	13,083,779	13,083,779	-
Pimco	Money Market Funds	7,000,000	-	7,000,000	7,000,000	-
Victory	Money Market Funds	99,094,310	-	99,094,310	99,094,310	-
Victory	Money Market Funds	-	97,275,930	97,275,930	97,275,930	-
	Purchases for	<u>\$ 119,178,089</u>				
	Sale for		<u>\$ 108,990,725</u>			
	Issue aggregate total			<u>\$ 229,633,120</u>	<u>\$ 228,168,814</u>	
	Net Gain					<u>\$ (1,464,306)</u>

See independent auditor's report.