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 10/01/2023 and ending 09/30/2024

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
- [X] 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
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1997

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 TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

288 PARK AVE.
SUITE 87234
NEW YORK, NY 10003

2b Employer Identification Number (EIN) 06-1498630

2c Plan Sponsor's telephone number 888-617-6521

2d Business code (see instructions) 238100

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.	09/18/2025	GERALD MAROTTI
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/18/2025	MICHAEL THOMPSON
	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

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	757
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)**	488
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	559
b	Retired or separated participants receiving benefits	**6b**	308
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	867
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**	69

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

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

4A 4B 4D 4E 4F 4L 4Q 4U

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 4
- **(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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

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
NATIONWIDE LIFE INSURANCE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
31-4156830	66869	NWL00118CT-02	560	10/01/2023	09/30/2024

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	512347
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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

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
STANDARD 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
35-0980405	61069	AL00006624	485	10/01/2023	09/30/2024

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

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

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

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

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

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(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	

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [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**	71462
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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

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
LABOR FIRST, LLC

(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
06-1750191	28207	CT018GRS	321	10/01/2023	09/30/2024

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [X] 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**	646538
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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

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
ANTHEM HEALTH PLANS, 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
06-1475928	60217	JCT033	0	10/01/2023	12/31/2023

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service 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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

I SHARES INC
400 HOWARD STREET
SAN FRANCISCO, CA 94105

(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)

CAPITAL RX, INC.

35-2512946

(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	401661	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INSURANCE ADMINISTRATORS OF AMERICA

THE IAA BUILDING, 1934 OLNEY AVE
CHERRY HILL TOWNSHIP, NJ 08003

(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	381157	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BENEFITS DNA, LLC

2400 MARKET STREET, SUITE 245
PHILADELPHIA, PA 19103

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	NONE	214992	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)

HLH HOLDINGS, LLC

130 N 18TH ST. 26TH FL STE 2675
PHILADELPHIA, PA 19103

(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	128898	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ZENITH AMERICAN SOLUTIONS

52-1590516

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	117489	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [ ] No [X]

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

CIGNA

P.O. BOX 20002
NASHVILLE, TN 37202

(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	116282	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)

REID & RIEGE, P.C.

06-0867204

(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	107020	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ANTHEM HEALTH PLANS, INC.

06-1475928

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 49 50 62	NONE	46938	Yes [X] No [ ]	Yes [ ] No [X]	4047	Yes [ ] No [X]

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

ROBERT M. CHEVERIE & ASSOCIATES

06-1335139

(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	36125	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)

NOVAK FRANCELLA, LLC

61-1436956

(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	25419	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LOWER HUDSON VALLEY EAP

13-3240307

(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	18981	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MERRILL LYNCH PIERCE FENNER & SMITH

13-5674085

(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?
28 50	NONE	18051	Yes [X] No [ ]	Yes [X] No [ ]	0	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)

HINES & ASSOCIATES

36-3545085

(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	14272	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

HINGE HEALTH

455 MARKET STREET, SUITE 700
SAN FRANCISCO, CA 94105

(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	8955	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ZELIS HEALTHCARE LLC

58-2167964

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	8509	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)

KEY BANK

127 PUBLIC SQUARE
CLEVELAND, OH 44114

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	8199	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 [ ]

(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
ZENITH AMERICAN SOLUTIONS	12 13	0

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
ZELIS MED 58-2167964	

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ANTHEM HEALTH PLANS, INC.	22 53 55	4047

(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.
MPL, LLC 06-1537302	

(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

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(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 10/01/2023 and ending 09/30/2024

A Name of plan
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT- WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

D Employer Identification Number (EIN)
06-1498630

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	2719221	624903
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	2039731	1674669
(2) Participant contributions	1b(2)	3198	81873
(3) Other	1b(3)	445748	363504
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	34559	2234331
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	1955506	2211272
(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)	807328	1007705
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

			(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:			
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
e	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	8005291	8198257
	Liabilities			
g	Benefit claims payable	1g	1386212	2475219
h	Operating payables	1h	27962	238005
i	Acquisition indebtedness	1i		
j	Other liabilities	1j	82889	402204
k	Total liabilities (add all amounts in lines 1g through1j)	1k	1497063	3115428
	Net Assets			
l	Net assets (subtract line 1k from line 1f)	1l	6508228	5082829

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)	10308387	
	(B) Participants	2a(1)(B)	1236892	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		11545279
b	**Earnings on investments:**			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	3239	
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)	91434	
	(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)		94673
	(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)	17419	
	(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		17419
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	400000	
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)	399626	
	(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		374
	(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)	99177	
	(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		99177

		(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)		273660
c Other income	2c		1714070
d Total income. Add all **income** amounts in column (b) and enter total	2d		13744652
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	12150110	
(2) To insurance carriers for the provision of benefits	2e(2)	1342515	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		13492625
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1243142	
(3) Recordkeeping fees	2i(3)	6219	
(4) IQPA audit fees	2i(4)	19200	
(5) Investment advisory and investment management fees	2i(5)	18051	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	214992	
(8) Legal fees	2i(8)	143145	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	32677	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		1677426
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		15170051
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-1425399
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: NOVAK FRANCELLA, LLC **(2)** EIN: 61-1436956

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

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

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

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

INTERNATIONAL UNION OF BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 CONNECTICUT HEALTH FUND

FINANCIAL STATEMENTS

SEPTEMBER 30, 2024

INTERNATIONAL UNION OF BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 CONNECTICUT HEALTH FUND

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

SEPTEMBER 30, 2024 AND 2023

CONTENTS

Novak Francella LLC | CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
International Union of Bricklayers
and Allied Craftworkers Local 1
Connecticut Health Fund

Opinion

We have audited the financial statements of the International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund (the Plan), 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 of benefit obligations as of September 30, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of September 30, 2024 and 2023, and the changes in its net assets available for benefits and 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 audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan'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 GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan 's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan 's ability to continue as a going concern for a reasonable period of time.

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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedules of Benefits, Insurance Premiums and Administrative Service Fees, Schedules of Administrative Expenses, and Schedule of Assets Held at End of Year, together referred to as "supplemental information," are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year represents supplemental information required by ERISA. Such information is the responsibility of the Plan's 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 audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Novak Francella LLC

Killingworth, Connecticut
September 16, 2025

International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund

Statements of Net Assets Available for Benefits

September 30, 2024 and 2023

	2024	2023
Assets		
Investments - at fair value		
Interest bearing cash and cash equivalents	$ 2,234,331	$ 34,559
Corporate notes and bonds	2,211,272	1,955,506
Exchange traded fund	1,007,705	807,328
Total investments	5,453,308	2,797,393
Receivables		
Employer contributions, net of allowance for doubtful accounts of $142,860 for 2024 and 2023	1,674,669	2,039,731
Reciprocals	190,747	96,118
Medicare Part D	76,543	75,402
Employee contributions	81,873	3,198
Prescription rebates	-	220,628
Accrued investment income	20,304	15,866
Lien reimbursements	13,963	37,734
Total receivables	2,058,099	2,488,677
Other assets		
Cash	624,903	2,719,221
Prepaid expense	61,947	-
Total other assets	686,850	2,719,221
Total assets	8,198,257	8,005,291
Liabilities and net assets		
Liabilities		
Accounts payable	238,005	27,962
Reciprocal payable	-	8,074
Due to related organizations	395,108	46,313
Deferred revenue	7,096	28,502
Total liabilities	640,209	110,851
Net assets available for benefits	$ 7,558,048	$ 7,894,440

See accompanying notes to financial statements.

International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund

Statements of Changes in Net Assets Available for Benefits

Years Ended September 30, 2024 and 2023

	2024	2023
Additions		
Investment income		
Interest and dividends	$ 112,092	$ 71,520
Net appreciation in fair value of investments	373,211	156,505
	485,303	228,025
Less investment fees	18,051	16,279
Net investment income	467,252	211,746
Contributions		
Employer	9,360,058	10,167,570
Reciprocals, net of payments	948,329	778,707
Self-pay members	1,236,892	1,371,211
Total contributions	11,545,279	12,317,488
Other income		
Lien reimbursements	156,118	58,451
Medicare Part D reimbursement	243,099	275,034
Contractor interest	11,912	17,981
Total other income	411,129	351,466
Total additions	12,423,660	12,880,700
Deductions		
Benefits paid	11,061,103	9,667,932
Reimbursements:		
Stop-loss reimbursement	-	(5,150)
Prescription rebates	(1,302,941)	(650,680)
Benefits, net	9,758,162	9,012,102
Insurance premiums and administrative service fees	2,448,515	2,384,134
Administrative expenses	553,375	481,080
Total deductions	12,760,052	11,877,316

See accompanying notes to financial statements.

	2024	2023
NET (DECREASE) INCREASE	$ (336,392)	$ 1,003,384
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	7,894,440	6,891,056
End of year	$ 7,558,048	$ 7,894,440

See accompanying notes to financial statements.

International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund

Statements of Benefit Obligations

September 30, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents		
Claims payable	$ 969,934	$ 335,212
Other obligations for current benefit coverage, at present value of estimated amounts:		
Claims incurred but not reported	1,505,285	1,051,000
Accumulated eligibility credits	1,779,683	2,913,008
	3,284,968	3,964,008
Total obligations other than postretirement benefit obligations	4,254,902	4,299,220
Postretirement benefit obligations		
Current retirees, spouses and beneficiaries	18,769,419	15,916,311
Other participants fully eligible for benefits	10,138,228	8,818,228
Other participants not fully eligible for benefits	15,161,364	7,413,787
	44,069,011	32,148,326
Total benefit obligations	$ 48,323,913	$ 36,447,546

See accompanying notes to financial statements.

International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund

Statements of Changes in Benefit Obligations

Years Ended September 30, 2024 and 2023

	2024	2023
Amounts currently payable		
Balance at beginning of year	$ 335,212	$ 353,452
Claims reported and approved for payments	13,043,340	11,016,774
Claims and insurance premiums paid	(12,408,618)	(11,035,014)
Balance at end of year	969,934	335,212
Other obligations for current benefit		
Coverage at present value of estimated amounts		
Balance at beginning of year	3,964,008	3,984,989
Claims incurred but not reported	454,285	(132,626)
Accumulated eligibility credits	(1,133,325)	111,645
Balance at end of year	3,284,968	3,964,008
Total obligations other than postretirement benefit obligations	4,254,902	4,299,220
Postretirement benefit obligation		
Balance at beginning of year	32,148,326	29,192,189
Benefits paid	(1,575,125)	(1,319,658)
Change in actuarial assumptions and gain	5,881,844	176,348
Benefit accumulation	4,153,439	1,616,166
Passage of time	3,460,527	2,483,281
Balance at end of year	44,069,011	32,148,326
Total benefit obligations	$ 48,323,913	$ 36,447,546

See accompanying notes to financial statements.

INTERNATIONAL UNION OF BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 CONNECTICUT HEALTH FUND

NOTES TO FINANCIAL STATEMENTS

SEPTEMBER 30, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following description of the International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund (the Plan) provides only general information. Participants should refer to the Plan document and its Summary Plan Description for a more complete description of the Plan's provisions.

General - The Plan is a collectively bargained multiemployer welfare benefit plan that was established in 1997 pursuant to an Agreement and Declaration of Trust and the collective bargaining agreement (the CBA) between the Labor Relations Division of the Associated General Contractors of Connecticut, Inc. and the International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut. The Plan was established to provide health care benefits to the employees in covered employment covered by the CBA and their dependents that meet certain eligibility requirements. The trust agreement also provides for the payment from the Plan of all health benefits, reasonable and necessary expenses in administering the affairs of the Plan and the collection of contributions. The Plan is administered by a Board of Trustees consisting of representatives of both labor and management. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Plan Amendment - On June 14, 2023, the Board of Trustees voted to adopt the Fourth Amendment to the trust agreement effective April 1, 2023 which sets forth the current Trustees, the Trustee Appointment process, number of Trustees for a quorum, voting rules, and Co-Chairman designations. The amendment also defines the term "Contributing Employer" effective May 1, 2023.

Benefits - The Plan provides health, dental, prescription drug, vision, hearing, disability, death, accidental death and dismemberment and mental health and substance abuse benefits to eligible participants. The Plan also provides a plan of benefits to retired participants who meet certain qualification requirements and make the required self-payments.

Anthem Life Insurance Company (Anthem) has issued the Plan group insurance policy for the years ended September 30, 2024 and 2023, to provide coverage for the life insurance and accidental death and dismemberment benefits. The life insurance benefit is $50,000 for active members, which is in lieu of any amounts in a member's allocation account. During the years ended September 30, 2024 and 2023, the Plan paid $70,212 and $66,155 respectively, in premiums for this coverage.

NOTE 1. DESCRIPTION OF THE PLAN (continued)

All contributions received for hours worked on or after October 1, 1997 were placed into an allocation account for each active participant. This allocation account was then used to determine eligibility. Any contributions accumulated and not used for benefits incurred on or after October 1, 1997 were able to be disbursed to the participant for any unreimbursed medical/dental and/or vision expenses as well as health care premiums, including but not limited to Medicare Part B premiums (see subsequent paragraph).

Effective January 1, 2004 the allocation account was frozen with respect to distributions. As of that date, participants are no longer reimbursed from this account for unreimbursed medical, dental, vision or health care premiums. For participants who were not retired and had not been participants in the Plan for two years, their allocation account balance was forfeited, effective January 1, 2004. The allocation account was used for eligibility purposes only.

Participants who are no longer eligible under normal provisions of the Plan may obtain continuing coverage through self-payment contributions, at a fixed premium level, based on the coverage option selected. The length of self-payment varies.

Health and life insurance benefits for retired participants are provided under several insurance policies.

On November 30, 2022, the Board of Trustees voted to increase the Plan's vision benefits effective January 1, 2023. Also on November 30, 2022, the Board of Trustees voted to increase the Plan's self-insured death benefit to $10,000 for any retiree who passes away on or after December 1, 2022.

Funding - Contributions to the Plan are made by contributing employers at rates established by the collective bargaining agreement. The collective bargaining agreement provides for an hourly contribution rate of $13.28 effective January 3, 2022. Employer contributions are accounted for as exchange transactions. Contributing employers primarily conduct business in the State of Connecticut.

The allowance for doubtful accounts represents the estimated losses that may be incurred in the collection of specific employer contributions receivable.

The Plan also accepts contributions on behalf of or from: 1) non-collectively bargained employees of contributing employers based on separate participation agreements; 2) from new employees and apprentices who have not been able to satisfy the initial eligibility rules; and 3) from certain retirees requesting continued coverage.

The costs of the postretirement benefit plan are shared by the Plan's participating employers and retirees. In addition to deductibles and copayments, monthly participant contributions are listed in the schedule below. On September 23, 2015, the Board of Trustees voted to increase the rates, effective June 1, 2016. The rates remained current during the year ended September 30, 2024.

NOTE 1. DESCRIPTION OF THE PLAN (continued)

	Effective June 1, 2016	
	Medical and Rx	Medical, Rx, and Dental/Vision
Single not Medicare eligible	$374	$451
Retiree and spouse not Medicare eligible	$750	$902
Single Medicare eligible (under age 80)	$223	$317
Retiree and Spouse Medicare eligible (under age 80)	$445	$635
Retiree/spouse and family one Medicare eligible and one (or more) not Medicare eligible	$953	$1,159
Two Medicare eligible (under age 80) and one (or more) not Medicare eligible	$659	$849
Widow not Medicare eligible	$367	$443
Widow Medicare eligible	$203	$297
One Medicare eligible (under age 80) and one not Medicare eligible	$596	$769
Retiree/Spouse and family no one Medicare eligible	$1,103	$1,293

Subsequent to year end, on March 5, 2025, the Trustees voted to increase these rates effective July 1, 2025 and again on January 1, 2026.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting - The accompanying financial statements have been prepared on the accrual basis of accounting.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Valuation of Investments and Income Recognition - The Plan's investments are administered by the Chrys Group of Merrill Lynch. Subject to an investment policy adopted by the Trustees, the investments, which consist of corporate notes and bonds, an exchange traded fund, and cash equivalents. These investments are stated at fair value, as represented by the Plan's investment custodian.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

See Note 14 for a discussion on Fair Value Measurements.

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

Credit Risk - The Plan maintains its cash with a financial institution deemed to be credit worthy. Cash balance is insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 in a single bank. As of September 30, 2024, cash on deposit with Key Bank exceeded FDIC coverage in a single bank by $897,861 and cash on deposit with Guilford Savings Bank exceeded FDIC coverage by $1,443,457.

Stop-Loss Coverage - The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims). Premiums for stop-loss insurance are included in premium payments in the accompanying statements of changes in net assets available for benefits. Stop-loss refunds totaling $-0- and $5,150 in 2024 and 2023, respectively, have been netted with claims paid in the accompanying statement of changes in net assets.

Refunds - The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as receivable, with the offset being netted against claims paid. Pharmacy rebates totaling $1,302,941 and $650,680 have been netted with claims paid in the accompanying statements of changes in net assets available for benefits for the years ended September 30, 2024 and 2023, respectively.

Reclassifications – Certain reclassifications have been made to amounts previously reported to conform with classifications made for the year ended September 30, 2024.

NOTE 3. BENEFIT OBLIGATIONS

Postretirement Benefit Obligations - The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated 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. Postretirement benefits include future benefits, principally health benefits, expected to be paid to or for eligible (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing plan assets. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary 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.

For measurement purposes, the following health care cost trend rates were assumed:

	Year	Pre-65	Post 65
Year 1 Trend	October 1, 2025	7.00%	7.00%
Ultimate Trend	October 1, 2035 & Later	4.50%	4.50%
Grading Per Year		0.25%	0.25%

The following are other significant assumptions used in the valuation as of September 30, 2024 and 2023:

- Discount rate of 4.95% for the year ended September 30, 2024 and 5.63% for the year ended September 30, 2023.
- Mortality: RP 2014 Healthy Male and Female Tables are based on the Employee and Healthy Annuitant Tables for both pre & post retirement projected with mortality improvement using the most current Society of Actuaries Mortality Improvement Scale MP-2021. The RP 2014 table reflects the Blue Collar table for valuation purposes, consistent with the prior valuation. The MP-2021 table is the same table as the prior valuation, since a new table was not released.

NOTE 3. BENEFIT OBLIGATIONS (continued)

Illustrative turnover rates are shown below:

Age	Turnover Rate
25	4.89%
30	3.70%
35	2.35%
40	1.13%
45	0.26%
50 and later	0.00%

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

The Plan's deficiency of net assets over benefit obligations at September 30, 2024 and 2023, relates primarily to the Plan's postretirement benefit obligations, the funding of which will be done on a pay-as-you-go basis through the contribution rate provided by the current bargaining agreements. The Trustees have the right to terminate or change the terms of the Plan at any time.

The weighted-average health care cost-trend assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would decrease the net obligation as of September 30, 2024 and 2023, by $(6,633,965) and $(4,662,729), respectively.

Medicare Part D Subsidy - For the years ending September 30, 2024 and 2023, the actuarial calculation included an estimate for retiree subsidies that the Plan was eligible to receive. The Plan has been determined to be actuarially equivalent to the Medicare Part D Standard Benefit. The present value of future retiree drug subsidy payments were 15.7% of gross pharmacy cost for post-65 coverage for the years ended September 30, 2024 and 2023.

Benefit claims currently payable include the Plan's liability for claims incurred as of September 30, 2024 and 2023 but not reported, and the Plan's liability for claims reported as of September 30, 2024 and 2023 but not yet processed. The Plan's liability for claims incurred but not yet reported as of September 30, 2024 and 2023 were estimated by the Plan's actuary in accordance with accepted actuarial principles by taking into consideration prior claims experience and the expected time period from the date such claims are incurred to the date that the related claims are submitted and paid, as presented in lag data reports prepared by the Plan Administrator. Health claims incurred by retired participants but not reported at year end are included in claims incurred but not reported.

Plan obligations at September 30, 2024 and 2023 also include accumulated eligibility of participants as estimated by the Plan's actuary in accordance with accepted actuarial principles. This estimate is based on average claim costs incurred during the respective plan year and the number of months of continued eligibility beyond the plan year-end.

NOTE 4. BENEFITS ADMINISTRATION

The Plan had an agreement with Zenith American Solutions (Zenith) through December 31, 2023 to administer the processing and payment of claims. The Plan also had an administration agreement with Zenith through December 31, 2023.

The Plan had an agreement with Anthem Blue Cross Shield of Connecticut, through December 31, 2023, to provide network access and discount claims repricing and provider payment services on behalf of the Plan's participants. Participation in the Anthem network is voluntary and is available to all eligible members and their families, other than Medicare primary member, spouses and dependents.

The Plan has an agreement with Cigna Health and Life Insurance Company (Cigna), effective January 1, 2024, to provide network access services on behalf of the Plan's participants. Participation in the Cigna network is voluntary and is available to all eligible members and their families, other than Medicare primary members, spouses and dependents.

The Plan has an agreement with Insurance Administrator of America, LLC (IAA), effective January 1, 2024, to administer the processing and payment of claims.

The Plan has life and accidental death and dismemberment insurance contracts with Anthem (See Note 1).

The Plan has an insurance contract with RMTS, LLC/Gerber, Nationwide to provide stop-loss insurance. The policy provides for reimbursement to the Plan of medical benefit claims exceeding $250,000 per covered individual per year.

The Plan's prescription benefits are administered under an agreement with Capital Rx. Under this arrangement, the Board of Trustees determine the types and limits of covered prescriptions and was responsible for the funding of all prescription claims. Capital Rx provides processing services and administers actual payment of prescription benefits.

The Plan's Employee Assistance Services program is administered under an agreement with Lower Hudson Valley Building Construction Trades EAP. The Employee Assistance Services program provides benefits for members and their dependents in the form of counseling services.

The Plan has an agreement with Capital Rx (Cap Rx) to administer the Plan, effective January 1, 2024. This agreement is effective for a term of three years and automatically extends for one year periods, unless terminated by either party.

The Plan had an agreement with the University of Connecticut Speech and Hearing Clinic to provide a benefit program for hearing care for eligible members and their dependents. On August 28, 2024, the Board of Trustees voted to terminate this agreement effective January 1, 2025.

The Plan had an agreement with Innovative Care Management (ICM) to provide medical and behavioral health utilization review and case management services. On August 28, 2024, the Board of Trustees approved to terminate this agreement and to retain IAA for the Plan's Preauthorization/Utilization Management services effective October 1, 2024.

NOTE 5. EMPLOYER CONTRIBUTIONS RECEIVABLE

Employer contributions receivable represents uncollected contributions for covered employment prior to the Plan's year end and are as follows:

	September 30, 2024	September 30, 2023
Collections subsequent to year end	$ 1,817,529	$ 2,182,591
Less allowance for doubtful accounts	(142,860)	(142,860)
	$ 1,674,669	$ 2,039,731

The allowance account was established based on an assessment of the collectability of contributions receivable. There were no uncollectible accounts written off during the years ended September 30, 2024 and 2023.

NOTE 6. DUE TO RELATED ORGANIZATIONS

Amounts due to related organizations are for payments received in the Health Fund's escrow account and paid out as follows:

	September 30, 2024	September 30, 2023
Bricklayers Local 1 Labor Management Cooperation Trust	$ 209,321	$ 9,043
International Union of Bricklayers & Allied Craftworkers Local 1 Connecticut	147,364	36,679
AGC/CCIA Building Contractors Labor Division of Connecticut, Inc.	10,098	-
CT Mason Industry Advance Fund	22,888	24
Tile Contractors Assoc. of Connecticut	1,044	567
International Pension Fund	4,393	-
	$ 395,108	$ 46,313

NOTE 7. PLAN TERMINATION

The Trustees expect and intend to continue the Plan indefinitely but reserve the right to amend or terminate it. In the event the Plan terminates, the Trustees shall first apply the net assets to any obligations outstanding and any remaining balance in such manner as will best effectuate the purpose of the Plan.

Under no circumstances shall any portion of the Plan, directly or indirectly, revert or accrue to the benefit of any contributing employer or the union.

NOTE 8. TAX STATUS

The Plan obtained its latest determination letter in July 1998, in which the Internal Revenue Service (IRS) stated that the Plan, as then designed, was exempt from federal income tax under section 501(c)(9) of the Internal Revenue Code. The Plan has been amended since receiving this determination letter. However, the Plan's legal counsel believes that the Plan is currently designed, and the Plan administrator believes that the Plan is currently being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, they believe that the Plan is tax-exempt under Section 501(c)(9) of the Internal Revenue Code as of the financial statement date.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 9. RELATED PARTY TRANSACTIONS

The Bricklayers Local 1 Labor Management Cooperation Trust (LMCT) is related to the Plan through common trustees. The Plan's portion of shared meeting expenses totaled $1,665 and $1,424 for the years ended September 30, 2024 and 2023, respectively.

The International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut contribute to the Plan. Contributions totaled $81,384 and $96,036 for the years ended September 30, 2024 and 2023, respectively.

NOTE 10. PARTY IN INTEREST TRANSACTIONS

The Plan paid certain expenses related to plan operations and investment activity to various service providers. These transactions are party in interest transactions under ERISA. These service providers provide necessary administrative services to the Plan and the Trustees have determined that these expenses are reasonable for the services provided.

NOTE 11. RISKS AND UNCERTAINTIES

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

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care 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 could be material to the financial statements.

NOTE 12. RECIPROCAL AGREEMENTS

Participants of other funds from time to time are employed within the territorial jurisdiction of the Plan. The Plan transfers contributions received for these participants to the fund of their home locals in accordance with provisions of signed reciprocal agreements.

NOTE 13. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	September 30,	
	2024	2023
Net assets available for benefits per the financial statements	$ 7,558,048	$ 7,894,440
Benefit obligations currently payable	(2,475,219)	(1,386,212)
Net assets available for benefits per the Form 5500	$ 5,082,829	$ 6,508,228

The following is a reconciliation of benefits paid to participants per the financial statements to the Form 5500:

	Year ended September 30, 2024
Benefits paid to participants per the financial statements	$ 12,403,618
Add: Amounts payable at September 30, 2024	2,475,219
Less: Amounts payable at September 30, 2023	(1,386,212)
Benefits paid to participants per Form 5500	$ 13,492,625

Amounts currently payable to or for participants, dependents and beneficiaries are included on the Form 5500 for benefit claims that have been processed and approved for payment prior to September 30 but were not paid as of that date and for claims incurred but not reported as of that date.

NOTE 14. FAIR VALUE MEASUREMENTS

The framework for measuring fair value 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) and the lowest priority to unobservable inputs (level 3). The three levels of the fair value hierarchy are described as follows:

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

Basis of Fair Value Measurement:

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 asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset or liability.

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

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no changes in the methodologies used at September 30, 2024 and 2023.

Cash equivalents consist of cash investments in a money market fund. Cash investments in the money market fund are valued under the market approach through the use of quoted market prices in an active market, which is the net asset value of the underlying funds and are classified within Level 1 of the valuation hierarchy.

Corporate notes and bonds are valued using prices obtained from an independent third party pricing service to measure fair value of certain investment securities. The custodian validates prices received from the pricing service using methods including; comparison to prices received from additional pricing services, comparison to quoted market prices, where available, comparison to internal valuation models, and review of other relevant market data, and are classified within Level 2 of the valuation hierarchy.

Exchange traded funds are valued at the net asset value of shares held by the Plan at year end and are classified within level 1 of the valuation hierarchy.

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

The following table presents assets and liabilities measured at fair value on a recurring basis at September 30, 2024:

	Fair Value Measurements at September 30, 2024			
	Total	Level 1	Level 2	Level 3
Corporate notes and bonds	$ 2,211,272	$ -	$ 2,211,272	$ -
Exchange traded fund	1,007,705	1,007,705	-	-
Cash equivalents	2,234,331	2,234,331	-	-
	$ 5,453,308	$ 3,242,036	$ 2,211,272	$ -

The following table presents assets and liabilities measured at fair value on a recurring basis at September 30, 2023:

	Fair Value Measurements at September 30, 2023			
	Total	Level 1	Level 2	Level 3
Corporate notes and bonds	$ 1,955,506	$ -	$ 1,955,506	$ -
Exchange traded fund	807,328	807,328	-	-
Cash equivalents	34,559	34,559	-	-
	$ 2,797,393	$ 841,887	$ 1,955,506	$ -

NOTE 15. CLASS ACTION LAWSUIT

On August 31, 2022, the Board of Trustees voted for the Plan to be a representative of a class action lawsuit against Anthem.

NOTE 16. SUBSEQUENT EVENTS

Subsequent to year end, the Board of Trustees voted to adopt the following benefit changes:

- Implement a self-pay option on a month to month basis effective January 1, 2025,
- Increase the Plan's calendar year deductibles effective January 1, 2026, and
- Increase the Plan's copayments effective January 1, 2026.

Subsequent events have been evaluated through September 16, 2025 which is the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting records.

SUPPLEMENTAL INFORMATION

International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund

Schedules of Benefits, Insurance Premiums and Administrative Service Fees

Years Ended September 30, 2024 and 2023

	2024	2023
Benefits		
Health, dental, vision and disability claims and taxes	$ 7,965,596	$ 6,776,099
Prescription drug program	3,036,768	2,735,786
Death	40,000	41,999
Hearing	18,536	58,452
CT and RI vaccine assessment	203	55,596
Total benefits	$ 11,061,103	$ 9,667,932
Insurance premiums and administrative service fees		
Insurance premiums		
Labor First premiums	$ 759,956	$ 787,165
Stop-loss insurance	512,347	513,762
Life insurance	70,212	66,155
Administrative service fees		
Network access/claims repricing fees:		
Capital Rx	283,693	252,269
HLH Holdings, LLC	128,898	142,145
Cigna	116,282	-
Anthem	46,938	183,545
Zelis Claim Integrity	8,509	16,986
Medicare Part D fees	-	20
Managed care programs		
Lower Hudson Valley EAP	18,981	15,682
Utilization review fees	12,760	10,798
Hinge Health	8,955	-
Case management fees	1,512	19,171
Claims processing fees		
Insurance Administrators of America	381,157	-
Zenith American Solutions	93,132	372,528
PCORI fee	5,183	3,908
Total premiums and administrative service fees	$ 2,448,515	$ 2,384,134

International Union of Bricklayers and Allied Craftworkers Local 1
Connecticut Health Fund

Schedules of Administrative Expenses

Years Ended September 30, 2024 and 2023

	2024	2023
Actuarial/consulting	$ 214,992	$ 214,992
Legal	143,145	69,440
Administration fees	142,325	97,428
Audit	19,200	15,200
Dues assessment - CT Coalition	17,369	30,939
Bank charges	8,199	13,004
Accounting - employer audits	6,219	16,696
Trustee expenses and meetings	1,665	1,424
Printing and postage	261	6,601
Fiduciary liability and fidelity bond insurance	-	15,356
Total administrative expenses	$ 553,375	$ 481,080

INTERNATIONAL UNION OF BRICKLAYERS
AND ALLIED CRAFTWORKERS LOCAL 1
CONNECTICUT HEALTH FUND

SCHEDULE OF ASSETS HELD AT END OF YEAR

SEPTEMBER 30, 2024

Form 5500, Schedule H, Item 4i

EIN: 06-1498630
Plan No. 501

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value				Cost	Current Value
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	Corporate notes and bonds:					
Abbott Laboratories	Bond	99,000	3.750 %	11/30/26	$ 98,510	$ 98,936
Abbvie Inc.	Bond	50,000	4.250	11/14/28	48,016	50,543
American Express Co	Bond	50,000	VAR	07/27/29	50,438	51,787
Apple Inc.	Bond	51,000	3.000	11/13/27	48,562	49,974
Anthem Inc.	Bond	52,000	3.650	12/01/27	49,917	51,272
Anheuser-Busch Inbev Co.	Bond	50,000	4.000	04/13/28	48,933	50,122
Amgen Inc.	Bond	53,000	2.200	02/21/27	48,463	50,750
AT&T Inc.	Bond	52,000	4.350	03/01/29	48,930	52,315
Bank of NY Mellon Corp	Bond	97,000	VAR	03/14/30	100,113	100,187
BB&T Corporation	Bond	92,000	2.850	10/26/24	90,150	91,832
BP Cap Markets America Co.	Bond	98,000	3.796	09/21/25	97,329	97,592
Charles Schwab Corp.	Bond	93,000	2.000	03/20/28	83,551	86,661
Cigna Corp	Bond	50,000	4.375	10/15/28	48,956	50,195
Citigroup Inc.	Bond	52,000	VAR	10/27/28	48,019	50,762
Capital One Financial Co.	Bond	50,000	3.750	03/09/27	47,733	49,365
CVS Health Corp	Bond	51,000	5.000	01/30/29	49,780	52,072
DowDupont Inc.	Bond	49,000	4.725	11/15/28	48,327	49,935
Duke Energy Corp.	Bond	50,000	2.650	09/01/26	46,605	48,619
Fifth Third Bancorp	Bond	49,000	VAR	07/27/29	50,329	52,084
Fiserv Inc.	Bond	53,000	2.250	06/01/27	47,413	50,428
Goldman Sachs Group Inc.	Bond	101,000	3.750	02/25/26	98,800	100,350
HP Enterprise Co.	Bond	51,000	4.900	10/15/25	51,115	51,043
JP Morgan Chase & Co.	Bond	99,000	3.900	07/15/25	98,131	98,625
Lowe's Cos. Inc.	Bond	52,000	2.500	05/15/26	49,131	50,792
Merck & Co., Inc.	Bond	52,000	2.750	02/10/25	50,772	51,603
McDonald's Corp.	Bond	52,000	3.700	01/30/26	51,268	51,689
Morgan Stanley	Bond	49,000	3.950	04/23/27	47,080	48,512
Northrop Grumman Corp.	Bond	52,000	3.250	01/15/28	51,396	50,531
Pfizer Investment Enter	Bond	7,000	4.650	04/19/30	7,170	7,173
Philip Morris Intl Inc	Bond	93,000	5.625	11/17/29	97,192	98,758
PNC Financial Services	Bond	95,000	VAR	06/12/29	92,864	98,884
Salesforce.com Inc.	Bond	12,000	3.700	04/11/28	11,486	11,933

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value				Cost	Current Value
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	Corporate notes and bonds:					
Shire Acq. Inv Ireland	Bond	50,000	3.200 %	09/23/26	$ 47,473	$ 49,213
United Technologies Corp.	Bond	52,000	3.950	08/16/25	51,719	51,723
Verizon Communications	Bond	52,000	3.376	02/15/25	51,182	51,691
Walt Disney Company	Bond	55,000	2.200	01/13/28	49,875	52,204
Wells Fargo & Co.	Bond	51,000	4.300	07/22/27	49,799	51,117
	Total corporate notes and bonds				2,156,527	2,211,272
	Exchange traded fund:					
iShares Corp S&P 500 ETF		1,747			686,816	1,007,705
	Cash equivalents:					
Cash		3,904			3,904	3,904
BLF Money Fund		23,367			23,367	23,367
Key Business Select MMDA		513,603			513,603	513,603
Guilford Savings Bank		1,693,457			1,693,457	1,693,457
	Total cash equivalents				2,234,331	2,234,331
	Total investments				$ 5,077,674	$ 5,453,308

THE FINANCIAL STATEMENTS WILL BE PLACED IN THE ATTACHMENT FOR THE ACCOUNTANT'S OPINION

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

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 10/01/2023 and ending 09/30/2024

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.)

B This return/report is: [ ] a single-employer plan [ ] a DFE (specify) _____
[ ] the first return/report [ ] the final return/report
[X] 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
INT'L UNION OF BRICKLAYERS & ALLIED CRAFT-WORKERS LOCAL 1 CONNECTICUT HEALTH FUND

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 10/01/1997

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 TRUSTEES-IUBAC LOCAL 1 CT HEALTH FUND

288 PARK AVE.
SUITE 87234
NEW YORK NY 10003

2b Employer Identification Number (EIN) 06-1498630

2c Plan Sponsor's telephone number 888-617-6521

2d Business code (see instructions) 238100

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	X [signature] Signature of plan administrator	9/18/2025 Date	GERALD MAROTTI Enter name of individual signing as plan administrator
SIGN HERE	X [signature] Signature of employer/plan sponsor	09/18/25 Date	MICHAEL THOMPSON Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2023)
v. 230728

318401 11-21-23

09320917 758412 30425A 2023.06010 BOARD OF TRUSTEES-IUBAC L 30425A_1

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**	757
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)**	488
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	559
b	Retired or separated participants receiving benefits	**6b**	308
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	867
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)**	
(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**	69

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

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

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

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

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

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

b General Schedules
- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information - Small Plan)
- **(3)** [X] **A** (Insurance Information) - Number Attached 4
- **(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 _____