Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
ARGONNE RETIREE HEALTH REIMBURSEMENT ACCOUNT

1b Three-digit plan number (PN) ▶ 533

1c Effective date of plan 01/01/2017

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
UCHICAGO ARGONNE, LLC
ARGONNE NATIONAL LABORATORY

9700 S. CASS AVENUE
LEMONT, IL 60439

2b Employer Identification Number (EIN) 68-0628477

2c Plan Sponsor's telephone number 630-252-2989

2d Business code (see instructions) 541700

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	07/13/2025	MICHAEL CAIN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address ☐ Same as Plan Sponsor

UCHICAGO ARGONNE, LLC

9700 S. CASS AVENUE
LEMONT, IL 60439

3b Administrator's EIN: 68-0628477

3c Administrator's telephone number: 630-252-2989

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	2008
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	2008
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	1997
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	1997
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

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

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [ ] General assets of the sponsor

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

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

b General Schedules
- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [ ] **A** (Insurance Information) – Number Attached 0
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
ARGONNE RETIREE HEALTH REIMBURSEMENT ACCOUNT

B Three-digit plan number (PN) ▶ 533

C Plan sponsor's name as shown on line 2a of Form 5500
UCHICAGO ARGONNE, LLC

D Employer Identification Number (EIN)
68-0628477

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).. . . . . [X] 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

ALIGHT SOLUTIONS
2300 DISCOVERY DRIVE
ORLANDO, FL 32826

36-2235791

(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

(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

(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

(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)

ALIGHT SOLUTIONS

2300 DISCOVERY DRIVE
ORLANDO, FL 32826

36-2235791

(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 99	RECORD KEEPER	0	Yes [X] No [ ]	Yes [X] No [ ]	45532	Yes [X] No [ ]

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

ANL Plan 533 – Explanation for not attaching Schedule A

The reason that Schedule A is not attached in the Argonne Retiree Health Reimbursement Account (HRA) Form 5500 filing is because Argonne National Laboratory (UCHICAGO ARGONNE) does not have any insurance contract or policy for the HRA.

The Argonne Retiree Health Reimbursement Account ("HRA") offers retirees and their eligible Dependents reimbursement for certain health care costs if they purchase individual Medicare Advantage or Medigap plan coverage through the Aon Retiree Health Exchange. (The Aon Retiree Health Exchange is an independent medical plan exchange for Medicare-Eligible individuals.) The Argonne HRA reimburses expenses that retirees pay out of their pocket, such as premiums for coverage and their share of eligible health care expenses. The Contributions provided under the HRA replaced the Company's subsidy for Medicare-Eligible individuals provided by an Argonne group health plan and the Prescription Drug Plan for Post-65 Retirees as well as the contribution for post-65 retirees participating in the Argonne Group Dental Plan, which ended December 31, 2016.

The Aon Retiree Health Exchange is an independent medical plan exchange that contracts with medical carriers to offer Medicare-eligible individuals a variety of individual Medicare supplemental health care policies and offers assistance in helping individuals choose the one that best meets their health care coverage needs.

Alight Solutions
2300 Discovery Drive
Orlando, FL 32826

alight.com

Proprietary & Confidential

April 21, 2025,

Private and Confidential

Okezie Akandu
Argonne National Laboratory

Dear Okezie Akandu: :

We are providing information on Alight's/Your Spending Account's indirect compensation for 2024 relating to our plan administration services for your Retiree HRA accounts. This information is for purposes of Form 5500, Schedule C disclosure. Please note that we do not know whether you need to file a Schedule C. Many health care accounts are exempt from filing. Whether a filing is needed, is a determination for you and your counsel.

In calendar year 2024, Alight's Your Spending Account (YSA) service received compensation in the amount of $1.90 per HRA account from Aon Retiree Health Exchange for the administration of the retiree health reimbursement arrangement (HRA) sponsored by Argonne National Laboratory . We believe this may be reportable as indirect compensation on the Schedule C.

Indirect Compensation Disclosure

Schedule C requires plan sponsors to report the amount of indirect compensation received by plan service providers. Generally, indirect compensation is fees received from parties other than the plan or plan sponsor, relating to plan services. Not all indirect compensation has to be reported on the Form 5500 Schedule C. Accordingly, you have received two separate disclosure documents.

- The Form 5500 Schedule C Disclosure Summary provides the information that we believe you need to enter on the Form 5500. The information is provided with the corresponding Schedule C line entry, for your convenience.

- The Eligible Indirect Compensation Disclosure provides the information necessary to meet the alternative disclosure requirements for eligible indirect compensation. This information is for your records, but does not have to be reported on the Schedule C.

- Non-monetary Compensation

ANL PLAN 533, Schedule C Disclosure

Non-monetary Compensation

Non-monetary compensation is a form of indirect compensation. Alight's Code of Conduct restricts our employees from receiving cash or non-monetary gifts or gratuities from outside parties, in order to avoid any conflict of interest situations. Accordingly, we have no non-monetary indirect compensation to report.

Please note that Alight may have provided non-monetary compensation, such as meals or business entertainment, to your employees during the plan year. If you believe you have employees who have received non-monetary compensation from all sources of $5,000 or more related to the plan and you would like additional information on amounts provided by Alight, please request a summary of non-monetary compensation paid for the plan year.

Direct Compensation

If your plan is subject to Schedule C filing requirements, the reporting rules for direct compensation have not changed significantly from prior years. Direct compensation is plan fees paid by the plan trust or the plan sponsor. Only direct compensation paid from the plan trust (as opposed to amounts paid by the plan sponsor) is required to be reported on the Schedule C.

To avoid confusion, this disclosure does not contain information relating to our direct compensation. If your plan has a trust, that information has typically been provided by the plan trustee because the trust generally has more accurate information as to the amounts paid by the plan. Of course, we can provide direct compensation information if you request it. However, our information will include all compensation received, not only the amount that was paid from the plan. Accordingly, there may be inconsistencies with any trust records.

Sincerely,

Alight Solutions

Alight Solutions
Carmen Torres

CC:
Leesa Mallek
Okezie Akandu

ANL PLAN 533, Schedule C Disclosure

Health and Welfare Plan Administrative Services Disclosure
Form 5500 Schedule C Disclosure Summary for Recordkeeping and Administrative Services
01/01/2024–12/31/2024

Part 1, Line 1—***Information on person(s) excluded from the remainder of the Schedule C because they received only eligible indirect compensation***

Excluded? *Line 1(a)*	Name *Line 1(b)*	EIN or Address *Line 1(b)*
No	NA	NA

Part 1, Line 2—***Information on service providers receiving direct or indirect compensation***

Name *Line 2(a)*	EIN *Line 2(a)*	Service Code(s) *Line 2(b)*	Relationship to ER, EE, ORG or PII *Line 2(c)*	Direct Comp paid by plan[1] *Line 2(d)*	Did Service Provider receive indirect comp? *Line 2(e)*	Did indirect comp include eligible indirect comp? *Line 2(f)*	Total indirect comp rec'd by service provider excluding eligible indirect comp *Line 2(g)*	Did service provide give formula instead of amount? *Line 2(h)*
Alight	36-2235791	15, 99	Record keeper	Plan sponsor or trustee to determine	Yes	Yes	$0.00	No

Part 1, Line 3—***Information on service providers receiving direct compensation***

Name *Line 3(a)*	Service Codes(s) *Line 3(b)*	Amt of Indirect Comp *Line 3(c)*	Name of Source of Indirect Comp *Line 3(d)*	EIN/Address of Source of Indirect Comp *Line 3(d)*	Description of Indirect Comp (Formula) *Line 3(e)*
N/A	N/A	N/A	N/A	N/A	N/A

[1] Alight does receive direct compensation from the plan and this element 2(d) must be completed on the actual Schedule C. However, to avoid confusion, no amount has been entered in this disclosure. That information is provided by the plan trustee because the trust records are more accurate as to the amounts actually paid by the plan. If you would like information as to

the total compensation we receive, please contact Alight.

Health and Welfare Plan Administrative Services Disclosure
Eligible Indirect Compensation Disclosure for Recordkeeping and Administrative Services
01/01/2024–12/31/2024

This document contains the disclosures required for eligible indirect compensation that Alight has received for calendar year 2024 for Health and Welfare administrative services. Specifically, this information relates to your Health care account administration[1].

This detailed information should be retained for your records. This information is intended to meet the requirements for eligible indirect compensation disclosure. Accordingly, pursuant to the Form 5500 instructions, the detailed information provided below does not have to be included in the submission of the Schedule C.

Name of Source of Eligible Indirect Compensation	Name of Person(s) Receiving Eligible Indirect Compensation	Services Provided or Purpose of Payment for Eligible Indirect Compensation	Annualized Amount or Formula Used to Calculate Eligible Indirect Compensation
Aon Retiree Health Exchange	Alight Solutions	Claims Administrator	$1.90 per HRA account per month

[1] Your Spending Account™ facilitates the HC Account administration on behalf of clients.