

<p>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p>MANUFACTURING COMMITTEE ADMINISTRATION</p> <p>4065 SOUTH VIRGINIA STREET SUITE 101 RENOT, NV 89502</p>	<p>3b Administrator's EIN 88-0041905</p> <p>3c Administrator's telephone number 775-636-9550</p>
<p>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:</p> <p>a Sponsor's name RENO SPARKS CHAMBER MANUFACTURING COMMITTEE ASSOCIATION</p> <p>c Plan Name RENO SPARKS CHAMBER MANUFACTURING COMMITTEE ASSOCIATION HEALTH PLAN</p>	<p>4b EIN 88-0041905</p> <p>4d PN 502</p>
<p>5 Total number of participants at the beginning of the plan year</p>	<p>5 445</p>
<p>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).</p>	
<p>a(1) Total number of active participants at the beginning of the plan year</p>	<p>6a(1) 445</p>
<p>a(2) Total number of active participants at the end of the plan year</p>	<p>6a(2) 342</p>
<p>b Retired or separated participants receiving benefits.....</p>	<p>6b 4</p>
<p>c Other retired or separated participants entitled to future benefits</p>	<p>6c 0</p>
<p>d Subtotal. Add lines 6a(2), 6b, and 6c.....</p>	<p>6d 346</p>
<p>e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.</p>	<p>6e</p>
<p>f Total. Add lines 6d and 6e</p>	<p>6f</p>
<p>g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p>	<p>6g(1)</p>
<p>g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p>	<p>6g(2)</p>
<p>h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</p>	<p>6h</p>
<p>7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)</p>	<p>7</p>

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 4Q

<p>9a Plan funding arrangement (check all that apply)</p> <p>(1) <input checked="" type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>	<p>9b Plan benefit arrangement (check all that apply)</p> <p>(1) <input checked="" type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input type="checkbox"/> Trust</p> <p>(4) <input type="checkbox"/> General assets of the sponsor</p>
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

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

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

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

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

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

Receipt Confirmation Code 159987741

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**

A Name of plan RENO + SPARKS CHAMBER MANUFACTURING COMMITTEE ASSOCIATION HEALTH PLAN		B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 RENO + SPARKS CHAMBER OF COMMERCE		D Employer Identification Number (EIN) 88-0041905

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
PROMINENCE HEALTH PLAN

(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
88-0193357	11079	RSCM	489	03/01/2024	02/28/2025

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 115607	(b) Total amount of fees paid 0
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CLARK & ASSOCIATES **520 HAMILL LANE**
RENO, NV 89511

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
66068	0	N/A	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
DISTINCTIVE INSURANCE **9555 HILL**
SUITE 140
LAS VEGAS, NV 89134

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
13412	0	N/A	3

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

THE MULTICARE GROUP LLC
 5715 W ALEXANDER ROAD
 SUITE 130
 LAS VEGAS, NV 89130

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7316	0	N/A	3

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

J&M LEWIS INC.
 1535 DESERET DR
 MINDEN, NV 89423

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6666	0	N/A	3

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

HEALTH BENEFITS ASSOCIATES, INC.
 3716 LAKESIDE DR
 NO 100
 RENO, NV 89509

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5233	0	N/A	3

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

A AND H INSURANCE, INC.
 PO BOX 7340
 RENO, NV 89510

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5028	0	N/A	3

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

ASSURED PARTNERS OF NEVADA, LLC
 5985 HOME GARDENS DR
 SUITE A
 RENO, NV 89502

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
3245	0	N/A	3

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

DL BUTCHER CONSULTING LLC
 415 CHURCH ST
 UNIT 2302
 NASHVILLE, TN 37219

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2819	0	N/A	3

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

LAURIE MCLELLAND
 PO BOX 34570
 RENO, NV 34570

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1974	0	N/A	3

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

LEAVITT GROUP BENEFITS SERVICES
 7881 W CHARLESTON BLVD #140
 LAS VEGAS, NV 89117

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1458	0	N/A	3

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

JOHN DRAKULICH
 2215 N MCCARRAN
 SPARKS, NV 89431

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1207	0	N/A	3

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

HENDRICKS & ASSOCIATES
 PO BOX 3077
 RENO, NV 89505

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1181	0	N/A	3

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)		
	(2) Increase (decrease) in amount due but unpaid	9a(2)		
	(3) Increase (decrease) in unearned premium reserve	9a(3)		
	(4) Earned ((1) + (2) - (3))		9a(4)	0
b	Benefit charges (1) Claims paid	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))		9b(3)	0
	(4) Claims charged		9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions	9c(1)(A)		
	(B) Administrative service or other fees	9c(1)(B)		
	(C) Other specific acquisition costs	9c(1)(C)		
	(D) Other expenses	9c(1)(D)		
	(E) Taxes	9c(1)(E)		
	(F) Charges for risks or other contingencies	9c(1)(F)		
	(G) Other retention charges	9c(1)(G)		
	(H) Total retention		9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
	(2) Claim reserves		9d(2)	
	(3) Other reserves		9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a		1715912
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

Multiple Employer Plan Participating Employer Information

Reno +Sparks Chamber Manufacturing Committee Association Health

Plan EIN: 88-0041905; Plan No. 502

Plan Year Ended: February 28, 2025

(a) Name of participating employer	(b) EIN
ADVANCED PRECISION LLC	47-1214443
AMAZING IRON WORKS INC	20-5361115
BUSHMASTER FIREARMS INDUSTRIES INC. DBA BUSHMASTER FIREARMS	85-3370778
CUBIX CORPORATION LLC	88-0390495
DIGIPRINT CORPORATION	88-0312458
EIKELBERGER AWNING AND DRAPERY INC.	26-2295742
ESTILL RANCHES LLC	91-1785563
FRANKLIN ARMORY	81-5165223
GABEL DISTRIBUTORS LLC	26-0432205
HVA LLC	88-0372701
LABELMATE MFG LLC DBA LABELMATE USA	88-2852411
LABELSMITH INC.	72-1550368
MAGNUS ORNAMENTAL METALS LLC	87-2846826
MARATHON INDUSTRIES INC DBA MARATHON TRUCK BODY	83-1937433
MODVANS INC	45-4540049
NU-CLEAN LLC	46-4118739
NUTRIENT FOODS LLC	32-0379407
ON TRACK SCHEDULING INC	20-2088483
OPTAMA INC.	88-2250363
SHORTIES CANDLES LLC DBA SHORTIES CANDLE COMPANY	48-1304652
SIMPLE PUMP COMPANY LLC	90-0142043
SLICK INDUSTRIES DBA MX TROPHIES	74-3123042
SPI DESIGN LLC	39-2074341
THINK INK & THREAD	46-0879824
WATERPROOF LLC	45-1595056
YAK GRAPHICS INC.	77-0463296

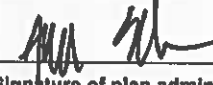
<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form Is Open to Public Inspection</p>
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Part I Annual Report Identification Information	
For calendar plan year 2024 or fiscal plan year beginning <u>03/01/2024</u> and ending <u>02/28/2025</u>	
A This return/report is for:	<input type="checkbox"/> a multiemployer plan <input checked="" type="checkbox"/> a multiple-employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.....▶	<input type="checkbox"/>
D Check box if filing under:	<input type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.....▶	<input type="checkbox"/>

Part II Basic Plan Information—enter all requested information	
<p>1a Name of plan Reno + Sparks Chamber Manufacturing Committee Association Health Plan</p>	<p>1b Three-digit plan number (PN) ▶ 502</p>
<p>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) Reno + Sparks Chamber of Commerce</p> <p>4065 S. Virginia Street Suite 101 Reno NV 89502</p>	<p>1c Effective date of plan 03/01/2021</p> <p>2b Employer Identification Number (EIN) 88-0041905</p> <p>2c Plan Sponsor's telephone number 775-636-9550</p> <p>2d Business code (see instructions) 813000</p>

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

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

SIGN HERE		<u>9-21-05</u>	Ann Silver
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor Manufacturing Committee Administration 4065 South Virginia Street Suite 101 Renot NV 89502	3b Administrator's EIN 88-0041905 3c Administrator's telephone number 775-636-9550
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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 Reno Sparks Chamber Manufacturing Committee Association c Plan Name Reno Sparks Chamber Manufacturing Committee Association Health Plan	4b EIN 88-0041905 4d PN 502
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5 Total number of participants at the beginning of the plan year	5	445
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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) 445
a(2) Total number of active participants at the end of the plan year	6a(2) 342
b Retired or separated participants receiving benefits	6b 4
c Other retired or separated participants entitled to future benefits	6c 0
d Subtotal. Add lines 6a(2), 6b, and 6c.	6d 346
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

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 4Q

9a Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

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

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

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

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

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

Receipt Confirmation Code 000159987741