

<p><b>Form 5500</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p>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>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan  a DFE (specify) \_\_\_\_\_

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

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

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

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

special extension (enter description)

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

**Part II Basic Plan Information—enter all requested information**

<p><b>1a</b> Name of plan <u>ARGONNE NATIONAL LABORATORY MASTER 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>UCHICAGO ARGONNE, LLC</u> <u>ARGONNE NATIONAL LABORATORY</u></p> <p><u>9700 S. CASS AVENUE</u> <u>LEMONT, IL 60439</u></p>	<p><b>1c</b> Effective date of plan <u>01/01/1948</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>68-0628477</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>630-252-2989</u></p> <p><b>2d</b> Business code (see instructions) <u>541700</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.	07/13/2025	MICHAEL CAIN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	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

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	3807
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	3807
	<b>6a(2)</b>	3896
	<b>6b</b>	263
	<b>6c</b>	0
	<b>6d</b>	4159
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	

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

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

4A 4B 4D 4H 4L 4Q

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

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

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

- b General Schedules**
- (1)  **H** (Financial Information)
  - (2)  **I** (Financial Information – Small Plan)
  - (3)  **A** (Insurance Information) – Number Attached 7
  - (4)  **C** (Service Provider Information)
  - (5)  **D** (DFE/Participating Plan Information)
  - (6)  **G** (Financial Transaction Schedules)

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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

**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 \_\_\_\_\_

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

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

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

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	(c) Amount	(d) Purpose	

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<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>	0
<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>	0

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		184904
<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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER WELFARE PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶ <b>501</b></p>	
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>UCHICAGO ARGONNE, LLC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>68-0628477</b></p>	

**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  
**LIFE INSURANCE COMPANY OF NORTH AMERICA (LIFE INSURANCE)**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
<b>23-1503749</b>	<b>65498</b>	<b>FLX960856</b>	<b>3344</b>	<b>01/01/2024</b>	<b>12/31/2024</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.

(a) Total amount of commissions paid <b>0</b>	(b) Total amount of fees paid <b>31990</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  
**WATCHTOWER TECHNOLOGIES INC. 306 WEST ERIE STREET FLOOR 3 CHICAGO, IL 60654**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	<b>21990</b>	<b>SERVICE FEES</b>	<b>3</b>

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**B&B INSURANCE AGENCY OF VA INC. 11220 ASSET LOOP SUITE 304 MANASSAS, VA 20109**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	<b>10000</b>	<b>OVERRIDES</b>	<b>3</b>

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

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

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

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

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

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

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

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

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

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

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<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>	0
<b>e</b> Deductions:	<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>	0

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		1465979
<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. ▶



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

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

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

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<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>	0
<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>	0

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

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

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

**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>	0
<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>	0
(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>	0
(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>	13014
<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. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER 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>UCHICAGO ARGONNE, LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>68-0628477</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  
**AETNA LIFE INSURANCE COMPANY (STOP LOSS)**

<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>06-6033492</b>	<b>60054</b>	<b>0187704-SL</b>	<b>3552</b>	<b>01/01/2024</b>	<b>12/31/2024</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>(b)</b> Total amount of fees paid
---	--------------------------------------

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

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

<b>(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	

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0	
<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>	0	
<b>e</b> Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year		<b>7e(1)</b>
	(2) Administration charge made by carrier.....		<b>7e(2)</b>
	(3) Transferred to separate account .....		<b>7e(3)</b>
	(4) Other (specify below) .....		<b>7e(4)</b>
(5) Total deductions .....	<b>7e(5)</b>	0	
<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>	0	

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		2312394
<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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER WELFARE PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>UCHICAGO ARGONNE, LLC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>68-0628477</b></p>	

**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  
**UNUM LIFE INSURANCE COMPANY OF AMERICA (LONG TERM DISABILITY)**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
01-0278678	62235	917625	3086	01/01/2024	12/31/2024

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

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;">24849</p>
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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

**BROWN & BROWN INSURANCE SERVICES**      **901 MARQUETTE AVENUE**  
**SUITE 1800**  
**MINNEAPOLIS, MN 55402**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	24849	ADDITIONAL COMPENSATION	3

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

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

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

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

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

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

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

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

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

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

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

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

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<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>	0
<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>	0

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		1200122
<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

**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**

<b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER 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>UCHICAGO ARGONNE, LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>68-0628477</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

**DELTA DENTAL OF ILLINOIS**

<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>36-2612058</b>	<b>47589</b>	<b>20084</b>	<b>3666</b>	<b>01/01/2024</b>	<b>12/31/2024</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>(b)</b> Total amount of fees paid
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

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

<b>(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	

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	0
<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>	0
<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>	0

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		129303
<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. ▶

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER WELFARE PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>UCHICAGO ARGONNE, LLC</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>68-0628477</b></p>	

**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  
**FIRST UNUM LIFE INSURANCE COMPANY (LONG TERM DISABILITY)\_**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1898173	64297	918241	8	12/01/2024	12/31/2024

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

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;">24</p>
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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

**BROWN & BROWN INSURANCE SERVICES**      **901 MARQUETTE AVENUE**  
**SUITE 1800**  
**MINNEAPOLIS, MN 55402**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<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** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

<b>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>	0
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
(5) Total deductions .....	<b>7e(5)</b>	0
<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>	0

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

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

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

**9** Experience-rated contracts:

<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>	0
<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>	0
	(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>	0
	(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>		1185
<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>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<b>A</b> Name of plan <b>ARGONNE NATIONAL LABORATORY MASTER 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>UCHICAGO ARGONNE, LLC</b>	<b>D</b> Employer Identification Number (EIN) <b>68-0628477</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>EXPRESS SCRIPTS, INC.</b>	<b>1 EXPRESS WAY ST. LOUIS, MO 63121</b>
<b>43-1420563</b>	

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

<b>AETNA LIFE INSURANCE COMPANY</b>	<b>151 FARMINGTON AVENUE HARTFORD, CT 06156</b>
<b>06-6033492</b>	

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

<b>ALLONE HEALTH</b>	<b>100 N. PENNSYLVANIA AVENUE WILKES-BARRE, PA 18701</b>
<b>36-3444982</b>	

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

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

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

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

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

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**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)

EXPRESS SCRIPTS, INC.

1 EXPRESS WAY  
ST. LOUIS, MO 63121

43-1420563

(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 50 62 99	PHARMACY BENEFIT MGMT	1014744	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

AETNA LIFE INSURANCE COMPANY

151 FARMINGTON AVENUE  
HARTFORD, CT 06156

06-6033492

(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	CONTRACT ADMINISTRATOR	2799770	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	60307	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

ALLONE HEALTH

100 N PENNSYLVANIA AVENUE  
WILKES-BARRE, PA 18701

36-3444982

(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	84797	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
EXPRESS SCRIPTS, INC.	12 50 62 99	0
(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.	
EXPRESS SCRIPTS, INC.  43-1420563	1 EXPRESS WAY ST. LOUIS, MO 63121	ESI RX BILLS DRUG MANUFACTURERS FOR REBATES BASED UPON ITS AGREEMENTS WITH THESE MANUFACTURERS. FROM THE TIME THAT ESI RX RECEIVES REBATES UNTIL IT DISTRIBUTES REBATES, IT ACCRUES INTEREST AT THE CURRENT BANK RATE. THIS RATE HAS BEEN LESS THAN 1%.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
AETNA LIFE INSURANCE COMPANY	13	2799770
(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.	
AETNA LIFE INSURANCE COMPANY  06-6033492	151 FARMINGTON AVENUE HARTFORD, CT 06156	0
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
ALLONE HEALTH	13	0
(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.	
ALLONE HEALTH  36-3444982	100 N PENNSYLVANIA AVENUE WILKES-BARRE, PA 18701	0

**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:



ERISA 5500 SC  
PO BOX 818091  
CLEVELAND OH 44181

\*000371\*J1KNERE\*000907\*

**Important Document Enclosed**

**March 19, 2025**

**ANL Plan 501 - AETNA Schedule A Information**

UCHICAGO ARGONNE LLC  
KATHY PIPAL  
9700 S. CASS AVENUE  
LEMONT IL 60439

**Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)  
For: UCHICAGO ARGONNE LLC  
0187704-SL  
Policy Period: January 01, 2024 through December 31, 2024**

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Life Insurance Co. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.

Information may also be included in the enclosure(s) for your consideration in completing Schedule C of your Form 5500. This information may consist of one or more of the following: Producer Service Fees, Indirect Compensation (as it pertains to meals and entertainment) and/or Direct Billed Fees. Information pertaining to Indirect Compensation and Direct Billed Fees is provided on a calendar year basis, which may not coincide with your plan year.

If you have other benefits plans with Aetna Life Insurance Co., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Life Insurance Co. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Life Insurance Co.

Enclosure

## ANL Plan 501 - AETNA Schedule A Information



INSURANCE INFORMATION  
**AETNA LIFE INSURANCE COMPANY  
 AND AFFILIATES**

The following information is intended for your use in completing Schedule A of Form 5500.

For Fiscal Plan Year beginning 01/01/2024 and ending 12/31/2024

C. Name of the Plan Sponsor: UCHICAGO ARGONNE LLC

**PART I** Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: Traditional Prospective

(a) Name of Insurance Carrier: Aetna Life Insurance Co.	(d) Contract Number or Identification: 0187704-SL	(e) Approximate Number of persons covered at the end of policy or contract year: <b>3,552</b>	Policy or contract Year	
(b) EIN: 06-6033492			(f) From: 01/01/2024	(g) To: 12/31/2024
(c) NAIC Code: See Attached Listing				

2. Insurance Fees and commissions paid to agents and brokers:

Contract or Identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
0187704-SL				
<b>TOTAL</b>				

Reported fees and commissions may be attributed to multiple Aetna companies.

**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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

7. Benefit and contract type (check all applicable boxes)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Health (other than dental or vision)         | <input type="checkbox"/> Dental                | <input type="checkbox"/> Vision                    | <input type="checkbox"/> Life Insurance     |
| <input type="checkbox"/> Temporary disability (accident and sickness) | <input type="checkbox"/> Long-term disability  | <input type="checkbox"/> Supplemental unemployment | <input type="checkbox"/> Prescription drug  |
| <input checked="" type="checkbox"/> Stop loss (large deductible)      | <input type="checkbox"/> HMO contract          | <input type="checkbox"/> PPO contract              | <input type="checkbox"/> Indemnity contract |
| <input type="checkbox"/> Accidental Death & Dismemberment             | <input type="checkbox"/> Short Term Disability |  |   |

8. Experience rated contracts: NA

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier..... \$2,312,393.60

(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 2 above, report amount .....  
 Specify nature of costs -->

This information was generated as of 03/13/2025

Date 03/13/2025 FINAL RELEASE  
Scott Shade  
 Registrar

**AETNA LIFE INSURANCE COMPANY AND AFFILIATES**  
 hereby certifies that the foregoing statement is  
 complete and accurate

ANL Plan 501 - AETNA Schedule A Information

<b><u>NAIC Code</u></b>	<b><u>Service Area</u></b>
95094	Aetna Health Inc. (a Georgia Corporation)
95003	Aetna Health Inc. (an Arizona Corporation)
60054	Aetna Life Insurance Company
N/A	Aetna Dental of California Inc.
11183	Aetna Dental Inc (a New Jersey Corporation)
95910	Aetna Dental Inc (a Texas Corporation)



## ERISA Form 5500 Information

The following information is related to your self insured benefits program in order to complete the Schedule C of Form 5500 ("Service Provider Information" & "Financial Information"). For further clarification on reporting requirements, you should contact your company's tax attorney or legal counsel.

In the event that your request occurs prior to the completion of the annual accounting, provided information is estimated at this time.

### General Information

Name of Contract Holder:	Uchicago Argonne LLC		
Customer Number:	187704		
Plan Year:	January 1, 2024	through	December 31, 2024

### Part I - Service Provider Information

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

##### (a) Name and EIN

Legal Entity:	Aetna Life Insurance Company
Address:	151 Farmington Ave. Hartford, CT 06156
Tax Identification Number:	06-6033492

(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	Contract Administrator	\$2,799,770	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

The information included here reflects currently available amounts of direct and indirect compensation related to services provided by Aetna to your plan. We will provide additional information regarding indirect compensation through supplemental documentation, as applicable.

#### Please note for plans including pharmacy:

Although the following amounts are not included or required in this disclosure, you should be aware that Aetna's PBM may (i) employ spread pricing and retain any positive margin resulting therefrom and (ii) retain or share pharmaceutical company rebates with its customers at its discretion.

You should also be aware that Aetna may receive a percentage of banking fees paid by health care providers who elect to use one of our third-party electronic payment programs. The percentage of banking fees that Aetna may receive varies under each program depending on the aggregate annual amount of all payments received by health care providers through such programs.

Date Prepared: 03/25/2025



## Schedule C (Form 5500) Worksheet

**Contract Holder:** Uchicago Argonne LLC  
**Customer Number:** 187704  
**Plan Year Start Date:** January 1, 2024  
**Plan Year End Date:** December 31, 2024

**Direct Compensation:** Payments made directly by the plan for services rendered to the plan.

Subscriber Count - Traditional	3,608
--------------------------------	-------

Description	Amount
Paid Administrative Fees - Traditional	\$1,773,325
Direct Billed Charges Paid	\$13,000
ASC Surplus Paid Current Year	(\$11,100)
Claim Wire Billed Charges*	\$1,024,546

<b>Total Direct Compensation</b>	<b>\$2,799,770</b>
----------------------------------	--------------------

<b>*Claim Wire Billed Detail</b>	
National Advantage Program (NAP)	\$228,468
No Surprise Billing (Arbitration and NSA Admin fees)	\$133,077
Overpayment Recovery	\$121,123
Teladoc PMPM	\$19,178
Claim and Code Review Program	\$450,520
Enhanced Maternity-Maven	\$72,180

**Schedule C (Form 5500) Worksheet**

**Contract Holder:** Uchicago Argonne LLC  
**Customer Number:** 187704  
**Plan Year Start Date:** January 1, 2024  
**Plan Year End Date:** December 31, 2024

**Indirect Compensation:** Compensation received from sources other than directly from the plan.

Description	Amount
Meals/Entertainment	\$307
Commission Bonus	\$60,000
CVS Caremark	\$0
<b>Total Indirect Compensation</b>	<b>\$60,307</b>



100 N Pennsylvania Ave, Wilkes-Barre, PA, 18701-3503

February 12, 2025

Okezie Akandu  
Benefits Accountant  
Argonne National Laboratory  
9700 S Cass Ave.  
Lemont, IL 60439

RE: 5500: Schedule C



Dear Okezie:

Pursuant to your request for information contained within your email of February 12, 2025 the following is provided.

**AllOne Health**                      **Tax ID (EIN)**                      **36-3444982**  
Compensation paid to Perspectives for EAP services from **Argonne National Laboratory** for the period **1/1/2024 through 12/31/2024**.

Participant count	4,140
Indirect compensation, service fees	\$84,796.68
Brokerage commission, fees etc	\$ - 0 -
Float revenues	\$ - 0 -
Soft dollar commissions	\$ - 0 -
Investment service fees	\$ - 0 -
Custodial fees	\$ - 0 -
Record keeping fees	\$ - 0 -
Finder's fees	\$ - 0 -
Research fees	\$ - 0 -
Shareholder fees	\$ - 0 -
Meals and gifts	\$ - 0 -

If you need any additional information please do not hesitate to call me @ direct: 312-558-1578 or email me at [Stephanie.Jackson@allonehealth.com](mailto:Stephanie.Jackson@allonehealth.com).

Sincerely,

*Stephanie Jackson*

Stephanie Jackson, MA  
Senior Account Manager  
100 N Pennsylvania Ave,  
Wilkes-Barre, PA,  
18701-3503

New York Life Group Benefit Solutions  
P.O. Box 20643  
Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
SOLUTIONS

UChicago Argonne, LLC.  
9700 S Cass Ave  
Building 201  
Argonne IL 60439

January 9, 2025

Dear Valued Customer:

The enclosed report provides some important information regarding your group insurance policy for the recently completed policy year. This information includes, among other things, total premiums paid, as well as compensation paid to agents or brokers in connection with your policy.

If your policy is issued in connection with an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), then you will find this information useful in preparing the ERISA annual report (Form 5500). Please contact your attorney or benefits consultant if you have questions regarding the applicability of ERISA to your plan, Form 5500, or other requirements. We hereby certify that the information provided here is accurate and complete.

If your policy is not subject to ERISA, then we are providing this information as a service, for your use in the management of your benefit plan. Our goal is to provide the highest degree of service to our customers, and we are committed to providing this important information to you.

This information may include an entry which shows other compensation received by your broker from New York Life Group Benefit Solutions, in addition to commissions. New York Life Group Benefit Solutions companies offer programs under which agents and brokers can qualify for additional compensation, for providing our insurance companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. This additional compensation may be paid either as an override (contingent on meeting new sales and persistency goals), or as a supplemental commission (measured as a percentage of premium). For plans subject to ERISA and required to file Form 5500, the U.S. Department of Labor has advised that such payments must be reported on Schedule A of Form 5500. Thus, if your broker received a payment during the policy year under one of these programs, a portion (equal to the amount, which was based on premiums or commissions, that was paid with respect to the policy) has been allocated and is included with the Schedule A information that is enclosed. While this compensation has been, for this purpose, allocated to specific policies, it is funded from our general overhead for all policies, regardless of whether a broker participates in these agreements.

Your agent or broker may also have participated, at the insurance company's expense, in producer events sponsored by our insurance companies during which information concerning our products and services was exchanged. Please contact your agent or broker if you would like specific information about their participation in these programs. In addition, the insurance company offers agents and brokers the opportunity to receive the benefit of New York Life's favorable pricing with vendors of various goods and services.

New York Life Group Benefit Solutions has a longstanding commitment to our customers to deliver the highest level of quality service. Millions of individuals continue to rely on New York Life Group Benefit Solutions for the insurance protection they need. We value the trust our customers place in us, and unwaveringly pledge to adhere to ethical business standards.

Sincerely,

  
*Carol L. Bailey*  
Carol L. Bailey  
Revenue Management

New York Life Group Benefit Solutions  
 P.O. Box 20643  
 Lehigh Valley, PA 18002-0643



GROUP BENEFIT SOLUTIONS

UChicago Argonne, LLC.  
 9700 S Cass Ave  
 Building 201  
 Argonne, IL 60439

Date Prepared: January 9, 2025

Anniversary  
**Annual Policy Information Report**

Name of Insurance Carrier	
Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	FLX0960856
Contract/Policy Year From:	01/01/2024
Contract/Policy Year To:	12/31/2024

Policy or Benefit Type
BTL Fully Insured Basic Group
VTL Fully Insured Voluntary Group

Approximate Number of persons covered at the end of the policy year:\*

*\*Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: \$ 1,465,978.93

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
CGI-053494	WatchTower Technologies Inc dba ThreeFlo 306 W ERIE ST FLOOR 3 CHICAGO IL 60654	\$ 0.00	\$ 21,989.68	Service Fees
CGI-004829	BROWN & BROWN INSURANCE AGENCY OF VA INC 11220 ASSET LOOP SUITE 304 MANASSAS VA 20109	\$ 0.00	\$ 10,000.00	Overrides
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact a Revenue Management representative at 800.243.7445.



FORM 5500 INFORMATION

Delta Dental of Illinois  
FEIN: 36-2612058  
NAIC Code: 047589

Delta Dental of Illinois is providing the following information that you may need to complete Form 5500 and related schedules to comply with the requirements of the Employee Retirement Income Security Act of 1994 ("ERISA"). You should contact your own advisors to address any questions you may have on whether certain plan disclosure and reporting requirements apply to your organization and, if the requirements apply, how to complete Form 5500 and related schedules.

- 1. Name of Company: UCHICAGO ARGONNE, LLC
- 2. Group Number: 20084
- 3. Period Covered: 1/1/24 - 12/31/24
- 4. Approximate Number of Persons Covered at end of Contract Period: 3,666
- 5. Premium/Administrative Fees Paid, as applicable: \$129,303.08
- 6. Commissions and Service Fees:

	All Brokers
Base Commissions: <sup>1</sup>	
Other Fees and Commissions: <sup>2</sup>	
Special programs and/or bonuses: <sup>3</sup>	\$0.00

1. These are the commissions we have paid to your broker of record in connection with your benefit program.  
 2. These are other commission we have paid – for example, general agent commissions – in connection with your benefit program.  
 3. These are based on a broker's/consultant's total volume: The portion of the bonus allocated to your benefit program is calculated as follows: your eligible volume is divided by the broker's/consultant's total volume and that fraction is multiplied by the total bonus. This allocation is based on the calendar year book of business.

New York Life Group Benefit Solutions  
P.O. Box 20643  
Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
SOLUTIONS

UChicago Argonne, LLC.  
9700 S Cass Ave  
Building 201  
Argonne IL 60439

January 9, 2025

Dear Valued Customer:

The enclosed report provides some important information regarding your group insurance policy for the recently completed policy year. This information includes, among other things, total premiums paid, as well as compensation paid to agents or brokers in connection with your policy.

If your policy is issued in connection with an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), then you will find this information useful in preparing the ERISA annual report (Form 5500). Please contact your attorney or benefits consultant if you have questions regarding the applicability of ERISA to your plan, Form 5500, or other requirements. We hereby certify that the information provided here is accurate and complete.

If your policy is not subject to ERISA, then we are providing this information as a service, for your use in the management of your benefit plan. Our goal is to provide the highest degree of service to our customers, and we are committed to providing this important information to you.

This information may include an entry which shows other compensation received by your broker from New York Life Group Benefit Solutions, in addition to commissions. New York Life Group Benefit Solutions companies offer programs under which agents and brokers can qualify for additional compensation, for providing our insurance companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. This additional compensation may be paid either as an override (contingent on meeting new sales and persistency goals), or as a supplemental commission (measured as a percentage of premium). For plans subject to ERISA and required to file Form 5500, the U.S. Department of Labor has advised that such payments must be reported on Schedule A of Form 5500. Thus, if your broker received a payment during the policy year under one of these programs, a portion (equal to the amount, which was based on premiums or commissions, that was paid with respect to the policy) has been allocated and is included with the Schedule A information that is enclosed. While this compensation has been, for this purpose, allocated to specific policies, it is funded from our general overhead for all policies, regardless of whether a broker participates in these agreements.

Your agent or broker may also have participated, at the insurance company's expense, in producer events sponsored by our insurance companies during which information concerning our products and services was exchanged. Please contact your agent or broker if you would like specific information about their participation in these programs. In addition, the insurance company offers agents and brokers the opportunity to receive the benefit of New York Life's favorable pricing with vendors of various goods and services.

New York Life Group Benefit Solutions has a longstanding commitment to our customers to deliver the highest level of quality service. Millions of individuals continue to rely on New York Life Group Benefit Solutions for the insurance protection they need. We value the trust our customers place in us, and unwaveringly pledge to adhere to ethical business standards.

Sincerely,



*Carol L. Bailey*

Carol L. Bailey  
Revenue Management

New York Life Group Benefit Solutions  
 P.O. Box 20643  
 Lehigh Valley, PA 18002-0643



GROUP BENEFIT SOLUTIONS

UChicago Argonne, LLC.  
 9700 S Cass Ave  
 Building 201  
 Argonne, IL 60439

Date Prepared: January 9, 2025

Anniversary  
**Annual Policy Information Report**

Name of Insurance Carrier	
Life Insurance Company of North America	
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	ABL0652339
Contract/Policy Year From:	01/01/2024
Contract/Policy Year To:	12/31/2024

Policy or Benefit Type
BTA Fully Insured Basic Group
BTA WAR Fully Insured Basic Group

Approximate Number of persons covered at the end of the policy year:\*

*\*Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: \$ 13,014.00

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
CGI-004829	BROWN & BROWN INSURANCE AGENCY OF VA INC 11220 ASSET LOOP SUITE 304 MANASSAS VA 20109	\$ 0.00	\$ 34.57	Overrides
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact a Revenue Management representative at 800.243.7445.**

New York Life Group Benefit Solutions  
P.O. Box 20643  
Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
SOLUTIONS

UChicago Argonne, LLC.  
9700 S Cass Ave  
Building 201  
Argonne IL 60439

January 9, 2025

Dear Valued Customer:

The enclosed report provides some important information regarding your group insurance policy for the recently completed policy year. This information includes, among other things, total premiums paid, as well as compensation paid to agents or brokers in connection with your policy.

If your policy is issued in connection with an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), then you will find this information useful in preparing the ERISA annual report (Form 5500). Please contact your attorney or benefits consultant if you have questions regarding the applicability of ERISA to your plan, Form 5500, or other requirements. We hereby certify that the information provided here is accurate and complete.

If your policy is not subject to ERISA, then we are providing this information as a service, for your use in the management of your benefit plan. Our goal is to provide the highest degree of service to our customers, and we are committed to providing this important information to you.

This information may include an entry which shows other compensation received by your broker from New York Life Group Benefit Solutions, in addition to commissions. New York Life Group Benefit Solutions companies offer programs under which agents and brokers can qualify for additional compensation, for providing our insurance companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. This additional compensation may be paid either as an override (contingent on meeting new sales and persistency goals), or as a supplemental commission (measured as a percentage of premium). For plans subject to ERISA and required to file Form 5500, the U.S. Department of Labor has advised that such payments must be reported on Schedule A of Form 5500. Thus, if your broker received a payment during the policy year under one of these programs, a portion (equal to the amount, which was based on premiums or commissions, that was paid with respect to the policy) has been allocated and is included with the Schedule A information that is enclosed. While this compensation has been, for this purpose, allocated to specific policies, it is funded from our general overhead for all policies, regardless of whether a broker participates in these agreements.

Your agent or broker may also have participated, at the insurance company's expense, in producer events sponsored by our insurance companies during which information concerning our products and services was exchanged. Please contact your agent or broker if you would like specific information about their participation in these programs. In addition, the insurance company offers agents and brokers the opportunity to receive the benefit of New York Life's favorable pricing with vendors of various goods and services.

New York Life Group Benefit Solutions has a longstanding commitment to our customers to deliver the highest level of quality service. Millions of individuals continue to rely on New York Life Group Benefit Solutions for the insurance protection they need. We value the trust our customers place in us, and unwaveringly pledge to adhere to ethical business standards.

Sincerely,

  
*Carol L. Bailey*  
Carol L. Bailey  
Revenue Management

New York Life Group Benefit Solutions  
 P.O. Box 20643  
 Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
 SOLUTIONS

UChicago Argonne, LLC.  
 9700 S Cass Ave  
 Building 201  
 Argonne, IL 60439

Date Prepared: January 9, 2025

Anniversary  
**Annual Policy Information Report**

Name of Insurance Carrier	Life Insurance Company of North America
EIN	23-1503749
NAIC Code	65498
Contract/Policy Number	OK 0960750
Contract/Policy Year From:	01/01/2024
Contract/Policy Year To:	12/31/2024

Policy or Benefit Type
BACC Fully Insured Basic Group
VACC Fully Insured Voluntary Group
Participant Accident Basic Insurance Group

Approximate Number of persons covered at the end of the policy year:\*

*\*Please refer to your census reports or billing statement for this information.*

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: \$ 184,904.36

See below for total commissions and fees paid by Insurance Company during the policy year.

Agent Number	Name and Address of Each Recipient of Fees and/or Commissions	Amount of Commissions Paid	Amount of Fees Paid	Purpose for Which Paid
CGI-05349	WatchTower Technologies Inc dba ThreeFlo 306 W ERIE ST FLOOR 3 CHICAGO IL 60654	\$ 0.00	\$ 2,773.57	Service Fees
CGI-00482	BROWN & BROWN INSURANCE AGENCY OF VA INC 11220 ASSET LOOP SUITE 304 MANASSAS VA 20109	\$ 0.00	\$ 1,233.67	Overrides
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	

**If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact a Revenue Management representative at 800.243.7445.**



Unum  
1 Fountain Square  
Chattanooga, TN 37402

## ANL Plan 501 UNUM Contract # 917625 Schedule A Information

March 08, 2025

UCHICAGO ARGONNE, LLC  
HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION  
9700 S. CASS AVE  
LEMONT, IL 60439

### PERSONAL & CONFIDENTIAL

Contract/Policy No: 000000917625

Re: Employee Retirement Income Security Act of 1974 (ERISA)  
Insurance Information Schedule A (Form 5500)

Unum's policy is to fully disclose and report all compensation associated with the insurance plans we offer in accordance with our internal guidelines and with all applicable regulations. We are pleased to certify the reported Schedule A data with respect to the filing of an ERISA Form 5500 Annual Report.

This information is forwarded to you in the event your company has determined it is required to make this filing. Unum does not take any position or provide any advice on ERISA's applicability to any of your company's benefit plans.

The enclosed Primary Schedule A data is reported by the insuring company and includes all Base Commissions, Supplemental Compensation and Fees paid to a broker/entity for this policy issued by the insuring company during the plan year as reported through Unum's commission systems. If no plan year has been specified in our records the information is for the period reported on the form.

Base Commissions are a fixed percentage of the policy premium, and may include a one time flat amount. If no compensation has been paid, this figure will be zero (.00). If Base Commission is reported, it will be reflected under the Sales Commissions Paid column.

Supplemental Compensation, other than Base Commissions, may be received by a broker/entity for this policy. If no Supplemental Compensation has been paid, this figure will be zero (.00). If Supplemental Compensation is reported, it will be reflected under the Additional Compensation Paid column.

In some instances a broker/entity may receive a Fee for services provided to the policyholder. If no Fee has been paid, this figure will be zero (.00). If a fee is reported, it will be reflected under the Fees Paid column.

The Supplemental Schedule A data identifies any additional or other compensation including, but not limited to, any final payments under prior incentive plans, overrides, and non-cash compensation. If no such additional or other compensation has been paid, this figure will be zero (.00).

If you have any questions regarding the enclosed data or think that you may have received this information in error, contact us at 1-800-ASK-UNUM (1-800-275-8686) or email us at AskUnum@unum.com. We would be glad to assist you with any questions relating to Unum insurance coverages or broker compensation. However, we may not provide legal advice on the applicability of particular laws or regulations to your company. For these issues, you should consult your company's attorneys or other advisors.

We appreciate this opportunity to provide service to you.

### Broker Compensation Services

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

**SUPPLEMENTAL COMPENSATION DATA FOR SCHEDULE A (FORM 5500)**

As required by Section 104 of the Employee Retirement Income Security Act of 1974. Premium and commission data is provided on the Primary insurance form. This is intended to comply with various regulators' reporting and disclosure requirements, including the Department of Labor.

Prepared for: UCHICAGO ARGONNE, LLC

1. Name of carrier, service or other organization:

Unum Life Insurance Company of America

Tax ID: 010278678      NAIC: 62235

2. Contract Number: 000000917625

3. Date for period: from 2024-01-01 to 2025-01-01

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4. Additional Broker Compensation:

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Name and Address of Agent, Broker or other entity receiving compensation:	Amount of Additional Compensation Paid	Amount of Additional Fees Paid
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No Additional Compensation



\*0000000206250006250S\*

03/13/2025

UCHICAGO ARGONNE, LLC  
 HUMAN RESOURCES DEPARTMENT - OFFICIAL ERISA NOTIFICATION  
 9700 S. CASS AVE  
 LEMONT IL 60439

00917625  
 J5\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)  
 AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: UCHICAGO ARGONNE, LLC

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:  
 Unum Life Insurance Company of America  
 TAX ID: 010278678 NAIC: 62235
2. CONTRACT NUMBER: 917625
3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 3086
4. DATE FOR PERIOD: FROM 01-01-2024 TO 01-01-2025

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 5. INSURANCE FEES AND COMMISSION INFORMATION:  
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NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
Brown & Brown Insurance Servic Ste 700 80 South 8th St Minneapolis MN 55402	.00	.00	24,849.35
Brown & Brown Insurance Servic Suite 700 80 South 8th St Minneapolis MN 55402	.00	.00	.00
Brown & Brown - Headquarters PO Box 2412 Daytona Beach FL 32115	.00	.00	.00
Brown & Brown Insurance Servic Ste 700 80 South 8th St Minneapolis MN 55402	.00	.00	.00

6. COVERAGE/BENEFITS PROVIDED: LTD
7. NON-PARTICIPATING CONTRACTS (PREMIUMS):
  - (A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....\$ 1,200,122.40
  - (B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....\$ .00
  - (C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....\$ .00

J5\DM

ANL Plan 501 UNUM Contract # 917625 Schedule A Information

00918241  
 J5\DM

INSURANCE DATA FOR SCHEDULE A (FORM 5500)  
 AS REQUIRED BY SECTION 104 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF  
 1974. ADDITIONAL COMPENSATION DATA IS PROVIDED ON THE SUPPLEMENTAL COMPENSATION  
 FORM. THIS IS INTENDED TO COMPLY WITH VARIOUS REGULATORS' REPORTING AND  
 DISCLOSURE REQUIREMENTS, INCLUDING THE DEPARTMENT OF LABOR.

PREPARED FOR: UCHICAGO ARGONNE, LLC

1. NAME OF CARRIER, SERVICE OR OTHER ORGANIZATION:

First Unum Life Insurance Company

TAX ID: 131898173 NAIC: 64297

2. CONTRACT NUMBER: 918241

3. APPROXIMATE NUMBER OF PERSONS COVERED AT END OF POLICY YEAR: 008

4. DATE FOR PERIOD: FROM 01-01-2024 TO 01-01-2025

5. INSURANCE FEES AND COMMISSION INFORMATION:

NAME AND ADDRESS OF EACH SOLICITING AGENT OR BROKER RECEIVING COMPENSATION:	SALES COMMISSION PAID	FEES PAID	ADDITIONAL COMPENSATION PAID
Brown & Brown Insurance Servic Ste 700 80 South 8th St Minneapolis MN 55402	.00	.00	23.71
Brown & Brown - Headquarters PO Box 2412 Daytona Beach FL 32115	.00	.00	.00

6. COVERAGE/BENEFITS PROVIDED: DBL

7. NON-PARTICIPATING CONTRACTS (PREMIUMS):

(A) TOTAL PREMIUM OR SUBSCRIPTION CHARGES PAID TO CARRIER.....\$	1,184.74
(B) PREMIUMS DUE AND UNPAID AT END OF THE PLAN YEAR.....\$	273.22
(C) IF THE CARRIER, SERVICE OR OTHER ORGANIZATION INCURRED SPECIFIC COSTS IN CONNECTION WITH THE ACQUISITION OR RETENTION OF THE CONTRACT OR POLICY, OTHER THAN REPORTED IN NO. 5 ABOVE, REPORT AMOUNT.....\$	.00

# ANL Plan 501 - Express Scripts, Inc. Admin fees

Admin Invoices

Payment Terms

07C

7 Cal days of receipt of inv.

Invoice Date	Doc Type	Invoice Amount	Amount Paid	Balance Amount	Due Date	Close Date	Days Late	Invoice Number
12/15/24	AI	72,245.92	72,245.92	0.00	12/22/24	12/23/24	1	30725051
11/17/24	AI	82,061.82	82,061.82	0.00	11/24/24	11/25/24	1	30637841
10/20/24	AI	105,907.16	105,907.16	0.00	10/27/24	10/28/24	1	30553771
09/15/24	AI	61,587.64	61,587.64	0.00	09/22/24	09/23/24	1	30454961
08/18/24	AI	91,347.59	91,347.59	0.00	08/25/24	08/26/24	1	30369881
07/21/24	AI	79,668.95	79,668.95	0.00	07/28/24	07/29/24	1	30285461
06/16/24	AI	92,956.49	92,956.49	0.00	06/23/24	06/24/24	1	30162471
05/19/24	AI	109,360.04	109,360.04	0.00	05/26/24	05/28/24	2	30075521
04/21/24	AI	88,625.13	88,625.13	0.00	04/28/24	04/29/24	1	29987551
03/17/24	AI	79,954.05	79,954.05	0.00	03/24/24	03/25/24	1	29885981
02/18/24	AI	85,256.47	85,256.47	0.00	02/25/24	02/26/24	1	29794321
01/21/24	AI	65,772.75	65,772.75	0.00	01/28/24	01/29/24	1	29702151

## ANL Plan 501 - Express Scripts, Inc. Admin fees

Express Scripts, Inc.  
Payment History Report

02/05/2025 15:26:45  
Page no. 2 of 2

Invoice Date	Doc Type	Invoice Amount	Amount Paid	Balance Amount	Due Date	Close Date	Days Late	Invoice Number
<b>Total</b>		<u>1,014,744.01</u>	<u>1,014,744.01</u>	<u>0.00</u>				

Claim Average Days Late	1
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Admin Average Days Late	1
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February 5, 2025

RE: 2024 Form 5500 Schedule C Reporting for Compensation Received by Express Scripts, Inc.  
(EIN: 43-1420563)

To: UChicago Argonne LLC.

We have received your request for information regarding the direct and indirect compensation that Express Scripts, Inc. (“ESI”) received for providing pharmaceutical benefit management services in 2024 to UChicago Argonne LLC (the “Plan”). You requested this information in connection with preparing Schedule C to the Plan’s Form 5500.

ESI takes seriously its obligation to provide to plan administrators the information required by the Form 5500 instructions. As you know, in addition to the guidance regarding this obligation provided in the instructions themselves, the U.S. Department of Labor issued frequently asked questions (“FAQs”) in February 2010 that significantly clarified the information reporting obligations of pharmacy benefit managers such as ESI.

Based on its understanding of the Form 5500 instructions and the FAQs, ESI has concluded that it did not receive any “indirect” compensation from the Plan that needs to be reported on Schedule A and/or C for 2024. However, ESI may have received direct compensation for providing services to the Plan. In case you do not have the amount directly paid to ESI for that period readily available, we have provided the data for 2024 that includes the total amount ESI received directly from the Plan and/or the Plan’s sponsor for that period.

As you know, the Plan administrator is solely responsible for completing and filing the Form 5500 and determining whether Schedule A and /or C must be included with the filing (and, if so, the information that must be reported on the Schedule A and/or C). Although the information provided above reflects ESI’s interpretation of the Schedule A and /or C reporting rules applicable to compensation ESI may have received, ESI cannot provide legal advice to the Plan, the Plan administrator, or the Plan sponsor. You should consult your own counsel regarding the Form 5500 filing obligations.

We hope that this letter is helpful. Please contact me at [BNHollingsworth@express-scripts.com](mailto:BNHollingsworth@express-scripts.com) if you have any additional questions.

Respectfully,

**Brittany Hollingsworth**  
Senior Account Manager – Government Markets, Federal Pharmacy Services Division  
Express Scripts | One Express Way | St. Louis, MO 63121  
m 513.497.5350 | [BNHollingsworth@express-scripts.com](mailto:BNHollingsworth@express-scripts.com)