Form 5500	Annual Return/Report of Employee Benefit Plan	OMB Nos. 1210-0110 1210-0089
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code). ▶ **Complete all entries in accordance with the instructions to the Form 5500.**	**2023** **This Form is Open to Public Inspection**

Part I Annual Report Identification Information

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A This return/report is for:
- [X] 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. . . . . ▶ [X]

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
IOWA LABORERS HEALTH AND WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 11/01/1969

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
IOWA LABORERS HEALTH AND WELFARE FUND

3400 E. EUCLID AVENUE, SUITE B
DES MOINES, IA 50317

2b Employer Identification Number (EIN) 42-0946060

2c Plan Sponsor's telephone number 515-270-6963

2d Business code (see instructions) 237310

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	07/21/2025	WILLIAM GERHARD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/21/2025	JAMES PIAZZA JR.
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	2684
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	2154
a(2) Total number of active participants at the end of the plan year	**6a(2)**	2078
b Retired or separated participants receiving benefits	**6b**	524
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	2602
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	195

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 4D 4F 4L

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶
IOWA LABORERS HEALTH AND WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
IOWA LABORERS HEALTH AND WELFARE FUND	42-0946060

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

WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA

(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
42-0318333	88848	913	2347	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

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

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

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

(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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	20590731		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned (**(1)** + **(2)** - **(3)**)			9a(4)	20590731
b Benefit charges (1) Claims paid	9b(1)	19245896		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	19245896
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)	1344806		
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)	30		
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	1344836
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶
IOWA LABORERS HEALTH AND WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
IOWA LABORERS HEALTH AND WELFARE FUND	42-0946060

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

1 Coverage Information:

(a) Name of insurance carrier

THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year **(f)** From	**(g)** To
13-1423090	69744	SL10355	2212	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
9819	0

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

THE SEGAL COMPANY
333 WEST 34TH STREET
NEW YORK, NY 10001

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
9819			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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	773661
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶
IOWA LABORERS HEALTH AND WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
IOWA LABORERS HEALTH AND WELFARE FUND	42-0946060

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

1 Coverage Information:

(a) Name of insurance carrier

HUMANA INSURANCE COMPANY

(b) 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
39-1263473	73288	306633	6	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
1559	0

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

SEGAL CO MIDWEST INC THE
7701 FRANCE AVE S, STE 225
EDINA, MN 55435

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
1559			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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	44379
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶
IOWA LABORERS HEALTH AND WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
IOWA LABORERS HEALTH AND WELFARE FUND	42-0946060

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

1 Coverage Information:

(a) Name of insurance carrier

HUMANA INSURANCE COMPANY

(b) 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
39-1263473	73288	306641	580	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
49142	0

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

SEGAL CO MIDWEST INC THE
7701 FRANCE AVE S, STE 225
EDINA, MN 55435

(b) Amount of sales and base commissions paid	Fees and other commissions paid **(c)** Amount	**(d)** Purpose	**(e)** Organization code
49142			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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((**1**) + (**2**) - (**3**))			9a(4)	
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add (**1**) and (**2**))			9b(3)	
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	1537538
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.** ▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶
IOWA LABORERS HEALTH AND WELFARE FUND	501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
IOWA LABORERS HEALTH AND WELFARE FUND	42-0946060

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

WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA

(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
42-0318333	88848	913	2851	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
0	0

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

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

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

(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 **(c)** Amount	**(d)** Purpose	**(e)** Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year		**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**		
	(2) Dividends and credits	**7c(2)**		
	(3) Interest credited during the year	**7c(3)**		
	(4) Transferred from separate account	**7c(4)**		
	(5) Other (specify below) ▶	**7c(5)**		
	(6)Total additions		**7c(6)**	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).		**7d**	
e	Deductions:			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**		
	(2) Administration charge made by carrier	**7e(2)**		
	(3) Transferred to separate account	**7e(3)**		
	(4) Other (specify below) ▶	**7e(4)**		
	(5) Total deductions		**7e(5)**	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)		**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	234405		
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned (**(1)** + **(2)** - **(3)**)			9a(4)	234405
b Benefit charges (1) Claims paid	9b(1)	211698		
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	211698
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)	22707		
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	22707
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).	2023
Department of Labor Employee Benefits Security Administration	▶ **File as an attachment to Form 5500.**	**This Form is Open to Public Inspection.**
Pension Benefit Guaranty Corporation		

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan
IOWA LABORERS HEALTH AND WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
IOWA LABORERS HEALTH AND WELFARE FUND

D Employer Identification Number (EIN)
42-0946060

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BENEFITS MANAGEMENT GROUP INC

20-0188125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14	NONE	696000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LECET

665 N. BROAD STREET - 4TH FLOOR
PHILADELPHIA, PA 19123

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	202706	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MIDWEST REGIONAL HEALTH AND SAFETY

1 NORTH OLD STATE CAPITOL PLAZA, SU
SPRINGFIELD, IL 62701

(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?
38	NONE	140048	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

EMPLOYEE FRINGES AUDIT COMPANY

42-1122328

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	84700	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DELTA DENTAL OF IL

39-6094742

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	76897	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STROKE DETECTION PLUS

2407 SW 9TH ST
DES MOINES, IA 50315

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	65700	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

CEDAR RAPIDS BANK & TRUST

42-1524302

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19	NONE	63463	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BLAKE & UHLIG, P.A.

48-0918231

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	53446	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE RESOURCE SYSTEMS

29 E MADISON ST.
CHICAGO, IL 60602

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	38929	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

UHY, LLP

20-0694403

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10	NONE	35171	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TRAVELERS INSURANCE

PO BOX 660307
DALLAS, TX 75266-0307

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
23	NONE	10690	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

O'SULLIVAN ASSOCIATES INC.

20-8199367

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	6800	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

WASHINGTON STREET INSURANCE

PO BOX 360
PALOS PARK, IL 60464

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
23	NONE	6451	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEGAL

13-1975125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	5123	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

Part I Service Provider Information (continued)

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

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

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

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500)	Financial Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ **File as an attachment to Form 5500.**	**2023** **This Form is Open to Public Inspection**

For calendar plan year 2023 or fiscal plan year beginning 11/01/2023 and ending 10/31/2024

A Name of plan
IOWA LABORERS HEALTH AND WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
IOWA LABORERS HEALTH AND WELFARE FUND

D Employer Identification Number (EIN)
42-0946060

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	2522986	2462655
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	971742	584911
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	5148236	4263387
(2) U.S. Government securities	1c(2)	276049	287616
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	2489952	2228821
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	2043298	1830340
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	5530848	9912098
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	779829	577317

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	19762940	22147145
Liabilities			
g Benefit claims payable	1g	17827000	17349000
h Operating payables	1h	96853	197843
i Acquisition indebtedness	1i		
j Other liabilities	1j	366504	413476
k Total liabilities (add all amounts in lines 1g through1j)	1k	18290357	17960319
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	1472583	4186826

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	26859048	
(B) Participants	2a(1)(B)	2557391	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		29416439
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	500027	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		500027
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	100494	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		100494
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	1351397	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		1351397

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		408307
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		31776664
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	20858195	
(2) To insurance carriers for the provision of benefits	2e(2)	5302765	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		26160960
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	2376357	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	35171	
(5) Investment advisory and investment management fees	2i(5)	63463	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	6800	
(8) Legal fees	2i(8)	53446	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	366224	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		2901461
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		29062421
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		2714243
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: UHY, LLP **(2)** EIN: 20-0694403

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

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

Part IV Compliance Questions

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

During the plan year:

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

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)

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

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

IOWA LABORERS DISTRICT COUNCIL
HEALTH AND WELFARE FUND

AUDITED FINANCIAL STATEMENTS
AND
SUPPLEMENTAL INFORMATION

Years Ended October 31, 2024 and 2023

IOWA LABORERS DISTRICT COUNCIL
HEALTH AND WELFARE FUND

TABLE OF CONTENTS

	Page
Independent Auditor's Report	1
Financial Statements	
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	5
Statements of Plan Benefit Obligations	6
Statements of Changes in Plan Benefit Obligations	7
Notes to Financial Statements	8
Supplemental Information	
Schedule of Assets (Held at End of Year)	16
Schedule of Reportable Transactions	18

INDEPENDENT AUDITOR'S REPORT

To the Trustees
Iowa Laborers District Council Health and Welfare Fund

Opinion

We have audited the financial statements of Iowa Laborers District Council Health and Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of plan benefit obligations as of October 31, 2024 and 2023, the related statements of changes in net assets available for benefits and of changes in plan benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of the Plan as of October 31, 2024 and 2023, and the changes in its net assets available for benefits and plan benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America (GAAP).

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with GAAP, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for one year after the date that the financial statements are issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of October 31, 2024 and reportable transactions for the year ended October 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

UHY LLP

West Des Moines, Iowa
July 18, 2025

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	October 31,	
	2024	2023
Assets		
Cash and cash equivalents	$ 3,477,774	$ 2,547,168
Investments, at fair value:		
Short-term investments	786,630	2,602,034
U.S. government securities	287,616	276,049
Certificates of deposit	299,543	496,159
Mortgage-backed securities	143,046	148,993
Corporate bonds	2,228,821	2,489,952
Mutual funds and exchange traded funds	9,912,098	5,530,848
Common stocks	1,830,340	2,043,298
Total investments	15,488,094	13,587,333
Receivables:		
Employer contributions	2,462,655	2,522,986
Rebates and stop loss recoveries	541,000	921,659
Accrued interest	43,911	50,083
Total receivables	3,047,566	3,494,728
Prepaid expenses	133,711	133,711
Total assets	22,147,145	19,762,940
Liabilities		
Payables and accruals:		
Accounts payable	197,843	96,853
Reciprocity payable	133,358	139,885
Prepaid contributions	280,118	226,619
Total liabilities	611,319	463,357
Net assets available for benefits	$ 21,535,826	$ 19,299,583

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

	Years Ended October 31,	
	2024	**2023**
Additions		
Contributions:		
Employer contributions	$ 26,859,048	$ 24,362,806
Employee contributions	2,557,391	2,660,425
Total contributions	29,416,439	27,023,231
Investment income:		
Interest and dividend income	600,522	524,850
Net appreciation in fair value of investments	1,759,703	215,146
Investment fees	(63,463)	(61,585)
Net investment income	2,296,762	678,411
Total additions	31,713,201	27,701,642
Deductions		
Claims, net of recoveries on stop-loss policy of $33,973 ($508,659 for the year ended October 31, 2023)	21,336,195	20,907,566
Prescription drug claims	2,988,680	2,811,387
Retiree insurance premiums	1,579,482	1,585,237
Stop-loss insurance premiums	734,603	659,905
Administration (Note 4):		
Wellmark Blue Cross Blue Shield	1,361,825	1,244,192
Benefits Management Group, Inc.	696,000	696,000
Delta Dental of Illinois	76,897	107,459
Contribution processing (Note 4)	202,706	193,278
Employee assistance program	38,929	37,148
Health fairs	216,286	170,154
Contractor payroll audits	84,700	93,850
Fund consultant (Note 4)	5,123	25,744
Legal (Note 4)	53,446	54,602
Audit (Note 4)	35,171	42,265
Travel and meeting	1,934	2,333
Office	49,138	59,385
Government fees	8,723	8,469
Telephone and utilities	320	3,849
Actuary (Note 4)	6,800	6,500
Total deductions	29,476,958	28,709,323
Net increase (decrease) in net assets	2,236,243	(1,007,681)
Net assets available for benefits		
Beginning of year	19,299,583	20,307,264
End of year	$ 21,535,826	$ 19,299,583

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
STATEMENTS OF PLAN BENEFIT OBLIGATIONS

	October 31,	
	2024	**2023**
Amounts currently payable to or for participants, beneficiaries and dependents		
Claims payable and claims incurred but not reported	$ 2,969,000	$ 3,107,000
Other obligations for current benefit coverage, at present value or estimated amounts		
Liability for continued coverage	14,380,000	14,720,000
Total obligations other than postretirement benefit obligations	17,349,000	17,827,000
Postretirement benefit obligations, net of amount currently payable		
Retirees	39,248,000	40,814,000
Active fully eligible	41,143,000	38,705,000
Active not fully eligible	34,402,000	38,436,000
Total postretirement benefit obligations	114,793,000	117,955,000
Total plan benefit obligations	$ 132,142,000	$ 135,782,000

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
STATEMENTS OF CHANGES IN PLAN BENEFIT OBLIGATIONS

	Years Ended October 31,	
	2024	2023
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Balance at beginning of year	$ 3,107,000	$ 2,523,000
Claims and insurance premiums incurred	26,500,960	26,548,095
Claims and insurance premiums paid	(26,638,960)	(25,964,095)
Balance at end of year	2,969,000	3,107,000
Other obligations for current benefit coverage, at present value of estimated amounts:		
Balance at beginning of year	14,720,000	15,162,000
Net change during year	(340,000)	(442,000)
Balance at end of year	14,380,000	14,720,000
Total obligations other than postretirement benefit obligations	17,349,000	17,827,000
Postretirement benefit obligations		
Balance at beginning of year	117,955,000	129,255,000
Increase (decrease) during year:		
Change due to experience gain	(1,436,000)	(7,215,000)
Change due to retiree self-pay rates	(2,683,000)	3,464,000
Change due to actuarial assumptions	(5,676,000)	(12,896,000)
Change due to estimated net benefits paid	(4,120,000)	(3,847,000)
Change due to passage of time	5,293,000	4,889,000
Change due to benefits earned and other changes	5,460,000	4,305,000
Balance at end of year	114,793,000	117,955,000
Total benefit obligations at end of year	$ 132,142,000	$ 135,782,000

The effect of a 1.0% increase in the medical trend rate would change the postretirement benefit obligations to $139,817,000 and $145,412,000 as of October 31, 2024 and 2023, respectively.

NOTE 1 — DESCRIPTION OF PLAN

The Iowa Laborers District Council Health and Welfare Fund (the Plan) is a partially self-insured health and welfare fund, which provides medical, disability, vision, dental, prescription drug, short-term disability, and death benefits for participants and their dependents as specified in the Plan document. The Plan also provides fully-insured medical and prescription drug benefits to retired employees (in excess of Medicare coverage) and their dependents through a policy with Humana, Inc. if they have continued their eligibility through self-contributions. Participants should refer to the Plan document for a more complete description of the Plan's provisions. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan purchases a stop-loss insurance policy from The Union Labor Life Insurance Company, which provides for a $350,000 deductible per participant for medical claims and no maximum benefits. The claims for self-insured benefits are processed by the Plan's third-party claims processors under administrative services-only arrangements.

Contributions on behalf of laborer-employees are made to the Plan by contractor-employers having collective bargaining agreements with the Laborers International Union of North America and its affiliated locals. In accordance with these agreements, employers contribute a specified amount for each hour worked by a laborer. Individuals whose credited hours satisfy specified requirements are eligible for benefits. A laborer must have 600 credited hours within a 12-month period to initially qualify for benefits and must work 375 hours quarterly to maintain eligibility.

Continuing eligibility for bargaining unit participants is tracked through an hour bank. The hour bank is increased when contributions are received by the Plan for hours worked in excess of the 375 hours required for coverage. Participants accumulate excess hours in the hour bank up to a maximum of 750 hours. The hour bank can be applied only to maintain the participant's eligibility for coverage in this Plan in the event the participant does not meet the minimum 375 hours for a quarter. Non-bargaining unit participants do not accumulate a bank but are eligible for coverage for those months that the contributing employers submit contributions on their behalf.

A portion of the employer contributions is allocated into participant's individual Health Reimbursement Accounts (HRA) based on hours worked. The amount in the HRAs can be used for certain healthcare expenses not payable by the regular benefits under the Plan. In the event the participant has insufficient hours to maintain eligibility, the participant's HRA balances may be used to cover any self-contribution requirements necessary to maintain eligibility. Participant's HRA balances as of October 31, 2024 and 2023 were approximately $5,957,000 and $5,690,000, respectively.

Plan participants who have been terminated by contractor-employers or work less than the required hours may make direct contributions to the Plan to maintain eligibility for themselves and their dependents. Plan participants may continue their eligibility under this self-contribution provision for no more than three consecutive quarters beyond the date that their eligibility ordinarily would have ceased. In addition, benefits may be extended under provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

NOTE 1 — DESCRIPTION OF PLAN (Continued)

Normal or early retired participants may continue coverage for himself or herself and his or her dependents through the Plan under the Retiree Program. To be eligible for the Retiree Program, the participant must (1) have been eligible in this Plan at least 12 of the 20 coverage quarters immediately before his/her retirement, and (2) he/she is eligible in the Plan at the time of his/her retirement. If the participant is eligible for the Retiree Program, he or she must exercise the option when first eligible to do so. Once the retiree or dependent becomes eligible for Medicare benefits, the Plan requires the retiree to enroll. Short-term disability and death benefits are not available under the Retiree Program.

NOTE 2 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The accompanying financial statements have been prepared using the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America (GAAP). Under this basis, revenues are recognized when earned and expenses are recognized when incurred.

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein, and disclosure of contingent assets and liabilities. The most significant estimates used are the actuarial assumptions used to determine accumulated plan benefits. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consists of funds held in depository accounts at financial institutions with original maturities of less than 90 days. Cash balances and money market accounts held by the Plan's custodian are presented as a short-term investment component of the Plan's investment portfolio. At various times during the two years ended October 31, 2024, the Plan maintained balances in excess of Federal Deposit Insurance Corporation limits. The Plan believes that it is not exposed to any significant credit risk on cash and cash equivalents.

Valuation of Investments and Investment Income

Investments are reported at fair value. Fair value is defined as the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date. See Note 7 for discussion of fair value measurements. Purchases and sales of securities are recorded on a trade-date basis. Interest and dividends are recorded on the accrual basis. Net appreciation (depreciation) in fair value of investments includes both realized gains and losses from sales and unrealized market gains and losses.

NOTE 2 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Income Taxes

The Internal Revenue Service (IRS) has ruled (latest determination was August 17, 1977) that the Plan qualifies under Section 501(c)(9) of the Internal Revenue Code (IRC), and is, therefore, not subject to tax under present income tax law. Once qualified, the Plan is required to operate in conformity with the IRC to maintain qualification. The Board of Trustees is not aware of any course of action or series of events that has occurred that might adversely affect the Plan's qualified status.

GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. As of October 31, 2024 and 2023, the Plan administrator does not believe any event has occurred that would require recognition of a tax liability (or asset).

Risks and Uncertainties

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

The actuarial present value of accumulated plan benefits is reported based on certain assumptions pertaining to interest rates, inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term could materially affect the amounts reported and disclosed in the financial statements.

Refunds

Refunds due from the Plan's pharmacy benefits manager (PBM) are recorded when earned and are netted with prescription claims paid in the accompanying statements of changes in net assets available for benefits. Refunds due as of the financial statement date have been reported as a receivable.

Claims, Claims Payable and Claims Incurred but not Reported

Claims expense is recorded when paid by the Plan or the claims processor is reimbursed by the Plan. Claims payable consists of an estimate for claims presented for payment before the end of the year and paid after the year-end. Obligations for claims incurred but not reported considers obligation for claims incurred before fiscal year-end, of which claim applications had not yet been made and which were paid after the fiscal year-end. Subsequent actual claim experience may differ from the estimated liability due to variances in estimated and actual utilization of healthcare services, the amount of charges and other factors.

NOTE 2 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Liability for Continued Coverage

The eligibility rules of the Plan provide for the payment of benefits for a period of time subsequent to the financial statement date for those participants who have accumulated sufficient eligibility credits. At October 31, 2024 and 2023, such accumulated eligibility credits represent a benefit obligation of the Plan arising from prior employee service for which employer contributions have been received. Accumulated eligibility credits are estimated by applying current insurance premium rates for insured coverage, the average cost of benefits per eligible participant for the self-insured coverage, and estimated administration costs, to accumulated eligibility credits. The cost ultimately incurred as a result of the accumulated eligibility credits could differ materially from the estimates reflected in the accompanying financial statements.

Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to October 31, 2024 and 2023. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is calculated by applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims' costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

The cost of the postretirement benefit obligations is shared by the Plan's participating employers and retirees. In addition to deductibles and co-payments, retiree contributions are expected to fund approximately 46.6% and 47.3% of the estimated cost of post retirement benefits as of October 31, 2024 and 2023, respectively.

NOTE 2 — SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Postretirement Benefits (Continued)

In 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act (the Act). The Act provides prescription drug and other benefits to senior citizens and disabled persons. The accumulated postretirement benefit obligation has not been adjusted for any amount associated with the Medicare subsidy as the Plan is not directly entitled to the subsidy due to the fully-insured policies obtained for retirees through Humana, Inc.

The following were other significant valuation assumptions used as of October 31:

	2024	2023
Medical trend rate	6.0% graded to 3.0% over six years	6.0% graded to 3.0% over six years
Weighted-average discount rate	5.25%	4.50%
Mortality	PRI-2012 Blue Collar (Sex Distinct) using Scale MP-2021 generational mortality improvement	PRI-2012 Blue Collar (Sex Distinct) using Scale MP-2021 generational mortality improvement
Administrative expenses	5% of claims cost	5% of claims cost

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

Benefit Obligations

At October 31, 2024 and 2023, the Plan has a deficiency in net assets available for benefits over benefit obligations. It is expected that the deficiency will be funded through future increases in the collectively bargained contribution rates.

NOTE 3 — TRANSACTIONS WITH RELATED PARTIES

The Plan provides benefits to the employees of the Iowa Laborers District Council, the Iowa Laborers District Council Building Training Fund, the Iowa Laborers-Employers Cooperation and Education Trust (LECET), and the Iowa Laborers Education and Training Fund based on hours worked.

NOTE 4 — TRANSACTIONS WITH PARTIES-IN-INTEREST

Under the terms of the agreement between the Plan and the Plan's administrator, Benefits Management Group, Inc. (the Administrator), the Administrator's monthly charges were $58,000 from November 1, 2022 through October 31, 2024 for administrative fees and vision, HRA, disability, and death claims payments.

NOTE 4 — TRANSACTIONS WITH PARTIES-IN-INTEREST (Continued)

The Plan has contracted Wellmark Blue Cross Blue Shield of Iowa for payment of non-retiree medical claims for a monthly fee of $49.84 and $47.20 per participant for administration and network access during 2024 and 2023, respectively. The Plan was contracted with Delta Dental of Illinois to administer dental benefits through August 2024, in August 2024 the Plan contracted with Wellmark Blue Cross Blue Shield of Iowa to administer dental benefits for a monthly fee of $2.75. PBM services are provided by Sav-Rx Prescription Services in exchange for 15% of the prescription drug rebates that the Plan is entitled to, approximately $159,400 and $124,400 for the years ended October 31, 2024 and 2023, respectively.

LECET provides contribution processing services to the Plan in exchange for a fee equal to 2% of contributions collected each month, subject to a maximum of approximately $199,000 for the period from May 1 to April 30 annually.

The Plan has contracted with Segal Consulting for $58,300 per year for consultation. Segal Consulting receives partial payment for their services by way of commissions received related to the Plan's policy with Humana, Inc. Expense of $5,123 and $25,744 to the funds consultant was recognized during the years ended October 31, 2024 and 2023, respectively. During the years ended October 31, 2024 and 2023, Segal fees were reduced by $58,300 and $40,041, respectively, for commissions earned by Segal.

Other transactions with parties-in-interest, including legal fees, audit, actuarial and investment fees, are disclosed on the statements of changes in net assets available for benefits.

NOTE 5 — TERMINATION OF PLAN

In the event that the Plan terminates, the procedures are as follows:

1. To pay all expenses incurred up to the date of termination and expenses incident to the termination;
2. To have an audit of the financial statements of the Plan as of the termination date;
3. To distribute any remaining surplus of the Plan in a manner which, in the opinion of the Trustees, best effectuates the purposes of the Plan, complying with all applicable statutes and tax regulations; and,
4. To give proper notice and to prepare and file reports which may be required by law.

NOTE 6 — RECONCILIATION TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 as of October 31:

	2024	2023
Net assets available for benefits per the financial statements	$ 21,535,826	$ 19,299,583
Claims payable and claims incurred but not reported	(2,969,000)	(3,107,000)
Liability for continued coverage	(14,380,000)	(14,720,000)
Net assets per Form 5500	$ 4,186,826	$ 1,472,583

NOTE 6 — RECONCILIATION TO FORM 5500 (Continued)

The following is a reconciliation of the net decrease in net assets available for benefits per the financial statements to the Form 5500 for the year ended October 31:

	2024	2023
Net increase (decrease) in net assets per the financial statements	$ 2,236,243	$ (1,007,681)
Decrease (increase) in claims payable and claims incurred but not reported	138,000	(584,000)
Decrease in liability for continued coverage	340,000	442,000
Net loss per Form 5500	$ 2,714,243	$ (1,149,681)

NOTE 7 — FAIR VALUE MEASUREMENTS

GAAP establishes a three-tier fair value hierarchy, which categorizes the inputs used in measuring fair value of investments. These categories include (in descending order of priority):

Level 1, defined as unadjusted quoted prices in active markets accessible at the measurement date for identical, unrestricted assets or liabilities;

Level 2, defined as quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar instruments in inactive markets, inputs other than quoted prices that are observable for the asset or liability, and inputs that are derived principally from or corroborated by observable market data by correlation or other means; and

Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The asset's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

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

- *Mutual funds, exchange traded funds (ETFs), and common stocks:* Valued based on quoted prices of identical assets in active markets.

- *Money market fund, U.S. government securities, certificated of deposit, mortgage-backed securities, municipal bonds and corporate bonds:* Valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for similar securities, the instrument is valued under a discounted cash flows approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks.

NOTE 7 — FAIR VALUE MEASUREMENTS (Continued)

The following tables show the amounts measured at fair value as of October 31, 2024 and 2023 on the Plan's statements of net assets available for benefits and the associated input categories:

	Investments at Fair Value as of October 31, 2024			
Description	Level 1	Level 2	Level 3	Total
Short-term investments:				
Money market fund	$ -	$ 786,630	$ -	$ 786,630
U.S. government securities	-	287,616	-	287,616
Certificates of deposit	-	299,543	-	299,543
Mortgage-backed securities	-	143,046	-	143,046
Corporate bonds	-	2,228,821	-	2,228,821
Mutual funds and ETFs	9,912,098	-	-	9,912,098
Common stocks	1,830,340	-	-	1,830,340
	$ 11,742,438	$ 3,745,656	$ -	$ 15,488,094

	Investments at Fair Value as of October 31, 2023			
Description	Level 1	Level 2	Level 3	Total
Short-term investments:				
Money market fund	$ -	$ 2,602,034	$ -	$ 2,602,034
U.S. government securities	-	276,049	-	276,049
Certificates of deposit	-	496,159	-	496,159
Mortgage-backed securities	-	148,993	-	148,993
Corporate bonds	-	2,489,952	-	2,489,952
Mutual funds and ETFs	5,530,848	-	-	5,530,848
Common stocks	2,043,298	-	-	2,043,298
	$ 7,574,146	$ 6,013,187	$ -	$ 13,587,333

NOTE 8 — SUBSEQUENT EVENTS

The state of Iowa passed a law effective July 1, 2025 to regulate pharmacy benefit managers, management is currently analyzing the impact to the Plan.

Management evaluated all subsequent events through July 18, 2025, the date the financial statements were available to be issued.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

EIN: 42-0946060, Plan No. 501

October 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Short-Term Investments			
*	CSB Institutional Insured Money Market	Money Market, 785,613.55 Shares	$ 786,630	$ 786,630
	U.S. Government Securities			
	US Treasury Note	$100,000; 2.00%; 11/15/26	96,814	95,855
	US Treasury Note	$200,000 Shares; 2.25%; 2/15/27	197,574	191,761
			294,388	287,616
	Certificates of Deposit			
	Alaska USA	$100,000, 4.900%, 1/30/25	100,000	99,974
	CIBC Bank	$200,000, 4.750%, 2/24/25	199,751	199,569
			299,751	299,543
	Mortgage-backed Securities			
	Federal Home Loan Mortgage Corp.	$12,670; 3.50%; 12/01/24	17	16
	Federal National Mortgage Assn.	$11,725; 3.50%; 9/01/25	1,968	1,888
	Federal National Mortgage Assn.	$155,302; 2.28%; 11/01/26	141,608	141,142
			143,593	143,046
	Corporate Bonds			
	Berkshire Hathaway	$250,000, 3.125%, 3/15/26	250,427	245,580
	BNY Mellon Corp.	$200,000, 2.05%, 1/26/27	200,239	189,912
	CitiGroup Inc.	$250,000, 2.750%, 11/27/24	250,000	249,496
	HSBC	$100,000, 5.625%, 3/17/25	100,052	100,279
	Huntington National Bank	$500,000, 4.600%, 2/27/25	501,818	498,846
	Oracle Corp.	$100,000, 2.950%, 11/15/24	100,492	99,904
	Royal Bank of Canada	$225,000, 6.300%, 10/18/33	224,792	232,493
	Tapestry Inc.	$100,000, 4.125%, 7/15/27	105,070	97,369
	Target Corp.	$250,000, 2.500%, 4/15/26	238,634	244,473
	United Health Group	$150,000, 4.750%, 7/15/45	167,392	137,689
	Visa Inc.	$150,000, 4.300%, 12/14/45	158,994	132,780
			2,297,910	2,228,821
	Mutual Funds and Exchange Traded Funds			
	Dodge and Cox Income Fund Class I	139,706.016 Shares	1,729,980	1,760,296
	Federated Instl High Yield Bond Fund	199,524.754 Shares	1,894,741	1,777,766
	iShares Core S&P Small Cap ETF	4,752.000 Shares	261,669	541,348
	iShares Mid Cap 400 Growth ETF	2,634.000 Shares	116,500	238,798
	iShares Mid Cap 400 Value ETF	1,897.000 Shares	125,626	234,602
	iShares Core MSCI EAFE ETF	7,161.000 Shares	454,699	528,339
	Vanguard Intermediate-Term Bond Index Fund	265,785.522 Shares	2,683,786	2,726,958
	Vanguard 500 Index Fund	1,273.189 Shares	482,500	670,818
	Vanguard Short Term Inflation Protected ETF	8,270.000 Shares	399,810	403,411
	Vanguard FTSE Developed Markets ETF	10,622.000 Shares	389,263	532,162
	Vanguard FTSE Emerging Markets ETF	10,685.000 Shares	376,903	497,600
			8,915,477	9,912,098

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)
EIN: 42-0946060, Plan No. 501
October 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Common Stocks			
	Abbott Laboratories	533 Shares	38,482	60,426
	Adobe Systems Inc.	107 Shares	44,616	51,155
	Alphabet Inc. Class C	739 Shares	15,551	127,618
	Amazon.com Inc.	708 Shares	63,887	131,971
	American Tower Corp.	235 Shares	45,654	50,182
	Apple Inc.	511 Shares	7,707	115,440
	Blackrock Inc.	74 Shares	23,593	72,596
	Blackstone Inc.	440 Shares	42,926	73,810
	Chevron Corp.	285 Shares	26,302	42,414
	Comcast Corp. Class A	1,171 Shares	39,007	51,138
	Costco Wholesale Corp.	93 Shares	36,285	81,299
	The Walt Disney Company	462 Shares	31,726	44,444
	Exxon Mobil Corp.	437 Shares	34,919	51,033
	General Dynamics Corp.	178 Shares	23,313	51,907
	Honeywell International Inc.	263 Shares	30,284	54,094
	JP Morgan Chase & Co.	321 Shares	27,843	71,236
	Mastercard Inc.	117 Shares	24,875	58,452
	McDonald's Corp.	174 Shares	26,090	50,827
	Meta Platforms Inc.	100 Shares	30,481	56,758
	Microsoft Corp.	278 Shares	8,098	112,965
	Mondelez International Inc.	678 Shares	27,877	46,429
	Nike Inc. Class B	458 Shares	37,245	35,326
	Nvidia Corp.	1,510 Shares	28,104	200,467
	Palo Alto Networks	229 Shares	27,687	82,516
	TJX Companies Inc.	494 Shares	13,944	55,837
			756,496	1,830,340
	Total investments		$ 13,494,245	$ 15,488,094

* Party-in-interest

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS

EIN:42-0946060, Plan No. 501

Year Ended October 31, 2024

(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or Loss
Purchases					
Short-Term Investments:					
CRBT Institutional Insured Money Market	$ 473,161	$ -	$ 473,161	$ 473,161	$ -
CSB Institutional Insured Money Market	2,435,626	-	2,435,626	2,435,626	
Vanguard Intermediate-Term Bond Index Fund	1,855,991	-	1,855,991	1,855,991	-
Sales					
Short-Term Investments:					
CRBT Institutional Insured Money Market	$ -	$ 3,075,195	$ 3,075,195	$ 3,075,195	$ -
CSB Institutional Insured Money Market	-	1,648,996	1,648,996	1,648,996	-

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

EIN: 42-0946060, Plan No. 501

October 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Short-Term Investments			
*	CSB Institutional Insured Money Market	Money Market, 785,613.55 Shares	$ 786,630	$ 786,630
	U.S. Government Securities			
	US Treasury Note	$100,000; 2.00%; 11/15/26	96,814	95,855
	US Treasury Note	$200,000 Shares; 2.25%; 2/15/27	197,574	191,761
			294,388	287,616
	Certificates of Deposit			
	Alaska USA	$100,000, 4.900%, 1/30/25	100,000	99,974
	CIBC Bank	$200,000, 4.750%, 2/24/25	199,751	199,569
			299,751	299,543
	Mortgage-backed Securities			
	Federal Home Loan Mortgage Corp.	$12,670; 3.50%; 12/01/24	17	16
	Federal National Mortgage Assn.	$11,725; 3.50%; 9/01/25	1,968	1,888
	Federal National Mortgage Assn.	$155,302; 2.28%; 11/01/26	141,608	141,142
			143,593	143,046
	Corporate Bonds			
	Berkshire Hathaway	$250,000, 3.125%, 3/15/26	250,427	245,580
	BNY Mellon Corp.	$200,000, 2.05%, 1/26/27	200,239	189,912
	CitiGroup Inc.	$250,000, 2.750%, 11/27/24	250,000	249,496
	HSBC	$100,000, 5.625%, 3/17/25	100,052	100,279
	Huntington National Bank	$500,000, 4.600%, 2/27/25	501,818	498,846
	Oracle Corp.	$100,000, 2.950%, 11/15/24	100,492	99,904
	Royal Bank of Canada	$225,000, 6.300%, 10/18/33	224,792	232,493
	Tapestry Inc.	$100,000, 4.125%, 7/15/27	105,070	97,369
	Target Corp.	$250,000, 2.500%, 4/15/26	238,634	244,473
	United Health Group	$150,000, 4.750%, 7/15/45	167,392	137,689
	Visa Inc.	$150,000, 4.300%, 12/14/45	158,994	132,780
			2,297,910	2,228,821
	Mutual Funds and Exchange Traded Funds			
	Dodge and Cox Income Fund Class I	139,706.016 Shares	1,729,980	1,760,296
	Federated Instl High Yield Bond Fund	199,524.754 Shares	1,894,741	1,777,766
	iShares Core S&P Small Cap ETF	4,752.000 Shares	261,669	541,348
	iShares Mid Cap 400 Growth ETF	2,634.000 Shares	116,500	238,798
	iShares Mid Cap 400 Value ETF	1,897.000 Shares	125,626	234,602
	iShares Core MSCI EAFE ETF	7,161.000 Shares	454,699	528,339
	Vanguard Intermediate-Term Bond Index Fund	265,785.522 Shares	2,683,786	2,726,958
	Vanguard 500 Index Fund	1,273.189 Shares	482,500	670,818
	Vanguard Short Term Inflation Protected ETF	8,270.000 Shares	399,810	403,411
	Vanguard FTSE Developed Markets ETF	10,622.000 Shares	389,263	532,162
	Vanguard FTSE Emerging Markets ETF	10,685.000 Shares	376,903	497,600
			8,915,477	9,912,098

See notes to financial statements.

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR) (CONTINUED)

EIN: 42-0946060, Plan No. 501

October 31, 2024

(a)	(b) Identity of Issue, Borrower, Lessor or Similar Party	(c) Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(d) Cost	(e) Current Value
	Common Stocks			
	Abbott Laboratories	533 Shares	38,482	60,426
	Adobe Systems Inc.	107 Shares	44,616	51,155
	Alphabet Inc. Class C	739 Shares	15,551	127,618
	Amazon.com Inc.	708 Shares	63,887	131,971
	American Tower Corp.	235 Shares	45,654	50,182
	Apple Inc.	511 Shares	7,707	115,440
	Blackrock Inc.	74 Shares	23,593	72,596
	Blackstone Inc.	440 Shares	42,926	73,810
	Chevron Corp.	285 Shares	26,302	42,414
	Comcast Corp. Class A	1,171 Shares	39,007	51,138
	Costco Wholesale Corp.	93 Shares	36,285	81,299
	The Walt Disney Company	462 Shares	31,726	44,444
	Exxon Mobil Corp.	437 Shares	34,919	51,033
	General Dynamics Corp.	178 Shares	23,313	51,907
	Honeywell International Inc.	263 Shares	30,284	54,094
	JP Morgan Chase & Co.	321 Shares	27,843	71,236
	Mastercard Inc.	117 Shares	24,875	58,452
	McDonald's Corp.	174 Shares	26,090	50,827
	Meta Platforms Inc.	100 Shares	30,481	56,758
	Microsoft Corp.	278 Shares	8,098	112,965
	Mondelez International Inc.	678 Shares	27,877	46,429
	Nike Inc. Class B	458 Shares	37,245	35,326
	Nvidia Corp.	1,510 Shares	28,104	200,467
	Palo Alto Networks	229 Shares	27,687	82,516
	TJX Companies Inc.	494 Shares	13,944	55,837
			756,496	1,830,340
	Total investments		$ 13,494,245	$ 15,488,094

* Party-in-interest

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS

EIN:42-0946060, Plan No. 501

Year Ended October 31, 2024

(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or Loss
Purchases					
Short-Term Investments:					
CRBT Institutional Insured Money Market	$ 473,161	$ -	$ 473,161	$ 473,161	$ -
CSB Institutional Insured Money Market	2,435,626	-	2,435,626	2,435,626	
Vanguard Intermediate-Term Bond Index Fund	1,855,991	-	1,855,991	1,855,991	-
Sales					
Short-Term Investments:					
CRBT Institutional Insured Money Market	$ -	$ 3,075,195	$ 3,075,195	$ 3,075,195	$ -
CSB Institutional Insured Money Market	-	1,648,996	1,648,996	1,648,996	-

See notes to financial statements.