

<p style="text-align: center;">Form 5500</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p style="font-size: small;">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 style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">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 01/01/2024 and ending 12/31/2024

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

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: 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

<p>1a Name of plan <u>ALASKA ELECTRICAL HEALTH AND WELFARE FUND</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>502</u></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) <u>JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND</u></p> <p><u>701 E TUDOR ST SUITE 200</u> <u>ANCHORAGE, AK 99503</u></p>	<p>1c Effective date of plan <u>12/12/1961</u></p> <p>2b Employer Identification Number (EIN) <u>92-6001972</u></p> <p>2c Plan Sponsor's telephone number <u>907-276-1246</u></p> <p>2d Business code (see instructions) <u>238210</u></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	Filed with authorized/valid electronic signature.	10/02/2025	LAURIE BUTCHER
	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 checked="" type="checkbox"/> 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	3726
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	2863
	6a(2)	2929
	6b	4
	6c	0
	6d	2933
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	117

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 4Q

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

<p>A Name of plan ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 92-6001972</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
RELIASTAR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
41-0451140	67105	LIFE	2918	01/01/2024	12/31/2024

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	0
	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:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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

8 Benefit and contract type (check all applicable boxes)

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

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		92744
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (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>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 92-6001972</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
RELIASTAR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
41-0451140	67105	AD&D	2918	01/01/2024	12/31/2024

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year	7b	0
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	0
	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:	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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

8 Benefit and contract type (check all applicable boxes)

- a** Health (other than dental or vision)
- b** Dental
- c** Vision
- d** Life insurance
- e** Temporary disability (accident and sickness)
- f** Long-term disability
- g** Supplemental unemployment
- h** Prescription drug
- i** Stop loss (large deductible)
- j** HMO contract
- k** PPO contract
- l** Indemnity contract
- m** Other (specify) ▶ **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)	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		9630
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (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>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶ 502</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 92-6001972</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
RELIASTAR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
41-0451140	67105	EXRK	2935	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 7500	(b) Total amount of fees paid 216851
-----------------------------------------------------	------------------------------------------------

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
CENTERSTONE INSURANCE & FINANCIAL **4851 LBJ FWY STE 100**
DALLAS, TX 75244

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7500	216851	ADMINISTRATION FEE	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CENTERSTONE INSURANCE & FINANCIAL **4851 LBJ FWY STE 100**
DALLAS, TX 75244

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7500	0	SUPP COMPENSATION	3

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

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

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

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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	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

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		4337018
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b		

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan ALASKA ELECTRICAL HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 92-6001972	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

FIRST AMERICAN FUNDS	800 NICOLLET MALL MINNEAPOLIS, MN 55402-4302
-----------------------------	---------------------------------------------------------

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

NATIONAL COOPERATIVE RX	5510 RESEARCH PARK DRIVE SUITE 150 FITCHBURG, WI 53711
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(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

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)

AETNA

06-6033492

(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	830576	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ZELIS CLAIMS INTEGRITY, INC.

86-1040704

(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 99 50	NONE	232622	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	165212	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

(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 49 13 50	NONE	338481	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

HEALTH CARE COST MANAGEMENT CORP AK

94-3283661

(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	184886	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RENALOGIC, INC

22-3857341

(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	175536	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RAEL & LETSON, INC

94-1701048

(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 16	NONE	142686	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

TELEDOC HEALTH

04-3705970

(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	114341	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LAURIE BUTCHER

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	104787	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GREGORY STOKES

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	87099	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

BARLOW COUGHRAN MORALES & JOSEPHSON

91-0889948

(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	84375	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GENARO GARCIA

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	79498	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PATTI JANUSIEWICZ

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	76837	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

COLOR ART PRINTING

92-0027042

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	73333	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CATHERINE LAURIO

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	56369	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

TRANSCARENT, INC

84-3296541

(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	50568	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

CLIFTONLARSONALLEN LLP

41-0746749

(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	47077	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CAMERON NEWSTROM

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	46620	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

COREEN SIMANTEL

91-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	41755	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

MELANIE FLOWERS

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	40402	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VANESSA BUSBY

91-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	39810	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EDUCATION MANAGEMENT SERVICES

92-0071890

(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	39299	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

MICHELLE HOKKANEN

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	32871	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

U.S. BANK NATIONAL ASSOCIATION

31-0841368

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 50	NONE	32049	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JIAN GUO

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	30181	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

JULIA BELARDE

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	29695	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

U.S. BANK

200 S 6TH ST.
MINNEAPOLIS, MN 55402

(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 19	NONE	28398	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

INTERNATIONAL DATA SYSTEMS INC

01-0622708

(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	27531	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

CLARA BELLE GLORIA

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	26533	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VISION SERVICE PLAN

92-0078509

(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	26303	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MEGHAN GRANDORFF

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	25571	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

LAURA MAHORIC

92-6005171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
30 50	EMPLOYEE	25462	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LOKAN & ASSOCIATES

92-0169686

(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	23276	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EXPRESS BUSINESS SERVICES LLC

91-1807227

(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	22717	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

CORELLIAN SOFTWARE INC

47-1372895

(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	21915	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SHORETT COMMUNICATIONS

91-2196270

(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	21563	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CVS PHARMACY INC.

05-0340626

(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	18516	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

EXTEND HEALTH

26-0775680

(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	18123	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

VITAL RECORDS HOLDINGS, LLC

82-0796154

(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	9686	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KEEPITSAFE, INC.

46-4821305

(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	8893	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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)

BIRCH HORTON BITTER & CHEROT

92-0046806

(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	6839	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
ZELIS CLAIMS INTEGRITY, INC	99	165212
(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.	
ZENITH AMERICAN SOLUTIONS 52-1590516	COST CONTAINMENT SERVICES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan ALASKA ELECTRICAL HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 JOINT BOARD OF TRUSTEES ALASKA ELECTRICAL HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 92-6001972

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	4017513	3960830
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	6027562	5819911
(2) Participant contributions	1b(2)	339043	336914
(3) Other	1b(3)	1696357	1499885
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	51728	86225
(2) U.S. Government securities	1c(2)	0	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)	0	0
(B) All other	1c(3)(B)	0	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	0	0
(B) Common	1c(4)(B)	0	0
(5) Partnership/joint venture interests	1c(5)	0	0
(6) Real estate (other than employer real property)	1c(6)	0	0
(7) Loans (other than to participants)	1c(7)	0	0
(8) Participant loans	1c(8)	0	0
(9) Value of interest in common/collective trusts	1c(9)	0	0
(10) Value of interest in pooled separate accounts	1c(10)	0	0
(11) Value of interest in master trust investment accounts	1c(11)	0	0
(12) Value of interest in 103-12 investment entities	1c(12)	0	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	40134564	44621337
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	0	0

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)	0	0
(2) Employer real property.....	1d(2)	0	0
e Buildings and other property used in plan operation.....	1e	42351	41750
f Total assets (add all amounts in lines 1a through 1e).....	1f	52309118	56366852
Liabilities			
g Benefit claims payable.....	1g	13900987	11125107
h Operating payables.....	1h	493517	393850
i Acquisition indebtedness.....	1i	0	0
j Other liabilities.....	1j	0	0
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	14394504	11518957
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	37914614	44847895

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)	75155223	
(B) Participants.....	2a(1)(B)	4138281	
(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)		79293504
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(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)	1499708	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1499708
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(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)		259360
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		81052572

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	64705025	
(2) To insurance carriers for the provision of benefits	2e(2)	4439392	
(3) Other	2e(3)	2118922	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		71263339
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)	1460221	
(2) Contract administrator fees	2i(2)	356604	
(3) Recordkeeping fees	2i(3)	19502	
(4) IQPA audit fees	2i(4)	27575	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	60999	
(7) Actuarial fees	2i(7)	17420	
(8) Legal fees	2i(8)	91215	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	10482	
(11) Other expenses	2i(11)	811934	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2855952
j Total expenses. Add all expense amounts in column (b) and enter total	2j		74119291

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		6933281
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: CLIFTONLARSONALLEN LLP

(2) EIN: 41-0746749

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

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

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



INDEPENDENT AUDITORS' REPORT

Board of Trustees
Alaska Electrical Health and Welfare Fund
Anchorage, Alaska

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the Alaska Electrical Health and Welfare 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 December 31, 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 financial statements referred to above present fairly, in all material respects, the net assets available for benefits and of benefit obligations of the Alaska Electrical Health and Welfare Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and of changes in 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 Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Alaska Electrical Health and Welfare Fund 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 the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditors' 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 auditors' 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 Alaska Electrical Health and Welfare Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Alaska Electrical Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

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

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

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

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedules of administrative expenses for the years ended December 31, 2024 and 2023 are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.



CliftonLarsonAllen LLP

Bellevue, Washington
September 19, 2025

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
E.I.N. 92-6001972 PLAN NO. 502
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS
YEAR ENDED DECEMBER 31, 2024

(a)	(b)	(c)	(d)	(e)	(f)	(g)
Identity of Party Involved	Description of Assets	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Category (i) - Single Transaction in Excess of 5% of Plan Assets:						
First Am Govt Ob Fd Cl X	Money Market Fund 2,642,444 Units	\$ -	\$ 2,642,444	\$ 2,642,444	\$ 2,642,444	\$ -
First Am Govt Ob Fd Cl X	Money Market Fund 3,102,566 Units	3,102,566	-	3,102,566	3,102,566	-
Category (iii) - Series of Transaction in Excess of 5% of Plan Assets:						
First Am Govt Ob Fd Cl X	Mutual Fund:					
	110 Purchases	61,877,562	-	61,877,562	61,877,562	-
	171 Sales	-	59,994,119	59,994,119	59,994,119	-

There were no category (ii) or (iv) transactions.

From: ftwilliam.com
To: [Michael Mead](#)
Subject: [External] 5558 Status Update
Date: Friday, April 18, 2025 8:34:59 AM

CAUTION: This email originated from outside your organization. Exercise caution when opening attachments or on clicking links from unknown senders.

Think Security – This email originated from an external source. Be cautious with any links or attachments.

Dear Michael Mead,

The status for the 2024 filing for:

Alaska Electrical Health And Welfare Fund (92-6001972 - 502)

has been updated to 'Submitted' with AckID '20250418113426NAL0004975122001'.

ftwilliam.com

Legal & Regulatory U.S

Wolters Kluwer

Phone: 800.596.0714

Fax: 414.226.2443

ALASKA ELECTRICAL HEALTH AND WELFARE FUND

**FINANCIAL STATEMENTS,
ERISA-REQUIRED SUPPLEMENTAL SCHEDULES,
AND SUPPLEMENTAL INFORMATION**

YEARS ENDED DECEMBER 31, 2024 AND 2023



CPAs | CONSULTANTS | WEALTH ADVISORS

CLAcconnect.com

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
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YEARS ENDED DECEMBER 31, 2024 AND 2023**

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INDEPENDENT AUDITORS' REPORT

Board of Trustees
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Anchorage, Alaska

Report on the Audit of the Financial Statements

Opinion

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In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and of benefit obligations of the Alaska Electrical Health and Welfare Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and of changes in 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 Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Alaska Electrical Health and Welfare Fund 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.

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- 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 Alaska Electrical Health and Welfare Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Alaska Electrical Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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CliftonLarsonAllen LLP

Bellevue, Washington
September 19, 2025

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
DECEMBER 31, 2024 AND 2023**

	2024	2023
ASSETS		
INVESTMENTS (at Fair Value)		
Interest Bearing Cash	\$ 86,225	\$ 51,728
Shares of Registered Investment Funds	44,621,337	40,134,564
Total Investments at Fair Value	44,707,562	40,186,292
RECEIVABLES		
Employer Contributions	5,761,190	5,911,485
Reciprocity Contributions	58,721	116,077
Participant Contributions	336,914	339,043
Due from Stop-Loss Carrier	1,397,013	1,602,700
Accrued Interest and Dividends	64,842	77,572
Other	10,172	-
Total Receivables	7,628,852	8,046,877
Cash	3,960,830	4,017,513
Office Furniture and Equipment, Net of Accumulated Depreciation of \$308,156 in 2024 and \$300,927 in 2023	41,750	42,351
Other Assets	27,858	16,085
Total Assets	56,366,852	52,309,118
LIABILITIES		
LIABILITIES		
Accounts Payable	288,431	422,481
Reciprocity Payable	105,419	71,036
Total Liabilities	393,850	493,517
NET ASSETS AVAILABLE FOR BENEFITS	\$ 55,973,002	\$ 51,815,601

See accompanying Notes to Financial Statements.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
YEARS ENDED DECEMBER 31, 2024 AND 2023**

	2024	2023
ADDITIONS:		
INVESTMENT INCOME		
Net Appreciation in Fair Value of Investments	\$ 259,360	\$ 619,567
Interest and Dividends	1,499,708	1,091,483
Total	1,759,068	1,711,050
Less: Investment Expenses	(60,999)	(67,067)
Net Investment Income	1,698,069	1,643,983
CONTRIBUTIONS		
Employers	75,386,273	70,834,952
Reciprocity	(231,050)	193,323
Participants	4,138,281	11,867,951
Total Contributions	79,293,504	82,896,226
 Total Additions	 80,991,573	 84,540,209
DEDUCTIONS:		
PAYMENTS FOR HEALTH CLAIMS AND INSURANCE PREMIUMS		
Claims Paid (Net of Refunds and Other Income of \$9,353,694 in 2024 and \$11,863,141 in 2023)	67,480,905	70,153,619
Insurance Premiums for Stop-Loss Coverage, Life and AD&D	4,439,392	4,848,248
Total Payments for Health Claims and Insurance Premiums	71,920,297	75,001,867
OTHER CLAIMS-RELATED FEES PAID TO THIRD PARTIES	2,475,526	2,422,983
ADMINISTRATIVE EXPENSES	2,438,349	2,192,851
Total Deductions	76,834,172	79,617,701
NET INCREASE	4,157,401	4,922,508
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of Year	51,815,601	46,893,093
End of Year	\$ 55,973,002	\$ 51,815,601

See accompanying Notes to Financial Statements.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
STATEMENTS OF BENEFIT OBLIGATIONS
DECEMBER 31, 2024 AND 2023**

	2024	2023
Amounts Currently Payable:		
Claims Payable and Claims Incurred but not Reported	\$ 11,125,107	\$ 13,900,987
Other Obligations for Current Benefit Coverage at Estimated Amounts:		
Estimated Future Benefits Based on Participants' Accumulated Eligibility	23,473,476	20,937,925
Total Obligations Other Than Postretirement Benefit Obligations	34,598,583	34,838,912
Postretirement Benefit Obligations:		
Current Retirees and Spouses	42,502,800	41,457,600
Other Participant Fully Eligible for Benefits	29,042,400	36,902,500
Participants not yet Fully Eligible for Benefits	62,284,700	66,808,500
Total Postretirement Benefit Obligations	133,829,900	145,168,600
Total Benefit Obligations	\$ 168,428,483	\$ 180,007,512

See accompanying Notes to Financial Statements.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS
YEARS ENDED DECEMBER 31, 2024 AND 2023**

	2024	2023
Amounts Currently Payable:		
Balance - Beginning of Year	\$ 13,900,987	11,604,357
Increase (Decrease) in Claims Payable and Claims Incurred but not Reported	(2,775,880)	2,296,630
Balance - End of Year	11,125,107	13,900,987
Other Obligations for Current Benefit Coverage at Estimated Amounts:		
Balance - Beginning of Year	20,937,925	19,665,204
Increase in Accumulated Eligibility Credits	2,535,551	1,272,721
Balance - End of Year	23,473,476	20,937,925
Total Obligations Other Than Postretirement Benefit Obligations	34,598,583	34,838,912
Postretirement Benefit Obligations		
Balance - Beginning of Year	145,168,600	224,297,500
Increase (Decrease) in Postretirement Benefits Attributable to:		
Benefits Earned	5,516,200	6,181,400
Expected Benefit Payments	(4,239,800)	(6,615,100)
Changes in Actuarial and Other Assumptions	(16,946,600)	9,638,500
Changes in Participant Demographics	-	(9,000,100)
Interest	7,058,100	11,360,500
Claims Experience	(2,726,600)	-
Plan Amendments	-	(90,694,100)
Balance - End of Year	133,829,900	145,168,600
Total Benefit Obligations at End of Year	\$ 168,428,483	\$ 180,007,512

See accompanying Notes to Financial Statements.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 1 DESCRIPTION OF PLAN

The following description of the Alaska Electrical Health and Welfare Fund (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

General

The Plan is a trust established and maintained under several collective bargaining agreements between contributing employers and the International Brotherhood of Electrical Workers (IBEW) Local 1547. The collective bargaining agreements have various expiration dates from March 2025 through December 2029. The term "Health and Welfare Plan" or "Plan" as used herein means a program or programs of benefits provided by employer and participant contributions, the conditions of eligibility for such benefits, and such other terms as the Trustees shall deem it necessary to include. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Eligibility

Employees are entitled to participate in this Plan if they work under one of the collective bargaining agreements mentioned above. Certain non-bargaining unit employees are entitled to participate pursuant to special agreements between their employers and the Board of Trustees.

A self-pay option is available for a maximum of 18 to 36 calendar months after eligibility terminates, depending upon the status of the qualified beneficiary.

The eligibility rules that determine which participants and beneficiaries are entitled to benefits are set forth in summary plan description binders describing the various benefit programs administered for the Plan. These binders are available for examination at the Alaska Electrical Trust Fund's (the Trust) administrative office.

Benefits

The Plan provides the following kinds of benefits to eligible participants: hospitalization, surgical, medical, prescription, dental and vision care, life and accidental death and dismemberment insurance, and short-term disability benefits. Prior to January 1, 2024, eligible retirees received hospitalization, surgical, medical, and prescription benefits only.

Effective January 1, 2024, current retirees and future eligible retirees who were covered by the Fund's plan for active members are able to choose from the marketplace of individual health plans to select a plan that best suits their needs. The Fund established the Health Reimbursement Arrangement Plan (HRA) to help offset retiree medical costs, for eligible retirees, spouses, and dependents.

Medical and dental benefits are administered by Zenith American Solutions, Inc. (Zenith), a third-party administrator. Disability benefits are administered through the Trust's administrative office. Prescription and vision benefits are administered through Caremark and Vision Services Plan, respectively.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 1 DESCRIPTION OF PLAN (CONTINUED)

Funding

The Plan is self-funded for medical, prescription, dental, vision, and short-term disability benefits. Specific stop-loss for individual medical claims over \$425,000 and \$400,000 for the years ended December 31, 2024 and 2023, respectively, fully insured life and accidental death and dismemberment benefits are provided by Reliastar Life Insurance.

Cash on the statements of net assets available for benefits includes a reserve account with Zenith with a balance of \$829,453 and \$(194,238) at December 31, 2024 and 2023, respectively. This account is used to pay claims and is reimbursed by the Plan on a weekly basis.

Reciprocal Agreements (ERTS)

The Plan participates in the IBEW/NECA Electronic Reciprocal Transfer System (ERTS) that provides for the transfer of contributions to the home fund of individuals who receive contributions from contributing employers and the receipt of contributions from other funds in which the participants participate while employed outside of the Plan's jurisdiction. Participants must submit such requests through the ERTS.

Termination of the Plan

Upon termination of the Plan, any and all assets remaining after the payment of all expenses shall be used for the continuance of one or more benefits of the type provided by the Plan until such assets have been depleted.

Employer Contributions

Monthly contribution rates range from \$2,155 to \$2,412 for 2024 and \$2,123 to \$2,352 for 2023. Under agreements requiring hourly contributions, the employers contributed \$10.44 to \$14.52 per hour for 2024 and \$10.44 to \$14.40 per hour for 2023. Hours are prorated if the contribution rate per hour is less than the actual hourly cost of the Plan, due to a high number of hours worked.

Participant Contributions

Participant contributions consist of payments received from participants and their eligible dependents who select the COBRA self-payment option, retirees who select a retiree self-payment option, and participant payments collected and remitted by the employer. For the years ended December 31, self-pay contributions were:

	<u>2024</u>	<u>2023</u>
Participant Self-Pay Contributions	\$ 186,620	\$ 302,428
Retiree Self-Pay Contributions	-	7,510,933
Participant Payments	3,951,661	4,054,590
Total	<u>\$ 4,138,281</u>	<u>\$ 11,867,951</u>

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting.

Investment Valuation and Income Recognition

The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by the investment advisers and custodians. See Note 4 for discussion of fair value measurements.

The Plan presents in the statements of changes in net assets available for benefits the net appreciation (depreciation) in the fair value of its investments, which consists of the realized gains and losses for all securities, including securities bought and sold during the year and the unrealized appreciation (depreciation) on those investments. 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.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein, claims payable and claims incurred but not reported, eligibility credits, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Office Furniture and Equipment

Office furniture and equipment are recorded at cost and are depreciated on the straight-line method over the estimated useful lives of the assets. Depreciation expense for the years ended December 31, 2024 and 2023 was \$10,883 and \$12,501, respectively, and is included in administrative expenses.

Other Receivables

Other receivables include employer audit billings and refunds to be received from providers.

Employer Contributions

Additions to Plan assets from employer contributions are determined by the contractual employer contribution rates in effect. Employer contributions are included as an addition to Plan assets during the period in which the work is performed.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Employer Contributions Receivable

Contributions due but not paid prior to year-end are recorded as contributions receivable. Contributions are due from employers as specified in the collective bargaining or participation agreement. In general, contributions are due on the 15th day of each month following the work month. Delinquent contributions and payroll audit findings are individually analyzed for collectability. The estimate for expected credit losses considers historical loss experience, current economic conditions, and forward-looking information, including factors such as payment history, employer financial condition, and labor trends. As of December 31, 2024 and 2023, the allowance for credit losses was insignificant.

Participant Contributions

Active participants under monthly agreements pay the difference between the cost of the Plan chosen by the bargaining group and the employer contribution required under the collective bargaining agreement.

Retirees are required as a condition of participation to make self-payment contributions at a level, dependent on age and length of service, set from time to time by the Board of Trustees. In 2023, retiree contributions covered approximately 64% of the cost of their benefits. Effective January 1, 2024, retiree health benefits will no longer be provided directly through the fund. Instead, eligible retirees who satisfy the service and age requirements are eligible to purchase individual health coverage, and may be eligible to participate in the Retiree Health Reimbursement Arrangement Plan.

Benefits Paid to Participants

Benefits are deducted from plan assets when the claims are paid. Health claims incurred by active participants and retirees but not reported at December 31 are estimated by the Plan's actuary based upon historical experience and run-out and are reported in the accompanying statements of plan benefit obligations. The Plan receives stop loss refunds through their contract with Reliastar. The refunds received in 2024 related to stop loss were \$4,768,053. The refunds received in 2023 related to stop loss were \$3,969,442. The Plan receives formulary rebates through their agreement with NationalCooperative. For the years ended December 31, 2024 and 2023, the Plan received \$3,049,706 and \$3,129,022 in formulary rebates, respectively. The amount of rebates cannot be reasonably estimated and are recorded when received as an offset to benefits paid.

Benefits paid to participants for the Plan year ended December 31, 2024 included \$2,084,784 in HRA claims.

Other Claims-Related Fees Paid to Third Parties

Other claims-related fees include case management, network fees, state and federal claim surcharges, claims clearing services, and patient-centered outcome research fees.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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 such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The value, liquidity, and related income of these securities are sensitive to changes in economic conditions, delinquencies or defaults, or both, and may be adversely affected by shifts in the market's perception of the issuers and changes in interest rates.

The estimate for claims payable and claims incurred but not reported is based on certain assumptions pertaining to trend rates, claims lag, and historical claims data. The estimate for future benefits based on participants' accumulated eligibility is based on certain assumptions pertaining to trends and inflation rates. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

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

Accumulated Eligibility Credits – Postemployment Benefits

The Plan records an estimated liability for hours worked that are applied toward future eligibility for which employer contributions have been received. There are two types of agreements – hourly and monthly. For the hourly agreement, participants must work a minimum of 130 hours per month to maintain coverage subsequent to establishing initial eligibility. The excess number of hours over the minimum required to maintain eligibility is applied to coverage under the Plan in a subsequent month. The maximum number of hours that can be accumulated is 1,040 in 2024 and 2023. For the monthly agreement, collective bargaining agreements specify the number of hours required to maintain eligibility. Eligibility is determined month to month, whereby if the minimum number of hours pursuant to the collective bargaining agreement has been worked, the participant will be covered for the subsequent month. For the hourly agreement, the hours are utilized on a first-in, first-out basis. The liability at the end of the year is calculated based upon accumulated hours and the current cost of providing benefits. Because of the limitations applied to hours worked, which can be used during periods of unemployment to maintain coverage and, in the event of death, can be used to provide coverage for eligible dependents, the effects of employee turnover and mortality are not considered to be significant to this estimate.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Postretirement Benefits

The Accumulated Postretirement Benefit Obligation (APBO) represents the total actuarial present value of those estimated future benefits, net of retiree self-pay contributions, that are attributed to employee service rendered through December 31. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the APBO 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 Accumulated 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 significant assumptions were used in the valuations as of December 31:

		2024	
		HRA	Operating Expense
Medical Inflation	1st Year	6.00%	6.00%
	2nd Year	5.75	5.75
	3rd Year	5.50	5.50
	4th Year	5.25	5.25
	5th Year	5.00	5.00
	6th Year	4.75	4.75
	7th Year	4.50	4.50
	8th Year	4.25	4.25
	9th Year	4.00	4.00
	10th Year and Thereafter	4.00	4.00

		2023	
		HRA	Operating Expense
	1st Year	6.25%	4.00%
	2nd Year	6.00	4.00
	3rd Year	5.75	4.00
	4th Year	5.50	4.00
	5th Year	5.25	4.00
	6th Year	5.00	4.00
	7th Year	4.75	4.00
	8th Year	4.50	4.00
	9th Year	4.25	4.00
	10th Year and Thereafter	4.00	4.00

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Postretirement Benefits (Continued)

Discount Rate	2024	5.50%
	2023	4.75%
Retirement Age	2024 and 2023	Rates varying by age from age 48 to age 70 and over
Mortality - Healthy and Disabled	2024 and 2023	Sex-Distinct RP2014 Blue Collar Mortality Table (separate for employees, annuitants, and disabled) set forward one year with a generational projection based on 75% of the ultimate rate of improvement from the MP-2015 scale
Health Reimbursement Account	2024	The Plan's retiree contribution structure is based on the Medicare status of the individual and the attained age/service of the retiree. The maximum HRA subsidy amounts are multiplied by the percentage corresponding to the retiree's attained age and service at retirement

	Maximum HRA Subsidy
Non Medicare	\$11,328
Medicare	\$1,768

Retirement Attained Age	<u>Months of Eligibility at Retirement</u>				
	0-119	120-179	180-239	240-299	300+
48-54	0%	0%	0%	0%	0%
55	0	0	0	0	30
56	0	0	0	30	50
57	0	0	30	50	60
58	0	30	50	60	100
59	0	50	60	80	100
60+	0	50	80	100	100

Retiree Contribution per Person	2023	The Plan's retiree contribution structure is based on the attained age/service of the retiree. Under the current structure, the minimum retiree contribution will be 50% of cost and the maximum will be 100% of cost for retirees age 60 and above.
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Participation Rates	Rates varying by months of eligibility at retirement		
	Months of Eligibility at Retirement	Participation Rate	
		2024	2023
	60-119	30%	30%
	120-179	40	40
	180-239	50	50
	240-299	70	70
	300+	70	70

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

The Plan has an Employer Group Waiver Plan (EGWP) arrangement. Under this program, the Plan received subsidies in various forms (direct, low income, federal reinsurance and coverage gap discounts on Brand drugs). The subsidy received in 2023 under the EGWP program, as well as the remainder from RDS was \$2,481,690. The subsidy received in 2024 under the EGWP program was \$530,094. Drug manufacturer rebates are also received under the EGWP program. For the years ended December 31, 2024 and 2023, the EGWP manufacturer rebates received were \$1,005,841 and \$2,282,987, respectively.

The subsidies and rebates are included in the statements of changes in net assets available for benefits as a reduction in benefits paid to participants.

NOTE 3 BENEFIT OBLIGATIONS

The Plan provides healthcare benefits to active eligible participants and retirees. The Board of Trustees retains full and exclusive authority, for use at its discretion, to determine the extent to which monies are available and to determine the expenditure of such monies for retiree healthcare. The program is not guaranteed to continue indefinitely and may be terminated or modified at any time by the Board of Trustees.

The Plan's deficiency of net assets over benefit obligations at December 31, 2024 and 2023 relates primarily to the postretirement benefit obligation, the funding of which was not covered by the contribution rates provided by the current bargaining agreements nor by the retirees self-pay contribution rates required by the Plan for 2023. For 2023, it was expected that funding for retiree benefits would be through employer and retiree contributions necessary to fund the Plan on a year-for-year basis. In 2024, the HRA benefit and administrative costs are fully subsidized by the fund. Retirees pay 0% of the estimated cost of postretirement benefits in the current year.

The healthcare cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. An increase in the medical trend by 1% in each future year would increase the postretirement benefit obligation by \$22.5 million and \$26.9 million as of December 31, 2024 and 2023, respectively.

During 2024, the Plan had a decrease of approximately \$16.9 million related to a change in actuarial assumptions and methods, which included an increase in the discount rate from 5.50% to 4.75%. The Plan had a \$2.7 million decrease related to financial plan experience changes, and a \$8.3 million net increase based on an increase in service cost and interest cost, and a decrease in expected benefit payments.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 3 BENEFIT OBLIGATIONS (CONTINUED)

During 2023, the Plan had an increase of approximately \$9.6 million related to a change in actuarial assumptions and methods, which included a decrease in the discount rate from 5.00% to 4.75%. The Plan had a \$9.0 million decrease related to Census Demographic changes, and a \$10.9 million net increase based on an increase in service cost and interest cost, and a decrease in expected benefit payments. Effective January 1, 2024, the Plan was amended to allow retirees to choose their own coverage and receive a Trust contribution in the form of a Health Reimbursement Account (HRA) which resulted in an additional \$90.7 million decrease.

NOTE 4 FAIR VALUE OF INVESTMENTS

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 (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

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

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, such as:

- 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 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.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 4 FAIR VALUE OF INVESTMENTS (CONTINUED)

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

The Plan's interest bearing cash is valued at cost, which represents fair value.

The Plan's investments in shares of registered investment companies are reported at fair value based on quoted market prices in an active market.

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

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31:

	2024			
	Level 1	Level 2	Level 3	Total
Interest-Bearing Cash	\$ 86,225	\$ -	\$ -	\$ 86,225
Shares of Registered Investment Companies	44,621,337	-	-	44,621,337
Total Investments in the Fair Value Hierarchy	\$ 44,707,562	\$ -	\$ -	\$ 44,707,562
	2023			
	Level 1	Level 2	Level 3	Total
Interest-Bearing Cash	\$ 51,728	\$ -	\$ -	\$ 51,728
Shares of Registered Investment Companies	40,134,564	-	-	40,134,564
Total Investments in the Fair Value Hierarchy	\$ 40,186,292	\$ -	\$ -	\$ 40,186,292

NOTE 5 EMPLOYEE WAGES AND BENEFITS

The Plan is administered by employees of the Trust. The employees are provided benefits through special agreements with the Alaska Electrical Pension Plan, Alaska Electrical Health and Welfare Plan, Alaska Electrical Legal Plan, and the Alaska Electrical Retirement Savings Plan. The total amount of benefit expense related to these employees, which is included in administrative expenses for 2024 and 2023 was \$513,054 and \$453,997, respectively. The total amount of wages expense was \$868,795 and \$693,935 for 2024 and 2023, respectively.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 6 RELATED PARTY TRANSACTIONS

The Plan's Board of Trustees are also members of boards of trustees of other entities organized primarily to provide services and benefits to members of the IBEW Local 1547 and non-bargaining unit employees covered under a special agreement.

The administrative functions of the Plan, including facility costs, are provided by the Alaska Electrical Pension Plan and the expenses are allocated to the Plan based on continuing studies of costs of providing services to the various user organizations and by agreement between the parties. Administrative expenses include salaries and other direct costs attributable to the Plan as well as any indirect costs incurred. Administrative expenses and other reimbursable costs, including insurance premiums, and other claims-related fees of \$9,120,642 and \$9,234,512 were paid to the Alaska Electrical Pension Plan for the years ended December 31, 2024 and 2023, respectively. Rent expense paid was \$131,701 and \$133,732 for 2024 and 2023, respectively. Accounts payable consists of amounts allocated to the Plan that will be paid by the Alaska Electrical Pension Plan for administrative expenses incurred for the years ended December 31, 2024 and 2023.

The Trust's employees are covered under the Plan by a special agreement. The total 2024 and 2023 contributions received by the Plan for health and welfare benefits related to these employees were \$682,098 and \$644,088, respectively.

NOTE 7 INCOME TAXES

The Plan is exempt from federal income taxes under the provisions of Section 501(a) of the Internal Revenue Service (IRS), pursuant to a tax determination letter obtained from the IRS dated June 21, 1991. The Plan has been amended since receiving the determination letter; however, the Plan administrator believes the Plan is currently designed and being operated in compliance with the applicable requirements of the Code.

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 the organization has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan administrator has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan administrator believes it is no longer subject to income tax examinations for years prior to 2021.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

NOTE 8 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of differences between information contained in the financial statements and the net assets available for benefits, benefit obligation, and benefits paid to participants for health claims reported in Form 5500 as of December 31:

	2024	2023
Net Assets Available for Benefits Per the Financial Statements	\$ 55,973,002	\$ 51,815,601
Less:		
Claims Payable and Estimated Liability for Claims Incurred but not Reported	(11,125,107)	(13,900,987)
Net Assets Available for Benefits per Form 5500	\$ 44,847,895	\$ 37,914,614

The following is a reconciliation of the cost of benefits provided per the financial statements to Form 5500 for the year ended December 31, 2024:

Cost of Benefits Provided per the Financial Statements	\$ 67,480,905
Add: Amounts Payable at December 31, 2024	11,125,107
Less: Amounts Payable at December 31, 2023	(13,900,987)
Benefits Paid per Form 5500	\$ 64,705,025

NOTE 9 CONTINGENCIES

The Plan is involved in various claims and legal actions arising in the ordinary course of business. In the opinion of management, the ultimate disposition of these matters will not have a material adverse effect on the Plan's financial status.

NOTE 10 MULTIEMPLOYER PENSION PLAN AND OTHER POST-RETIREMENT BENEFITS

The Plan contributes to one multiemployer pension plan on behalf of all of the Plan's employees pursuant to a special agreement. The risk of participating in this multiemployer plan is different from a single-employer plan in the following aspects:

- Assets contributed to the multiemployer pension plan by one employer may be used to provide benefits to employees of other participating employers.
- If a participating employer stops contributing to the pension plan, the unfunded obligations of the pension plan may be borne by the remaining participating employers.
- If the Plan chooses to stop participating in its multiemployer pension plan, the Plan may be required to pay the pension plan an amount based on the underfunded status of the pension plan, referred to as a withdrawal liability.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023**

**NOTE 10 MULTIEMPLOYER PENSION PLAN AND OTHER POST-RETIREMENT BENEFITS
(CONTINUED)**

The Plan’s participation in this pension plan for the years ended December 31, 2024 and 2023 is outlined in the tables below. The Employer Identification Number (EIN) “EIN/Pension Plan Number” column provides the EIN and the three-digit plan number, if applicable. The most recent Pension Protection Act (PPA) zone status available is for the pension plan’s year-end as of December 31, 2024. The zone status is based on information that the Plan received from the pension plan and is certified by the pension plan’s actuary. Among other factors, plans in the red zone (critical status) are generally less than 65% funded. Plans in the yellow zone (endangered status) are (1) less than 80% funded or (2) the plan has an accumulated funding deficiency (the credit balance has been exhausted) in the current plan year or is expected to have a deficiency in any of the next six plan years (taking into consideration any amortization extensions). Plans in the orange zone (seriously endangered status) have met both yellow zone conditions. Plans in the green zone are at least 80% funded. The “FIP/RP Status Pending/Implemented” column indicates plans for which a funding improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented. The last column lists the expiration date of the collective bargaining agreements (CBA) to which the plans are subject.

<u>Pension Fund</u>	<u>EIN/Pension Plan Number</u>	<u>Pension Protection Act Zone Status</u>		<u>FIP/RP Status</u>
		<u>2024</u>	<u>2023</u>	<u>Pending/ Implemented</u>
Alaska Electrical Pension Fund	92-6005171	Green	Green	No

<u>Pension Fund</u>	<u>Employer Contributions</u>		<u>Surcharge</u>	<u>Expiration</u>
	<u>2024</u>	<u>2023</u>	<u>Imposed</u>	
Alaska Electrical Pension Fund	\$ 180,782	\$ 148,588	No	N/A *

*The Plan participates in the above pension plan pursuant to an open-ended special agreement.

The Plan’s employees are also covered by the Alaska Electrical Health and Welfare Fund, the Alaska Electrical Retirement Savings Plan, and the Alaska Electrical Legal and Welfare Benefits Fund, multiemployer plans that provide health, retirement, and legal and welfare benefits to eligible participants and their dependents and retirees. Contributions to these plans are made monthly under the terms of a special agreement. Contributions to these plans for the years ended December 31, 2024 and 2023 totaled \$306,269, \$22,543, and \$3,460 and \$280,562, \$21,624, and \$3,224, respectively.

NOTE 11 SUBSEQUENT EVENTS

Subsequent events were evaluated through September 19, 2025, the date the financial statements were available to be issued.

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
E.I.N. 92-6001972 PLAN NO. 502
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)
DECEMBER 31, 2024

(a)	(b)	(c)	(d)	(e)
Identity of Issuer, Borrower, Lessor, or Similar Party	Description of Investment	Cost	Current Value	
Cash and Cash Equivalents:				
Northrim Bank	Institutional Bank Deposit Account (.90%)	\$ 34,312	\$ 34,312	
US Bank	Institutional Bank Deposit Account	51,913	51,913	
Total Cash and Cash Equivalents		<u>86,225</u>	<u>86,225</u>	
Number of Shares				
Shares of Registered Investment Companies:				
First Am Govt Ob Fd Class X	19,525,756	19,525,756	19,525,756	
Fidelity Short Term Bond Index	2,545,191	24,840,259	25,095,581	
Total Shares of Registered Investment Companies		<u>44,366,015</u>	<u>44,621,337</u>	
Total Investments		<u>\$ 44,452,240</u>	<u>\$ 44,707,562</u>	

* Designates party-in-interest

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
E.I.N. 92-6001972 PLAN NO. 502
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS
YEAR ENDED DECEMBER 31, 2024

(a)	(b)	(c)	(d)	(e)	(f)	(g)
Identity of Party Involved	Description of Assets	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain (Loss)
Category (i) - Single Transaction in Excess of 5% of Plan Assets:						
First Am Govt Ob Fd CI X	Money Market Fund 2,642,444 Units	\$ -	\$ 2,642,444	\$ 2,642,444	\$ 2,642,444	\$ -
First Am Govt Ob Fd CI X	Money Market Fund 3,102,566 Units	3,102,566	-	3,102,566	3,102,566	-
Category (iii) - Series of Transaction in Excess of 5% of Plan Assets:						
First Am Govt Ob Fd CI X	Mutual Fund:					
	110 Purchases	61,877,562	-	61,877,562	61,877,562	-
	171 Sales	-	59,994,119	59,994,119	59,994,119	-

There were no category (ii) or (iv) transactions.

**ALASKA ELECTRICAL HEALTH AND WELFARE FUND
SCHEDULES OF ADMINISTRATIVE EXPENSES
YEARS ENDED DECEMBER 31, 2024 AND 2023**

	2024	2023
Salaries and Benefits	\$ 1,454,454	\$ 1,206,160
Printing and Postage	205,453	186,347
Services Purchased	141,138	124,930
Rent and Utilities	133,974	160,008
Consultant Fees	116,273	91,711
Attorney Fees	91,215	104,692
Dues and Subscriptions	64,242	31,990
Accounting Fees	47,077	60,032
Office Supplies and Equipment	43,720	37,198
Web Design and EPR Implementation	43,478	75,359
Fiduciary Liability Insurance	41,755	41,805
Miscellaneous	21,604	22,813
Other Insurance	15,196	14,893
Depreciation	10,883	12,501
Trustee Meetings	6,075	7,870
Conferences and Conventions	5,835	17,859
Travel	4,339	5,925
IBEW/NECA Reimbursement	(8,362)	(9,242)
Total Administrative Expenses	\$ 2,438,349	\$ 2,192,851



CLA (CliftonLarsonAllen LLP) is a network member of CLA Global. See CLAGlobal.com/disclaimer. Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.

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

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

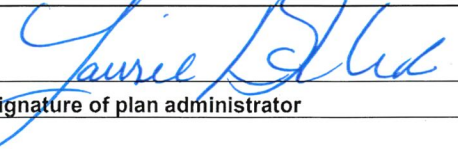
- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- a single-employer plan a DFE (specify) _____
- B** This return/report is: the first return/report the final return/report
- an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here.
- D** Check box if filing under: 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 ALASKA ELECTRICAL HEALTH AND WELFARE FUND	1b Three-digit plan number (PN) ▶	502
	1c Effective date of plan 12/12/1961	
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) Joint Board Of Trustees Alaska Electrical Health And Welfare Fund 701 E Tudor St Suite 200 Anchorage AK 99503	2b Employer Identification Number (EIN) 92-6001972	
	2c Plan Sponsor's telephone number 907-276-1246	
	2d Business code (see instructions) 238210	

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>9/30/25</u>	Laurie Butcher
	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

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

Form 5500 (2024)
v. 240311

ALASKA ELECTRICAL HEALTH AND WELFARE FUND
E.I.N. 92-6001972 PLAN NO. 502
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)
DECEMBER 31, 2024

(a)	(b)	(c)	(d)	(e)
Identity of Issuer, Borrower, Lessor, or Similar Party	Description of Investment	Cost	Current Value	
Cash and Cash Equivalents:				
Northrim Bank	Institutional Bank Deposit Account (.90%)	\$ 34,312	\$ 34,312	
US Bank	Institutional Bank Deposit Account	51,913	51,913	
Total Cash and Cash Equivalents		<u>86,225</u>	<u>86,225</u>	
Number of Shares				
Shares of Registered Investment Companies:				
First Am Govt Ob Fd Class X	19,525,756	19,525,756	19,525,756	
Fidelity Short Term Bond Index	2,545,191	24,840,259	25,095,581	
Total Shares of Registered Investment Companies		<u>44,366,015</u>	<u>44,621,337</u>	
Total Investments		<u>\$ 44,452,240</u>	<u>\$ 44,707,562</u>	

* Designates party-in-interest