

<p style="text-align: center;"><b>Form 5500</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></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;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 2em; 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><b>1a</b> Name of plan <u>NECA LOCAL 145 IBEW WELFARE PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>NECA LOCAL 145 WELFARE FUND</u></p> <p style="margin-top: 20px;"><u>1700 52ND AVENUE, SUITE B</u> <u>MOLINE, IL 61265</u></p>	<p><b>1c</b> Effective date of plan <u>12/01/1961</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>42-6062181</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>309-757-7558</u></p> <p><b>2d</b> 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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	05/28/2025	TRENT FLETCHER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	05/28/2025	BRANDON CURRIE
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE



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

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

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

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

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**11c** Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

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**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NECA LOCAL 145 WELFARE FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>42-6062181</b>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**THE UNION LABOR LIFE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>13-1423090</b>	<b>69744</b>	<b>G3122 C4408</b>	<b>1092</b>	<b>04/01/2023</b>	<b>03/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions .....	<b>7e(5)</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	129244
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A?.....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NECA LOCAL 145 WELFARE FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>42-6062181</b>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**AMALGAMATED LIFE INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>13-5501223</b>	<b>60216</b>	<b>SL 1069</b>	<b>1225</b>	<b>04/01/2023</b>	<b>03/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....		<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>		
	<b>7c(2)</b>		
	<b>7c(3)</b>		
	<b>7c(4)</b>		
	<b>7c(5)</b>		
(6) Total additions .....		<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....		<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>		
	<b>7e(2)</b>		
	<b>7e(3)</b>		
	<b>7e(4)</b>		
	(5) Total deductions .....		
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....		<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier.....	<b>10a</b>	909306
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A?.....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

**2023**

**This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning **10/01/2023** and ending **09/30/2024**

<b>A</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>		<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NECA LOCAL 145 WELFARE FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>42-6062181</b>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**HUMANA INSURANCE COMPANY**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>39-1263473</b>	<b>73288</b>	<b>311921</b>	<b>373</b>	<b>01/01/2023</b>	<b>12/31/2023</b>

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

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
<b>0</b>	<b>0</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(6) Total additions.....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	(5) Total deductions.....	<b>7e(5)</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	

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

**8** Benefit and contract type (check all applicable boxes)

- a**  Health (other than dental or vision)     
 **b**  Dental     
 **c**  Vision     
 **d**  Life insurance  
**e**  Temporary disability (accident and sickness)     
 **f**  Long-term disability     
 **g**  Supplemental unemployment     
 **h**  Prescription drug  
**i**  Stop loss (large deductible)     
 **j**  HMO contract     
 **k**  PPO contract     
 **l**  Indemnity contract  
**m**  Other (specify) ▶

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier.....	<b>10a</b>	685683
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A?.....  Yes  No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

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

<b>A</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NECA LOCAL 145 WELFARE FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>42-6062181</b>	

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

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

<b>DIMENSIONAL FUND ADVISORS LP</b>	<b>6300 BEE CAVE ROAD, BUILDING ONE AUSTIN, TX 78746</b>
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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

<b>T. ROWE PRICE ASSOCIATES, INC</b>	<b>100 EAST PRATT STREET BALTIMORE, MD 21202</b>
--------------------------------------	--

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

<b>THE VANGUARD GROUP, INC</b>	<b>100 VANGUARD BLVD MALVERN, PA 19355</b>
--------------------------------	--

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

<b>WASATCH GLOBAL INVESTORS</b>	<b>PO BOX 2172 MILWAUKEE, WI 53201</b>
---------------------------------	--

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

PIMCO FUNDS

650 NEWPORT CENTER DRIVE  
NEWPORT BEACH, CA 92660

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

GOLDMAN SACHS ASSET MANAGEMENT, L.P

71 S WACKER DR  
CHICAGO, IL 60606

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

ABRDN INC.

1395 BRICKELL AVENUE  
MIAMI, FL 33131

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

FIDELITY INVESTMENTS

245 SUMMER STREET  
BOSTON, MA 02210

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

DRIEHAUS CAPITAL MANAGEMENT LLC

25 E ERIE STREET  
CHICAGO, IL 60611

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

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

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

**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)

BLUE CROSS BLUE SHIELD OF ILLINOIS

300 EAST RANDOLPH STREET  
CHICAGO, IL 60601

36-1236610

(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	NONE	513567	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)

TRUENORTH COMPANIES, LC

500 FIRST STREET SE  
CEDAR RAPIDS, IA 52401

42-1513015

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14	NONE	345536	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)

MIDWEST ASSOCIATION OF H&W FUNDS

4709 ROCK 44TH STREET, STE 4  
ROCK ISLAND, IL 61201

20-0489036

(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	RELATED PARTY	223085	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)

MEDONE, LC

1590 UNIVERSITY AVE  
DUBUQUE, IA 52001

26-1769761

(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	NONE	149837	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)

TELLIGEN

711 JORIE AVE  
OAK BROOK, IL 60523

36-3545085

(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	NONE	143845	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)

GALLAGHER BENEFIT SERVICES

300 S RIVERSIDE PLAZA  
CHICAGO, IL 60606

(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?
	NONE	61000	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)

CONSOCIATE INC

2828 N. MONROE ST.  
DECATUR, IL 62526

37-1351918

(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?
15	NONE	49784	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)

PERSONAL ASSISTANCE SERVICES

3200 W KIMBERLY RD  
DAVENPORT, IA 52806

43-1613278

(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	NONE	29799	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)

QUAD CITY BANK & TRUST

3551 7TH STREET  
MOLINE, IL 61265

42-1410409

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19	NONE	29766	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)

CAVANAGH O'HARA LLP

2319 W JEFFERSON ST  
SPRINGFIELD, IL 62702

37-1259635

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	29284	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)

SENTRY HEALTH

7410 NEW LAGRANGE RD  
LOUISVILLE, KY 40222

01-0580124

(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?
23 70	NONE	29205	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)

GENESIS OCCUPATIONAL HEALTH

PO BOX 1246  
MOLINE, IL 61266

42-1418847

(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?
	NONE	24676	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)

CALIBRE CPA GROUP, PLLC

230 W. MONROE STREET, SUITE 310  
CHICAGO, IL 60606

47-0900880

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	20000	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)

VISION SERVICE PLAN

3333 QUALITY DR  
RANCHO CORDOVA, CA 95670

20-0891619

(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	NONE	19325	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 5402  
LISLE, IL 60532

(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	NONE	17683	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)

UNITED ACTUARIAL SERVICES

11590 N. MERIDAN ST 610  
CARMEL, IN 46032

35-2156428

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	10300	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)

INVESTMENT CONSULTING GROUP

5117 JERSEY RIDGE ROAD  
DAVENPORT, IA 52807

42-1358707

(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	NONE	10000	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)

EMPLOYEE TECH

1300 ELMWOOD AVE  
DEERFIELD, IL 60015

55-5000666

(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?
15	NONE	6972	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**Part I Service Provider Information (continued)**

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

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

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  ▶ <b>File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2023</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2023 or fiscal plan year beginning <b>10/01/2023</b> and ending <b>09/30/2024</b>	
<b>A</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NECA LOCAL 145 WELFARE FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>42-6062181</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
---------------	--------------------------------------

**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.

Assets	(a) Beginning of Year	(b) End of Year
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b> 929982	-1135
<b>b</b> Receivables (less allowance for doubtful accounts):		
<b>(1)</b> Employer contributions .....	<b>1b(1)</b> 1690540	1815543
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>	
<b>(3)</b> Other .....	<b>1b(3)</b> 464766	771800
<b>c</b> General investments:		
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b> 5977828	6622739
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b> 1018960	1305840
<b>(3)</b> Corporate debt instruments (other than employer securities):		
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>	
<b>(B)</b> All other .....	<b>1c(3)(B)</b>	
<b>(4)</b> Corporate stocks (other than employer securities):		
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>	
<b>(B)</b> Common .....	<b>1c(4)(B)</b>	
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>	
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>	
<b>(8)</b> Participant loans .....	<b>1c(8)</b>	
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>	
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>	
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>	
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>	
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b> 41117198	45625190
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>	
<b>(15)</b> Other .....	<b>1c(15)</b>	

<b>1d</b> Employer-related investments:		<b>(a)</b> Beginning of Year	<b>(b)</b> End of Year
(1) Employer securities .....	<b>1d(1)</b>		
(2) Employer real property .....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation .....	<b>1e</b>	40088	36220
<b>f</b> Total assets (add all amounts in lines 1a through 1e) .....	<b>1f</b>	51239362	56176197
<b>Liabilities</b>			
<b>g</b> Benefit claims payable .....	<b>1g</b>	882964	691470
<b>h</b> Operating payables .....	<b>1h</b>	378845	170180
<b>i</b> Acquisition indebtedness .....	<b>1i</b>		
<b>j</b> Other liabilities .....	<b>1j</b>	38912447	41292499
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j) .....	<b>1k</b>	40174256	42154149
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f) .....	<b>1l</b>	11065106	14022048

**Part II Income and Expense Statement**

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

<b>Income</b>		<b>(a)</b> Amount	<b>(b)</b> Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers .....	<b>2a(1)(A)</b>	18265840	
<b>(B)</b> Participants .....	<b>2a(1)(B)</b>	2123220	
<b>(C)</b> Others (including rollovers) .....	<b>2a(1)(C)</b>		
(2) Noncash contributions .....	<b>2a(2)</b>		20389060
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit) .....	<b>2b(1)(A)</b>	282080	
<b>(B)</b> U.S. Government securities .....	<b>2b(1)(B)</b>	24428	
<b>(C)</b> Corporate debt instruments .....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants) .....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans .....	<b>2b(1)(E)</b>		
<b>(F)</b> Other .....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		306508
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock .....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock .....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds) .....	<b>2b(2)(C)</b>	2119857	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		2119857
<b>(3)</b> Rents .....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds .....	<b>2b(4)(A)</b>	1600000	
<b>(B)</b> Aggregate carrying amount (see instructions) .....	<b>2b(4)(B)</b>	1599220	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result .....	<b>2b(4)(C)</b>		780
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate .....	<b>2b(5)(A)</b>		
<b>(B)</b> Other .....	<b>2b(5)(B)</b>	141166	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts.....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts.....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts.....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities.....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		5781318
<b>c</b> Other income .....	<b>2c</b>		
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		28738689

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	20813430	
(2) To insurance carriers for the provision of benefits.....	<b>2e(2)</b>	1036195	
(3) Other.....	<b>2e(3)</b>	3345950	
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		25195575
<b>f</b> Corrective distributions (see instructions).....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances.....	<b>2i(1)</b>		
(2) Contract administrator fees.....	<b>2i(2)</b>	352508	
(3) Recordkeeping fees.....	<b>2i(3)</b>	2067	
(4) IQPA audit fees.....	<b>2i(4)</b>	22460	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	10000	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	30716	
(7) Actuarial fees .....	<b>2i(7)</b>	71300	
(8) Legal fees .....	<b>2i(8)</b>	29284	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>	4753	
(11) Other expenses .....	<b>2i(11)</b>	63084	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		586172
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		25781747

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		2956942
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**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: CALIBRE CPA GROUP PLLC

(2) EIN: 47-0900880

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		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.)

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

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

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



**NECA LOCAL NO. 145 IBEW WELFARE PLAN**

FINANCIAL STATEMENTS

SEPTEMBER 30, 2024





**NECA LOCAL NO. 145 IBEW WELFARE PLAN**

FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of  
NECA Local No. 145 IBEW Welfare Plan  
Moline, Illinois

### Opinion

We have audited the accompanying financial statements of the NECA Local No. 145 IBEW Welfare Plan (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 benefit obligations as of September 30, 2024 and 2023, and the related statements of changes in net assets available for benefits and 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, the net assets available for benefits and benefit obligations of the Plan as of September 30, 2024 and 2023, and the changes in its net assets available for benefits and benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.


### Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of 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 the financial statements are available to be issued.


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

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

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

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

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



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

### **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 reportable transactions are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's (DOL) 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 generally accepted auditing standards.

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 DOL'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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

### **Other Supplemental Information**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the financial statements. 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 auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

*Calibre CPA Group, PLLC*

Chicago, IL  
May 15, 2025



## NECA LOCAL NO. 145 IBEW WELFARE PLAN

### STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

SEPTEMBER 30, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
<b>Assets</b>		
<b>Investments, at fair value</b>	\$ <u>53,553,769</u>	\$ <u>48,113,986</u>
<b>Receivables</b>		
Employer contributions	1,568,264	1,308,798
Reciprocal contributions	247,279	381,742
Claims refunds receivable	631,645	296,468
Accrued interest and dividends	<u>140,155</u>	<u>168,298</u>
Total receivables	<u>2,587,343</u>	<u>2,155,306</u>
<b>Prepaid expenses</b>	<u>36,220</u>	<u>40,088</u>
<b>Cash</b>	<u>(1,135)</u>	<u>929,982</u>
Total assets	<u>56,176,197</u>	<u>51,239,362</u>
<b>Liabilities and Net Assets</b>		
<b>Liabilities</b>		
Accounts payable	9,379	9,218
Due to affiliated funds	21,909	1,660
Reciprocity payable	52,732	127,063
Deferred self-pay contributions	<u>86,160</u>	<u>240,904</u>
Total liabilities	<u>170,180</u>	<u>378,845</u>
<b>Net assets available for benefits</b>	<u>\$ 56,006,017</u>	<u>\$ 50,860,517</u>

See accompanying notes to financial statements.

## NECA LOCAL NO. 145 IBEW WELFARE PLAN

### STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

	2024	2023
<b>Additions</b>		
Contribution income		
Employer contributions - net of reciprocity	\$ 18,265,840	\$ 16,810,777
Participants' self-pay	2,123,220	2,276,139
Total contribution income	20,389,060	19,086,916
Investment income (expense)		
Change in fair value of investments	5,919,591	2,029,831
Interest and dividends	2,430,038	2,517,717
Less: investment expenses	(37,372)	(36,808)
Investment income - net	8,312,257	4,510,740
Total additions	28,701,317	23,597,656
<b>Deductions</b>		
Cost of benefits		
Claims paid (net of refunds)		
Medical and dental	13,595,883	12,752,825
Vision	179,279	171,334
Prescription	2,778,442	2,676,224
Health reimbursement accounts	1,833,927	1,616,195
Disability	237,341	184,479
Life insurance premiums	130,942	121,120
Stop-loss insurance premiums	905,253	856,186
Advocate program services	29,305	31,616
Case management services	122,644	104,367
Drug testing expense	29,238	24,885
Claims administrative fees	973,281	902,854
Family medical center	2,129,773	1,589,672
Health fair expense	21,842	17,784
Members' assistance program	29,799	21,166
PCORI fee	10,068	9,570
Total cost of benefits	23,007,017	21,080,277
General and administrative expenses	548,800	526,248
Total deductions	23,555,817	21,606,525
<b>Net change</b>	5,145,500	1,991,131
<b>Net assets available for benefits</b>		
Beginning of year	50,860,517	48,869,386
End of year	\$ 56,006,017	\$ 50,860,517

See accompanying notes to financial statements.

## NECA LOCAL NO. 145 IBEW WELFARE PLAN

### STATEMENTS OF BENEFIT OBLIGATIONS

SEPTEMBER 30, 2024 AND 2023

	2024	2023
<b>Amounts currently payable to or for participants, beneficiaries and dependents</b>		
Claims payable	\$ 691,470	\$ 882,964
<b>Other obligations for current benefit coverage, at present value of estimated amounts</b>		
Claims incurred but not reported	1,061,822	774,393
Banked dollars	27,723,666	25,959,331
Accumulated balance in participants HRA accounts	12,507,011	12,178,723
Total current obligations	41,292,499	38,912,447
<b>Postretirement benefit obligations (net of amounts currently payable)</b>		
Current retirees	18,768,215	12,098,065
Other participants fully eligible for benefits	12,335,505	9,032,859
Other participants not yet fully eligible for benefits	31,945,915	29,912,010
Total postretirement benefit obligations	63,049,635	51,042,934
Total benefit obligations	\$ 105,033,604	\$ 90,838,345

See accompanying notes to financial statements.

## NECA LOCAL NO. 145 IBEW WELFARE PLAN

### STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

	2024	2023
<b>Amounts currently payable to or for participants, beneficiaries and dependents</b>		
Balance at beginning of year	\$ 882,964	\$ 646,824
Claims and premiums incurred	20,592,950	19,091,824
Claims and insurance premiums paid	<u>(20,784,444)</u>	<u>(18,855,684)</u>
Balance at end of year	<u>691,470</u>	<u>882,964</u>
<b>Other obligations for current benefit coverage, at present value of estimated amounts</b>		
Balance at beginning of year	38,912,447	37,044,792
Increase (decrease) during year attributable to changes in		
Claims incurred but not reported	287,429	(62,311)
Banked dollars	1,764,335	1,053,378
Accumulated balance in participants HRA accounts	<u>328,288</u>	<u>876,588</u>
Balance at end of year	<u>41,292,499</u>	<u>38,912,447</u>
<b>Postretirement benefit obligations (net of amounts currently payable)</b>		
Balance at beginning of year	51,042,934	49,896,890
Increase (decrease) during year attributable to		
Changes in actuarial assumptions	9,609,017	1,047,914
Benefits earned and other changes	1,011,435	(1,810,711)
Interest	2,934,969	2,744,329
Benefits paid	<u>(1,548,720)</u>	<u>(835,488)</u>
Balance at end of year	<u>63,049,635</u>	<u>51,042,934</u>
Total benefit obligations	<u>\$ 105,033,604</u>	<u>\$ 90,838,345</u>

See accompanying notes to financial statements.

# NECA LOCAL NO. 145 IBEW WELFARE PLAN

## NOTES TO FINANCIAL STATEMENTS

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

### NOTE 1. DESCRIPTION OF THE PLAN

The following description of the NECA Local No. 145 IBEW Welfare Plan (the Plan) provides general information only. Participants should refer to the plan document for a more complete description of the Plan's provisions.

**General** - The Plan was established in 1961 under an agreement and declaration of Trust between the Local No. 145 IBEW (the Union) and participating employers. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan's disbursements are under the joint control of union designated and employer designated trustees.

**Benefits** - The Plan provides health benefits which include medical, dental, vision, disability, life insurance and accidental death and dismemberment benefits, as well as a Health Reimbursement Account (HRA) program.

Life insurance and accidental death and dismemberment benefits for active members are provided through an insurance contract with Union Labor Life Insurance Company. All other benefit payments are self-insured.

The Plan has a contract with Amalgamated Life Insurance Company which provides stop-loss protection for claims expenses. The stop-loss attachment point is \$210,000 per claimant per year. Effective April 1, 2024, the Plan has a contract with Stealth Partner Group which provides stop-loss protection for claims expenses. The stop-loss attachment point is \$230,000 per claimant per year.

**Eligibility** - Initial eligibility is based on working 800 hours in a maximum of nine consecutive months. Coverage under the Plan will commence with the first day of the calendar quarter following nine consecutive months during which the individual has a total of 800 hours.

If a member elects accelerated eligibility, coverage under the Plan will commence with the first day of the second month following a period during which the member has earned contributions for a total of 130 hours. The 130 hours must be worked in a maximum of 3 consecutive months.

To remain eligible quarterly, 390 hours of contributions must be paid on a participant's behalf in a contribution quarter per the following schedule:

<u>Contribution Quarters</u>	<u>Coverage Quarters</u>
January - March	July - September
April - June	October - December
July - September	January - March
October - December	April - June



## **NOTE 1. DESCRIPTION OF THE PLAN (CONTINUED)**

Participants who do not meet the continuing eligibility hours requirement may be permitted to maintain their eligibility through the Plan's Dollar Bank program or through self-contributions.

## **NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Method of Accounting** - The accompanying financial statements have been prepared using the accrual basis of accounting. Under this basis, revenue is recognized when earned and expenses are recognized when incurred.

**Employer Contributions Receivable** - The Plan estimates amounts receivable from reporting employers at year-end based upon amounts collected subsequent to year-end. Employer records are subject to audit and additional revenue, if any, which may arise as a result of these audits is recognized when received. Based on a review of historical losses, current economic conditions and supportable and reasonable forecast assumptions, management of the Plan has concluded that any expected credit losses on balances outstanding at year end will be immaterial.

**Deferred Self-Pay Contributions** - Deferred self-pay contributions represent contributions received before year end for eligibility after September 30.

**Reciprocity** - The Board of Trustees (Trustees) have entered into reciprocity agreements with other welfare funds. Under these reciprocity agreements, contributions on behalf of participants working outside of their home Local's jurisdiction will have their contributions reciprocated back to their home Local at the lesser of the home Local's contribution rate or the rate for the area in which they are working.

Reciprocity receivable represents amounts received after year end for work performed through September 30.

Reciprocity payable represents amount paid after year end for work performed through September 30.

**Investment Valuation and Income Recognition** - Investments of the Plan are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price).

Purchases and sales of securities are reported on a trade-date-basis. Dividend income is reported on the ex-dividend date. Interest income is reported on the accrual basis. Increase in fair value of investments includes the Plan's gains and losses on investments bought and sold as well as held during the year.

**Estimates** - The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.



## NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

**Medicare Part D Subsidies** - The recognition of federal subsidies payable under the Medical Modernization Act of 2003 is determined by the actuary and is calculated by estimating a per capita amount applying prescription drug trends for retiree prescription drug plan federal subsidies that the Plan is eligible to receive. The Plan has been determined to be actuarially equivalent to the Medicare Part D Standard Benefit. Effective January 1, 2019, the Plan will be insured and pay premiums under an Employer Group Waiver Plan (EGWP) and will no longer receive subsidies under Medicare Part D.

**Payment of Benefits** - Benefits are recognized when paid.

**Administrative Expenses** - The Plan's expenses are paid by the Plan as provided by the Plan document. Certain expenses incurred in connection with the general administration of the Plan that are paid by the Plan are reported as deductions in the accompanying statements of changes in net assets available for benefits. In addition, certain investment related expenses are included in net appreciation of fair value of investments presented in the accompanying statements of changes in net assets available for benefits.

**New Accounting Pronouncement Adopted** - During the year ended September 30, 2024, the Plan adopted the provisions of Accounting Standards Update (ASU) 2016-13, *Financial Instruments – Credit Losses* (Topic 326). This ASU replaced the incurred loss methodology with an expected loss methodology that is referred to as the current expected credit loss (CECL) methodology. The ASU requires employee benefit plans to immediately recognize the estimated expected credit losses over the life of a financial instrument, including contributions receivable due from employers. The estimate of expected credit losses considers not only historical information, but also current and future economic conditions and events.

The Plan adopted the ASU effective October 1, 2023. The impact of the adoption was not considered material to the financial statements and primarily resulted in additional disclosures.

## NOTE 3. TAX STATUS

The Trust established under the Plan to hold the Plan's net assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC), and, accordingly, the Trust's net investment income is exempt from income taxes. The Trust has obtained a favorable tax determination letter from the Internal Revenue Service (IRS), and the Plan sponsor believes that the Trust, as amended, continues to qualify and operate in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan has analyzed the tax positions taken by the Plan and has concluded that as of September 30, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a



### **NOTE 3. TAX STATUS (CONTINUED)**

liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan believes it is no longer subject to income tax examinations for years prior to the year ended September 30, 2021.

### **NOTE 4. PRIORITIES UPON TERMINATION**

It is the intent of the Trustees to continue the Plan in full force and effect. However, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. Termination shall not permit any part of the Plan assets to be used for or diverted to purposes other than the exclusive benefit of the participants. In the event the Plan terminates, the net assets of the Plan will be allocated as prescribed by ERISA and its related regulations.

### **NOTE 5. CASH CONCENTRATIONS**

The Plan maintains its cash balances in financial institutions deemed to be creditworthy. Balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 per financial institution. At September 30, 2024, cash balances did not exceed the FDIC insured limit. The Trustees do not believe it has a significant risk of loss at this time.

### **NOTE 6. FAIR VALUE MEASUREMENTS**

Accounting standards provide the framework for measuring fair value which 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 (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

- Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
- Level 2 - Inputs to the valuation methodology include other significant observable inputs including:
- 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.

## NOTE 6. FAIR VALUE MEASUREMENTS (CONTINUED)

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

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

Description	Fair Value Measurements at September 30, 2024			
	Total	Quoted Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Money market funds	\$ 4,066,900	\$ 4,066,900	\$ -	\$ -
Certificates of deposit	2,555,839	2,555,839	-	-
Registered investment companies	45,625,190	45,625,190	-	-
U.S. Government agency obligations	1,305,840	1,305,840	-	-
Total investments at fair value	<u>\$ 53,553,769</u>	<u>\$ 53,553,769</u>	<u>\$ -</u>	<u>\$ -</u>

Description	Fair Value Measurements at September 30, 2023			
	Total	Quoted Prices (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Money market funds	\$ 2,220,611	\$ 2,220,611	\$ -	\$ -
Certificates of deposit	3,757,217	3,757,217	-	-
Registered investment companies	41,117,198	41,117,198	-	-
U.S. Government agency obligations	1,018,960	1,018,960	-	-
Total investments at fair value	<u>\$ 48,113,986</u>	<u>\$ 48,113,986</u>	<u>\$ -</u>	<u>\$ -</u>

Following are descriptions 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.

*Registered investment companies, certificates of deposit, and money market funds:* The fair value of the Plan's investments in registered investment companies, certificates of deposit, and money market funds are valued using the quoted prices for identical investments on the active markets they are traded.

*U.S. Government agency obligations:* The fair value of the Plan's investments in U.S. Government agency obligations are valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing values on yields currently available on comparable securities of issuers with similar credit ratings.



## NOTE 7. POSTRETIREMENT BENEFIT OBLIGATIONS

**Postretirement Benefits** - The postretirement benefit obligation represents the total actuarial present value of those estimated future benefits that are attributed to employee service rendered through September 30, 2024 and 2023. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers.

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.

Some of the more significant actuarial assumptions used in the valuations as of September 30, 2024 and 2023 are as follows:

The assumed mortality rates were 100% of the PRI-2012 Blue Collar Mortality Table projected forward using the MP-2021 projection scale.

The discount rate used was 5.00% and 5.75% for September 30, 2024 and 2023, respectively.

The medical trend rate for September 30, 2024 and 2023 was 7.90% annually grading down to 4.00% and 7.90% annually grading down to 4.00%, respectively.

The trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates are increased by one percentage point in each year, it would increase the postretirement obligation as of September 30, 2024 and 2023 by \$11,967,066 and \$8,657,211, respectively.

**Other Plan Benefit Obligations** - Plan obligations at September 30, 2024 and 2023 for claims incurred but not reported at that date and for accumulated eligibility of participants (banked hours) at September 30, 2024 and 2023 are estimated by the Plan. Such estimated amounts are reported in the accompanying statements of the Plan's benefit obligations at present value and are based largely on actual activity after September 30 and hours worked prior to September 30. Accumulated balance in participants HRAs is the balance as of September 30.

## NOTE 8. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 56,006,017	\$ 50,860,517
Amounts currently payable to or for participants, beneficiaries and dependents		
Claims payable	(691,470)	(882,964)
Obligations for current benefit coverage, at present value of estimated amounts		
Claims incurred but not reported	(1,061,822)	(774,393)
Banked dollars	(27,723,666)	(25,959,331)
Accumulated balance in participants HRA accounts	<u>(12,507,011)</u>	<u>(12,178,723)</u>
Net assets available for benefits per Form 5500	<u>\$ 14,022,048</u>	<u>\$ 11,065,106</u>

The following is a reconciliation of benefits paid to participants from the financial statements to the Form 5500 at September 30, 2024:

Total benefits paid to participants per the financial statements	\$ 56,006,017
Increase (decrease) during year attributable to changes in beneficiaries and dependents	
Claims payable	(191,494)
Increase (decrease) in obligations for current benefit coverage, at present value of estimated amounts	
Claims incurred but not reported	287,429
Banked dollars	1,764,335
Accumulated balance in participants HRA accounts	<u>328,288</u>
Total cost of benefits per Form 5500	<u>\$ 58,194,575</u>

The following is a reconciliation of the additions and deductions per the financial statements to the Form 5500 at September 30, 2024:

Total additions per audited financial statements	\$ 28,701,317
Investment management expense	<u>37,372</u>
Total additions per Form 5500	<u>\$ 28,738,689</u>
Total deductions per audited financial statements	\$ 23,555,817
Effects of changes in benefit obligations	2,188,558
Investment management expense	<u>37,372</u>
Total deductions per Form 5500	<u>\$ 25,781,747</u>



## **NOTE 9. CONTRIBUTIONS**

The trust agreement provides that participating employers make contributions to the Plan of a specified amount for each hour worked to provide benefits for employees. The contribution rate is determined by the provision in the applicable collective bargaining agreement. Retired members and surviving dependents of an eligible member may contribute specified amounts, determined by the Plan's actuary, to extend benefit coverage.

## **NOTE 10. 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 that such change could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of accumulated plan benefits is reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimates 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.

## **NOTE 11. RELATED PARTIES AND PARTIES-IN-INTEREST TRANSACTIONS**

The Plan is a limited liability partner of the Midwest Association of Health & Welfare Funds, LLC (company), a claims payment center for the payment of health and welfare benefits. The Plan's share of the capital is 45% and the value of capital is \$18,504 and \$18,429 at September 30, 2024 and 2023, respectively. The Plan paid administrative fees of \$223,085 and \$207,534 for the years ended September 30, 2024 and 2023, respectively, for payment of the Plan's health and welfare claims.

Local No. 145 IBEW Pension Plan, an affiliated pension plan, paid \$20,324 and \$20,089 during the years ended September 30, 2024 and 2023, respectively, in investment expenses for the Plan. There was a payable due to NECA Local No. 145 IBEW Pension Plan of \$40,413 and \$20,089, as of September 30, 2024 and 2023, respectively.

As disclosed in Note 2, the Plan pays certain administrative, investment, and professional fees to various service providers. These transactions are party in interest transactions under ERISA.

## **NOTE 12. SUBSEQUENT EVENTS**

Subsequent events have been evaluated through May 15, 2025, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.



**SUPPLEMENTAL INFORMATION**





**NECA LOCAL NO. 145 IBEW WELFARE PLAN**

SCHEDULES OF GENERAL AND ADMINISTRATIVE EXPENSES

YEARS ENDED SEPTEMBER 30, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Actuarial fees	\$ 71,300	\$ 43,000
Administrative fees	352,508	345,706
Audit and accounting fees	24,527	21,376
Bank charges	3,344	3,684
Computer consulting	8,416	9,780
Conferences and meetings	4,753	800
Insurance	28,454	15,381
Legal fees	29,284	34,745
Membership dues	-	1,640
Office supplies and expenses	<u>26,214</u>	<u>50,136</u>
Total	<u>\$ 548,800</u>	<u>\$ 526,248</u>

# NECA LOCAL NO. 145 IBEW WELFARE PLAN

## SCHEDULE OF ASSETS (HELD AT END OF YEAR)

SEPTEMBER 30, 2024

Form 5500, Part IV, Schedule H, Line 4(i)

E.I.N. No.: 42-6062181  
Plan No.: 501

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Par/Maturity Value or Shares			(d) Cost	Value
		Description	Maturity Date	Rate of Interest		
	Money market funds					
	Instl Insured Money Market	Money market	N/A	N/A	4,066,900	<u>\$ 4,066,900</u> <u>\$ 4,066,900</u>
	Certificates of deposit					
	Amer Natl Bank CD	Certificates of deposit	12/29/25	4.150%	150,000	150,000
	Bankers Bank CD	Certificates of deposit	03/09/26	4.850%	200,000	200,000
	Beal Bank US	Certificates of deposit	04/02/25	2.200%	170,000	170,000
	Beal Bank US	Certificates of deposit	04/09/25	2.250%	230,000	230,000
	BMW Bank CD	Certificates of deposit	10/29/24	2.700%	250,000	250,000
	CIBC Bank CD	Certificates of deposit	06/15/26	4.650%	215,000	215,000
	Discover Bank CD	Certificates of deposit	09/08/26	4.850%	200,000	200,000
	Dollar Savings Bank CD	Certificates of deposit	02/17/26	4.850%	200,000	200,000
	First Federal Savings Bank CD	Certificates of deposit	10/28/24	1.950%	150,000	150,000
	First Internet Bank CD	Certificates of deposit	12/23/25	4.250%	250,000	250,000
	Morgan Stanley Bank CD	Certificates of deposit	09/08/26	4.850%	200,000	200,000
	Peak Bancorp CD	Certificates of deposit	06/09/26	4.550%	185,000	185,000
	UBS Bank CD	Certificates of deposit	07/12/27	4.650%	150,000	150,000
	Total certificates of deposit				<u>2,550,000</u>	<u>2,555,839</u>
	Registered investment companies					
	Aberdeen Emerging Markets ex-China Instl	Registered investment co.	N/A	N/A	130,291	1,613,004
	DFA International Value I	Registered investment co.	N/A	N/A	90,191	1,949,937
	DFA US Small Cap Value I	Registered investment co.	N/A	N/A	52,320	1,419,263
	Driehaus Emerging Markets Small Cap Growth	Registered investment co.	N/A	N/A	75,058	1,613,004
	Fidelity 500 Index Fund	Registered investment co.	N/A	N/A	10,655	1,672,815
	Goldman Sachs International Equity Income	Registered investment co.	N/A	N/A	147,543	2,319,000
	PIMCO Short-Term Instl	Registered investment co.	N/A	N/A	767,617	7,498,290
	T. Rowe Price Small-Cap Stock I	Registered investment co.	N/A	N/A	34,023	950,289
	Vanguard Equity-Income Adm	Registered investment co.	N/A	N/A	143,290	8,063,344
	Vanguard Short-Term Investment-Grade I	Registered investment co.	N/A	N/A	689,122	7,397,638
	Wasatch Core Growth Institutional	Registered investment co.	N/A	N/A	22,813	1,712,576
	Total registered investment companies				<u>36,209,160</u>	<u>45,625,190</u>
	U.S. Government agency obligations					
	UST	U.S. Gov't agency obligations	02/28/25	2.750%	400,000	396,523
	UST	U.S. Gov't agency obligations	07/15/25	3.000%	505,000	503,366
	UST	U.S. Gov't agency obligations	10/15/26	4.625%	400,000	400,875
	Total U.S. Government agency obligations				<u>1,300,764</u>	<u>1,305,840</u>
	Total assets (held at end of year)				<u>\$ 44,126,824</u>	<u>\$ 53,553,769</u>

# NECA LOCAL NO. 145 IBEW WELFARE PLAN

## SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED SEPTEMBER 30, 2024

Schedule H, Part IV, Line 4(j)

E.I.N. No.: 42-6062181  
Plan No.: 501

Description	Purchase Price	Selling Price	Cost of Asset	Fair Value of Asset at Transaction Date	Net Gain or (Loss)
<u>Purchases</u>					
Instl Insured Money Market	\$ 15,573,864	\$ -	\$ 15,573,864	\$ 15,573,864	\$ -
<u>Sales</u>					
Instl Insured Money Market	-	13,727,574	13,727,574	13,727,574	-

# NECA LOCAL NO. 145 IBEW WELFARE PLAN

## SCHEDULE OF ASSETS (HELD AT END OF YEAR)

SEPTEMBER 30, 2024

Form 5500, Part IV, Schedule H, Line 4(i)

E.I.N. No.: 42-6062181  
Plan No.: 501

(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	(c) Description of Investment Including Maturity Date, Rate of Interest, Par/Maturity Value or Shares			Par/Maturity Value or Shares	(d) Cost	Value
		Description	Maturity Date	Rate of Interest			
	Money market funds						
	Instl Insured Money Market	Money market	N/A	N/A	4,066,900	<u>\$ 4,066,900</u>	<u>\$ 4,066,900</u>
	Certificates of deposit						
	Amer Natl Bank CD	Certificates of deposit	12/29/25	4.150%	150,000	150,000	149,410
	Bankers Bank CD	Certificates of deposit	03/09/26	4.850%	200,000	200,000	201,187
	Beal Bank US	Certificates of deposit	04/02/25	2.200%	170,000	170,000	167,682
	Beal Bank US	Certificates of deposit	04/09/25	2.250%	230,000	230,000	226,831
	BMW Bank CD	Certificates of deposit	10/29/24	2.700%	250,000	250,000	249,434
	CIBC Bank CD	Certificates of deposit	06/15/26	4.650%	215,000	215,000	216,026
	Discover Bank CD	Certificates of deposit	09/08/26	4.850%	200,000	200,000	202,246
	Dollar Savings Bank CD	Certificates of deposit	02/17/26	4.850%	200,000	200,000	201,126
	First Federal Savings Bank CD	Certificates of deposit	10/28/24	1.950%	150,000	150,000	149,565
	First Internet Bank CD	Certificates of deposit	12/23/25	4.250%	250,000	250,000	249,312
	Morgan Stanley Bank CD	Certificates of deposit	09/08/26	4.850%	200,000	200,000	203,819
	Peak Bancorp CD	Certificates of deposit	06/09/26	4.550%	185,000	185,000	185,581
	UBS Bank CD	Certificates of deposit	07/12/27	4.650%	150,000	<u>150,000</u>	<u>153,620</u>
	Total certificates of deposit					<u>2,550,000</u>	<u>2,555,839</u>
	Registered investment companies						
	Aberdeen Emerging Markets ex-China Instl	Registered investment co.	N/A	N/A	130,291	1,613,004	1,687,270
	DFA International Value I	Registered investment co.	N/A	N/A	90,191	1,949,937	1,993,229
	DFA US Small Cap Value I	Registered investment co.	N/A	N/A	52,320	1,419,263	2,543,775
	Driehaus Emerging Markets Small Cap Growth	Registered investment co.	N/A	N/A	75,058	1,613,004	1,721,839
	Fidelity 500 Index Fund	Registered investment co.	N/A	N/A	10,655	1,672,815	2,138,752
	Goldman Sachs International Equity Income	Registered investment co.	N/A	N/A	147,543	2,319,000	2,782,671
	PIMCO Short-Term Instl	Registered investment co.	N/A	N/A	767,617	7,498,290	7,399,829
	T. Rowe Price Small-Cap Stock I	Registered investment co.	N/A	N/A	34,023	950,289	2,175,078
	Vanguard Equity-Income Adm	Registered investment co.	N/A	N/A	143,290	8,063,344	13,718,543
	Vanguard Short-Term Investment-Grade I	Registered investment co.	N/A	N/A	689,122	7,397,638	7,208,226
	Wasatch Core Growth Institutional	Registered investment co.	N/A	N/A	22,813	<u>1,712,576</u>	<u>2,255,978</u>
	Total registered investment companies					<u>36,209,160</u>	<u>45,625,190</u>
	U.S. Government agency obligations						
	UST	U.S. Gov't agency obligations	02/28/25	2.750%	400,000	396,523	397,272
	UST	U.S. Gov't agency obligations	07/15/25	3.000%	505,000	503,366	501,015
	UST	U.S. Gov't agency obligations	10/15/26	4.625%	400,000	<u>400,875</u>	<u>407,553</u>
	Total U.S. Government agency obligations					<u>1,300,764</u>	<u>1,305,840</u>
	Total assets (held at end of year)					<u>\$ 44,126,824</u>	<u>\$ 53,553,769</u>

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

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

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

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

OMB Nos. 1210 - 0110  
1210 - 0089

**2023**

**This Form is Open to Public Inspection**

**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.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 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

<b>1a</b> Name of plan <b>NECA LOCAL 145 IBEW WELFARE PLAN</b>	<b>1b</b> Three-digit plan number (PN) ▶ <b>501</b> <b>1c</b> Effective date of plan <b>12/01/1961</b>
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <b>NECA LOCAL 145 WELFARE FUND</b>  <b>1700 52ND AVENUE, SUITE B</b>  <b>MOLINE IL 61265</b>	<b>2b</b> Employer Identification Number (EIN) <b>42-6062181</b> <b>2c</b> Plan Sponsor's telephone number <b>309-757-7558</b> <b>2d</b> Business code (see instructions) <b>238210</b>

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

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

<b>SIGN HERE</b>		<u>5/28/25</u>	<u>TRENT FLETCHER</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		<u>5/28/2025</u>	<u>BRANDON CURRIE</u>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2023)  
v. 230728

# NECA LOCAL NO. 145 IBEW WELFARE PLAN

## SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED SEPTEMBER 30, 2024

Schedule H, Part IV, Line 4(j)

E.I.N. No.: 42-6062181  
Plan No.: 501

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