Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

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

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [X]

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1956

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

8150 MADISON AVENUE
INDIANAPOLIS, IN 46227

2b Employer Identification Number (EIN) 35-6073275

2c Plan Sponsor's telephone number 219-255-9692

2d Business code (see instructions) 525100

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	08/13/2025	MARK MCCLESKEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	1133
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	1080
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	1154
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	49
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	1203
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	325

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 4F 4Q

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

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
BERKSHIRE HATHAWAY SPECIALTY 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
63-0202590	22276	47-MSL000366-02	1154	11/01/2023	10/31/2024

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(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	

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
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** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	693981
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

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

1 Coverage Information:

(a) Name of insurance carrier
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	**(c)** NAIC code	**(d)** Contract or identification number	**(e)** Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	**(g)** To
13-1423090	69744	G3273 & C4538	1204	11/01/2023	10/31/2024

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

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

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

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
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** [X] 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** [X] Other (specify) ▶ ACCIDENTAL DEATH & 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)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	82095
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

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
HCC 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
35-1817054	92711	HCCLOT40599	1153	11/01/2023	10/31/2024

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	188789
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

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
EXPRESS SCRIPTS INC.

(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
43-1420563	60025	RX-INS H&W	56	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
5159	

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

STERLING BENEFIT ADVISORS
1428 N. POTTER ROAD
PARK RIDGE, IL 60068

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
5159			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**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
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)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	95447
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 A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

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
UNITED HEALTHCARE

(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
94-0734860	71420	H2001	61	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
14760	

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

STERLING BENEFIT ADVISORS
1428 N. POTTER ROAD
PARK RIDGE, IL 60068

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
14760			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
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)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	87484
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)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**2023** **This Form is Open to Public Inspection.**

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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(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)

ANTHEM INSURANCE COMPANIES

35-0781558

(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?
62 49 50 13 12	NONE	702121	Yes [X] No [ ]	Yes [ ] No [X]	894249	Yes [ ] No [X]

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

EVERSIDE HEALTH LLC

45-3449075

(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?
99 50	NONE	404088	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ARNOLD AND KADJAN

36-2498571

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	385706	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

BENISTAR INC.

06-1490685

(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?
50 49	NONE	168699	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INNOVATION SOFTWARE SOLUTIONS

(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?
50 49	NONE	119975	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EAGAN & ASSOCIATES PC

35-2079674

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	106332	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

FOSTER & FOSTER

59-1921114

(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?
50 11	NONE	88781	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

RICHARD J. WOLF AND COMPANY, INC.

36-3182363

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	66164	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

FIFTH THIRD BANK

31-0676865

(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?
50 49	NONE	32175	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

L. M. HENDERSON & CO, LLP

20-5520612

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	31000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

COMPUSYS OF UTAH, INC

84-0869853

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	25294	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MIDWEST PRESORT SERVICES

32-0092401

(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?
50 36	NONE	24791	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

WINCHESTER PROPERTIES

80-0480837

(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?
99 50	NONE	23150	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CAPFINANCIAL PARTNERS, LLC

26-0058143

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	20500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

VIRTUAL INNOVATIONS

27-3239893

(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?
50 49	NONE	11329	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

ABS BUSINESS PRODUCTS

2268 WESTBROOKE DR
COLUMBUS, OH 43228

(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?
36 50	NONE	9221	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MARK MCCLESKY

35-6073275

(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?
30 50	EMPLOYEE	130000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

JACOB SWITZER

35-6073275

(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?
30 50	EMPLOYEE	70385	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

LISA WILDE

35-6073275

(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?
30 50	EMPLOYEE	45775	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

JOSH TODD

35-6073275

(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?
30 50	EMPLOYEE	39885	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

Part I Service Provider Information (continued)

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

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

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

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

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

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

(complete as many entries as needed)

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

a Name:

b EIN:

c Position:

d Address:

e Telephone:

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

2023

This Form is Open to Public Inspection

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

A Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASON HEALTH & WELFARE

D Employer Identification Number (EIN)
35-6073275

Part I Asset and Liability Statement

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

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	2029664	2105320
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	866830	835308
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	3585916	6438207
(2) U.S. Government securities	1c(2)	2596953	3157015
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	17218109	19714223
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	422171	256971

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	47825	29135
f Total assets (add all amounts in lines 1a through 1e)	1f	26767468	32536179
Liabilities			
g Benefit claims payable	1g	2365000	1925000
h Operating payables	1h	410349	1311720
i Acquisition indebtedness	1i		
j Other liabilities	1j	9545274	11498630
k Total liabilities (add all amounts in lines 1g through1j)	1k	12320623	14735350
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	14446845	17800829

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)	18460506	
(B) Participants	2a(1)(B)	738511	
(C) Others (including rollovers)	2a(1)(C)	95107	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		19294124
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	30577	
(B) U.S. Government securities	2b(1)(B)	84000	
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		114577
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	693562	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		693562
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	9262991	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	10476796	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		-1213805
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	38971	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		38971

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		3473510
c Other income	2c		613089
d Total income. Add all **income** amounts in column (b) and enter total	2d		23014028
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	13680762	
(2) To insurance carriers for the provision of benefits	2e(2)	4227858	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		17908620
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)	286794	
(2) Contract administrator fees	2i(2)	106332	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	97164	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	23313	
(7) Actuarial fees	2i(7)	88781	
(8) Legal fees	2i(8)	385706	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	18474	
(11) Other expenses	2i(11)	744860	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		1751424
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		19660044
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		3353984
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: L.M. HENDERSON & COMPANY, LLP **(2)** EIN: 20-5520612

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**			

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

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

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

5b(1) Name of plan(s)	**5b(2)** EIN(s)	**5b(3)** PN(s)
ISC OF PLASTERERS & CEMENT MASON PENSION FUND	35-6244870	001

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 _____.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

FINANCIAL STATEMENTS

Years Ended October 31, 2024 and October 31, 2023

L | M | H

L. M. HENDERSON & COMPANY LLP
CERTIFIED PUBLIC ACCOUNTANTS / ADVISORS

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

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NOTE: All other schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

L | M | H

"Serving Our Clients Since 1948"

L. M. HENDERSON & COMPANY LLP
CERTIFIED PUBLIC ACCOUNTANTS / ADVISORS

James J. Cline, Jr.
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Jude A. Thompson
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Independent Auditor's Report

To the Board of Trustees of
Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund
Indianapolis, IN

Opinion

We have audited the accompanying financial statements of Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund, 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 plan obligations as of October 31, 2024 and October 31, 2023, and the related statements of changes in net assets available for benefits and of changes in plan benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and plan benefit obligations for Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund as of October 31, 2024 and October 31, 2023, and the changes in its net assets available for benefits and changes in its plan benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

Management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

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

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

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund'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 Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule as listed in the accompanying index is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

L. M. Henderson & Company, L.L.P.

Certified Public Accountants
Indianapolis, Indiana

August 8, 2025

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

Statements of Net Assets Available for Benefits

at October 31, 2024 and October 31, 2023

	October 31, 2024	October 31, 2023
ASSETS		
Investments at fair value:		
Cash and cash equivalents	$ 60,220	$ 7,471
U.S. Government securities	3,157,015	2,596,953
Mutual funds - equity	4,222,548	3,324,328
Mutual funds - fixed income	15,491,675	13,893,781
Total investments	22,931,458	19,822,533
Receivables:		
Contributions & reciprocity	2,105,320	2,029,664
Accrued interest	4,755	10,209
Due from Pension Fund	306,544	474,898
Other receivables	524,009	381,723
Total receivables	2,940,628	2,896,494
Other assets:		
Cash on deposit - checking	6,295,370	3,479,305
Cash on deposit - HRA checking	82,617	99,140
Prepaid expenses	212,752	349,046
Property and equipment, net of depreciation	29,135	47,825
Right-of-use assets, net of amortization	44,219	73,125
Total other assets	6,664,093	4,048,441
Total assets	32,536,179	26,767,468
LIABILITIES		
Accounts payable	1,151,174	155,200
Reciprocity payable	67,662	64,154
Due to other funds	5,464	87,505
Accrued expenses	43,201	30,365
Lease liabilities	44,219	73,125
Total liabilities	1,311,720	410,349
NET ASSETS AVAILABLE FOR BENEFITS	$ 31,224,459	$ 26,357,119

See Notes to Financial Statements.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

Statements of Changes in Net Assets Available for Benefits

Years Ended October 31, 2024 and October 31, 2023

	Year Ended	
	October 31, 2024	October 31, 2023
ADDITIONS:		
Investment income:		
Net appreciation (depreciation) in fair value of investments	$ 2,298,676	$ (232,426)
Interest and dividend income	808,139	676,762
	3,106,815	444,336
Less: Investment expenses	(23,313)	(22,418)
Net investment income	3,083,502	421,918
Employer contributions, net reciprocity paid	18,460,506	16,369,453
Self-pay contributions	738,511	681,927
Merger contributions	-	124,580
Subrogation	22,216	-
Other	18,301	22,977
Collections from other funds	54,590	33,511
Total additions	22,377,626	17,654,366
DEDUCTIONS:		
Claims, net of rebates	11,897,538	13,132,799
Claims - participant's benefits bank	2,223,224	1,753,745
Insurance premiums	1,142,998	921,561
Claims fees	727,416	495,139
Clinic administration fees	404,088	336,000
	16,395,264	16,639,244
Administrative and other expense:		
Administrative fees	106,332	240,659
Trustee expenses	18,474	12,057
Financial statement, tax preparation and payroll audit fees	97,164	98,132
Legal fees	385,706	320,753
Actuarial consulting fees	88,781	137,438
Software licensing fees	253,144	93,287
Fund office (payroll, rent, printing, postage, miscellaneous)	778,510	555,750
	1,728,111	1,458,076
Less: Reimbursements from Pension Fund	(613,089)	(404,831)
Net administrative and other expense	1,115,022	1,053,245
Total deductions	17,510,286	17,692,489
NET INCREASE (DECREASE)	4,867,340	(38,123)
NET ASSETS AVAILABLE FOR BENEFITS:		
Balance, beginning of year	26,357,119	27,210,443
Prior period adjustment	-	(815,201)
	26,357,119	26,395,242
Balance, end of year	$ 31,224,459	$ 26,357,119

See Notes to Financial Statements.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

Statements of Plan Benefit Obligations

at October 31, 2024 and October 31, 2023

	October 31, 2024	October 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS:		
Medical claims payable	$ 26,065	$ 436,887
	26,065	436,887
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGES AT PRESENT VALUE OF ESTIMATED AMOUNTS:		
Claims incurred but not reported	1,898,935	1,928,113
Accumulated eligibility credits	11,498,630	9,545,274
	13,397,565	11,473,387
TOTAL OBLIGATIONS OTHER THAN POST-RETIREMENT BENEFIT OBLIGATIONS	13,423,630	11,910,274
POST-RETIREMENT BENEFIT OBLIGATIONS:		
Net post-retirement benefit obligations:		
Retired participants and beneficiaries	2,219,000	3,316,000
Other participants fully eligible to receive benefits	7,659,000	7,728,000
Participants not yet eligible to receive benefits	9,648,000	11,074,000
	19,526,000	22,118,000
TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	$ 32,949,630	$ 34,028,274

See Notes to Financial Statements.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

Statements of Changes in Plan Benefit Obligations

Years Ended October 31, 2024 and October 31, 2023

	Year Ended	
	October 31, 2024	October 31, 2023
AMOUNTS CURRENTLY PAYABLE		
Balance at beginning of year	$ 2,365,000	$ 3,559,000
Claims reported and approved for payment, including benefits reclassified from benefit obligations	10,294,782	11,771,095
Change in claims incurred but not reported	(440,000)	(1,194,000)
Claims paid	(10,294,782)	(11,771,095)
Balance at end of year	1,925,000	2,365,000
ACCUMULATED ELIGIBILITY CREDITS, NET OF AMOUNTS CURRENTLY PAYABLE		
Balance at beginning of year	9,545,274	9,327,638
Increase of estimated obligation for future group insurance coverage based on participants' accumulated eligibility arising from contributions received	1,953,356	217,636
Balance at end of year	11,498,630	9,545,274
TOTAL OBLIGATIONS OTHER THAN POST-RETIREMENT BENEFIT OBLIGATIONS	13,423,630	11,910,274
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESEVENT VALUE OF ESTIMATED AMOUNTS		
Balance at beginning of year	22,118,000	21,228,000
Increase (decrease) in post-retirement benefits attributable to:		
Service cost	891,000	926,000
Interest cost	1,299,000	1,131,000
Benefits paid	(614,000)	(662,000)
Claims cost and self pay rates	(4,058,000)	(1,283,000)
Changes in actuarial assumptions including gains (losses)	(110,000)	778,000
Balance at end of year	19,526,000	22,118,000
TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	$ 32,949,630	$ 34,028,274

See Notes to Financial Statements.

Notes to Financial Statements

October 31, 2024 and October 31, 2023

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies followed by the Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund (the Plan) are listed below:

Basis of Accounting
Assets and liabilities and income and expense are recognized on the accrual basis of accounting.

Investment Valuation and Income Recognition
Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements.

In accordance with the policy of stating investments at fair value, net unrealized appreciation or depreciation for the year is reflected in the statements of changes in net assets available for benefits.

The Plan follows FASB ASU 2015-07, *Fair Value Measurements*: *Disclosure for Investments in Certain Entities that Calculate Net Asset Value (NAV) per Share* (Topic 820). The Plan also follows FASB ASU 2015-12: *Plan Accounting: Health and Welfare Benefit plans: Part 2 - Plan Investment Disclosures*. ASU 2015-07 and 2015-12 were simplifications of certain employee benefit plan investment disclosures. The Fund adopted ASU 2018-13, *Fair Value Measurements* (Topic 820): *Disclosure Framework Changes to the Disclosure Requirements for Fair Value Measurements* during 2021 and applied it retrospectively. ASU 2018-13 streamlines the disclosure requirements within Accounting Standards Codification (ASC) Topic 820.

Concentrations of Credit Risk
The Plan maintains cash balances with financial institutions which may exceed the Federal Deposit Insurance Corporation limit of $250,000. In addition, the Plan maintains accounts with brokerage firms which contain cash and securities. Balances are protected up to $500,000 (with a limit of $250,000 for cash) by the Securities Investor Protection Corporation. See Note 10.

Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Trustees to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Property and Equipment
Property and equipment are carried at cost. Depreciation is computed using the straight-line method over the useful lives. When assets are retired or otherwise disposed of, the costs and related accumulated depreciation are removed from the accounts, and any resulting gain or loss is recognized as income for the period. The cost of maintenance and repairs is charged to expense as incurred; significant renewals and improvements are capitalized. Depreciation expense, included in fund office expense, for the years ended October 31, 2024 and October 31, 2023 was $18,690 and $18,207 respectively.

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Leases
The Plan follows FASB ASU 2016-02, *Leases* (Topic 842) and all subsequent lease related ASUs. This standard modified the guidance used by lessors and lessees to account for leasing transactions. The Plan elected practical expedients permitted under the transition guidance permitting the Plan to not assess historical lease classification, prior conclusions related to indirect costs, and whether any expired or existing contracts are or contain leases. See Note 8 for additional information

Actuarial Present Value of Accumulated Plan Benefits
The amount reported as the post-retirement benefit obligation represents the actuarial present value of the estimated cost of future benefits that are attributed by the terms of the Plan to employees' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Post-retirement benefits include future benefits expected to be paid to or for:

- Currently retired or terminated employees and their beneficiaries and dependents.
- Active employees and their beneficiaries and dependents after retirement.

The post-retirement benefit obligation is expected to be funded by contributions from the employers and from existing plan assets. Prior to an active employee's full eligibility date, the post-retirement benefit obligation is the portion of the expected post-retirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date. The actuarial present value of the expected post-retirement benefit obligation has been determined by the Plan's actuary under ASC 965, and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

The following were other significant assumptions used in the valuation as of October 31, 2024 and October 31, 2023:

October 31, 2024:	
Weighted-Average Discount Rate:	5.09%
Health Trend Rates:	7% graded down to 4% by 2074
Assumed percent electing coverage:	30% of single members and 80% of married members
Post-retirement Mortality Rates:	RPH-2015 total dataset mortality table fully generational using scale MP 2015.
Cost Method:	Projected unit credit

October 31, 2023:	
Weighted-Average Discount Rate:	5.72%
Health Trend Rates:	7% graded down to 4% by 2074
Assumed percent electing coverage:	30% of single members and 80% of married members
Post-retirement Mortality Rates:	RPH-2015 total dataset mortality table fully generational using scale MP 2015.
Cost Method:	Projected unit credit

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

Plan Termination
Although it has not expressed any interest to do so, the trustees have the right under the Plan to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, all Plan expenses incurred, but unpaid will be paid and remaining funds will be applied to the purpose and obligations for which the fund was established.

Subsequent Events
Management has evaluated subsequent events through August 8, 2025, the date in which the financial statements were available to be issued.

Reclassifications
Certain 2023 items have been reclassified to conform to 2024 presentation.

Note 2: DESCRIPTION OF THE PLAN

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

General
The Plan is a multi-employer defined benefit health and welfare plan established for members of participating locals of the Plasterers and Cement Mason International Union (the "Plan Sponsor"). The Plan is subjected to the provisions of ERISA.

Effective November 1, 2021, the Plan's Board of Trustees approved the merger of the Construction Industry Welfare Fund of Central Illinois into the Plan. Funding received from this merger totaled $-0- and $124,580 for the years ended October 31, 2024 and October 31, 2023, respectively.

Benefits
The Plan provides life insurance, accidental death and dismemberment insurance, disability income, prescription drug coverage, and major medical benefits to participants and dependents of participants who have sufficient contributions from participating employers or participant self-payments. Retired employees not covered by Medicare are entitled to similar health benefits. The Plan's Board of Trustees has the right to modify the benefits provided to participants at any time.

Eligibility
Members will be eligible for benefits the first day of the second month following the month they have accumulated, in the twenty-four most recent months, sufficient monthly contributions from the employers.

Contributions
Funding is from employers' contributions at rates specified in the collective bargaining agreements based on hours worked by the employee. Employees may be required to contribute specified amounts, in addition to deductibles and co-payments, determined periodically by the Plan's actuary to extend coverage to eligible dependents. The costs of post-retirement benefits are shared equally by the Plan's employers and retirees.

Employer and employee contributions receivable represent the total of employer and employee contributions received by the depository after October 31, which were applicable to the prior fiscal year. This amount does not reflect amounts due from employers who are contractually liable to the Plan but have failed to make contributions, or from employers who have filed inaccurate reports, if any.

The Plan follows Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2016-13, *Measurement of Credit Losses on Financial Instruments.* The standard requires recognition of an allowance that reflects a current estimate of credit losses expected to be incurred over the life of the asset. The Plan's third-party administrator continuously monitors collections and payments from employers and estimates the Plan's credit losses relating to its receivables based on a number of factors, including the age of receivable balances, history of losses, expectations of future credit losses, and the employers' ability to pay their obligations. As of October 31, 2024 and October 31, 2023, the Plan's allowance for uncollectible receivables was $-0- for both years.

Note 3: INVESTMENTS

Investments are held at U.S. Bank National Association. All investments are available for current, as well as future obligations. The following table represents the cost and fair value of investments:

	October 31, 2024		October 31, 2023	
	Cost	Fair Value	Cost	Fair Value
Cash and cash equivalents	$ 60,220	$ 60,220	$ 7,471	$ 7,471
U.S. Government securities	3,108,979	3,157,015	2,587,888	2,596,953
Mutual funds - equity	2,334,075	4,222,548	2,458,031	3,324,328
Mutual funds - fixed income	16,757,387	15,491,675	17,610,827	13,893,781
Total investments	$ 22,260,661	$ 22,931,458	$ 22,664,217	$ 19,822,533

During the years ended October 31, 2024 and October 31, 2023, the Plan's investments, including investments bought, sold, and held, appreciated (depreciated) by $2,298,676 and ($232,426), respectively.

The unrealized and realized gains and losses are computed differently for ERISA purposes than under accounting principles generally accepted in the United States of America. ERISA requires the gains and losses to be determined based on "revalued cost," that is, based on the current value of the assets at the beginning of the year (or based on the historical cost if the investment was acquired during the year), rather than by comparing historical cost to current value. During the year ended October 31, 2024, unrealized gains and realized losses were $3,512,482 and ($1,213,806), respectively. For ERISA purposes, unrealized losses and realized gains were ($2,771,690) and $473,014, respectively. During the year ended October 31, 2023, unrealized losses and realized gains were ($336,045) and $103,619, respectively. For ERISA purposes, unrealized and realized losses were ($226,674) and ($5,752), respectively.

Note 4: FAIR VALUE MEASUREMENTS

FASB ASC 820, *Fair Value Measurements,* establishes a framework for measuring fair value. The framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets;
- Quoted prices for identical or similar assets or liabilities in inactive markets;
- Inputs other than quoted prices that are observable for the assets or liabilities;
- Inputs that are derived principally from or corroborated by observable market data by correlation of other means.

If the assets or liabilities have a specified (contractual) term, the level 2 input must be observable for substantially the full term of the assets or liabilities.

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

The assets or liabilities fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

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

Cash equivalents: Valued at the cost which approximates fair value.

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

U.S. Government securities: Valued using pricing models maximizing the use of observable inputs for similar securities.

Note 4: FAIR VALUE MEASUREMENT (continued)

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

There were no transfers between levels during 2024 or 2023.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of October 31, 2024 and October 31, 2023:

	Assets at Fair Value as of October 31, 2024			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 60,220	$ -	$ -	$ 60,220
U.S. Government securities	-	3,157,015	-	3,157,015
Mutual funds - equity	4,222,548	-	-	4,222,548
Mutual funds - fixed income	15,491,675	-	-	15,491,675
Total assets at fair value	$ 19,774,443	$ 3,157,015	$ -	$ 22,931,458

	Assets at Fair Value as of October 31, 2023			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 7,471	$ -	$ -	$ 7,471
U.S. Government securities	-	2,596,953	-	2,596,953
Mutual funds - equity	3,324,328	-	-	3,324,328
Mutual funds - fixed income	13,893,781	-	-	13,893,781
Total assets at fair value	$ 17,225,580	$ 2,596,953	$ -	$ 19,822,533

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Note 5: PLAN BENEFIT OBLIGATIONS

Plan benefit obligations have been disclosed in accordance with FASB ASC 965-30. The post-retirement benefit obligations as shown in the statements of plan benefits were not reported as liabilities of the Plan on Form 5500 for the years ended October 31, 2024 and October 31, 2023. The liabilities are computed as follows:

Plan Benefit Obligations:
Medical claims payable at October 31, 2024 and October 31, 2023, totaled $26,065 and $436,887, respectively. Medical claims payable represents the amount currently due for medical claims incurred, reported, and processed prior to the end of the year.

Plan obligations at October 31, for health claims incurred by active participants but not reported (IBNR) was actuarily determined by dividing the four month claim run-out by the completion factor. The estimated obligation for IBNR by the Plan at October 31, 2024 and October 31, 2023 was calculated to be $1,898,935 and $1,928,113, respectively.

Such estimated amounts are reported in the accompanying statement of the Plan's benefit obligations at current value. Health claims incurred by retired participants but not reported at year-end are included in the post-retirement benefit obligation.

Accumulated eligibility credits:
The Plan collects employer contributions and self-payments on behalf of the participants. When the payments received exceed the cost of coverage, the Plan gives those participants credit for these funds in what is called a future benefit bank. These amounts, also known as accumulated eligibility credits, are maintained by the Plan administrator. The obligation for accumulated eligibility credits on the accompanying statement of benefit obligations represents the combined future benefit bank of all eligible participants. These amounts can be used by each participant for coverage, reimbursement of co-pays, and out-of-pocket costs when certain conditions are met. Accumulated eligibility credits at October 31, 2024 and October 31, 2023 were estimated to be $11,498,630 and $9,545,274, respectively.

Post-retirement benefit obligations:
Post-retirement benefit obligations were computed by an actuary, as required by FASB ASC 965-30. The post-retirement benefit obligation at October 31, 2024 and October 31, 2023, principally health benefits, relates to the following categories of participants (including their beneficiaries and dependents):

	October 31, 2024	October 31, 2023
Retired participants and beneficiaries	$ 2,219,000	$ 3,316,000
Other participants fully eligible to receive benefits	7,659,000	7,728,000
Participants not yet eligible to receive benefits	9,648,000	11,074,000
Totals	$ 19,526,000	$ 22,118,000

Note 5: PLAN BENEFIT OBLIGATIONS (continued)

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rate increased by one percentage, the total accumulated post-retirement benefit obligation as of October 31, 2024 and October 31, 2023 would increase by $2,387,000 and $2,537,000, respectively.

The Plan's deficiency of net assets over benefit obligations at October 31, 2024 and October 31, 2023, relates primarily to the post-retirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current bargaining agreements. It is expected that the post-retirement benefit obligation will be funded through future increases in the collectively bargained contribution rates.

Note 6: PRESCRIPTION REBATES AND STOP LOSS RECOVERIES

During the year ended October 31, 2024 and October 31, 2023, the Plan recognized $770,888 and $405,247 in prescription rebates, respectively, which are netted against benefits paid to or on behalf of participants on the statements of changes in net assets available for benefits.

The Plan's stop loss insurance assumes the liability for individual claims in excess of $325,000 annually per participant. Premiums paid for stop loss coverage were $674,328 and $502,779 for the years ended October 31, 2024 and October 31, 2023, respectively. Stop loss refunds of $-0- and $28,738 have been recorded in other receivables on the statements of net assets available for benefits and netted with claims paid in the accompanying statements of changes in net assets available for benefits for the years ended October 31, 2024 and October 31, 2023, respectively.

Note 7: MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003

Medicare eligible retirees are enrolled in a fully-insured Medicare supplement plan and in a separate Medicare Part D prescription drug plan. The claim costs associated with Medicare eligible retirees are not covered by the Plan. The Medicare supplement policies are purchased by participating retirees.

Note 8: LESSEE OPERATING LEASES

The Plan leases its office space and various office equipment under three different operating lease agreements. The leases are set to expire during the years ended October 31, 2025 through October 31, 2028. Two of these leases include purchase options at the expiration of the lease. There are no residual value guarantees and no restrictions or covenants imposed by any of the three leases. As of October 31, 2024 and October 31, 2023, the right-of-use assets totaled $100,657 and $100,657, respectively and the associated right-of-use amortization totaled $56,438 and $27,532, respectively. The right-of-use assets, net of amortization, are included within other assets on the statements of net assets available for benefit, and the associated lease liabilities are included in other liabilities on the statements of net assets available for benefit in the amount of $44,219 and $73,125 for the years ended October 31, 2024 and October 31, 2023, respectively.

Rental and operating lease expense for the years ended October 31, 2024 and October 31, 2023 totaled $30,710 and $26,738, respectively, and is recorded in fund office expense on the statements of changes in net assets available for benefits.

The weighted average remaining lease term is 27.58 months and the weighted average discount rate is 4.06% for the leases as of October 31, 2024. The Plan elected to use the risk-free rate practical expedient as the discount rate for all new and existing leases after November 1, 2022.

The following table represents the future undiscounted lease payments for all leases as of October 31, 2024:

Year Ended October 31,	Amount
2025	$ 28,510
2026	7,611
2027	7,611
2028	3,395
Total undiscounted lease payments	47,127
Less: net present value adjustment	2,908
Lease liability	$ 44,219

Note 9: TAX STATUS

The Internal Revenue Service ("IRS") has determined and informed the Plan Sponsor by a letter dated September 26, 1974, that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code ("IRC"). The Plan has been amended since receiving the determination letter; however, the Plan administrator believes that the Plan is currently designed and being operated in compliance with applicable requirements of the IRC and, therefore, believes that the Plan is qualified, and the related trust is tax exempt.

GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of October 31, 2024 and October 31, 2023, there are no uncertain tax positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Note 10: CREDIT RISK

In accordance with FASB ASC 825-10-50-20, credit risk is the possibility that a loss may occur from the failure of another party to perform according to the terms of a contract. Bank deposits are federally insured up to $250,000 per federally insured bank. The following are deposits in excess of federally insured limits for the years ended October 31, 2024 and October 31, 2023, respectively:

	October 31, 2023	October 31, 2022
Deposits	$ 6,377,987	$ 3,578,445
Federally insured	332,617	349,140
Deposits in excess of federally insured limits	$ 6,045,370	$ 3,229,305

Note 11: PARTY-IN-INTEREST TRANSACTIONS

Effective August 2022, the Plan began sharing office space and personnel with the Indiana State Council of Plasterers and Cement Masons Pension Fund (the "Pension Fund"). The Pension Fund paid the Plan 50% of the total office salaries, building costs, administrative expenses, trustee expenses, and certain professional fees. These shared expenses are paid directly by the Plan and then are proportionally reimbursed by the Pension Fund. The total incurred reimbursement for the years ended October 31, 2024 and October 31, 2023 totaled $613,089 and $404,831, respectively. At October 31, 2024 and October 31, 2023, the amount due from the Pension Fund totaled $306,544 and $474,898, respectively.

The Plan contributed to a multi-employer defined contribution plan. For the years ended October 31, 2024 and October 31, 2023, contributions to the Indiana State Council of Plasterers and Cement Masons Pension Fund totaled $89,637 and $75,392 respectively.

Note 12 PARTY-IN-INTEREST TRANSACTIONS (continued)

The Plan had an agreement with HealthSCOPE Benefits, Inc. to provide administrative services to the Plan. This agreement terminated in March 2023. The related expenses for this service amounted to $-0- and $97,541 for the years ended October 31, 2024 and October 31, 2023, respectively.

The Plan had an agreement with UMR to provide claims processing services. The agreement for these services terminated in March 2023; however, run-out claims are still being processed. The related expenses for this service amounted to $-0- and $171,228 for the years ended October 31, 2024 and October 31, 2023, respectively.

The Plan has agreements with third parties for investment management services to assist in the review and evaluation of the investment policies and objectives of the Plan. Total fees paid for the years ended October 31, 2024 and October 31, 2023 were $23,313 and $22,418, respectively.

The Plan has an agreement with a third party for actuarial and health consulting services. Total fees paid for the years ended October 31, 2024 and October 31, 2023 were $88,781 and $137,438, respectively.

Note 13: RISKS AND UNCERTAINTIES

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

The benefit obligations reported are based on certain assumptions pertaining to interest rates, health care cost inflation rates, and participant demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Note 14: PRIOR PERIOD ADJUSTMENT

At October 31, 2023, a prior adjustment is reflected to properly account for contributions in the amount of $815,201 that were improperly included as contributions receivable and revenue during the year ended October 31, 2022.

Note 15: RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the IRS Form 5500 at October 31, 2024 and October 31, 2023:

	October 31, 2024	October 31, 2023
Net assets available for benefits per the financial statements	$ 31,224,459	$ 26,357,119
Benefit obligations currently payable	(1,925,000)	(2,365,000)
Accumulated eligibility credits	(11,498,630)	(9,545,274)
Net assets available for benefits per Form 5500	$ 17,800,829	$ 14,446,845

The following is a reconciliation of benefits paid to participants per the financial statements to the IRS Form 5500 for the years ended October 31, 2024 and October 31, 2023:

	October 31, 2024	October 31, 2023
Total cost of benefits and insurance coverage per financial statements	$ 16,395,264	$ 16,639,244
Add: amounts currently payable at end of year		
Obligations payable	1,925,000	2,365,000
Accumulated eligibility credits	11,498,630	9,545,274
Deduct: amounts payable at beginning of year		
Obligations payable	(2,365,000)	(3,559,000)
Accumulated eligibility credits	(9,545,274)	(9,327,638)
Benefits paid to or on behalf of participants per Form 5500	$ 17,908,620	$ 15,662,880

The following is a reconciliation of the change in net assets per the financial statements to the Form 5500:

	October 31, 2024
Change in net assets per the financial statements	$ 4,867,340
Add: Amounts currently payable at beginning of year	11,910,274
Less: Amounts currently payable at end of year	(13,423,630)
Change in net assets per the Form 5500	$ 3,353,984

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

SUPPLEMENTARY INFORMATION

at October 31, 2024

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

EIN: 35-6073275 PN: 501

Schedule H line 4i - Schedule of Assets (Held at End of Year) at October 31, 2024

(a)	(b) Identity of issuer, borrower, lessor, or similar party	(c) Description of investment including interest rate, maturity date, par or quantity			(d) Cost	(e) Current Value
CASH AND CASH EQUIVALENTS						
	First Am Treas Ob Cl Y			60,220	$ 60,220	$ 60,220
U.S. GOVERNMENT SECURITIES						
	U.S. Treasury Bill			516,000	493,488	512,398
	U.S. Treasury Bill			590,000	562,440	580,023
	U.S. Treasury Bill			1,063,000	1,024,088	1,028,867
	U.S. Treasury Note	5.000%	09/30/25	1,030,000	1,028,963	1,035,727
					3,108,979	3,157,015
MUTUAL FUNDS - EQUITY						
	Vanguard Total Stock Mkt Idx Adm			30,862	2,334,075	4,222,548
MUTUAL FUNDS - FIXED INCOME						
	Baird Core Plus Bond Fund Institute			646,352	7,225,308	6,554,011
	Dodge Cox Income			451,878	5,658,781	5,693,659
	State Street Aggregate Bond Index K			37,699	3,873,298	3,244,005
					16,757,387	15,491,675
	Total Investments				$ 22,260,661	$ 22,931,458

* Denotes party-in-interest.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

EIN: 35-6073275 PN: 501

*Schedule H line 4j - Schedule of Reportable Transactions During the Year Ended October 31, 2024***

Identity of Party Involved	Description	Number of Transactions	Purchase Price	Selling Price	Cost of Asset	Current Value on Transaction Date	Net Gain (Loss)
Individual Transactions:							
*Dodge Cox Income	Purchase	1	$ 5,483,928	$ -	$ -	$ -	$ -
*Western Asset Core Plus Bond IS	Sale	1	$ -	$ 5,619,965	$ 6,965,071	$ 5,619,965	$ (1,345,106)
Series of Transactions:							
First Am Treas Ob Cl Y	Purchases	21	$ 1,810,159	$ -	$ -	$ -	$ -
First Am Treas Ob Cl Y	Sales	15	-	1,757,410	1,757,410	1,754,410	-
Dodge Cox Income	Purchases	4	5,658,781	-	-	-	-
Western Asset Core Plus Bond IS	Purchases	8	99,957	-	-	-	-
Western Asset Core Plus Bond IS	Sales	4	-	5,634,698	6,979,996	5,634,698	(1,345,298)

* Single transaction also included in series of transactions for securities of the same issue.

** A reportable transaction is any transaction during the plan year, with respect to any plan asset, involving an amount in excess of five percent (5%) of the current value of plan assets at the beginning of the plan year. This schedule includes securities transactions involving a single transaction within the Plan year in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year, and also includes securities transactions involving securities of the same issue during the Plan year where the aggregate amount involved in the transactions exceeds five percent (5%) of the current value of plan assets at the beginning of the Plan year.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

EIN: 35-6073275 PN: 501

Schedule H line 4i - Schedule of Assets (Held at End of Year) at October 31, 2024

(a)	(b) Identity of issuer, borrower, lessor, or similar party	(c) Description of investment including interest rate, maturity date, par or quantity			(d) Cost	(e) Current Value
CASH AND CASH EQUIVALENTS						
	First Am Treas Ob Cl Y			60,220	$ 60,220	$ 60,220
U.S. GOVERNMENT SECURITIES						
	U.S. Treasury Bill			516,000	493,488	512,398
	U.S. Treasury Bill			590,000	562,440	580,023
	U.S. Treasury Bill			1,063,000	1,024,088	1,028,867
	U.S. Treasury Note	5.000%	09/30/25	1,030,000	1,028,963	1,035,727
					3,108,979	3,157,015
MUTUAL FUNDS - EQUITY						
	Vanguard Total Stock Mkt Idx Adm			30,862	2,334,075	4,222,548
MUTUAL FUNDS - FIXED INCOME						
	Baird Core Plus Bond Fund Institute			646,352	7,225,308	6,554,011
	Dodge Cox Income			451,878	5,658,781	5,693,659
	State Street Aggregate Bond Index K			37,699	3,873,298	3,244,005
					16,757,387	15,491,675
	Total Investments				$ 22,260,661	$ 22,931,458

* Denotes party-in-interest.

Indiana State Council of Plasterers and Cement Masons Health and Welfare Fund

EIN: 35-6073275 PN: 501

*Schedule H line 4j - Schedule of Reportable Transactions During the Year Ended October 31, 2024***

Identity of Party Involved	Description	Number of Transactions	Purchase Price	Selling Price	Cost of Asset	Current Value on Transaction Date	Net Gain (Loss)
Individual Transactions:							
*Dodge Cox Income	Purchase	1	$ 5,483,928	$ -	$ -	$ -	$ -
*Western Asset Core Plus Bond IS	Sale	1	$ -	$ 5,619,965	$ 6,965,071	$ 5,619,965	$ (1,345,106)
Series of Transactions:							
First Am Treas Ob Cl Y	Purchases	21	$ 1,810,159	$ -	$ -	$ -	$ -
First Am Treas Ob Cl Y	Sales	15	-	1,757,410	1,757,410	1,754,410	-
Dodge Cox Income	Purchases	4	5,658,781	-	-	-	-
Western Asset Core Plus Bond IS	Purchases	8	99,957	-	-	-	-
Western Asset Core Plus Bond IS	Sales	4	-	5,634,698	6,979,996	5,634,698	(1,345,298)

* Single transaction also included in series of transactions for securities of the same issue.

** A reportable transaction is any transaction during the plan year, with respect to any plan asset, involving an amount in excess of five percent (5%) of the current value of plan assets at the beginning of the plan year. This schedule includes securities transactions involving a single transaction within the Plan year in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year, and also includes securities transactions involving securities of the same issue during the Plan year where the aggregate amount involved in the transactions exceeds five percent (5%) of the current value of plan assets at the beginning of the Plan year.

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2023

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

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

C If the plan is a collectively-bargained plan, check here ▶ [X]

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
BOARD OF TRUSTEE ISC OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/01/1956

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEE ISC OF PLASTERERS
& CEMENT MASON HEALTH & WELFARE

8150 MADISON AVENUE

INDIANAPOLIS IN 46227

2b Employer Identification Number (EIN)
35-6073275

2c Plan Sponsor's telephone number
219-255-9692

2d Business code (see instructions)
525100

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

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

SIGN HERE	Mark McCleskey	8/13/2025	MARK MCCLESKEY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	1133
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	1080
a(2) Total number of active participants at the end of the plan year	**6a(2)**	1154
b Retired or separated participants receiving benefits	**6b**	0
c Other retired or separated participants entitled to future benefits	**6c**	49
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	1203
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	325

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 4F 4Q

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code _____