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.)
- [X] 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:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
OWEN AMES KIMBALL CO EMPLOYEE BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan
06/01/1990

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)

OWEN AMES KIMBALL CO

TODD STEFFEN

126 OTTAWA AVE NW STE 600
GRAND RAPIDS, MI 49503-2852

126 OTTAWA AVE NW STE 600
GRAND RAPIDS, MI 49503-2852

2b Employer Identification Number (EIN)
38-0900420

2c Plan Sponsor's telephone number
616-456-1521

2d Business code (see instructions)
236200

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.	10/13/2025	JAKE HITSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2025	TODD STEFFEN
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
		3c Administrator's telephone number	
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	**4b** EIN	
a	Sponsor's name	**4d** PN	
c	Plan Name		
5	Total number of participants at the beginning of the plan year	**5**	187
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	182
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	186
b	Retired or separated participants receiving benefits	**6b**	3
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	189
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	189
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	0

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

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

- (1) [ ] **H** (Financial Information)
- (2) [ ] **I** (Financial Information – Small Plan)
- (3) [X] **A** (Insurance Information) – Number Attached 3
- (4) [X] **C** (Service Provider Information)
- (5) [ ] **D** (DFE/Participating Plan Information)
- (6) [ ] **G** (Financial Transaction Schedules)

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

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

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

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

11c Enter the Receipt Confirmation Code for the 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
OWEN AMES KIMBALL CO EMPLOYEE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OWEN AMES KIMBALL CO

D Employer Identification Number (EIN)
38-0900420

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
BLUE CARE NETWORK OF MICHIGAN

(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	Policy or contract year (g) To
38-2359234	95610	174837	465	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
74322	

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

GALLAGHER BENEFIT SRVCS
2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS, MI 48302-8302

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
	2136	COMMISSIONS	3

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

CHRISTOPHER GLASS
300 OTTAWA AVE NW STE 301
GRAND RAPIDS, MI 49503

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
30424			3

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

MICHAEL HAGERTY

2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS, MI 48302

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
41762			3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b Balance at the end of the previous year			**7b**	
c Additions: (1) Contributions deposited during the year	**7c(1)**			
(2) Dividends and credits	**7c(2)**			
(3) Interest credited during the year	**7c(3)**			
(4) Transferred from separate account	**7c(4)**			
(5) Other (specify below)	**7c(5)**			
▶				
(6)Total additions			**7c(6)**	
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)**	
f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

Line	Description	Line	Amount	Line	Total
a	Premiums: (1) Amount received	**9a(1)**	2416646		
	(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)**	2416646
b	Benefit charges (1) Claims paid	**9b(1)**	3408132		
	(2) Increase (decrease) in claim reserves	**9b(2)**	-24122		
	(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	3384010
	(4) Claims charged			**9b(4)**	2497503
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)**	322448		
	(C) Other specific acquisition costs	**9c(1)(C)**			
	(D) Other expenses	**9c(1)(D)**			
	(E) Taxes	**9c(1)(E)**	13050		
	(F) Charges for risks or other contingencies	**9c(1)(F)**	9614		
	(G) Other retention charges	**9c(1)(G)**	266596		
	(H) Total retention			**9c(1)(H)**	611708
	(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
	(2) Claim reserves			**9d(2)**	355706
	(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:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE 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
OWEN AMES KIMBALL CO EMPLOYEE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OWEN AMES KIMBALL CO

D Employer Identification Number (EIN)
38-0900420

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
BLUE CROSS BLUE SHIELD OF MICHIGAN

(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	Policy or contract year (g) To
38-2069753	54291	174837	11	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
3322	

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

GALLAGHER BENEFIT SRVCS
2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS, MI 48302

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
	144	COMMISSIONS	3

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

CHRISTOPHER GLASS
300 OTTAWA AVE NW STE 301
GRAND RAPIDS, MI 49503

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
1170			3

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

MICHAEL HAGERTY

2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS, MI 48302

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	
2008			3

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b Balance at the end of the previous year			**7b**	
c Additions: (1) Contributions deposited during the year	**7c(1)**			
(2) Dividends and credits	**7c(2)**			
(3) Interest credited during the year	**7c(3)**			
(4) Transferred from separate account	**7c(4)**			
(5) Other (specify below) ▶	**7c(5)**			
(6) Total additions			**7c(6)**	
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)**	
f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

Item	Line	Amount	Line	Amount
a Premiums: (1) Amount received	**9a(1)**	106974		
(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)**	106974
b Benefit charges (1) Claims paid	**9b(1)**	31549		
(2) Increase (decrease) in claim reserves	**9b(2)**	-4231		
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	27318
(4) Claims charged			**9b(4)**	27318
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)**	9293		
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**	1380		
(F) Charges for risks or other contingencies	**9c(1)(F)**	3485		
(G) Other retention charges	**9c(1)(G)**	12989		
(H) Total retention			**9c(1)(H)**	27147
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	0
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	663
(3) Other reserves			**9d(3)**	0
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	0

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)	Insurance Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).	2024
Department of Labor Employee Benefits Security Administration	▶ **File as an attachment to Form 5500.**	
Pension Benefit Guaranty Corporation	▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).	**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
OWEN AMES KIMBALL CO EMPLOYEE BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
OWEN AMES KIMBALL CO

D Employer Identification Number (EIN)
38-0900420

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE LINCOLN NATIONAL 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	Policy or contract year (g) To
35-0472300	65676	000010100294	232	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
1061	0

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

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

GALLAGHER BENEFIT SERVICES INC
2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS, MI 48302

(b) Amount of sales and base commissions paid	Fees and other commissions paid (c) Amount	(d) Purpose	(e) Organization code
1061			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

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

(3) ☐ other (specify) ▶

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

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

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

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

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below) ▶	**7c(5)**			
	(6) Total additions			**7c(6)**	
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)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

Item	Line	Amount
a Total premiums or subscription charges paid to carrier	**10a**	8646
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ **File as an attachment to Form 5500.**	**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 OWEN AMES KIMBALL CO EMPLOYEE BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OWEN AMES KIMBALL CO	D Employer Identification Number (EIN) 38-0900420	

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

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

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

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

VARIPRO

5300 PATTERSON AVE SE
GRAND RAPIDS, MI 49512

(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	TPA	9108	Yes ☐ No ☒	Yes ☐ No ☒		Yes ☐ No ☒

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

GALLAGHER BENEFIT SERVICES, INC.

PO BOX 95287
CHICAGO, IL 60694-5287

(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?
22 53 55 56	AGENT	0	Yes ☒ No ☐	Yes ☐ No ☒	562	Yes ☐ No ☒

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(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

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

(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:

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

The Lincoln National Life
Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114-4066
toll free (800) 423-2765
www.LFG.com

March 25, 2025

OWEN-AMES-KIMBALL CO.
126 OTTAWA AVENUE NW SUITE 600
GRAND RAPIDS MI 49503

RE: Group Policy Number: 000010100294 00000
Schedule A Reporting For: 01/01/2024 to 12/31/2024

Dear Client:

ERISA regulations may require your employee benefit plan administrator to file an annual report (Form 5500 and Schedule A) with the Department of Labor if the plan had 100 or more participants at the beginning of the plan year. If you are not sure whether you need to file a Form 5500, you may want to contact your own attorney, tax or benefits consultant.

As an aid in your completion of Schedule A, enclosed is the required information for your group insurance plan underwritten by The Lincoln National Life Insurance Company. Premiums reported are based on premiums received and applied within the reporting period listed above.

Contingent compensation payments are part of our overall expenses and are spread into the pricing across all lines of business. Please be advised that the broker listed below has previously received a copy of this information.

We appreciate your business and thank you for being a valued Lincoln Financial Group customer. For your convenience, please visit us at www.lincolnfinancial.com to view forms and policy information, access online service options and much more.
If you have any questions, please contact us at 800-423-2765.

Enclosure

CC: GALLAGHER BENEFIT SERVICES INC
2600 S TELEGRAPH RD STE 100
BLOOMFIELD HILLS MI 48302

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY
SCHEDULE A REPORTING INFORMATION

A. Name of Plan: OWEN-AMES-KIMBALL CO.

Part I - Information Concerning Insurance Contract Coverage, Fees, and Commissions

1. Coverage:
   (a) Name of insurance carrier: The Lincoln National Life Insurance Company
   (b) EIN: 35-0472300
   (c) NAIC code: 65676
   (d) Contract or identification number: 000010100294 00000

Benefits & Contract Type (Part III,#8)	**Number of Persons on the Last Day of the Reporting Period (e)**	**Reporting Period From (f)**	**Reporting Period To (g)**
AD&D	232	01/01/2024	12/31/2024
Life	232	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
$1,061.06	$0.00

3. Insurance fees and commissions paid to agents, brokers, and other persons:

Name and address to whom payments were paid (a)	Amount of sales and base commissions paid (b)	Fees and other commissions paid Amount (c)	Purpose(d)	Org. Code(e)
GALLAGHER BENEFIT SERVICES INC 2600 S TELEGRAPH RD STE 100 BLOOMFIELD HILLS, MI 48302	$1,061.06			3
Totals:	**$1,061.06**	**$0.00**		

Part III - Welfare Benefit Contract Information

8. Benefit and contract type: see Part I, section 1, column 1 above
10. Nonexperience-rated contracts:
    (a) Total premiums or subscription charges paid to carrier... $8,645.86

The Lincoln National Life Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114-4066

5500 Schedule A Information

Period Beginning: January 1, 2024 — Period Ending: December 31, 2024

Name of Plan: Owen-Ames-Kimball Company

Approximate number of persons covered at the end of policy year: **188 Dental**

Name of Insurance Carrier: N/A

Carrier EIN: N/A

Policy Number: N/A

Premiums Paid to Carrier: N/A

Name and Address of Agents, Brokers, or Other Individuals to whom commissions or fees are paid:

Gallagher Benefit Services, Inc.
PO Box 95287
Chicago, IL 60694-5287

Commission Amount: .25/ee
Total Commission Paid: $ 562.25

Varipro
5300 Patterson Ave SE
Grand Rapids, MI 49512

Dental Admin: $ 9,108.45

TOTAL Fees Paid: $ 9,670.70

Claims Paid
Dental: $ 79,165.00

Other Vendors Names, Address, EIN Numbers

N/A

Fees Paid: $ -

PREPARED BY: VARIPRO

BLUE CROSS BLUE SHIELD OF MICHIGAN

ERS Final Settlement

for

OWEN-AMES-KIMBALL CO

01/01/2024 - 12/31/2024

CUSTOMER ID: 174837

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: OWEN-AMES-KIMBALL CO

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CROSS BLUE SHIELD OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2069753
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	54291
(d) CONTRACT OR IDENTIFICATION NUMBER	174837
(e) APPROX. NUMBER OF PERSONS COVERED	11
(f) POLICY OR CONTRACT YEAR FROM	1/1/2024
(g) POLICY OR CONTRACT YEAR TO	12/31/2024

2. INSURANCE FEE AND COMMISSION INFORMATION	(SEE SCHEDULE A ADDENDUM)
3. PERSONS RECEIVING COMMISSIONS AND FEES	(SEE SCHEDULE A ADDENDUM)
PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION	NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (h) Prescription Drug, (k) PPO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:	
(i) AMOUNT RECEIVED	$106,974
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$106,974
(b) BENEFIT CHARGES:	
(i) CLAIMS PAID	$31,549
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	($4,231)
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$27,318
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$27,318
(c) REMAINDER OF PREMIUM	
(i) RETENTION CHARGES	
A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$9,293
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$1,380
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$3,485
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$12,989
H. TOTAL RETENTION	$27,147
(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED)	$0
(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR	
(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$663
(iii) OTHER RESERVES	$0
(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE	$0

10. NONEXPERIENCE-RATED CONTRACTS	NOT APPLICABLE
PART IV: PROVISION OF INFORMATION	(DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Cross Blue Shield Michigan
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	OWEN-AMES-KIMBALL CO
Group Number:	007014211
CID:	174837
Contract Year From:	01/01/2024
Contract Year To:	12/31/2024

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	GALLAGHER BENEFIT SRVCS (BF) 2600 S Telegraph Ste 100 Bloomfield Hills, MI 48302-8302
-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$144.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	MICHAEL HAGERTY 2600 S. Telegraph Rd Suite 100 Bloomfield Hills, MI -
-- Amount of Sales and Base Commissions Paid	$2,008.10
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	Christopher Glass 300 Ottawa Ave. NW STE 301 Grand Rapids, MI -
-- Amount of Sales and Base Commissions Paid	$1,169.96
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)	3

, -

BLUE CARE NETWORK OF MICHIGAN

ERS Final Settlement

for

OWEN-AMES-KIMBALL CO

01/01/2024 - 12/31/2024

CUSTOMER ID: 174837

SCHEDULE A (ERISA FORM 5500)
INSURANCE INFORMATION

GROUP NAME: OWEN-AMES-KIMBALL CO

PART I: Insurance Information

1. COVERAGE INFORMATION

(a) NAME OF INSURANCE CARRIER	BLUE CARE NETWORK OF MICHIGAN
(b) EMPLOYER IDENTIFICATION NUMBER (EIN)	38-2359234
(c) NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CODE	95610
(d) CONTRACT OR IDENTIFICATION NUMBER	174837
(e) APPROX. NUMBER OF PERSONS COVERED	465
(f) POLICY OR CONTRACT YEAR FROM	1/1/2024
(g) POLICY OR CONTRACT YEAR TO	12/31/2024

2. INSURANCE FEE AND COMMISSION INFORMATION (SEE SCHEDULE A ADDENDUM)

3. PERSONS RECEIVING COMMISSIONS AND FEES (SEE SCHEDULE A ADDENDUM)

PART II: INVESTMENT AND ANNUITY CONTRACT INFORMATION NOT APPLICABLE

PART III: WELFARE BENEFIT CONTRACT INFORMATION

8 BENEFIT AND CONTRACT TYPE
(a) Health, (h) Prescription Drug, (k) HMO contract

9. EXPERIENCE-RATED CONTRACTS

(a) PREMIUMS:	
(i) AMOUNT RECEIVED	$2,416,646
(ii) AND (iii)	NOT APPLICABLE
(iv) AMOUNT EARNED	$2,416,646
(b) BENEFIT CHARGES:	
(i) CLAIMS PAID	$3,408,132
(ii) INCREASE (DECREASE) IN CLAIM RESERVES	($24,122)
(iii) INCURRED CLAIMS (ADD (i) AND (ii))	$3,384,010
(iv) CLAIMS CHARGED (NET OF EXCESS CLAIMS)	$2,497,503
(c) REMAINDER OF PREMIUM	
(i) RETENTION CHARGES	
A. COMMISSIONS	NOT APPLICABLE
B. ADMINISTRATIVE SERVICE OR OTHER FEES	$322,448
C. OTHER SPECIFIC ACQUISITION COSTS	$0
D. OTHER EXPENSES (SUBSIDIES, ETC.)	$0
E. ESTIMATED TAXES, FEES AND ASSESSMENTS	$13,050
F. CHARGES FOR RISK OR OTHER CONTINGENCIES	$9,614
G. OTHER RETENTION CHARGES (POOLING CHARGE)	$266,596
H. TOTAL RETENTION	$611,708
(ii) DIVIDENDS OR RETROACTIVE RATE REFUNDS (CREDITED)	$0
(d) STATUS OF POLICYHOLDER RESERVES AT END OF YEAR	
(i) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT	NOT APPLICABLE
(ii) CLAIMS RESERVES	$355,706
(iii) OTHER RESERVES	$0
(e) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE	$0

10. NONEXPERIENCE-RATED CONTRACTS NOT APPLICABLE

PART IV: PROVISION OF INFORMATION (DETERMINED BY YOUR GROUP)

The REMAINDER OF PREMIUM shown include BCBSM's/BCN's estimates of applicable Federal and State taxes, fees and assessments. BCBSM's/BCN's estimates are subject to change. BCBSM/BCN will not reconcile or settle any amounts collected with actual amounts owed for such Federal and State taxes, fees, and assessments.

Blue Care Network
ADDENDUM TO SCHEDULE A/C (ERISA FORM 5500)

Client Name:	OWEN-AMES-KIMBALL CO
Group Number:	001748370
CID:	174837
Contract Year From:	01/01/2024
Contract Year To:	12/31/2024

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	GALLAGHER BENEFIT SRVCS (BF) 2600 S Telegraph Ste 100 Bloomfield Hills, MI 48302-8302
-- Amount of Sales and Base Commissions Paid	$0.00
-- Fees and Other Commissions Paid Amount	$2,136.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	MICHAEL HAGERTY 2600 S. Telegraph Rd Suite 100 Bloomfield Hills, MI -
-- Amount of Sales and Base Commissions Paid	$41,762.42
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

AGENT/BROKER COMMISSION & INCENTIVE PAYMENTS

-- Name and address of agent or broker:	Christopher Glass 300 Ottawa Ave. NW STE 301 Grand Rapids, MI -
-- Amount of Sales and Base Commissions Paid	$30,423.92
-- Fees and Other Commissions Paid Amount	$0.00
-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Organization Code (for Schedule A)	3
-- Service Codes (for Schedule C)	22, 53, 55, 56, 99

GROUP INFORMATION

-- Non-Monetary Compensations to Plan (gifts, meals, entertainments, etc.)	$0.00
-- Service Codes (for Schedule C)	3

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