

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A** This return/report is for:
 - a multiemployer plan
 - a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
 - a single-employer plan
 - a DFE (specify) _____
- B** This return/report is:
 - the first return/report
 - the final return/report
 - an amended return/report
 - a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ▶
- D** Check box if filing under:
 - Form 5558
 - automatic extension
 - the DFVC program
 - special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>IBEW LOCAL 332 HEALTH AND WELFARE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>509</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>BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE TRUST FUND</u> <u>6800 SANTA TERESA BLVD STE 100</u> <u>SAN JOSE, CA 95119</u>	1c Effective date of plan <u>09/01/1959</u> 2b Employer Identification Number (EIN) <u>94-6401540</u> 2c Plan Sponsor's telephone number <u>408-288-4400</u> 2d Business code (see instructions) <u>238210</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.	10/10/2025	MILLER KAPLAN ARASE LLP
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
	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	
5 Total number of participants at the beginning of the plan year	5	3331
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	2310
	6a(2)	2254
	6b	1312
	6c	0
	6d	3566
	6e	
	6f	3566
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	138

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

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

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

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

a Pension Schedules	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>8</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 _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6401540

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
KAISER FOUNDATION HEALTH PLAN INC

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1340523	00000	780	4432	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
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	33990542
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 IBEW LOCAL 332 HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>509</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE</p>	<p>D Employer Identification Number (EIN) 94-6401540</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
PRINCIPAL 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
42-0127290	61271	1116020	3699	01/01/2024	12/31/2024

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
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	238714
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE		D Employer Identification Number (EIN) 94-6401540

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

HEALTH NET

(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
95-4402957	N/A	5782/2212	171	01/01/2024	12/31/2024

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

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

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	

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
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	979360
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6401540

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
SYMETRA 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
91-0742147	68608	16-011745-000	972	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year	7b		0
c Additions: (1) Contributions deposited during the year	7c(1)		
	7c(2)		
	7c(3)		
	7c(4)		
	7c(5)		
(6) Total additions	7c(6)		0
d Total of balance and additions (add lines 7b and 7c(6))	7d		
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		0

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	
(2) Increase (decrease) in amount due but unpaid	9a(2)	
(3) Increase (decrease) in unearned premium reserve	9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)
b Benefit charges (1) Claims paid	9b(1)	
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))		9b(3)
(4) Claims charged		9b(4)
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions	9c(1)(A)	
(B) Administrative service or other fees	9c(1)(B)	
(C) Other specific acquisition costs	9c(1)(C)	
(D) Other expenses	9c(1)(D)	
(E) Taxes	9c(1)(E)	
(F) Charges for risks or other contingencies	9c(1)(F)	
(G) Other retention charges	9c(1)(G)	
(H) Total retention		9c(1)(H)
(2) Dividends or retroactive rate refunds. (These amounts were <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	2332576
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 A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6401540

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
HARTFORD LIFE AND ACCIDENT

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0838648	70815	AGP-003777	183	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

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	492245
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 A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE		D Employer Identification Number (EIN) 94-6401540

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
UNITEDHEALTHCARE OF CALIFORNIA

(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
95-2931460	933-0	H0543	169	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))		9a(4)
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	245
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 IBEW LOCAL 332 HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>509</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE</p>	<p>D Employer Identification Number (EIN) 94-6401540</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
VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1632821	N/A	00460200	3110	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	406640	
	(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)		406640
b	Benefit charges (1) Claims paid	9b(1)	363763	
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))	9b(3)		363763
	(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)	42877	
	(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)		42877
	(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	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE		D Employer Identification Number (EIN) 94-6401540

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

1 Coverage Information:

(a) Name of insurance carrier
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (G0360)

(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
95-4331852	62825	277786	2254	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

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	62135
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 IBEW LOCAL 332 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6401540	

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

SEI TRUST COMPANY

06-1271230

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

BARROW HANLEY MEWHINNEY & STRAUSS

75-2403190

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

MCMORGAN & COMPANY LLC

52-2334338

(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)

UNITED ADMINISTRATIVE SERVICES

94-1749354

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	808730	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)

KRAW LAW GROUP

77-0171216

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	350796	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)

EIDE BAILLY LLP

45-0250958

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	74925	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)

MILLER KAPLAN ARASE LLP

95-2036255

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	50782	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)

PSG CONSULTING LLC

14881 QUORUM DR STE 850
DALLAS, TX 75254

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	42600	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)

MILLIMAN

91-0675641

(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 50	NONE	95000	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)

SEGAL MARCO ADVISORS

13-2646110

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	6250	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)

MATRIX TRUST COMPANY

75-3182674

(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 50	NONE	13981	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

ALLIANCE BERNSTEIN

13-4064930

(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	36189	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)

LOOMIS SAYLES

04-3200030

(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	45939	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)

PARAMETRIC PORTFOLIO ASSOCIATES LLC

20-0292745

(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	17998	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)

VOYA INVESTMENT MANAGEMENT

06-1440627

(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	49647	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)

IBEW LOCAL 332

94-0577280

(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?
14 50	NONE	13056	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

95-3760980

(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 50	NONE	326080	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)

INVESTMENT PERFORMANCE SERVICES LLC

P.O. BOX 9510
SAVANNAH, GA 31412

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	35063	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)

FIRST DENTAL HEALTH

33-0655193

(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 50	NONE	56693	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)

BEAT IT

77-0111619

(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 50	NONE	43105	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)

MAXOR PLUS, LTD.

320 S POLK ST 200
AMARILLO, TX 79101

(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 50	NONE	17904	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)

SMART SOURCE CRITICAL COMMUNICATION

7270 MCGINNIS FERRY RD
SUWANEE, GA 30024

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	127130	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)

NATIONAL INVESTMENT SERVICES OF AME

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	13315	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)

POST ADVISORY GROUP, LLC

2049 CENTURY PARK E STE 3050
LOS ANGELES, CA 90067

(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	14224	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"/>

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>IBEW LOCAL 332 HEALTH AND WELFARE PLAN</u>	B Three-digit plan number (PN) ▶	<u>509</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE</u>	D Employer Identification Number (EIN) <u>94-6401540</u>	

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)
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a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NIS INTERMEDIATE FIXED INCOME QP FU</u>		
b Name of sponsor of entity listed in (a): <u>NATIONAL INVESTMENT SERVICES OF AMERICA, LLC</u>		
c EIN-PN <u>82-4087168-001</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>17456042</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>NORTHERN TRUST COMMON S&P 500 INDEX</u>		
b Name of sponsor of entity listed in (a): <u>NORTHERN TRUST INVESTMENTS, INC.</u>		
c EIN-PN <u>36-7361150-001</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>10508851</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>ALLIANCE BERNSTEIN INSTITUTIONAL</u>		
b Name of sponsor of entity listed in (a): <u>ALLIANCE BERNSTEIN L.P.</u>		
c EIN-PN <u>27-5255070-010</u>	d Entity code <u>E</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>0</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)
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)

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.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 509
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE	D Employer Identification Number (EIN) 94-6401540

Part I	Asset and Liability Statement
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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	29623675	30199786
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	6428174	6681492
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	713726	793590
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	35742939	45036335
(2) U.S. Government securities	1c(2)	0	11096257
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	0	5766733
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	0	17824855
(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)	28745542	27964893
(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)	18556652	0
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	37776033	0
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	186474	21830578

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	157773215	167194519
Liabilities			
g Benefit claims payable.....	1g	39862407	39807821
h Operating payables.....	1h	237062	2256395
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	8723143	10580462
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	48822612	52644678
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	108950603	114549841

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)	61116629	
(B) Participants.....	2a(1)(B)	11585210	
(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)		72701839
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	682307	
(B) U.S. Government securities.....	2b(1)(B)	30668	
(C) Corporate debt instruments.....	2b(1)(C)	31100	
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	8271	
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		752346
(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)	1348854	
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		1348854
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	92911612	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	93302169	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		-390557
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	-34235	
(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)		1546444
(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)		275484
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		3395475
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		79595650

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	31192110	
(2) To insurance carriers for the provision of benefits	2e(2)	40249589	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		71441699
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)	808730	
(3) Recordkeeping fees	2i(3)	74925	
(4) IQPA audit fees	2i(4)	50782	
(5) Investment advisory and investment management fees	2i(5)	218625	
(6) Bank or trust company trustee/custodial fees	2i(6)	14467	
(7) Actuarial fees	2i(7)	95000	
(8) Legal fees	2i(8)	350796	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	39787	
(11) Other expenses.....	2i(11)	901601	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		2554713
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		73996412

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		5599238
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: MILLER KAPLAN ARASE LLP

(2) EIN: 95-2036255

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		17824855
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

IBEW LOCAL 332 HEALTH AND WELFARE PLAN

FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023



INDEPENDENT AUDITOR'S REPORT

Board of Trustees
IBEW Local 332 Health and Welfare Plan
6800 Santa Teresa Boulevard, Suite 100
San Jose, California 95119

Members of the Board:

Opinion

We have audited the accompanying financial statements of IBEW Local 332 Health and Welfare Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of 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 for one year after the date the financial statements are available to be issued.

Management is also responsible for maintaining a current plan instrument, including all plan amendments; administering the plan; and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including

maintaining sufficient records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Plan's ability to continue as a going concern for a reasonable period of time.

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

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

San Francisco, California

October 1, 2025

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	December 31, 2024	December 31, 2023
ASSETS		
CASH	\$ 62,832,455	\$ 62,058,459
INVESTMENTS - AT FAIR VALUE		
Short Term Investment Funds	\$ 12,403,666	\$ 3,308,155
Mutual Funds	-	37,776,033
Corporate Debt	5,766,733	-
Government Debt	11,096,257	-
Common/Collective Trusts	27,964,893	-
Limited Partnership	17,824,855	-
Collective Investment Fund	21,830,578	28,745,542
103-12 Investment Entity	-	18,556,652
Futures and Derivatives	-	186,474
	96,886,982	88,572,856
TOTAL INVESTMENTS		
RECEIVABLES		
Employer Contributions	6,681,492	6,428,174
Accrued Interest and Dividends	166,115	11,782
Stop Loss Reimbursements	99,295	315,399
Prescription Drug Rebates	522,714	380,068
	7,469,616	7,135,423
TOTAL RECEIVABLES		
PREPAID EXPENSES	5,466	6,477
TOTAL ASSETS		
	167,194,519	157,773,215
LIABILITIES		
Accounts Payable	177,438	237,062
Reciprocity Contributions Payable	1,402,149	1,354,651
Payable for Investments Purchased, Net	2,078,957	-
Due to Other Trusts	9,178,313	7,368,492
	12,836,857	8,960,205
TOTAL LIABILITIES		
NET ASSETS AVAILABLE FOR BENEFITS	154,357,662	148,813,010
MEMORANDUM:		
Health Reimbursement Accounts ("HRA")	20,827,752	19,200,264
Benefit Obligations Other Than Postretirement Benefit Obligations	39,807,821	39,862,407
Excess of Net Assets Available For Benefits Over HRA and Benefit Obligations Other Than Postretirement Benefit Obligations	\$ 93,722,089	\$ 89,750,339

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

ADDITIONS	January 1, 2024 to December 31, 2024		January 1, 2023 to December 31, 2023	
CONTRIBUTIONS				
Employer Contributions	\$	54,063,463	\$	51,530,681
Participant Contributions		11,585,210		11,548,089
HRA Contributions		7,053,166	\$	6,671,778
		\$ 72,701,839	\$	69,750,548
NET INVESTMENT INCOME				
Interest and Dividends		2,111,453		2,234,867
Net Appreciation of Investments		4,782,358		6,393,449
Less: Investment Expenses		(233,092)	6,660,719	(206,767)
		6,660,719	8,421,549	8,421,549
TOTAL ADDITIONS		79,362,558		78,172,097
DEDUCTIONS				
BENEFITS PAID				
Premiums		39,353,144		37,904,994
Claims		27,752,800		26,747,695
HRA Claims		5,443,362		4,954,920
Less: Stop Loss Reimbursements		(101,794)		(1,370,243)
Prescription Drug Rebates		(951,227)	71,496,285	(1,131,208)
		(951,227)	71,496,285	67,106,158
EXPENSES				
Actuary Fees		95,000		36,000
Administrative Fees		625,304		607,700
Audit Fees		50,782		50,364
Benefits Processing Fees		532,862		540,565
Claims Review Fees		-		47,674
Conference and Meeting Expenses		39,787		25,252
Consulting Fees		-		63,540
HRA Processing Fees		183,426		143,286
Insurance		60,214		54,026
Legal Fees		350,796		182,937
Local Union Reimbursements		13,056		13,056
Miscellaneous		11,551		16,471
Payroll Compliance Fees		74,925		92,322
PCORI Fees		8,668		8,421
Prefunded Retiree Expenses		31,527		17,586
Prescription Drug Consultant Fees		42,600		90,738
Printing, Postage and Office Expenses		201,123	2,321,621	179,493
		201,123	2,321,621	179,493
TOTAL DEDUCTIONS		73,817,906		69,275,589
NET INCREASE FOR THE YEAR		5,544,652		8,896,508
NET ASSETS AVAILABLE FOR BENEFITS				
Balance, Beginning of Year		148,813,010		139,916,502
Balance, End of Year	\$	154,357,662	\$	148,813,010

(Attached notes are an integral part of this statement)

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
STATEMENTS OF BENEFIT OBLIGATIONS

	December 31, 2024	December 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Claims Payable	\$ 249,844	\$ 989,875
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Future Benefits Based on Participants'		
Accumulated Eligibility	8,868,946	10,011,647
Claims Incurred But Not Reported	3,539,000	3,750,000
Reserve Bank Liability	24,280,031	22,690,885
Prefunded Retiree Liability	2,870,000	2,420,000
	39,557,977	38,872,532
TOTAL OBLIGATIONS OTHER THAN POST-RETIREMENT BENEFIT OBLIGATIONS	39,807,821	39,862,407
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Current Retirees	71,184,528	82,948,562
Other Participants Fully Eligible for Benefits	36,267,858	49,130,838
Other Participants Not Yet Fully Eligible for Benefits	132,777,861	140,770,201
	240,230,247	272,849,601
PLAN'S TOTAL BENEFIT OBLIGATIONS	\$ 280,038,068	\$ 312,712,008

* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

	January 1, 2024 to December 31, 2024	January 1, 2023 to December 31, 2023
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Claims Payable at Beginning of Year	\$ 989,875	\$ -
Claims Reported and Approved for Payment	31,403,110	30,191,039
Claims Paid	(32,143,141)	(29,201,164)
Claims Payable at End of Year	249,844	989,875
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Balance at Beginning of Year	38,872,532	46,202,672
Net Change During the Year:		
Future Benefits Based on Participants' Accumulated Eligibility	(1,142,701)	1,321,975
Claims Incurred But Not Reported	(211,000)	1,323,000
Reserve Bank Liability	1,589,146	(10,515,115)
Prefunded Retiree Liability	450,000	540,000
Balance at End of Year	39,557,977	38,872,532
TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS	39,807,821	39,862,407
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Balance at Beginning of Year	272,849,601	376,782,541
Net Changes During the Year:		
Actuarial Assumptions	(24,574,028)	(16,736,683)
Actuarial Experience	(4,145,133)	(33,042,878)
Actual Health Costs Different than Expected	(27,264,841)	(87,126,695)
Expected Benefits Earned	14,721,610	21,381,276
Expected Benefits Paid Out	(5,040,818)	(8,113,318)
Interest	13,683,856	19,705,358
	240,230,247	272,849,601
PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	\$ 280,038,068	\$ 312,712,008

* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 1 - DESCRIPTION OF THE PLAN

The IBEW Local 332 Health and Welfare Plan (the "Plan") is a multiemployer welfare benefit plan established on June 30, 1959 for the purpose of providing health care benefits to eligible participants covered by collective bargaining agreements between International Brotherhood of Electrical Workers Local 332 (the "Local Union"), the National Electrical Contractors Association Santa Clara Valley Chapter and individual employers signatory to the agreements. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan documents include detailed rules for each situation. Participants should refer to the Plan agreement and any amendments regarding specific provisions of the Plan.

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Basis of Accounting

The financial statements are recorded on the accrual basis of accounting.

B. Estimates

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

C. Postretirement Benefits

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31. 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. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation was determined by an actuary and is the amount that results from applying actuarial assumptions to historical benefit cost data to estimate future annual incurred benefit 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.

The significant actuarial assumptions and methods used at December 31, 2024 were: (a) interest rate: 5.55% per annum, (b) Mortality – PRI-2012 Total Dataset Headcount-Weighted Mortality Table projected from 2012 using MP-2021 on a fully generational basis, (c) Retirement Age: 100% assumed to retire at age 65, (d) Expenses – assumed to be \$45 per retiree per month with an annual increase of 3.0%, and (e) other assumptions and methods for retirement rates, mix of type of retiree coverage, trend rates and per capita cost assumption.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

C. Postretirement Benefits (Continued)

The change in actuarial assumptions from 2023 to 2024 relates to the following: (1) the change in the discount rate from 4.80% to 5.50%, and (2) future health cost trends were updated.

The health care cost trend rate and retiree contribution trend rate have a significant effect on the postretirement benefit obligations. A 1% increase in the health care cost trend rate would increase the net postretirement benefit obligation as of December 31, 2024 and 2023 by \$50,043,527 and \$60,317,258, respectively.

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

D. Employer Contributions

Employer contributions, including HRA contributions, as reported are contributions made at a fixed rate per hour worked during the year. Contributions receivable is estimated based on contributions received subsequent to the end of the year. No allowance is provided for uncollectible accounts.

The Plan has reciprocal agreements in place with other collectively bargained IBEW Local Unions. If a participant works under the jurisdiction of another collectively bargained agreement, the contributions will be transferred to the participants home local in a subsequent month.

E. Employer Payroll Compliance

Remittance reports were accepted as submitted, without examination or verification of employers' payroll records. The system of internal control provides for examination of employers' records under a separate payroll compliance program.

F. Tax-Exempt Status

The Trust has received tax-exempt status from the federal government under Internal Revenue Code Section 501(c)(9) and the state of California under Revenue and Taxation Code Section 23701i. Therefore, no provision for federal or state income tax is made.

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

G. Risks and Uncertainties

Benefit obligations are reported based on certain assumptions pertaining to health care inflation rates and participant demographics which are subject to change. Due to uncertainties inherent in the estimation and assumption 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.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

G. Risks and Uncertainties (Continued)

Plan investments are exposed to various risks such as interest rate, market fluctuations and credit risk. Some estimated values may differ from values that would have been used had a ready market existed for the investments. Due to the level of risk associated with investments and the level of uncertainty with respect to the changes in the value of investments, it is reasonably possible that changes in risks in the near term would materially affect the amounts reported in the financial statements.

NOTE 3 - BENEFITS

A. Benefits

The Plan provides health and welfare benefits including medical, dental, vision, prescription drug, and disability for active participants and medical, dental, vision, and prescription drug for retirees. All disability and certain medical, dental, vision, and prescription drug claims are self-funded by the Plan. The claims for dental and prescription drugs are processed by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and are then paid by the Plan. Ultimate responsibility for payments to providers and participants is retained by the Plan. Certain medical benefits are insured with premiums paid by the Plan.

Plan management has entered into a stop-loss insurance arrangement in an effort to limit the Plan's exposure for self-funded medical benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims). Under the terms of the contract, individual participant claims incurred in excess of \$575,000 are reimbursed to the Plan.

B. Eligibility

In order for participants to become covered initially, they must accumulate an initial reserve of \$3,850 (2 months) in contributions before the monthly deduction for coverage can be made. Once the participant attains initial coverage, on the first day of the calendar month preceding each month for which the participant is covered, \$1,925 (1 month) is deducted from the reserve accumulation. The \$1,925 deduction covers medical, life, accidental death and dismemberment, short-term disability and hospital, surgical, dental, and vision benefits. The maximum accumulated reserve is \$23,100 (12 months). The participant may use their reserve accumulation to extend coverage only while employed or available for employment by a participating employer. When the participant is not employed or available for work by a participating employer, the reserve accumulation will be frozen and will not be entitled to use it until the participant resumes work for a participating employer or becomes available for work for a participating employer. If the reserve accumulation remains frozen for twelve consecutive months, it will be cancelled and if it is cancelled, the participant will not be eligible for benefit coverage until the requirements for initial eligibility are met. Notwithstanding the foregoing rules, a participant must use their reserve accumulation to provide extended coverage at the time of retirement or disability.

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

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 3 - BENEFITS (Continued)

B. Eligibility (Continued)

Retirees 65 and over, or retirees eligible for Medicare are required to select an HMO plan either offered by the Plan or one of their choosing in the event they were not in the service area of the plans offered by the Plan. The premiums are paid by the Plan after the retiree pays the applicable monthly self-pay contribution.

A pre-funded retirement program is contributed at \$1.00 per hour. Continued coverage under this pre-funded plan requires an annual determination by the Board of Trustees, in their sole and absolute discretion, as to whether adequate financial resources are available to continue the Plan. This Plan is for early retirees who qualify.

C. Health Reimbursement Accounts (HRA)

Effective May 30, 2016, an allocation per hour of the overall employer contributions rate was made to start an HRA program. The HRA contribution rate was \$2.00 per hour. Effective June 1, 2024, the HRA contribution rate increased to \$2.16 per hour.

Eligible participants may use the funds in their HRA to pay retiree premiums, COBRA, self-pay premiums and eligible out-of-pocket medical expenses. At the discretion of the Board of Trustees, HRA accounts that have a year-end balance may be allocated income or loss on those accounts for the plan year. There is no vested right to an HRA balance. Upon a participant's death with no dependents, if a retiree's HRA balance reaches zero, if there are 5 years of inactivity, or if the Board of Trustees terminate the HRA program, the HRA account will terminate and will revert to the general assets of the Plan.

NOTE 4 - CONCENTRATION OF CREDIT RISK

During 2024, the Plan periodically had bank accounts with cash balances in excess of the federally insured limit of \$250,000 per bank. The amount in excess of the limit was subject to risk if the financial institution did not perform. The Plan has not incurred any losses on the uninsured balances.

NOTE 5 - RELATED PARTY TRANSACTIONS

Local Union staff provides assistance to union members related to obtaining information and services pertaining to the Plan. As periodically approved by the Board of Trustees, the Plan reimburses the Local Union for a portion of the allocated share of salaries, fringes, and overhead. The total reimbursements paid to the Local Union during the years ended December 31, 2024 and 2023 were \$13,056 each year.

The Plan holds the lockbox transit account that receives contributions on behalf of related trust funds and other organizations. These contributions are allocated based on each plan's contribution rate and should be transferred monthly. At the years ended December 31, 2024 and 2023, the Plan owed the related trust funds \$9,178,313 and \$7,368,492, respectively.

NOTE 6 - INVESTMENT VALUATION AND INCOME RECOGNITION

FASB ASC 820 provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 6 - INVESTMENT VALUATION AND INCOME RECOGNITION (Continued)

measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

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

Level 2 – Inputs to the valuation methodology include:

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

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

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

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. There have been no changes in the methodologies used at December 31, 2024 and 2023.

The following is a description of the valuation methodologies used for assets measured at fair value. Level 1 investments consist of short term investment funds, mutual funds, and U.S. treasury notes valued at the closing prices reported on the active market on which the securities are traded. Level 2 investments consist of corporate debt securities and futures and derivatives valued based on quoted market prices or using matrices of trades in similar securities or third party pricing vendors.

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

The following tables summarize the Plan's investments at December 31 based on the inputs used to value them:

	December 31, 2024			Total
	Level 1	Level 2	Level 3	
Short Term Investment Funds	\$ 12,403,666	\$ -	\$ -	\$ 12,403,666
Corporate Debt	-	5,766,733	-	5,766,733
Government Debt	11,096,257	-	-	11,096,257
Total Assets in Fair Value Hierarchy	<u>\$ 23,499,923</u>	<u>\$ 5,766,733</u>	<u>\$ -</u>	29,266,656
Investments Measured at Net Asset Value ^				<u>67,620,326</u>
				<u>\$ 96,886,982</u>

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 6 - INVESTMENT VALUATION AND INCOME RECOGNITION (Continued)

	December 31, 2023			
	Level 1	Level 2	Level 3	Total
Short Term Investment Funds	\$ 3,308,155	\$ -	\$ -	\$ 3,308,155
Mutual Funds	37,776,033	-	-	37,776,033
Futures and Derivatives	-	186,474	-	186,474
Total Assets in Fair Value Hierarchy	<u>\$ 41,084,188</u>	<u>\$ 186,474</u>	<u>\$ -</u>	41,270,662
Investments Measured at Net Asset Value ^A				<u>47,302,194</u>
				<u>\$ 88,572,856</u>

^A In accordance with ASC 820, investments measured at net asset value per share (or its equivalent) are no longer classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to investments, at fair value presented in the statements of net assets available for benefits.

The unfunded commitments and significant terms of redemption for the Plan's investments measured at net asset value as of December 31, are as follows:

	Fair Value		Unfunded Commitments	Redemption Frequency	Redemption Notice Period
	2024	2023			
ACM IF - Global Fixed Income	\$ -	\$ 18,556,652	None	Weekly	4 Days
Fort Washington High Yield Investors II, LLC	21,830,578	-	None	Daily	30 Days
NHIT Core Plus Fixed Income Trust CL A	-	18,520,076	None	Daily	3-5 Days
NIS Intermediate Fixed Income QP Fund, LLC	17,456,042	-	None	Bi-monthly	3 Days
Northern Trust Common S&P 500 Index Fund - Lending	10,508,851	-	None	Daily	1 Day
Post Intermediate Term High Yield Fund, L.P	17,824,855	-	None	Monthly	30 Days
Voya Senior Loan Common Trust Fund	-	10,225,466	None	Monthly	30 Days
	<u>\$ 67,620,326</u>	<u>\$ 47,302,194</u>			

The investment strategies for investments that are not Direct Filing Entities valued at net asset value are as follows:

Fort Washington High Yield Investors II, LLC seeks to achieve superior fixed income returns on invested funds through exposure to higher quality, less volatile high yield debt securities.

Post Intermediate Term High Yield Fund, L.P. seeks to provide a high level of current income and total return. The fund achieves this by investing in below investment grade debt securities, bank loans, and other debt instruments from U.S. and non-U.S. issuers, seeking to capture upside potential while limiting downside risk through fundamental credit research.

Interest, dividends and realized gains and losses on the sale of investments are reported on the accrual basis. Realized and unrealized gains and losses are computed using investments' costs for financial statement purposes. For Form 5500 reporting, realized and unrealized gains and losses are computed using investments' market values as of the beginning of the Plan year.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 7 - FUTURES AND DERIVATIVES

Some investment managers have been authorized to use certain financial derivative instruments as specified by the written investment policy, manager guidelines or partnership/fund agreements. Financial derivative instruments may be used to hedge non-dollar exposure in foreign investments, rebalance asset categories, manage market exposures, and/or hedge or leverage positions in managed portfolios.

The use of financial derivative instruments is appropriate and customary for many of the strategies employed. They reduce certain investment risks and provide value enhancement opportunities. The investment managers are expected to be aware of and manage investment and counterparty risk associated with the use of derivatives.

The fair value of the futures and derivatives held by the Plan at December 31, 2023 was \$186,474. The Plan terminated futures and derivatives investing in 2024.

NOTE 8 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500

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

	<u>December 31, 2024</u>	<u>December 31, 2023</u>
Net Assets Available for Benefits Per the Financial Statements	\$ 154,357,662	\$ 148,813,010
Total Benefit Obligations Other Than Postretirement Benefit Obligations	<u>39,807,821</u>	<u>39,862,407</u>
Net Assets Per the Form 5500	<u>\$ 114,549,841</u>	<u>\$ 108,950,603</u>

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

	<u>January 1, 2024 to December 31, 2024</u>
Total Benefits Paid Per the Financial Statements	\$ 71,496,285
Add: Total Benefit Obligations Other Than Postretirement Benefit Obligations at December 31, 2024	39,807,821
(Less): Total Benefit Obligations Other Than Postretirement Benefit Obligations at December 31, 2023	<u>(39,862,407)</u>
Total Benefits Per the Form 5500	<u>\$ 71,441,699</u>

Amounts currently payable to or for participants, dependents, and beneficiaries are reported on the Form 5500 for benefits that have been earned prior to December 31, but not yet paid as of that date.

NOTE 9 - PRIORITIES UPON TERMINATION

It is the intent of the Board of Trustees to continue the Plan in full force and effect; however, the Plan may be terminated at any time by the Board of Trustees by an instrument in writing executed by mutual consent, subject to the provisions of the plan document. Upon termination, any monies remaining in the Plan after the payment of all expenses and obligations of the Plan, shall be paid or used for the continuance of one or more benefits in accordance with the provisions of this Plan until such Plan is exhausted. No assets of the Plan may revert to the signatory employers or be used for purposes other than for the exclusive benefit of the Plan's participants.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

NOTE 10 - SUBSEQUENT EVENTS

Management has evaluated subsequent events through October 1, 2025, the date on which the financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosures in these financial statements.

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H - LINE 4
E.I.N. 94-6401540; PLAN NO. 509

SUPPLEMENTAL SCHEDULES REQUIRED BY
THE DEPARTMENT OF LABOR



Independent Auditor's Report on Supplemental
Schedules Required by the Department of Labor

Board of Trustees
IBEW Local 332 Health and Welfare Plan
6800 Santa Teresa Boulevard, Suite 100
San Jose, California 95119

Members of the Board:

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

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.

Miller Kaplan Arase LLP

MILLER KAPLAN ARASE LLP

San Francisco, California

October 1, 2025

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6401540; PLAN NO. 509
DECEMBER 31, 2024

Face Value	<u>Short Term Investment Funds</u>	Maturity Date	Interest Rate	Fair Value	Cost
\$ 12,400,561	First American Government Obligations Fund Z			\$ 12,400,561	\$ 12,400,561
2,949	Federated Government Obligations Fund IS			2,949	2,949
156	Wilmington US Government Money Mkt Instl			156	156
<u>TOTALS - SHORT TERM INVESTMENT FUNDS</u>				\$ 12,403,666	\$ 12,403,666

Par Value	<u>Corporate Debt</u>	Maturity Date	Interest Rate	Fair Value	Cost
\$ 75,000	American Express Co.	10/30/31	6.489%	\$ 80,166	\$ 80,594
45,000	Amgen Inc	03/02/28	5.150%	45,328	45,460
115,000	Anthem Inc.	03/01/28	4.101%	112,384	112,470
120,000	Bx Trust	10/15/36	5.623%	119,663	119,325
160,000	Bank Of America Mtn	07/21/28	3.593%	154,920	154,886
85,000	Bank Of America Mtn	04/28/34	5.288%	84,286	85,037
40,000	Benchmark Mtg	01/12/57	5.805%	40,996	41,003
170,000	Boeing Co	02/04/26	2.196%	164,864	163,912
95,000	Boston Pptys Ltd L P	06/21/29	3.400%	87,176	87,182
75,000	Cvs Health Corp	02/21/33	5.250%	71,899	73,193
85,000	Capital One Finl	06/08/29	6.312%	87,771	88,104
75,000	Citigroup Inc	01/10/28	3.887%	73,518	73,534
75,000	Citigroup Inc	11/17/33	6.270%	78,645	79,566
55,000	D R Horton Inc Sr	10/15/27	1.400%	50,240	50,295
55,000	D R Horton Inc Sr	10/15/34	5.000%	53,096	53,065
90,000	DC Coml Mtg Tr	09/12/40	6.314%	92,278	92,599
95,000	Diamondback Energy	04/18/34	5.400%	93,408	94,340
160,000	Duke Energy Corp	09/01/26	2.650%	154,874	154,397
85,000	Energy Transfer L P	05/15/30	3.750%	79,303	79,365
75,000	Entergy Texas Inc	03/30/29	4.000%	72,571	72,547
85,000	Equinix Europe 2	06/15/34	5.500%	85,324	85,567
57,251	Extended Stay	07/15/38	5.804%	57,287	57,287
75,000	First Citizens	03/15/30	3.375%	74,557	74,363
75,000	Fiserv Inc	10/01/28	4.200%	72,944	73,262
85,000	Ford Motor Credit	11/07/33	7.122%	88,713	90,134
55,000	General Mtrs Finl	06/10/31	2.700%	46,601	46,732
95,000	General Motors Finl	10/15/28	2.400%	86,125	86,061
140,000	Goldman Sachs Group	02/12/26	0.855%	139,310	138,657
45,000	Hcp Inc	07/15/26	3.250%	43,985	43,983
85,000	Hungtington	02/02/35	5.709%	84,835	85,780
25,000	Hyatt Hotels Corp	01/30/27	5.750%	25,385	25,425
170,000	Jpmorgan Chase Co	04/22/26	2.083%	168,540	167,965
85,000	Kyndryl Hldgs	02/20/34	6.350%	88,430	88,470
160,000	Warnermedia Hldgs	03/15/26	6.412%	160,064	160,475
84,000	Marriott	04/15/28	4.000%	81,703	81,997
55,000	McDonalds Corp Mtn	08/14/28	4.800%	55,102	55,169
150,000	Morgan Stanley	07/22/28	3.591%	144,645	145,029
75,000	Morgan Stanley	10/18/33	6.342%	79,336	80,363
<u>Forward</u>				\$ 3,380,272	\$ 3,387,593

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6401540; PLAN NO. 509
DECEMBER 31, 2024

<u>Par Value</u>	<u>Corporate Debt (Continued)</u>	<u>Maturity Date</u>	<u>Interest Rate</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>			\$ 3,380,272	\$ 3,387,593
\$ 35,000	Occidental Pete Corp	01/01/32	5.375%	34,270	34,463
160,000	Pnc Finl Svcs Group	06/12/29	5.582%	162,794	163,147
85,000	Philip Morris Intl	02/13/31	5.125%	85,006	85,507
85,000	Plains All Amern L P	09/15/34	5.700%	84,823	85,615
75,000	Prologis L P	06/15/28	4.875%	75,182	75,554
85,000	Quanta Svcs Inc	10/01/30	2.900%	75,848	76,292
130,000	Regions Financial	08/12/28	1.800%	115,794	115,938
45,000	Slg Office Trust	07/15/41	2.585%	37,791	37,911
20,000	Santanr Drv Auto	07/17/28	6.560%	20,209	20,170
75,000	Southwest Airlines	06/15/27	5.125%	75,334	75,467
85,000	Southwestern Energy	02/01/29	5.375%	83,729	84,171
85,000	T Mobile USA Inc	07/15/33	5.050%	83,231	83,967
85,000	Tapestry Inc	03/11/30	5.100%	84,063	85,059
130,000	US Bancorp	02/01/34	4.839%	124,440	125,457
175,000	Verizon Ma Tr	08/20/30	4.170%	173,317	173,250
140,000	Wells Fargo Co Mtn	04/30/26	2.188%	138,733	138,341
85,000	Wells Fargo Co Mtn	04/24/34	5.389%	84,054	85,099
65,000	Wells Farg Cml Mtg	11/19/57	5.920%	66,968	67,186
85,000	Aercap Ireland L P	10/29/28	3.000%	78,707	78,835
115,000	B A T Intl Fin Plc	02/02/29	5.931%	118,403	118,953
75,000	Barclays Plc	09/13/29	6.490%	78,007	78,419
170,000	Deutsche Bk	11/24/26	2.129%	165,648	165,019
75,000	Enbridge Inc	11/15/30	6.200%	78,979	79,232
85,000	Hsbc Holdings	06/04/26	2.099%	83,998	83,642
105,000	Magna Intl Inc Sr Nt	06/15/30	2.450%	92,261	91,876
85,000	Pfizer Invt	05/19/26	4.450%	84,872	84,808
	<u>TOTALS - CORPORATE DEBT</u>			<u>\$ 5,766,733</u>	<u>\$ 5,780,971</u>
	<u>Government Debt</u>				
\$ 1,825,000	US Treasury Note	05/15/31	1.625%	\$ 1,539,643	\$ 1,544,050
1,235,000	US Treasury Note	06/30/28	1.250%	1,112,760	1,109,854
910,000	US Treasury Note	10/31/26	1.125%	860,259	856,266
2,450,000	US Treasury Note	03/31/29	2.375%	2,261,105	2,261,841
1,175,000	US Treasury Note	08/15/32	2.750%	1,042,025	1,047,942
1,570,000	US Treasury Note	03/31/30	3.625%	1,513,087	1,516,557
905,000	US Treasury Note	05/15/26	3.625%	897,534	895,773
585,000	US Treasury Note	11/15/33	4.500%	582,350	590,652
370,000	US Treasury Note	02/15/26	1.625%	359,429	358,410
1,015,000	US Treasury Note	05/31/27	0.500%	928,065	923,516
	<u>TOTALS - GOVERNMENT DEBT</u>			<u>\$ 11,096,257</u>	<u>\$ 11,104,861</u>

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
 FORM 5500
 SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
 E.I.N. 94-6401540; PLAN NO. 509
 DECEMBER 31, 2024

<u>No. of Shares</u>	<u>Common/Collective Trusts</u>	<u>Fair Value</u>	<u>Cost</u>
1,507	NIS Intermediate Fixed Income QP Fund, LLC	\$ 17,456,042	\$ 17,500,000
218,030	Northern Trust Common S&P 500 Index Fund - Lending	<u>10,508,851</u>	<u>10,836,168</u>
	<u>TOTALS - COMMON/COLLECTIVE TRUSTS</u>	<u>\$ 27,964,893</u>	<u>\$ 28,336,168</u>
	<u>Collective Investment Fund</u>		
66,251	Fort Washington High Yield Investors II, LLC	<u>\$ 21,830,578</u>	<u>\$ 21,700,000</u>
	<u>Limited Partnership</u>		
	Post Intermediate Term High Yield Fund, L.P	<u>\$ 17,824,855</u>	<u>\$ 17,700,000</u>
	<u>TOTALS - INVESTMENTS</u>	<u>\$ 96,886,982</u>	<u>\$ 97,025,666</u>

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
E.I.N. 94-6401540; PLAN NO. 509
JANUARY 1, 2024 TO DECEMBER 31, 2024

Description of Assets	Interest Rate (%)	Maturity Date	Purchase Price	Selling Price	Cost of Asset	Net Gain or (Loss)
American Funds Europacific Growth R5	N/A	N/A	\$ 187,033 -	\$ - 8,126,660	\$ 187,033 7,827,732	\$ - 298,928
PIMCO Income Instl	N/A	N/A	941,156 -	- 20,660,353	941,156 22,981,241	- (2,320,888)
Vanguard 500 Index Admiral	N/A	N/A	120,287 -	- 13,632,969	120,287 6,450,041	- 7,182,928
Federated Government Obligations Fund IS	N/A	N/A	62,388,946 -	- 65,055,364	62,388,946 65,055,364	- -
Voya Senior Loan Common Trust Fund	N/A	N/A	- -	- 10,759,168	- 8,810,400	- 1,948,768
ACM IF - Global Fixed Income	N/A	N/A	- -	- 18,921,470	- 17,273,537	- 1,647,933
NHIT Core Plus Fixed Income Trust CL A	N/A	N/A	- -	- 19,456,255	- 16,674,532	- 2,781,723
First American Government Obligations Fund Z	N/A	N/A	36,257,354 -	- 23,856,868	36,257,354 23,856,868	- -
Fort Washington High Yield Investors II, LLC	N/A	N/A	21,700,000 -	- -	21,700,000 -	- -
NIS Intermediate Fixed Income QP Fund, LLC	N/A	N/A	17,500,000 -	- -	17,500,000 -	- -
Northern Trust Common IS&P 500 Index Fund - Lending	N/A	N/A	10,836,168 -	- -	10,836,168 -	- -
Post Intermediate Term High Yield Fund, L.P	N/A	N/A	17,700,000 -	- -	17,700,000 -	- -

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 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> 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 01/01/2024 and ending 12/31/2024

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

B This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)

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

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

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

Part II Basic Plan Information - enter all requested information

1a Name of plan IBEW LOCAL 332 HEALTH AND WELFARE PLAN	1b Three-digit plan number (PN) ▶	509
	1c Effective date of plan	09/01/1959
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BOARD OF TRUSTEES, IBEW LOCAL 332 HEALTH AND WELFARE TRUST FUND 6800 SANTA TERESA BLVD STE 100 SAN JOSE, CA 95119	2b Employer Identification Number (EIN)	94-6401540
	2c Plan Sponsor's telephone number	408-288-4400
	2d Business code (see instructions)	238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		10/9/25	Peter G. Seaberg
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/9/25	DOUGLAS LUNG
	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

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
E.I.N. 94-6401540; PLAN NO. 509
JANUARY 1, 2024 TO DECEMBER 31, 2024

Description of Assets	Interest Rate (%)	Maturity Date	Purchase Price	Selling Price	Cost of Asset	Net Gain or (Loss)
American Funds Europacific Growth R5	N/A	N/A	\$ 187,033 -	\$ - 8,126,660	\$ 187,033 7,827,732	\$ - 298,928
PIMCO Income Instl	N/A	N/A	941,156 -	- 20,660,353	941,156 22,981,241	- (2,320,888)
Vanguard 500 Index Admiral	N/A	N/A	120,287 -	- 13,632,969	120,287 6,450,041	- 7,182,928
Federated Government Obligations Fund IS	N/A	N/A	62,388,946 -	- 65,055,364	62,388,946 65,055,364	- -
Voya Senior Loan Common Trust Fund	N/A	N/A	- -	- 10,759,168	- 8,810,400	- 1,948,768
ACM IF - Global Fixed Income	N/A	N/A	- -	- 18,921,470	- 17,273,537	- 1,647,933
NHIT Core Plus Fixed Income Trust CL A	N/A	N/A	- -	- 19,456,255	- 16,674,532	- 2,781,723
First American Government Obligations Fund Z	N/A	N/A	36,257,354 -	- 23,856,868	36,257,354 23,856,868	- -
Fort Washington High Yield Investors II, LLC	N/A	N/A	21,700,000 -	- -	21,700,000 -	- -
NIS Intermediate Fixed Income QP Fund, LLC	N/A	N/A	17,500,000 -	- -	17,500,000 -	- -
Northern Trust Common IS&P 500 Index Fund - Lending	N/A	N/A	10,836,168 -	- -	10,836,168 -	- -
Post Intermediate Term High Yield Fund, L.P	N/A	N/A	17,700,000 -	- -	17,700,000 -	- -

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6401540; PLAN NO. 509
DECEMBER 31, 2024

Face Value	<u>Short Term Investment Funds</u>	<u>Maturity Date</u>	<u>Interest Rate</u>	<u>Fair Value</u>	<u>Cost</u>
\$ 12,400,561	First American Government Obligations Fund Z			\$ 12,400,561	\$ 12,400,561
2,949	Federated Government Obligations Fund IS			2,949	2,949
156	Wilmington US Government Money Mkt Instl			156	156
<u>TOTALS - SHORT TERM INVESTMENT FUNDS</u>				\$ 12,403,666	\$ 12,403,666

<u>Par Value</u>	<u>Corporate Debt</u>				
\$ 75,000	American Express Co.	10/30/31	6.489%	\$ 80,166	\$ 80,594
45,000	Amgen Inc	03/02/28	5.150%	45,328	45,460
115,000	Anthem Inc.	03/01/28	4.101%	112,384	112,470
120,000	Bx Trust	10/15/36	5.623%	119,663	119,325
160,000	Bank Of America Mtn	07/21/28	3.593%	154,920	154,886
85,000	Bank Of America Mtn	04/28/34	5.288%	84,286	85,037
40,000	Benchmark Mtg	01/12/57	5.805%	40,996	41,003
170,000	Boeing Co	02/04/26	2.196%	164,864	163,912
95,000	Boston Pptys Ltd L P	06/21/29	3.400%	87,176	87,182
75,000	Cvs Health Corp	02/21/33	5.250%	71,899	73,193
85,000	Capital One Finl	06/08/29	6.312%	87,771	88,104
75,000	Citigroup Inc	01/10/28	3.887%	73,518	73,534
75,000	Citigroup Inc	11/17/33	6.270%	78,645	79,566
55,000	D R Horton Inc Sr	10/15/27	1.400%	50,240	50,295
55,000	D R Horton Inc Sr	10/15/34	5.000%	53,096	53,065
90,000	DC Coml Mtg Tr	09/12/40	6.314%	92,278	92,599
95,000	Diamondback Energy	04/18/34	5.400%	93,408	94,340
160,000	Duke Energy Corp	09/01/26	2.650%	154,874	154,397
85,000	Energy Transfer L P	05/15/30	3.750%	79,303	79,365
75,000	Entergy Texas Inc	03/30/29	4.000%	72,571	72,547
85,000	Equinix Europe 2	06/15/34	5.500%	85,324	85,567
57,251	Extended Stay	07/15/38	5.804%	57,287	57,287
75,000	First Citizens	03/15/30	3.375%	74,557	74,363
75,000	Fiserv Inc	10/01/28	4.200%	72,944	73,262
85,000	Ford Motor Credit	11/07/33	7.122%	88,713	90,134
55,000	General Mtrs Finl	06/10/31	2.700%	46,601	46,732
95,000	General Motors Finl	10/15/28	2.400%	86,125	86,061
140,000	Goldman Sachs Group	02/12/26	0.855%	139,310	138,657
45,000	Hcp Inc	07/15/26	3.250%	43,985	43,983
85,000	Hungtington	02/02/35	5.709%	84,835	85,780
25,000	Hyatt Hotels Corp	01/30/27	5.750%	25,385	25,425
170,000	Jpmorgan Chase Co	04/22/26	2.083%	168,540	167,965
85,000	Kyndryl Hldgs	02/20/34	6.350%	88,430	88,470
160,000	Warnermedia Hldgs	03/15/26	6.412%	160,064	160,475
84,000	Marriott	04/15/28	4.000%	81,703	81,997
55,000	McDonalds Corp Mtn	08/14/28	4.800%	55,102	55,169
150,000	Morgan Stanley	07/22/28	3.591%	144,645	145,029
75,000	Morgan Stanley	10/18/33	6.342%	79,336	80,363
<u>Forward</u>				\$ 3,380,272	\$ 3,387,593

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
FORM 5500
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
E.I.N. 94-6401540; PLAN NO. 509
DECEMBER 31, 2024

<u>Par Value</u>	<u>Corporate Debt (Continued)</u>	<u>Maturity Date</u>	<u>Interest Rate</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>			\$ 3,380,272	\$ 3,387,593
\$ 35,000	Occidental Pete Corp	01/01/32	5.375%	34,270	34,463
160,000	Pnc Finl Svcs Group	06/12/29	5.582%	162,794	163,147
85,000	Philip Morris Intl	02/13/31	5.125%	85,006	85,507
85,000	Plains All Amern L P	09/15/34	5.700%	84,823	85,615
75,000	Prologis L P	06/15/28	4.875%	75,182	75,554
85,000	Quanta Svcs Inc	10/01/30	2.900%	75,848	76,292
130,000	Regions Financial	08/12/28	1.800%	115,794	115,938
45,000	Slg Office Trust	07/15/41	2.585%	37,791	37,911
20,000	Santanr Drv Auto	07/17/28	6.560%	20,209	20,170
75,000	Southwest Airlines	06/15/27	5.125%	75,334	75,467
85,000	Southwestern Energy	02/01/29	5.375%	83,729	84,171
85,000	T Mobile USA Inc	07/15/33	5.050%	83,231	83,967
85,000	Tapestry Inc	03/11/30	5.100%	84,063	85,059
130,000	US Bancorp	02/01/34	4.839%	124,440	125,457
175,000	Verizon Ma Tr	08/20/30	4.170%	173,317	173,250
140,000	Wells Fargo Co Mtn	04/30/26	2.188%	138,733	138,341
85,000	Wells Fargo Co Mtn	04/24/34	5.389%	84,054	85,099
65,000	Wells Farg Cml Mtg	11/19/57	5.920%	66,968	67,186
85,000	Aercap Ireland L P	10/29/28	3.000%	78,707	78,835
115,000	B A T Intl Fin Plc	02/02/29	5.931%	118,403	118,953
75,000	Barclays Plc	09/13/29	6.490%	78,007	78,419
170,000	Deutsche Bk	11/24/26	2.129%	165,648	165,019
75,000	Enbridge Inc	11/15/30	6.200%	78,979	79,232
85,000	Hsbc Holdings	06/04/26	2.099%	83,998	83,642
105,000	Magna Intl Inc Sr Nt	06/15/30	2.450%	92,261	91,876
85,000	Pfizer Invt	05/19/26	4.450%	84,872	84,808
	<u>TOTALS - CORPORATE DEBT</u>			<u>\$ 5,766,733</u>	<u>\$ 5,780,971</u>
	<u>Government Debt</u>				
\$ 1,825,000	US Treasury Note	05/15/31	1.625%	\$ 1,539,643	\$ 1,544,050
1,235,000	US Treasury Note	06/30/28	1.250%	1,112,760	1,109,854
910,000	US Treasury Note	10/31/26	1.125%	860,259	856,266
2,450,000	US Treasury Note	03/31/29	2.375%	2,261,105	2,261,841
1,175,000	US Treasury Note	08/15/32	2.750%	1,042,025	1,047,942
1,570,000	US Treasury Note	03/31/30	3.625%	1,513,087	1,516,557
905,000	US Treasury Note	05/15/26	3.625%	897,534	895,773
585,000	US Treasury Note	11/15/33	4.500%	582,350	590,652
370,000	US Treasury Note	02/15/26	1.625%	359,429	358,410
1,015,000	US Treasury Note	05/31/27	0.500%	928,065	923,516
	<u>TOTALS - GOVERNMENT DEBT</u>			<u>\$ 11,096,257</u>	<u>\$ 11,104,861</u>

IBEW LOCAL 332 HEALTH AND WELFARE PLAN
 FORM 5500
 SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
 E.I.N. 94-6401540; PLAN NO. 509
 DECEMBER 31, 2024

<u>No. of Shares</u>	<u>Common/Collective Trusts</u>	<u>Fair Value</u>	<u>Cost</u>
1,507	NIS Intermediate Fixed Income QP Fund, LLC	\$ 17,456,042	\$ 17,500,000
218,030	Northern Trust Common S&P 500 Index Fund - Lending	10,508,851	10,836,168
	<u>TOTALS - COMMON/COLLECTIVE TRUSTS</u>	<u>\$ 27,964,893</u>	<u>\$ 28,336,168</u>
	<u>Collective Investment Fund</u>		
66,251	Fort Washington High Yield Investors II, LLC	\$ 21,830,578	\$ 21,700,000
	<u>Limited Partnership</u>		
	Post Intermediate Term High Yield Fund, L.P	\$ 17,824,855	\$ 17,700,000
	<u>TOTALS - INVESTMENTS</u>	<u>\$ 96,886,982</u>	<u>\$ 97,025,666</u>