

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 single-employer plan
 - a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
 - 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
 - special extension (enter description)
 - the DFVC program
- 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 <u>CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
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>TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</u> <u>C/O BENEFITS MANAGEMENT GROUP, INC.</u> <u>625 ENTERPRISE DR.</u> <u>OAKBROOK, IL 60523</u>	1c Effective date of plan <u>06/25/1959</u> 2b Employer Identification Number (EIN) <u>36-2125291</u> 2c Plan Sponsor's telephone number <u>630-472-0622</u> 2d Business code (see instructions) <u>541990</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	09/30/2025	MICHAEL CONSOLINO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	09/30/2025	THOMAS SOMMERS
	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

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:		4b EIN	
a Sponsor's name			
c Plan Name		4d PN	
5 Total number of participants at the beginning of the plan year		5	1311
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).			
a(1) Total number of active participants at the beginning of the plan year		6a(1)	805
a(2) Total number of active participants at the end of the plan year		6a(2)	810
b Retired or separated participants receiving benefits.....		6b	468
c Other retired or separated participants entitled to future benefits		6c	
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	1278
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	
f Total. Add lines 6d and 6e		6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		6g(1)	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		7	37

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 4F 4L

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 checked="" type="checkbox"/> D (DFE/Participating Plan Information)	
		(6) <input type="checkbox"/> G (Financial Transaction Schedules)	

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

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

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

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

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

Receipt Confirmation Code _____

<p>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 CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2125291</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
BERKSHIRE HATHAWAY SPECIALTY INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
63-0202590	22276	47-MSL-000450-0	1015	01/01/2024	12/31/2024

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <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	730708
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 CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2125291</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
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	G8141	777	02/01/2023	01/31/2024

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <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	42929
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>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 CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 36-2125291</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
HUMANA 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
39-1263473	73288	316751, 316847	442	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 42483</p>	<p>(b) Total amount of fees paid 0</p>
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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
HORTON GROUP INC - ORLAND PARK **10320 ORLAND PKWY**
ORLAND PARK, IL 60467-5627

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
42483			0

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))		9b(3)
	(4) Claims charged		9b(4)
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		9c(1)(H)
	(2) Dividends or retroactive rate refunds. (These amounts were <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	841533
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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 CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 36-2125291	

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

THE VANGUARD GROUP, INC.

23-1945930

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

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

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

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

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

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

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

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

BENEFITS MANAGEMENT GROUP, INC

20-0188125

(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 13 49	NONE	747757	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)

BLUE CROSS BLUE SHIELD OF ILLINOIS

36-1236610

(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 56 73	NONE	606267	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

REINHART BOERNER VAN DEUREN S.C.

39-1126909

(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	NONE	133089	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)

OPTUMRX, INC.

33-0441200

(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 99	NONE	55922	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LEGACY PROFESSIONALS LLP

32-0043599

(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 15	NONE	53929	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)

THE HORTON GROUP

36-3672171

(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 16 70	NONE	51772	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	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)

NATIONAL INVESTMENT SERVICES, INC.

84-3937993

(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 51	NONE	39916	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)

STRATEGIC CAPITAL INVESTMENT ADVISO

36-4268991

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	NONE	26500	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)

DELTA DENTAL OF ILLINOIS

36-2612058

(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	NONE	23556	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)

EMPLOYEE RESOURCE SYSTEMS, INC.

36-3867945

(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	NONE	17416	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)

SOMMERS & FAHRENBACH, INC

36-1796440

(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	NONE	16821	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)

AMALGAMATED BANK OF CHICAGO

36-0721895

(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 55 62	NONE	15955	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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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 <u>CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</u>	B Three-digit plan number (PN) ▶	<u>501</u>
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C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND</u>	D Employer Identification Number (EIN) <u>36-2125291</u>
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Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
---------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS CORE FIXED INCOME FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN <u>20-0005644-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>9027049</u>
---------------------------------------	-------------------------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS HIGH YIELD FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN <u>39-2021943-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>388446</u>
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE: NIS TOTAL ABSOLUTE RETURN FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES OF AMERICA, LLC

c EIN-PN <u>45-4783986-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>962295</u>
---------------------------------------	-------------------------------	---

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

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.	<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 CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 36-2125291

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	782353	232840
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1470853	1554330
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	1143727	1895899
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	198597	12454
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	11007458	10377790
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	21816454	22261709
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	36419442	36335022
Liabilities			
g Benefit claims payable.....	1g	1633300	2805700
h Operating payables.....	1h	281270	65930
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	87152	49711
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	2001722	2921341
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	34417720	33413681

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)	16279633	
(B) Participants.....	2a(1)(B)	1139300	
(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)		17418933
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	925	
(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)		925
(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)	551947	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		551947
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	1651550	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	1651550	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		0
(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)		370330
(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)		2343307
c Other income	2c		4407166
d Total income. Add all income amounts in column (b) and enter total	2d		25092608

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	23506729	
(2) To insurance carriers for the provision of benefits	2e(2)	779807	
(3) Other	2e(3)	685745	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		24972281
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	735600	
(3) Recordkeeping fees	2i(3)	7929	
(4) IQPA audit fees	2i(4)	46000	
(5) Investment advisory and investment management fees	2i(5)	67966	
(6) Bank or trust company trustee/custodial fees	2i(6)	14430	
(7) Actuarial fees	2i(7)	51772	
(8) Legal fees	2i(8)	133089	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	67580	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1124366
j Total expenses. Add all expense amounts in column (b) and enter total	2j		26096647

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-1004039
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: LEGACY PROFESSIONALS LLP

(2) EIN: 32-0043599

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

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

Part IV Compliance Questions

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

During the plan year:

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

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 _____.

**Chicago Graphic Arts
Health and Welfare Fund**

Financial Statements

December 31, 2024

**Chicago Graphic Arts
Health and Welfare Fund**

Financial Statements with Supplementary Information

December 31, 2024 and 2023

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Report of Independent Auditors

To the Participants and Trustees of
Chicago Graphic Arts
Health and Welfare Fund

Opinion

We have audited the financial statements of Chicago Graphic Arts 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 as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits for the years then ended, and the related notes to the financial statements.

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

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the *Auditors' Responsibilities for the Audit of the Financial Statements* section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of 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 Plan's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Responsibilities of Management for the Financial Statements (continued)

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

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

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

Legacy Professionals LLP

Westchester, Illinois

October 7, 2025

**Chicago Graphic Arts
Health and Welfare Fund**

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Assets		
Cash	\$ 248,554	\$ 1,247,470
Receivables		
Employer contributions	1,554,330	1,470,853
Prescription drug rebates	1,034,439	939,522
Stop-loss refunds	861,413	203,482
Accrued interest and dividends	47	723
Total receivables	<u>3,450,229</u>	<u>2,614,580</u>
Investments - at fair value		
Mutual funds	22,261,709	21,816,454
Common and collective trusts	10,377,790	11,007,458
Money market fund and investment cash	12,454	198,597
Total investments	<u>32,651,953</u>	<u>33,022,509</u>
Total assets	<u>36,350,736</u>	<u>36,884,559</u>
Liabilities and Net Assets		
Liabilities		
Checks in process	15,714	465,117
Due to broker	-	36,193
Contributions paid in advance	49,711	50,959
Accounts payable and accrued expenses	65,930	281,270
Total liabilities	<u>131,355</u>	<u>833,539</u>
Net assets available for benefits	<u>\$ 36,219,381</u>	<u>\$ 36,051,020</u>

See accompanying notes to financial statements.

**Chicago Graphic Arts
Health and Welfare Fund**

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Additions		
Investment income		
Net appreciation in fair value		
of investments	\$ 2,713,637	\$ 3,477,815
Interest and dividends	552,872	505,053
	<u>3,266,509</u>	<u>3,982,868</u>
Less investment expenses	(67,966)	(66,384)
Investment income - net	3,198,543	3,916,484
Employer contributions	16,279,633	13,905,268
Retiree contributions	1,070,576	1,174,050
Participant co-pay contributions	68,724	80,557
Prescription drug rebates	2,076,498	1,564,243
Stop-loss refunds	2,330,668	768,251
Total additions	<u>25,024,642</u>	<u>21,408,853</u>
Deductions (page 5)	<u>24,856,281</u>	<u>17,752,336</u>
Net increase	168,361	3,656,517
Net assets available for benefits		
Beginning of year	<u>36,051,020</u>	<u>32,394,503</u>
End of year	<u>\$ 36,219,381</u>	<u>\$ 36,051,020</u>

See accompanying notes to financial statements.

**Chicago Graphic Arts
Health and Welfare Fund**

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
Deductions		
Cost of benefits		
Medical claims paid by Plan	\$ 16,438,108	\$ 11,119,836
Prescription drug program	4,450,629	3,117,630
Retiree premiums	841,533	855,528
Dental program	586,643	554,655
PPO fees and provider fees	685,745	575,547
Stop-loss premiums	730,708	412,902
Life insurance premiums	49,099	42,285
Other	17,416	11,222
Total cost of benefits	<u>23,799,881</u>	<u>16,689,605</u>
Fees mandated by ACA	<u>4,183</u>	<u>3,912</u>
Administrative expenses		
Administration fees	735,600	742,100
Consulting fees	51,772	21,544
Legal fees	133,089	127,094
Audit and accounting fees	46,000	46,006
Postage	29,473	36,444
Payroll compliance audits	7,929	46,348
Commercial banking fees	14,430	15,141
Office expense	16,906	13,714
Insurance	14,449	10,428
Conferences and meetings	2,569	-
Total administrative expenses	<u>1,052,217</u>	<u>1,058,819</u>
Total deductions	<u>\$ 24,856,281</u>	<u>\$ 17,752,336</u>

See accompanying notes to financial statements.

Chicago Graphic Arts Health and Welfare Fund

Notes to Financial Statements

December 31, 2024 and 2023

Note 1. Summary of Significant Accounting Policies

Method of Accounting - The accompanying financial statements of Chicago Graphic Arts Health and Welfare Fund (the Plan) have been prepared using the accrual basis of accounting.

Contributions Receivable - Employer contributions due and not received by year end are recorded as contributions receivable. Employer contributions owed as a result of payroll compliance audits are recorded upon settlement with the employer. An allowance for uncollectible accounts is considered unnecessary and is not provided.

Investments - Investments are reported at fair value. The fair value of a financial instrument is the amount that would be received to sell that asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date (the exit price). Net appreciation or depreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Purchases and sales of the investments are reflected on a trade-date basis.

Dividends are recorded on the ex-dividend date. Interest income is recorded on the accrual basis.

Checks in Process - The policy of the Plan is to pay benefits through various zero balance checking accounts. Funds are transferred into these accounts as necessary to clear checks presented for payment. Checks in process represent outstanding checks not cleared at year end.

Contributions Paid in Advance - Certain retirees and participants make contributions to receive benefits under the Plan. Contributions received in advance of the corresponding eligibility period are recognized as deferred revenue.

Revenue Recognition - Revenue derived from employer contributions is recognized in the period in which covered work is performed, based on the number of weeks worked in covered employment and the contribution rates set forth in the collective bargaining agreements. Employers are required to remit contributions monthly. The Plan carries out its purpose described in Note 2 within a jurisdiction primarily located throughout Illinois, Indiana and Iowa.

Prescription Drug Rebates - The Plan utilizes a pharmacy benefit manager (PBM) who periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable.

Note 1. Summary of Significant Accounting Policies (continued)

Stop-Loss Insurance - The Plan maintains a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits. Under the terms of the contract, individual participant claims incurred in excess of \$350,000 within the contract year are reimbursed to the Plan.

Expenses - Certain investment related expenses are included in net appreciation in fair value of investments.

Benefit Obligation Presentation - As allowed by generally accepted accounting principles, the Plan is presenting its benefit obligations and changes in benefit obligations in the notes to the financial statements.

Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

Subsequent Events - Subsequent events have been evaluated through October 7, 2025, which is the date the financial statements were available to be issued.

Note 2. Description of the Plan

The Plan was established pursuant to a collective bargaining agreement between the local unions and various employers to provide medical, dental, disability and life insurance benefits for eligible participants. The Plan is a multiemployer welfare plan, subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Except for certain life insurance and dental benefits, the Plan is self-funded for the payment of benefits.

Post-age 65 retired participants are provided a fully-insured Medicare Advantage Plan with Prescription Drug coverage, or MAPD plan.

Certain participants may contribute specified amounts, determined periodically by the Plan's actuary, to extend coverage to eligible dependents.

The costs to provide postretirement benefits are shared by the Plan's participating employers and retirees.

The Plan covers former Franklin Association Plan members and dependent spouses. Retired members of this group have a separate schedule of benefits.

Note 2. Description of the Plan (continued)

To become eligible to participate, a participant must have been employed by one or more contributing employers and working within the jurisdiction of the local unions. An experienced lithographer, photoengraver or book binder becomes eligible for benefits on the date hired. An inexperienced lithographer, photoengraver or book binder becomes eligible for benefits after six months of active employment with a contributing employer.

Extension of eligibility is described in Note 9.

Provisions for termination of a participant's eligibility are detailed in the summary plan description.

Continuation of health care benefits is available to persons who would otherwise lose those benefits due to certain events, as mandated by Consolidated Omnibus Budget Reconciliation Act (COBRA), was adopted by the Plan.

Participants should refer to the summary plan description for more complete information.

Note 3. Priorities upon Termination

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

Note 4. Tax Status

The Internal Revenue Service has advised that the trust established under the Plan is exempt under Section 501(c)(9) of the Internal Revenue Code and is, therefore, not subject to tax under present income tax laws. The Plan has been amended since receiving the notice of exemption. The Plan's administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code, and therefore believe that the Plan was qualified and the related trust was tax-exempt as of the financial statement date.

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

Note 5. Funding Policy

The Plan is primarily funded by employer contributions, contributions from retirees and from participants electing COBRA coverage. Employer contributions to the Plan are made under various negotiated collective bargaining agreements between the local unions and the employers. A voluntary co-payment provides participants with a substantially improved schedule of benefits than the schedule of benefits offered without a co-payment. The monthly retiree contribution varies based on the number of active coverage years in the Plan. Contribution rates for the years ended December 31, 2024 and 2023 ranged between the following minimum and maximum levels:

	<u>2024</u>	<u>2023</u>
Employer portion	\$229 - \$278 per week	\$229 - \$270 per week
Participant co-pay	\$37 - \$78 per week	\$36 - \$76 per week
Retiree and spouse:		
Pre-Medicare (Ages 60 - 64)	\$536 - \$936 per month	\$520 - \$909 per month
Post-Medicare (Ages 65+)	\$155 per month	\$149 per month

Note 6. Fair Value Measurements

The *Fair Value Measurements and Disclosures* Topic of the FASB Accounting Standards Codification established a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below:

Basis of Fair Value Measurement

Level 1	Unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets or liabilities
Level 2	Quoted prices in markets that are not considered to be active or financial instruments for which all significant inputs are observable, either directly or indirectly
Level 3	Prices or valuations that require inputs that are both significant to the fair value measurement and unobservable

Note 6. Fair Value Measurements (continued)

The following tables set forth, by level within the fair value hierarchy, the Plan's investment assets at fair value as of December 31, 2024 and 2023. As required, assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. In accordance with generally accepted accounting principles, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in the following tables are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

	Total	Fair Value Measurements at 12/31/24 Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	\$ 22,261,709	\$ 22,261,709	\$ -	\$ -
Money market fund and investment cash	12,454	-	12,454	-
	22,274,163	\$ 22,261,709	\$ 12,454	\$ -
Investments measured at net asset value:				
Common and collective trusts	10,377,790			
Total	\$ 32,651,953			
	Total	Fair Value Measurements at 12/31/23 Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	\$ 21,816,454	\$ 21,816,454	\$ -	\$ -
Money market fund and investment cash	198,597	-	198,597	-
	22,015,051	\$ 21,816,454	\$ 198,597	\$ -
Investments measured at net asset value:				
Common and collective trusts	11,007,458			
Total	\$ 33,022,509			

Note 6. Fair Value Measurements (continued)

Level 1 Measurements

The fair values of the mutual funds are determined by reference to the funds' underlying assets, which are principally marketable equity and fixed income securities. Shares held in mutual funds are traded on national securities exchanges and are valued at the net asset value on the last business day of each period presented.

Level 2 Measurements

The money market fund and investment cash are valued at cost, which approximates fair value.

Measurements Using Net Asset Value as a Practical Expedient

The common and collective trusts are valued at the net asset value per share, used as a practical expedient to estimate fair value. The net asset value is based on the fair values of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different than the reported net asset value.

The common and collective trusts are direct filing entities (DFEs) and file a Form 5500 annual report with the U.S. Department of Labor. The Plan is not required to disclose the significant investment strategies of DFE investments. Redemptions are available monthly or quarterly with 15 days written notice.

Note 7. Self-funded Death Benefits

The Plan self-funds certain death benefits for retired participants under the former Franklin Association Plan, as follows:

<u>Participants Retiring</u>	<u>Benefit</u>
Prior to January 1, 1968	\$ 1,000
Between January 1, 1968 and August 31, 1989	\$ 2,000
After August 31, 1989	None

As calculated by the actuary, the present value of future death benefits payable was estimated to be approximately \$6,100 at December 31, 2024, and approximately \$5,700 at December 31, 2023, and is included in the Plan's postretirement benefit obligations.

Note 8. Benefit Obligations

The Plan's obligations for claims payable and claims incurred but not reported and for extended eligibility credits were estimated by the Plan's actuary in accordance with accepted actuarial principles. See Note 9 for a description of extended eligibility obligations and Note 10 for a description of postretirement benefit obligations. The following presents the components of the Plan's benefit obligations as of December 31, 2024 and 2023, and the related changes in the benefit obligations for the years then ended:

	<u>2024</u>	<u>2023</u>
Benefit Obligations		
Amounts currently payable		
Claims payable and claims incurred but not reported	\$ 2,805,700	\$ 1,633,300
Other obligations for current benefit coverage, at estimated amounts		
Extended eligibility credits	<u>6,589,000</u>	<u>6,192,000</u>
Postretirement benefit obligations		
Current retirees and beneficiaries	1,506,107	917,725
Other participants fully eligible for benefits	4,656,683	4,016,844
Other participants not yet fully eligible for benefits	<u>6,256,752</u>	<u>5,623,239</u>
Total postretirement benefit obligations	<u>12,419,542</u>	<u>10,557,808</u>
Total benefit obligations	<u>\$ 21,814,242</u>	<u>\$ 18,383,108</u>

Note 8. Benefit Obligations (continued)

	<u>2024</u>	<u>2023</u>
Changes in Benefit Obligations		
Amounts currently payable		
Balance at beginning of year	\$ 1,633,300	\$ 1,305,000
Increase during the year attributable to changes in		
Claims payable and claims incurred but not reported	<u>1,172,400</u>	<u>328,300</u>
Balance at end of year	<u>2,805,700</u>	<u>1,633,300</u>
Other obligations for current benefit coverage, at estimated amounts		
Balance at beginning of year	6,192,000	5,328,000
Increase during the year attributable to changes in		
Extended eligibility credits	<u>397,000</u>	<u>864,000</u>
Balance at end of year	<u>6,589,000</u>	<u>6,192,000</u>
Postretirement benefit obligations		
Balance at beginning of year	10,557,808	9,660,435
Increase (decrease) during the year attributable to		
Benefits earned and other changes	475,957	277,419
Actuarial experience	930,302	(485,859)
Change in claims cost, self-pay rates	-	256,457
Actuarial assumption changes	387,986	593,716
Changes due to passage of time	617,766	559,161
Benefits paid during the year	<u>(550,277)</u>	<u>(303,521)</u>
Balance at end of year	<u>12,419,542</u>	<u>10,557,808</u>
Total benefit obligations	<u>\$ 21,814,242</u>	<u>\$ 18,383,108</u>

Note 9. Extended Eligibility Credits

If an active participant is terminated or temporarily laid off from covered employment, coverage for the participant and the participant's dependents may be continued for a period not to exceed 52 weeks. Participants accrue this extended eligibility based on length of service. At December 31, 2024 and 2023, extended eligibility represented 19,006 and 18,577 weeks, respectively, of credits accrued. The provision for the estimated cost of future benefits based on participants' out-of-work extended coverage is determined from the average weekly benefit cost of the current year multiplied by the number of weeks of outstanding extended eligibility credits. Various actuarial assumptions have also been taken into consideration for this calculation. These assumptions include a discount rate of 5.39% for December 31, 2024 and 5.74% for December 31, 2023.

Note 10. Postretirement Benefit Obligations

The Plan provides lifetime health care coverage to certain retirees and their dependents. Retirees contributed approximately 57% of the estimated cost of providing their pre-Medicare postretirement benefits and 100% of the estimated cost of providing their post-Medicare postretirement benefits for the year ended December 31, 2024. Retirees contributed approximately 56% of the estimated cost of providing their pre-Medicare postretirement benefits and 100% of the estimated cost of providing their post-Medicare postretirement benefits for the year ended December 31, 2023. These benefits covered 468 and 506 retirees as of December 31, 2024 and 2023, respectively.

The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with participating employers.

The actuarial present value of the expected postretirement benefit obligations 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.

Note 10. Postretirement Benefit Obligations (continued)

Some of the more significant actuarial assumptions used to calculate the postretirement benefit obligations as of December 31, 2024 and 2023 were as follows:

Discount rate:

2024 - 5.39%

2023 - 5.74%

Mortality rate:

Pri-2012 Blue Collar Dataset Headcount-Weighted Mortality projected with Scale MP-2021

Medical trend rate:

2024 - 6.25% graded to 4.04% over 54 years

2023 - 6.50% graded to 4.04% over 55 years

The medical trend rate assumption has a significant effect on the calculation of postretirement benefit obligations. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 2024 by \$1,769,795 and by \$798,407 as of December 31, 2023.

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

The Plan empowers the Board of Trustees to increase or decrease the amount of self-payments by eligible retired participants, and to modify the terms and conditions under which retiree eligibility may be maintained; therefore, the cost to the Plan can be reduced or eliminated prospectively by action of the Board of Trustees.

Note 11. Risks and Uncertainties

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

Note 11. Risks and Uncertainties (continued)

As of December 31, 2024 and 2023, the Plan held units in the Baird Intermediate Bond Fund with a fair value of \$10,128,453 (28% of net assets) and \$10,091,757 (28% of net assets), respectively, units in the Vanguard Total Stock Market Index Fund with a fair value of \$12,133,255 (33% of net assets) and \$11,724,697 (33% of net assets), respectively, and units in the NIS Core Fixed Income Fund with a fair value of \$9,027,049 (25% of net assets) and \$9,013,493 (25% of net assets), respectively. It is reasonably possible that changes in the fair values of these investment funds could materially affect the amounts reported in the statements of net assets available for benefits. If a significant decline in the fair values of these investments occurred during the next year, a change in the assumed rates of return used to calculate the present value of postretirement benefit obligations may be needed.

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

Note 12. Concentration of Cash

The Plan maintains its cash balances with a financial institution deemed to be creditworthy. Balances are insured by the FDIC up to \$250,000. Balances may at times exceed insured limits.

Note 13. Major Employers

Contributions from four employers accounted for approximately 67% and 71% of total employer contributions for the years ended December 31, 2024 and 2023, respectively. In the event these employers suspend contributions, the Plan would terminate coverage to the employers' participants as described in the Plan document. The Plan would retain the risk of meeting current fixed administrative expenses until the appropriate adjustments were made.

Note 14. Participant Contributions

Employers withhold participant contributions through payroll deductions. U.S. Department of Labor (DOL) regulations provide that participant contributions to welfare plans must be made on the earliest date that they can reasonably be segregated from the employer's general assets, but in no event later than 90 business days following the month in which the participant contributions were withheld. Contributing employers can be held liable for investment losses and interest incurred during the period of any delay in remitting the contributions to the Plan, and the late deferrals would be considered prohibited transactions that must be reported on the Plan's Form 5500 until corrected. During the years ended December 31, 2024 and 2023, Plan management noted no instances where an employer remitted contributions in a timeframe that did not comply with the timeliness requirements prescribed by DOL regulations.

The Plan has a collection program that pursues legal action against delinquent employers. As part of its collection program, the Plan regularly collects contributions, liquidated damages, interest and attorney fees from delinquent employers. Delinquent contributions are credited to a participant's account upon receipt.

Note 15. Reconciliation of Financial Statements to Form 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 36,219,381	\$ 36,051,020
Less - benefit obligations currently payable	<u>(2,805,700)</u>	<u>(1,633,300)</u>
Net assets available for benefits per the Form 5500	<u>\$ 33,413,681</u>	<u>\$ 34,417,720</u>

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

Benefits paid to or for participants per the financial statements	\$ 23,799,881
Add - amounts currently payable at end of year	2,805,700
Less - amounts currently payable at beginning of year	<u>(1,633,300)</u>
Benefits paid to or for participants per the Form 5500	<u>\$ 24,972,281</u>

Report of Independent Auditors On Supplemental Schedules

To the Participants and Trustees of
Chicago Graphic Arts
Health and Welfare Fund

We have audited the financial statements of Chicago Graphic Arts Health and Welfare Fund (the Plan) as of and for the years ended December 31, 2024 and 2023, and our report thereon dated October 7, 2025, which expressed an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. Supplemental Schedules 1 and 2 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 are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Legacy Professionals LLP

Westchester, Illinois

October 7, 2025

Schedule H, Line 4i
Schedule of Assets (Held at End of Year)

SUPPLEMENTAL SCHEDULE 1

CHICAGO GRAPHIC ARTS HEALTH & WELFARE FUND
EIN #36-2125291 PLAN 501
YEAR ENDED 12/31/2024

SCHEDULE H, PART IV, ITEMS 4I - SCHEDULE OF INVESTMENTS HELD

	<u>Fair Market Value</u>	<u>Cost Value</u>
INTEREST BEARING CASH:		
AMALGAMATED BANK OF CHICAGO	PG. 2 <u>12,454</u>	See Attached
COMMON COLLECTIVE TRUST		
NATIONAL INVESTMENT SERVICES	PG. 4 <u>10,377,790</u>	See Attached
REGISTERED INVESTMENT COMPANIES - MUTUAL FUNDS:		
AMALGAMATED BANK OF CHICAGO	PG. 3 <u>22,261,709</u>	See Attached



TRADE DATE - INCOME ACCRUALS Page 4

Statement Period: 01/01/24 through 12/31/24
 Account Number:

**CHICAGO GRAPHIC ARTS
 HEALTH & WELFARE FUND**

Investment Review - Detail Of General Investments

SHARES/FACE	ASSET	CARRYING VALUE	CURRENT PRICE	MARKET VALUE	EST ANN INC	YIELD TO MKT
SHORT TERM INVESTMENTS						
12,454.27	GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47% 38141W273	12,454.27		12,454.27	557	4.47
MUTUAL FUNDS/FIXED						
986,217.437	BAIRD INTERMEDIATE BOND FUND INSTL 057071805	10,317,840.34	10.27	10,128,453.08	393,501	3.89



TRADE DATE - INCOME ACCRUALS Page 5

Statement Period: 01/01/24 through 12/31/24
 Account Number:

**CHICAGO GRAPHIC ARTS
 HEALTH & WELFARE FUND**

Investment Review - Detail Of General Investments

SHARES/FACE	ASSET	CARRYING VALUE	CURRENT PRICE	MARKET VALUE	EST ANN INC	YIELD TO MKT
MUTUAL FUNDS/EQUITY						
86,020.952	VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855 922908801	4,601,084.86	141.05	12,133,255.28	153,891	1.27
	Total Fund	14,931,426.80		22,274,209.96	547,949	2.46



Chicago Graphic Arts Health & Welfare Fund
 Total Fund

US Dollar
 12/31/2024

Quantity	Security	Unit Cost	Total Cost	Price	Market Value	% Assets	Yield
COMMINGLED FUND							
CORE FIXED INCOME FUNDS							
389.3971480	NIS CORE FIXED INCOME FUND 0.000% Due 1/1/2050	20,718.25	8,067,627.78	23,182.11	9,027,049.08	87.0	5.2
	Accrued Interest				0.00	0.0	
			8,067,627.78		9,027,049.08	87.0	5.2
HIGH YIELD CORPORATE FUNDS							
8.6458820	NIS HIGH YIELD FUND 0.000% Due 1/1/2050	31,320.84	270,796.32	44,928.43	388,445.86	3.7	6.8
	Accrued Interest				0.00	0.0	
			270,796.32		388,445.86	3.7	6.8
TOTAL RETURN FUNDS							
311.2924468	NIS TOTAL ABSOLUTE RETURN FUND LLC 0.000% Due 1/1/2050	2,457.69	765,061.71	3,091.29	962,294.65	9.3	6.2
	Accrued Interest				0.00	0.0	
			765,061.71		962,294.65	9.3	6.2
	COMMINGLED FUND Total		9,103,485.81		10,377,789.59	100.0	5.3
	Total Portfolio		9,103,485.81		10,377,789.59	100.0	5.3

SCHEDULE C OTHER SERVICE PROVIDER SERVICE CODES STATEMENT 1

NAME	SERVICE CODES
AMALGAMATED BANK OF CHICAGO	19
AMALGAMATED BANK OF CHICAGO	28
AMALGAMATED BANK OF CHICAGO	55
AMALGAMATED BANK OF CHICAGO	62
OPTUMRX, INC.	12
OPTUMRX, INC.	13
OPTUMRX, INC.	50
OPTUMRX, INC.	99

CODES TO SCHEDULE C, LINE 2(B)

SCHEDULE H OTHER RECEIVABLES STATEMENT 2

DESCRIPTION	BEGINNING	ENDING
ACCRUED INTEREST	723.	47.
PRESCRIPTION DRUG REBATES	939,522.	1,034,439.
STOP LOSS REFUND	203,482.	861,413.
TOTAL TO SCHEDULE H, LINE 1B(3)	1,143,727.	1,895,899.

SCHEDULE H OTHER PLAN LIABILITIES STATEMENT 3

DESCRIPTION	BEGINNING	ENDING
DEFERRED CONTRIBUTION REVENUE	50,959.	49,711.
DUE TO BROKER	36,193.	0.
TOTAL TO SCHEDULE H, LINE 1J	87,152.	49,711.

SCHEDULE H		OTHER INCOME	STATEMENT 4
DESCRIPTION			AMOUNT
PRESCRIPTION DRUG REBATES			2,076,498.
STOP LOSS REFUND			2,330,668.
TOTAL TO SCHEDULE H, LINE 2C			4,407,166.

SCHEDULE H		OTHER PAYMENTS TO PROVIDE BENEFITS	STATEMENT 5
DESCRIPTION			AMOUNT
PPO AND PROVIDER FEES			685,745.
TOTAL TO SCHEDULE H, LINE 2E(3)			685,745.

SCHEDULE H		OTHER ADMINISTRATIVE EXPENSES	STATEMENT 6
DESCRIPTION			AMOUNT
FEES MANDATED BY ACA			4,183.
INSURANCE EXPENSE			14,449.
OFFICE EXPENSE			16,906.
POSTAGE			29,473.
CONFERENCE			2,569.
TOTAL TO SCHEDULE H, LINE 2I(11)			67,580.

Form 5500 Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> 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 <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> <hr/> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning <u>01/01/2024</u> and ending <u>12/31/2024</u>	
A	This return/report is for: <input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
B	This return/report is: <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here <input checked="" type="checkbox"/>
D	Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description) _____
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here <input type="checkbox"/>

Part II	Basic Plan Information - enter all requested information
1a Name of plan CHICAGO GRAPHIC ARTS HEALTH AND WELFARE FUND	1b Three-digit plan number (PN) ▶ 501
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) TRUSTEES OF CHICAGO GRAPHIC ARTS HEALTH AND WELFARE C/O BENEFITS MANAGEMENT GROUP, INC. 625 ENTERPRISE DR. OAKBROOK IL 60523	1c Effective date of plan 06/25/1959 2b Employer Identification Number (EIN) 36-2125291 2c Plan Sponsor's telephone number 630-472-0622 2d Business code (see instructions) 541990

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	<i>Michael G. Consolino</i>	9/30/25	MICHAEL CONSOLINO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	<i>Thomas Sommers</i>	9/30/25	THOMAS SOMMERS
	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

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
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5 Total number of participants at the beginning of the plan year	5	1,311
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	805
a(2) Total number of active participants at the end of the plan year	6a(2)	810
b Retired or separated participants receiving benefits	6b	468
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	1,278
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	37

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 4F 4L

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

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u>3</u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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TRADE DATE - INCOME ACCRUALS Page 32

Statement Period: 01/01/24 through 12/31/24
Account Number:

CHICAGO GRAPHIC ARTS
HEALTH & WELFARE FUND

Schedule Of Reportable Transactions

PLAN NUMBER:

EIN NUMBER: 36-2125291

DESCRIPTION	PURCH/SELL PRICE EXPENSE INCURRED	COST OF ASSET	VALUE OF ASSET ON TXN DATE	NET GAIN OR LOSS
BEGINNING MARKET VALUE:	21,932,067.44			
SECURITY TRANSACTIONS EXCEEDING 5%:				
SHORT TERM INVESTMENTS				
CUSIP # 38141W273 GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%				
TOTAL ACTIVITY FROM 01/01/24 TO 12/31/24				
DEPOSIT	1,501,600.21	1,501,600.21	1,501,600.21	
WITHDRAWAL	1,651,550.00	1,651,550.00	1,651,550.00	
TOTAL	3,153,150.21	3,153,150.21	3,153,150.21	
TOTAL SHORT TERM INVESTMENTS	3,153,150.21	3,153,150.21	3,153,150.21	
MUTUAL FUNDS/EQUITY				
CUSIP # 922908801 VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855				
SOLD 1,320.306 SHS ON 01/03/24 AT 113.61 THRU FIDELITY SERVICES	150,000.00	69,194.96	149,999.96	80,805.04
PURCHASED 351.386 SHS ON 03/25/24 AT 125.87 FOR REINVESTMENT	44,228.97	44,228.97	44,116.51	
PURCHASED 356.239 SHS ON 07/01/24 AT 130.27 FOR REINVESTMENT	46,407.24	46,407.24	46,482.06	
SOLD 11,307.953 SHS ON 07/31/24 AT 132.65 THRU FIDELITY SERVICES	1,500,000.00	598,656.92	1,499,999.97	901,343.08
SOLD 3,689.22 SHS ON 08/30/24 AT 135.53 THRU FIDELITY SERVICES	500,000.00	195,311.84	499,999.99	304,688.16
PURCHASED 263.842 SHS ON 09/30/24 AT 137.34 FOR REINVESTMENT	36,236.05	36,236.05	36,378.53	
PURCHASED 274.559 SHS ON 12/24/24 AT 143.13 FOR REINVESTMENT	39,297.57	39,297.57	39,723.20	
TOTAL	2,316,169.83	1,029,333.55	2,316,700.22	1,286,836.28
TOTAL MUTUAL FUNDS/EQUITY	2,316,169.83	1,029,333.55	2,316,700.22	1,286,836.28
TOTAL SECURITY TRANSACTIONS EXCEEDING 5%		4,182,483.76		



TRADE DATE - INCOME ACCRUALS Page 33

Statement Period: 01/01/24 through 12/31/24
 Account Number: CHICAGO GRAPHIC ARTS
 HEALTH & WELFARE FUND

Schedule Of Reportable Transactions

PLAN NUMBER:

EIN NUMBER: 36-2125291

DESCRIPTION	PURCH/SELL PRICE EXPENSE INCURRED	COST OF ASSET	VALUE OF ASSET ON TXN DATE	NET GAIN OR LOSS
BEGINNING MARKET VALUE:	21,932,067.44			
SINGLE TRANSACTIONS EXCEEDING 5%:				
08/01/24 SOLD 11,307.953 SHS VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855 ON 07/31/24 AT 132.65 THRU FIDELITY SERVICES		598,656.92		
08/01/24 DEPOSIT GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%		1,500,056.33		
08/02/24 WITHDRAWAL GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%		1,500,000.00		
TOTAL SINGLE TRANSACTIONS EXCEEDING 5%		3,598,713.25		



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Statement Period 01/01/24 through 12/31/24
 Account Number

CHICAGO GRAPHIC ARTS
 HEALTH & WELFARE FUND

Schedule Of Reportable Transactions

BY ASSET	VALUATION	21,932,067.44	THRESHOLD	1,096,603.37				
DESCRIPTION	TRAN TYPE	SETTLE DATE/ SHARES/UNITS	PURCHASE/SALE COST/PROCEEDS	BROKER COMMISSION/ OTH EXPENSE	COST OF ASSET/ PREV ANNL MKT	NET GAIN/LOSS		
CUSIP # 38141W273 GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%	DEP	08/01/24	1,500,056.33		1,500,056.33 1,500,056.33			
CUSIP # 38141W273 GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%	WTH	08/02/24	1,500,000.00		1,500,000.00 1,500,000.00			
CUSIP # 922908801 VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855	SEL	08/01/24 11,307.953	1,500,000.00		598,656.92 1,307,183.08	192,816.92		
1 PURCHASES FOR			1,500,056.33	2 SALES FOR		3,000,000.00	ISSUE AGGREGATE TOTAL	4,500,056.33



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Statement Period 01/01/24 through 12/31/24
Account Number

CHICAGO GRAPHIC ARTS
HEALTH & WELFARE FUND

Schedule Of Reportable Transactions

AGGREGATE BY ASSET VALUATION 21,932,067.44 THRESHOLD 1,096,603.37

DESCRIPTION	TRAN TYPE	SETTLE DATE/ SHARES/UNITS	PURCHASE/SALE COST/PROCEEDS	BROKER COMMISSION/ OTH EXPENSE	COST OF ASSET/ PREV ANNL MKT	NET GAIN/LOSS
CUSIP # 38141W273 GOLDMAN FINANCIAL SQUARE GOVT-A FD# 465 (AMALFGOV) MASTER #2839100 4.47%	NET		1,501,600.21		1,501,600.21	
	NET		1,651,550.00		1,651,550.00	
12 PURCHASES FOR		1,501,600.21	6 SALES FOR	1,651,550.00	ISSUE AGGREGATE TOTAL	3,153,150.21
CUSIP # 922908801 VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855	SEL	01/04/24	150,000.00		69,194.96	2,508.55-
		1,320.306			152,508.55	
	BUY	03/25/24	44,228.97		44,228.97	
		351.386			44,228.97	
	BUY	07/01/24	46,407.24		46,407.24	
		356.239			46,407.24	
	SEL	08/01/24	1,500,000.00		598,656.92	192,816.92
		11,307.953			1,307,183.08	
	SEL	09/03/24	500,000.00		195,311.84	73,531.48
		3,689.220			426,468.52	
	BUY	09/30/24	36,236.05		36,236.05	
		263.842			36,236.05	
	BUY	12/24/24	39,297.57		39,297.57	
		274.559			39,297.57	
4 PURCHASES FOR		166,169.83	3 SALES FOR	2,150,000.00	ISSUE AGGREGATE TOTAL	2,316,169.83



TRADE DATE - INCOME ACCRUALS Page 36

Statement Period 01/01/24 through 12/31/24
 Account Number

CHICAGO GRAPHIC ARTS
 HEALTH & WELFARE FUND

Schedule Of Reportable Transactions

AGGREGATE BY BROKER VALUATION 21,932,067.44 THRESHOLD 1,096,603.37

DESCRIPTION	TRAN TYPE	SETTLE DATE/ SHARES/UNITS	PURCHASE/SALE COST/PROCEEDS	BROKER		COST OF ASSET/ PREV ANNL MKT	NET GAIN/LOSS
				COMMISSION/ OTH EXPENSE			
FIDELITY SERVICES							
CUSIP # 057071805	SEL	01/04/24	300,000.00			305,213.12	874.64-
BAIRD INTERMEDIATE BOND FUND INSTL		29,154.519				300,874.64	
CUSIP # 922908801	SEL	01/04/24	150,000.00			69,194.96	2,508.55-
VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855		1,320.306				152,508.55	
CUSIP # 922908801	SEL	08/01/24	1,500,000.00			598,656.92	192,816.92
VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855		11,307.953				1,307,183.08	
CUSIP # 922908801	SEL	09/03/24	500,000.00			195,311.84	73,531.48
VANGUARD TOTAL STOCK MARKET INDEX FD INSTITUTIONAL SHS - FD# 855		3,689.220				426,468.52	
0 PURCHASES FOR	0.00	4 SALES FOR	2,450,000.00	BROKER AGGREGATE TOTAL			2,450,000.00