

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

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.

Part I Annual Report Identification Information

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

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE (specify) G, B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report, C If the plan is a collectively-bargained plan, check here, D Check box if filing under: Form 5558, automatic extension, the DFVC program, special extension, 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: PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST
1b Three-digit plan number (PN): 502
1c Effective date of plan: 10/30/2003
2a Plan sponsor's name (employer, if for a single-employer plan): PENNSYLVANIA AUTOMOTIVE ASSOCIATION
2b Employer Identification Number (EIN): 20-6051638
2c Plan Sponsor's telephone number: 717-255-8311
2d Business code (see instructions)

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include plan administrator (JOHN DEVLIN), employer/plan sponsor (STEVEN J SMITH), and DFE.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor PENNSYLVANIA AUTOMOTIVE ASSOCIATION P.O. BOX 2955 HARRISBURG, PA 17105-2955	3b Administrator's EIN 23-1358051 3c Administrator's telephone number 717-255-8311																				
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 6261																				
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 a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:10%;">6a(1)</td><td style="text-align: right;">6242</td></tr> <tr><td>6a(2)</td><td style="text-align: right;">4345</td></tr> <tr><td>6b</td><td style="text-align: right;">23</td></tr> <tr><td>6c</td><td style="text-align: right;">0</td></tr> <tr><td>6d</td><td style="text-align: right;">4368</td></tr> <tr><td>6e</td><td></td></tr> <tr><td>6f</td><td></td></tr> <tr><td>6g(1)</td><td></td></tr> <tr><td>6g(2)</td><td></td></tr> <tr><td>6h</td><td></td></tr> </table>	6a(1)	6242	6a(2)	4345	6b	23	6c	0	6d	4368	6e		6f		6g(1)		6g(2)		6h	
6a(1)	6242																				
6a(2)	4345																				
6b	23																				
6c	0																				
6d	4368																				
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7																				

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

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

<p>A Name of plan PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST</p>	<p>B Three-digit plan number (PN) ▶ 502</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 PENNSYLVANIA AUTOMOTIVE ASSOCIATION</p>	<p>D Employer Identification Number (EIN) 20-6051638</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
AMERICAN FIDELITY ASSURANCE 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
73-0714500	60410	VARIOUS	1475	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 275216</p>	<p>(b) Total amount of fees paid 25241</p>
--	--

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
PENNSYLVANIA AUTO ASSOC INS AGY INC **1925 NORTH FRONT STREET**
HARRISBURG, PA 17105

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
122537	25241	FEES	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
AMERICAN FIDELITY ASSURANCE COMPANY **P.O. BOX 25360**
OKLAHOMA CITY, OK 73125-0360

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
109668			3

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

HR ADVANTAGE LLC 809 1ST ST
OCEAN CITY, NJ 08226

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
9985			3

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

BENEFIT WATCH INC 164 SOUTH MAIN STREET
YARDLEY, PA 19067

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7396			3

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

BUSH, JOSEPH P 215 CLOVER LN
PHOENIXVILLE, PA 19460

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6930			3

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

GALLAGHER BENEFIT SERVICES INC 4000 MIDLANTIC DRIVE #300
MOUNT LAUREL, NJ 08054

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5403			3

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

MARSH & MCLENNAN AGENCY LLC 161 WASHINGTON STREET
CONSHOHOCKEN, PA 19428

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3473			3

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

COLLEGEVILLE FINANCIAL GROUP LLC

41 WEST MAIN STREET
COLLEGEVILLE, PA 19426

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3199			3

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

MARSH & MCLENNAN AGENCY LLC

PARK 80M W PLAZA 2
SADDLE BROOK, NJ 07663

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2237			3

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

MADS INS AGCY INC

7 STATE CR #301
ANNAPOLIS, MD 21401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1927			3

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

GEORGE R VIOLAND

1087 PRESIDENTS DRIVE
LITITZ, PA 17543

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
747			3

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

BIG OAK INSURANCE SERVICES

3960 AIRPORT BLVD
DOYLESTOWN, PA 18902

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
627			3

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

SUPPLEMENTAL BENEFIT SERVICES INC PO BOX 927
MECHANICSBURG, PA 17055

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
548			3

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

NJ CAR SERVICES, INC. 856 RIVER ROAD
TRENTON, NJ 08628

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
217			3

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

MYERS BEAVER & VELLONE INS AGY INC PO BOX 1391
ALTOONA, PA 16603

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
133			3

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

TRION GROUP INC 2300 RENAISSANCE BLVD
KING OF PRUSSIA, PA 19406

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
87			3

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

CBIZ BENEFITS & INS SERVICES, INC. 700 W 47TH STREET #1100
KANSAS CITY, MO 64112

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
53			3

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

ROCHE FINANCIAL INC

1610 EAST THIRD STREET
WILLIAMSPORT, PA 17701

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
49			3

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

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

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

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

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

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

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

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

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		0
c Additions: (1) Contributions deposited during the year	7c(1)		
	7c(2)		
	7c(3)		
	7c(4)		
	7c(5)		
(6) Total additions	7c(6)		0
d Total of balance and additions (add lines 7b and 7c(6))	7d		0
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		0

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

8 Benefit and contract type (check all applicable boxes)

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

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)	0
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)	0
(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)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	2759066
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	---

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

<p>A Name of plan PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 PENNSYLVANIA AUTOMOTIVE ASSOCIATION</p>	<p>D Employer Identification Number (EIN) 20-6051638</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	PAA - ALL	2082	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">11145</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
--	---

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

PENNSYLVANIA AUTOMOTIVE ASSOCIATION **1925 NORTH FRONT STREET**
HARRISBURG, PA 17105

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
11145			3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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)		0
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)		0
	(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)		0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)		
	(2) Claim reserves		9d(2)		
	(3) Other reserves		9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e		

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a			185744
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b			

Specify nature of costs.

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
---	--	--

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

<p>A Name of plan PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 PENNSYLVANIA AUTOMOTIVE ASSOCIATION</p>	<p>D Employer Identification Number (EIN) 20-6051638</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
PRUDENTIAL INSURANCE COMPANY OF AMERICA

(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
22-1211670	68241	08450	1044	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">6158</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
---	---

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

PENNSYLVANIA AUTO ASSOS INS AGY INC **1925 NORTH FRONT STREET**
PO BOX 2955
HARRISBURG, PA 17105

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3984			3

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

EMERSON REID & CO INC **1305 WALT WHITMAN RD**
SUITE 310
MELVILLE, NY 11747

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2174			3

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

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

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

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

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

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)	0
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)	0
(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)		0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	72440
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
--	--	---

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

A Name of plan PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST	B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 PENNSYLVANIA AUTOMOTIVE ASSOCIATION	D Employer Identification Number (EIN) 20-6051638	

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

PNC BANK

22-1146430

(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)

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
---	--	---

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

A Name of plan <u>PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST</u>	B Three-digit plan number (PN)	<u>502</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>PENNSYLVANIA AUTOMOTIVE ASSOCIATION</u>	D Employer Identification Number (EIN) <u>20-6051638</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
---------------	--

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

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of plan sponsor STEVE MOYER SUBARU**c** EIN-PN 23-2353630-**a** Plan name**b** Name of plan sponsor SAVAGE KIA INC**c** EIN-PN 23-2919838-**a** Plan name**b** Name of plan sponsor SAVAGE L & B DODGE CHRYSLER INC**c** EIN-PN 23-2638762-**a** Plan name**b** Name of plan sponsor SAVAGE SALES & SERVICE (61)**c** EIN-PN 23-1709803-**a** Plan name**b** Name of plan sponsor CIOCCA FORD OF QUAKERTOWN INC**c** EIN-PN 23-2715152-**a** Plan name**b** Name of plan sponsor CIOCCA CHEVROLET LLC**c** EIN-PN 23-2316761-**a** Plan name**b** Name of plan sponsor FAULKNER TOYOTA**c** EIN-PN 20-0652734-**a** Plan name**b** Name of plan sponsor CIOCCA ENTERPRISES INC- HONDA**c** EIN-PN 23-2183344-**a** Plan name**b** Name of plan sponsor BENNETT G WEST LLC**c** EIN-PN 87-1572391-**a** Plan name**b** Name of plan sponsor MOYER AUTO GROUP OF LEBANON**c** EIN-PN 92-2589012-**a** Plan name**b** Name of plan sponsor CIOCCA MANAGEMENT SUBARU INC**c** EIN-PN 46-3167834-**a** Plan name**b** Name of plan sponsor BENNETT T LLC**c** EIN-PN 45-0581443-

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor	CIOCCA VOLKSWAGEN	c EIN-PN	23-1603789-
-------------------------------	-------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT I LLC	c EIN-PN	45-0058145-
-------------------------------	---------------	-----------------	-------------

a Plan name

b Name of plan sponsor	RAY PRICE MOTORS INC	c EIN-PN	23-2536475-
-------------------------------	----------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA FORD OF SOUDERTON	c EIN-PN	23-1674638-
-------------------------------	--------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	OUTTEN JT INC	c EIN-PN	86-3572222-
-------------------------------	---------------	-----------------	-------------

a Plan name

b Name of plan sponsor	NORTH STAR CHEVROLET	c EIN-PN	20-0767466-
-------------------------------	----------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	MOYER AUTO GROUP INC	c EIN-PN	23-1631431-
-------------------------------	----------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA HYUNDAI - QTOWN	c EIN-PN	33-1138562-
-------------------------------	------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT JLR LLC	c EIN-PN	45-0581447-
-------------------------------	-----------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT INFINITI OF WILKES BARRE	c EIN-PN	23-2536475-
-------------------------------	----------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	RAY PRICE MOTORS IMPORTS INC	c EIN-PN	27-2851731-
-------------------------------	------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	OUTTEN AUTOMOTIVE INC	c EIN-PN	23-2668617-
-------------------------------	-----------------------	-----------------	-------------

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of plan sponsor **OUTTEN CHEVROLET OF HAMBURG INC****c** EIN-PN **11-3713312-****a** Plan name**b** Name of plan sponsor **OUTTEN MOTORS LLC****c** EIN-PN **23-2119066-****a** Plan name**b** Name of plan sponsor **OUTTEN CHEVROLET INC****c** EIN-PN **47-3078070-****a** Plan name**b** Name of plan sponsor **CIOCCA IMPORTS - AUDI****c** EIN-PN **23-2515762-****a** Plan name**b** Name of plan sponsor **FAULKNER TOYOTA TREVOSE****c** EIN-PN **82-2759330-****a** Plan name**b** Name of plan sponsor **CIOCCA CHEVROLET OF PRINCETON****c** EIN-PN **81-4691911-****a** Plan name**b** Name of plan sponsor **BENNETT TOYOTA OF LEBANON****c** EIN-PN **82-5220626-****a** Plan name**b** Name of plan sponsor **CIOCCA MOTORSPORTS INC- MERCEDES****c** EIN-PN **83-0723421-****a** Plan name**b** Name of plan sponsor **NORTH STAR CHEVROLET WEST LIBERTY****c** EIN-PN **83-1934042-****a** Plan name**b** Name of plan sponsor **CIOCCA CHEVROLET OF WEST CHESTER INC****c** EIN-PN **83-3123195-****a** Plan name**b** Name of plan sponsor **CIOCCA MUNCY TOY INC****c** EIN-PN **83-3028253-****a** Plan name**b** Name of plan sponsor **CIOCCA MUNCY HO INC****c** EIN-PN **83-3078820-**

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor	CIOCCA MUNCY B INC	c EIN-PN	83-3106179-
-------------------------------	--------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA MUNCY HY INC	c EIN-PN	84-2867248-
-------------------------------	---------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	AUDI STATE COLLEGE	c EIN-PN	84-2844049-
-------------------------------	--------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	MERCEDES BENZ OF STATE COLLEGE	c EIN-PN	84-2867248-
-------------------------------	--------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA VOLKSWAGEN OF STATE COLLEGE	c EIN-PN	84-3489493-
-------------------------------	------------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA NQT INC	c EIN-PN	46-1305004-
-------------------------------	----------------	-----------------	-------------

a Plan name

b Name of plan sponsor	TMR/CAA INC DBA TOTAL MARKETING RESOURCES	c EIN-PN	83-2486681-
-------------------------------	---	-----------------	-------------

a Plan name

b Name of plan sponsor	MOYER NISSAN OF LEBANON	c EIN-PN	85-1598478-
-------------------------------	-------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA FAMILY HOLDINGS INC	c EIN-PN	83-3722754-
-------------------------------	----------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA SUBPL INC	c EIN-PN	85-3596107-
-------------------------------	------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA AC INC	c EIN-PN	86-2470849-
-------------------------------	---------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA SUBARU PHILA INC	c EIN-PN	86-2380662-
-------------------------------	-------------------------	-----------------	-------------

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name

b Name of plan sponsor	CIOCCA COLLISION QUAKERTOWN LLC	c EIN-PN	85-3937800-
-------------------------------	---------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT H WEST LLC	c EIN-PN	87-0958014-
-------------------------------	--------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT HY WEST LLC	c EIN-PN	87-1529071-
-------------------------------	---------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	BENNETT PRE OWNED OF LEBANON LLC	c EIN-PN	87-2224261-
-------------------------------	----------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA COLLISION PHILADELPHIA LLC	c EIN-PN	87-4783439-
-------------------------------	-----------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA COLLISION WILLIAMSPORT LLC	c EIN-PN	87-4799570-
-------------------------------	-----------------------------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA NJ K INC DBA CIOCCA KIA - TRENTON	c EIN-PN	88-0571159-
-------------------------------	--	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA SUBLV INC DBA CIOCCA SUBARU - TRENTON	c EIN-PN	88-0955453-
-------------------------------	--	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA FLNJ INC DBA CIOCCA FD LINC LAWRENCEVILLE	c EIN-PN	88-1067001-
-------------------------------	--	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA CDJR INC	c EIN-PN	88-2427770-
-------------------------------	-----------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA FMGM INC	c EIN-PN	88-2344196-
-------------------------------	-----------------	-----------------	-------------

a Plan name

b Name of plan sponsor	CIOCCA FMSUB INC - SUBARU	c EIN-PN	88-2455391-
-------------------------------	---------------------------	-----------------	-------------

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of plan sponsor CIOCCA FMFL INC - FORD**c** EIN-PN 88-2362990-**a** Plan name**b** Name of plan sponsor CIOCCA FMIN INC - INFINITI**c** EIN-PN 88-2319009-**a** Plan name**b** Name of plan sponsor CIOCCA FMPO INC- PORSCHE**c** EIN-PN 88-2406140-**a** Plan name**b** Name of plan sponsor CIOCCA FMAV INC (AUDI & VW)**c** EIN-PN 88-2384122-**a** Plan name**b** Name of plan sponsor CIOCCA CDJR DUN INC**c** EIN-PN 92-3132995-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION OF EWING**c** EIN-PN 88-3333165-**a** Plan name**b** Name of plan sponsor MOYER AUTO GRP STORE 5 KM INC**c** EIN-PN 92-1058147-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION BRIDGEWATER**c** EIN-PN 92-3748100-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION LANCASTER**c** EIN-PN 92-3096731-**a** Plan name**b** Name of plan sponsor CIOCCA PARTS WAREHOUSE OF FLEMINGTON**c** EIN-PN 93-2833635-**a** Plan name**b** Name of plan sponsor CIOCCA MBNL INC**c** EIN-PN 93-3785333-**a** Plan name**b** Name of plan sponsor DORAZIO 314 LLC**c** EIN-PN 93-3894658-

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of plan sponsor CIOCCA YKCH INC (CHEVROLET)**c** EIN-PN 93-3819072-**a** Plan name**b** Name of plan sponsor CIOCCA YKBM INC (BMW)**c** EIN-PN 93-3848674-**a** Plan name**b** Name of plan sponsor CIOCCA YKSUB INC (SUBARU)**c** EIN-PN 93-3871308-**a** Plan name**b** Name of plan sponsor CIOCCA RLCH INC (CHEVY RL)**c** EIN-PN 93-3915947-**a** Plan name**b** Name of plan sponsor CIOCCA RLFD INC (FORD RL)**c** EIN-PN 93-3945515-**a** Plan name**b** Name of plan sponsor CIOCCA YKHON (HONDA)**c** EIN-PN 93-3968702-**a** Plan name**b** Name of plan sponsor CIOCCA YKNIS INC (NISSAN)**c** EIN-PN 93-3992107-**a** Plan name**b** Name of plan sponsor CIOCCA YKFD INC (FORD)**c** EIN-PN 93-4013998-**a** Plan name**b** Name of plan sponsor CIOCCA HNC DJR INC (CDJR HANOVER)**c** EIN-PN 93-4213339-**a** Plan name**b** Name of plan sponsor CIOCCA HNHON (HONDA HAN)**c** EIN-PN 93-4234105-**a** Plan name**b** Name of plan sponsor YOUR AUTOMOTIVE SOURCE INC**c** EIN-PN 93-4059356-**a** Plan name**b** Name of plan sponsor AUTO 1 LANCASTER INC**c** EIN-PN 93-4083220-

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name**b** Name of plan sponsor CIOCCA CAR WASH YORK INC**c** EIN-PN 93-4105209-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION YORK INC**c** EIN-PN 93-4144324-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION HANOVER INC**c** EIN-PN 93-4170849-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION RED LION INC**c** EIN-PN 93-4253465-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION EAST INC**c** EIN-PN 93-2517922-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION WEST YORK INC**c** EIN-PN 80-0720584-**a** Plan name**b** Name of plan sponsor CIOCCA COLLISION EAST YORK INC**c** EIN-PN 92-3053940-**a** Plan name**b** Name of plan sponsor CIOCCA MANAGEMENT COMPANY**c** EIN-PN 93-4253465-**a** Plan name**b** Name of plan sponsor CIOCCA VW MUNCY INC**c** EIN-PN 93-2517922-**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN**a** Plan name**b** Name of plan sponsor**c** EIN-PN

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2024 or fiscal plan year beginning <u>01/01/2024</u> and ending <u>12/31/2024</u>	
A Name of plan <u>PENNSYLVANIA AUTOMOTIVE ASSOCIATION EXPERIENCE RATED INSURANCE TRUST</u>	B Three-digit plan number (PN) ▶ <u>502</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>PENNSYLVANIA AUTOMOTIVE ASSOCIATION</u>	D Employer Identification Number (EIN) <u>20-6051638</u>

Part I	Asset and Liability Statement
---------------	--------------------------------------

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	824508	1163489
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	116894	92490
(2) Participant contributions	1b(2)	0	0
(3) Other	1b(3)	1638313	1668004
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	0
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	0	0
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	0	0
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	0	0
(15) Other	1c(15)	0	0

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)	0	0
(2) Employer real property.....	1d(2)	0	0
e Buildings and other property used in plan operation.....	1e	0	0
f Total assets (add all amounts in lines 1a through 1e).....	1f	2579715	2923983
Liabilities			
g Benefit claims payable.....	1g	766352	1107754
h Operating payables.....	1h	0	0
i Acquisition indebtedness.....	1i	0	0
j Other liabilities.....	1j	106972	120561
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	873324	1228315
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	1706391	1695668

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)	7858980	
(B) Participants.....	2a(1)(B)	0	
(C) Others (including rollovers).....	2a(1)(C)	0	
(2) Noncash contributions.....	2a(2)	0	
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		7858980
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	0	
(B) U.S. Government securities.....	2b(1)(B)	0	
(C) Corporate debt instruments.....	2b(1)(C)	0	
(D) Loans (other than to participants).....	2b(1)(D)	0	
(E) Participant loans.....	2b(1)(E)	0	
(F) Other.....	2b(1)(F)	0	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)	0	
(B) Common stock.....	2b(2)(B)	0	
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	0	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents.....	2b(3)		0
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	0	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	0	
(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)	0	
(B) Other.....	2b(5)(B)	0	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	0
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	0
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	0
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	0
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	0
c Other income	2c	0
d Total income. Add all income amounts in column (b) and enter total.....	2d	7858980

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	0
(2) To insurance carriers for the provision of benefits	2e(2)	6601007
(3) Other.....	2e(3)	1207077
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	7808084
f Corrective distributions (see instructions)	2f	0
g Certain deemed distributions of participant loans (see instructions).....	2g	0
h Interest expense.....	2h	0
i Administrative expenses:		
(1) Salaries and allowances	2i(1)	0
(2) Contract administrator fees	2i(2)	61619
(3) Recordkeeping fees	2i(3)	0
(4) IQPA audit fees	2i(4)	0
(5) Investment advisory and investment management fees	2i(5)	0
(6) Bank or trust company trustee/custodial fees	2i(6)	0
(7) Actuarial fees	2i(7)	0
(8) Legal fees	2i(8)	0
(9) Valuation/appraisal fees	2i(9)	0
(10) Other trustee fees and expenses	2i(10)	0
(11) Other expenses.....	2i(11)	0
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)	61619
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j	7869703

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k	-10723
l Transfers of assets:		
(1) To this plan.....	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

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

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

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

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

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: **BOYER & RITTER**

(2) EIN: **23-1311005**

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

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

Part IV Compliance Questions

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

During the plan year:

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

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

**PENNSYLVANIA AUTOMOTIVE
ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

FINANCIAL REPORT

DECEMBER 31, 2024

CONTENTS

INDEPENDENT AUDITOR'S REPORT ON THE FINANCIAL STATEMENTS	1 - 2
---	-------

FINANCIAL STATEMENTS

Statements of Net Assets Available for Benefits	3
Statement of Changes in Net Assets Available for Benefits	4
Statements of Benefit Obligations	5
Statement of Changes in Benefit Obligations	6
Notes to Financial Statements	7 - 10

INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Pennsylvania Automotive Association
Experience Rated Insurance Trust
Harrisburg, Pennsylvania

Opinion

We have audited the financial statements of the Pennsylvania Automotive Association Experience Rated Insurance Trust (the Trust), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and statements of benefit obligations as of December 31, 2024 and 2023, the related statement of changes in net assets available for benefits and the statement of changes in benefit obligations for the year ended December 31, 2024, and the related notes to the financial statements.

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (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 Trust and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Responsibilities of Management for the Financial Statements (Continued)

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 Trust'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 Trust'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.

A handwritten signature in black ink that reads "Boyer & Ritter". The signature is written in a cursive, flowing style with a large, sweeping underline.

Camp Hill, Pennsylvania
July 7, 2025

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2024 and 2023**

	2024	2023
ASSETS		
Cash, non-interest bearing	\$ 1,163,489	\$ 824,508
Premiums receivable	92,490	116,894
Due from affiliated companies	1,668,004	1,638,313
Total assets	2,923,983	2,579,715
LIABILITIES		
Premiums payable to insurance companies	1,107,754	766,352
Dental premiums held	112,817	105,536
Due to affiliated companies	7,744	1,436
Total liabilities	1,228,315	873,324
Net assets available for benefits	\$ 1,695,668	\$ 1,706,391

See Notes to Financial Statements.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Year Ended December 31, 2024**

Additions to Plan Assets Attributed to:	
Contributions and premiums	
Participating employer contributions	\$ 6,601,006
Dental contributions	1,257,974
Total additions	<u>7,858,980</u>
Deductions from Plan Assets Attributed to:	
Benefits paid on behalf of participants	
Payments of premiums to insurance companies	6,601,007
Dental claims	1,207,077
	<u>7,808,084</u>
Administrative expenses	
Dental ASO commissions	37,739
Dental ASO admin fees	23,880
	<u>61,619</u>
Total deductions	<u>7,869,703</u>
Changes in net assets	(10,723)
Net Assets Available for Benefits:	
January 1, 2024	<u>1,706,391</u>
December 31, 2024	<u>\$ 1,695,668</u>

See Notes to Financial Statements.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

**STATEMENTS OF BENEFIT OBLIGATIONS
Years Ended December 31, 2024 and 2023**

	2024	2023
BENEFIT OBLIGATIONS		
Amount currently payable to or for participants, beneficiaries and dependents	\$ -	\$ -
Obligations for current benefit coverage		
Dental claims incurred but not reported	42,390	38,385
Total plan benefit obligations	\$ 42,390	\$ 38,385

See Notes to Financial Statements.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

**STATEMENT OF CHANGES IN BENEFIT OBLIGATIONS
Year Ended December 31, 2024**

<hr/>	
Amounts Currently Payable to or for Participants, Beneficiaries and Dependents	
Balance - January 1, 2024	\$ -
Dental claims reported and approved for payment	1,207,077
Dental claims paid	<u>(1,207,077)</u>
Balance - December 31, 2024	<u>-</u>
Other Obligations for Current Benefit Coverage	
Dental claims incurred but not reported	
Balance - January 1, 2024	38,385
Net change during the year	<u>4,005</u>
Balance - December 31, 2024	<u>42,390</u>
Total plan benefit obligations at end of year	<u><u>\$ 42,390</u></u>

See Notes to Financial Statements.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

NOTES TO FINANCIAL STATEMENTS

Note 1. Description of Trust and Group Insurance Arrangements

The following brief description of the Trust and provides only general information. Participants should refer to the Trust agreement for a more complete description of the Trust's provisions.

Description of Trust: The Trust provides benefits to active members and associate members of the Pennsylvania Automotive Association. The benefits are provided through several insurance companies for health, group term life insurance, accidental death and dismemberment and vision. The plan is self-insured for dental benefits. The Trust is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Fully Insured Benefits: Through insurance company contracts, the Trust provides for group term life insurance, accidental death and dismemberment insurance and a complete health insurance package including hospital, medical, surgical, major medical and vision coverage. The group term life insurance does not create any cash surrender or paid-up insurance values.

Self-Funded Dental Benefits: Effective July 1, 2018, the Trust was amended to offer self-insured dental to participating employers. The self-insured dental program is administered by the Pennsylvania Automotive Association Group Insurance Trust (Group Trust), an affiliate. The claims for self-insured benefits are processed by the Group Trust's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the Trust. Despite the Group Trust's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Trust.

COBRA - Consolidated Omnibus Budget Reconciliation Act: Generally effective for years beginning on or after July 1, 1986, the Trust is required to offer continuation of benefits for a specified period of time to qualified members and their dependents that would not otherwise be eligible for continued coverage because of a particular qualifying event as required by law.

Administrative Fees: The Trust pays administrative expenses that consist primarily of administrative fees paid to the third-party claims administrator. These expenses are reported on the Statement of Changes in Net Assets Available for Benefits. All other administrative expenses, such as professional fees, may be paid by the Trust.

Note 2. Summary of Significant Accounting Policies

Basis of Accounting: The Trust maintains its financial records on the accrual basis of accounting.

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

NOTES TO FINANCIAL STATEMENTS

Note 2. Summary of Significant Account Policies (Continued)

Employer Premiums: Employer premiums paid to the Program are intended to fund the insurance premiums assessed on participants by the insurance companies for fully insured products.

Payment of Benefits: Premiums paid by the Trust are recorded as premium payments in the accompanying statement of changes in net assets available for benefits. Claim payments are recorded when paid by the third-party claims processor.

Claims Incurred but not Reported: The Trust's liabilities for dental claims incurred but not reported as of December 31, 2024, were estimated based on historical claims information provided to management by the Trust's third-party administrator. These amounts are paid by the Trust only if claims are submitted and approved for payment.

Income Taxes: The Trust operates as a qualified taxable trust. Management evaluated the Trust's tax positions and concluded that the Trust had taken no uncertain tax positions that require adjustment to the financial statements.

The Trust is taxable to the extent that its investment income exceeds administrative expenses. In the event the Internal Revenue Service (IRS) audits the Trust and disallows the filing as a taxable trust, the Trust will be liable for income taxes and interest as a taxable organization. Management believes that any action by the IRS upon the Trust's filing status will not have a material adverse effect on the financial condition of the Trust.

Subsequent Events: The Trust's management has evaluated subsequent events through July 7, 2025, the date the financial statements were available to be issued.

Note 3. Concentrations of Credit Risk

Trust services are provided principally to participating new car and truck dealers in the Commonwealth of Pennsylvania. The ability of these employers to pay premiums and insurance carriers to pay claims is subject to changes in general economic conditions and the overall health of the participants.

The Trust maintains its cash balance at one financial institution. These balances may, at times, exceed federally insured limits. Accounts at the institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. The Trust has not experienced any losses maintaining its balances in excess of federally insured limits. Management believes it is not exposed to any significant concentration of credit risk on its cash accounts.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

NOTES TO FINANCIAL STATEMENTS

Note 4. Premiums Payable to Insurance Companies

Premiums payable to insurance companies at December 31, 2024 and 2023, consisted of premiums received in advance from participating employers. These amounts were paid in January 2025 and 2024, respectively.

Note 5. Dental Contributions Held

Dental contributions held consisted of contributions received in advance from participating employers. Contributions received by the Trusts from participating employers are segregated from fully insured assets and held to pay claims weekly as reported by United Concordia.

Note 6. Risks and Uncertainties

Benefit Obligations: The Trust's estimate of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimation and assumption process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

Governmental Regulations: The Trust is subject to Federal and state insurance regulations including rules related to permissible activities. The Trust is in compliance with applicable Federal regulations and is reviewing state regulations for certain self-insured activities.

Note 7. Related Parties and Party-in-Interest Transactions

The Pennsylvania Automotive Association (PAA), PAA Political Action Committee (PAC), PAA Services, Inc. and its Subsidiary, PAA Foundation and PAA Group Rated Insurance Trust are related organizations.

The Trust pays administrative expenses that consist primarily of administrative fees paid to third-party claims administrators. These transactions are party-in-interest transactions under ERISA.

**PENNSYLVANIA AUTOMOTIVE ASSOCIATION
EXPERIENCE RATED INSURANCE TRUST**

NOTES TO FINANCIAL STATEMENTS

Note 8. Plan Termination

In the event of termination of membership of a participating dealer from the program, the dealer is not entitled to any share of the residual assets of the Trust. In the event that the entire plan would be terminated, any surplus or deficit in the Trust would be determined at the time of termination. If a deficit exists at such time, the plan sponsor would be charged with funding the deficit.

Note 9. Dental Insurance Rate Stabilization Refund

The Trust has a contract with United Concordia for dental insurance. In 2015, the Trust renewed its agreement with United Concordia using a prospective rating which adjusts the premiums to reflect current losses instead of a retrospective rating which adjusts premiums based on prior period loss experience. When using the retrospective rating, the Trust paid in a premium creating a substantial rate stabilization reserve fund held by United Concordia. As part of the renewed agreement, United Concordia agreed to refund amounts in the rate stabilization fund over a three-year period beginning in February 2016. The total amount of the reserve repaid to the Trust was \$1,825,404.

The dental premiums are paid to the PAA Group Insurance Trust. The PAA Group Insurance Trust pays claims as assessed by the carrier on a weekly basis from premiums collected. Any excess or deficit premiums is transferred to or funded by the dental rate stabilization fund. The Trust will use these amounts to stabilize the dental rates of its subscribers in future years.