

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan a DFE (specify) _____

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

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

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

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description) _____

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

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>BOARD OF TRUSTEES, STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND</u></p> <p><u>232 WISE ROAD, SUITE #330</u> <u>HARMONY, PA 16037</u></p>	<p>1c Effective date of plan <u>01/01/1953</u></p> <p>2b Employer Identification Number (EIN) <u>25-6032450</u></p> <p>2c Plan Sponsor's telephone number <u>412-381-1133</u></p> <p>2d Business code (see instructions) <u>238900</u></p>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2025	JAMES HARDING
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2025	REGIS CLAU
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	2669
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)	1716
	6a(2)	1723
	6b	763
	6c	28
	6d	2514
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	161

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 4D 4E

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" 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>2</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

**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 STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	D Employer Identification Number (EIN) 25-6032450

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

HIGHMARK FREEDOM BLUE PPO

(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
23-1294723	54771	027818 01146502	1227	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 0	(b) Total amount of fees paid 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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	4935875
	(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)	4935875
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	
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 STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND		D Employer Identification Number (EIN) 25-6032450

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

METROPOLITAN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5581829	65978	151385	1720	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 0	(b) Total amount of fees paid 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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	236351
	(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)	236351
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	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

A Name of plan STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	D Employer Identification Number (EIN) 25-6032450	

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

(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)

HIGHMARK

120 FIFTH AVENUE PLACE
PITTSBURGH, PA 15222

23-1294723

(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	NONE	1475164	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)

CDS ADMINISTRATORS

232 WISE ROAD, SUITE 330
HARMONY, PA 16037

25-1352803

(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	NONE	308528	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DELTA DENTAL

ONE DELTA DRIVE
MECHANICSBURG, PA 17055

94-1461312

(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	NONE	76746	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)

MOBILE MEDICAL CORPORATION

2413 LYTLE ROAD
BETHEL PARK, PA 15102

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	66790	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)

SEGAL MARCO ADVISORS

1300 E. NINTH STREET, SUITE 1900
CLEVELAND, OH 44114

36-3555078

(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?
17	NONE	57000	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)

WINSLOW ASSET MANAGEMENT

3333 RICHMOND STREET, SUITE 180
CLEVELAND, OH 44122

34-1705163

(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	NONE	42729	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)

CHARTWELL INVESTMENT PARTNERS

1205 WESTLAKES DRIVE, SUITE 100
BERWYN, PA 19312

36-4776242

(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	NONE	40378	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)

HENRY ROSSI & CO., LLP

50 SECO ROAD, SUITE A
MONROEVILLE, PA 15146

25-1698043

(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	NONE	34470	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)

MEYER, UNKOVIC & SCOTT LLP

535 SMITHFIELD STREET, SUITE 1300
PITTSBURGH, PA 15222

25-1008021

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	22455	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)

ALLEGHENY COMMERCIAL PRINTING

1209 CHARTIERS AVE
MCKEES ROCKS, PA 15136

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36	NONE	21553	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)

BOYD WATTERSON

1301 E 9TH ST., 2900
CLEVELAND, OH 44114

(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	NONE	17974	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)

PNC INSTITUTIONAL INVESTMENTS

1900 E. 9TH STREET, 13TH FLOOR
CLEVELAND, OH 44114

25-1211909

(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	NONE	10248	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)

FOSTER & FOSTER

1136 HAMILTON STREET, SUITE 103
ALLENTOWN, PA 18101

23-2503024

(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 17 50	NONE	9600	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(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 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 STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES, STEAMFITTERS LOCAL #449 MEDICAL & BENEFIT FUND	D Employer Identification Number (EIN) 25-6032450

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	26777086	42409
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3583607	3277737
(2) Participant contributions	1b(2)	96305	76027
(3) Other	1b(3)	5920805	5283389
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1906520	24368018
(2) U.S. Government securities	1c(2)	4446114	6157308
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	9285157	11342898
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	8431036	9277895
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	32368750	41023668
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	92815380	100849349
Liabilities			
g Benefit claims payable.....	1g	2901507	5074461
h Operating payables.....	1h	189469	421630
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	3090976	5496091
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	89724404	95353258

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)	39211136	
(B) Participants.....	2a(1)(B)	4557170	
(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)		43768306
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	2669660	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		2669660
(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)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	1086193	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		47524159

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	4343743	
(2) To insurance carriers for the provision of benefits	2e(2)	36873625	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		41217368
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)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)	167833	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	9600	
(8) Legal fees	2i(8)	26750	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	473754	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		677937
j Total expenses. Add all expense amounts in column (b) and enter total	2j		41895305

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		5628854
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: HENRY ROSSI & CO., LLP

(2) EIN: 25-1698043

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		2000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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 _____.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND
FINANCIAL STATEMENTS
AND SUPPLEMENTAL INFORMATION
YEARS ENDED
DECEMBER 31, 2024 AND 2023

Independent Auditor's Report

Board of Trustees
Steamfitters Local 449 Medical & Benefit Fund
Pittsburgh, Pennsylvania

Opinion

We have audited the accompanying financial statements of Steamfitters Local 449 Medical & Benefit Fund, 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 the statements of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and the statements 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 total benefit obligations of Steamfitters Local 449 Medical & Benefit Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 Steamfitters Local 449 Medical & Benefit Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control, relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Steamfitters Local 449 Medical & Benefit Fund'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 Steamfitters Local 449 Medical & Benefit Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Steamfitters Local 449 Medical & Benefit Fund's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedule Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of (I) assets held at end of year at December 31, 2024 is presented for the purpose of additional analysis and is not a required part of the financial statements but is 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 schedule, we evaluated whether the supplemental schedule, including its form and content, is 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 schedule is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content is presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Henry Rossi & Co., LLP

Certified Public Accountants

September 29, 2025
Monroeville, Pennsylvania

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

	December 31	
	2024	2023
ASSETS:		
Investments at fair value	\$ 70,039,308	\$56,437,577
Accrued income	202,724	151,258
Employer contributions receivable	3,155,120	3,382,190
Reciprocal contributions receivable	122,617	201,417
Participant contributions receivable	76,027	96,305
Due from multiple funds account	5,059,775	4,916,436
Due from pension fund	-	831,411
Prepaid expenses	20,890	21,700
Operating cash - interest bearing	22,130,479	-
Operating cash - non-interest bearing	42,409	26,777,086
TOTAL ASSETS	100,849,349	92,815,380
LIABILITIES:		
Accounts payable	105,911	96,552
Reciprocal contributions payable	43,979	92,917
Due to Pension fund	271,740	-
TOTAL LIABILITIES	421,630	189,469
NET ASSETS AVAILABLE FOR BENEFITS	\$100,427,719	\$92,625,911

See notes to financial statements.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

	Year Ended December 31	
	2024	2023
CONTRIBUTIONS:		
Employer contributions	\$ 38,615,458	\$36,695,811
Participant contributions	4,557,170	4,656,264
Reciprocal contributions received	1,214,203	710,930
Reciprocal contributions paid	(618,525)	(243,359)
	43,768,306	41,819,646
INVESTMENT INCOME:		
Interest and dividend income	2,661,734	1,991,599
Net change in fair value of investments	1,086,193	3,237,241
Investment management fees	(167,833)	(90,926)
	3,580,094	5,137,914
OTHER INCOME	7,926	1,167
TOTAL ADDITIONS	47,356,326	46,958,727
BENEFITS:		
Insured	5,258,351	6,368,591
Self-insured	33,786,063	32,237,332
	39,044,414	38,605,923
OTHER DEDUCTIONS:		
Third party administrative fees	308,528	299,542
Legal expense	26,750	26,029
Other administrative expenses	92,511	47,016
Fiduciary and fidelity insurance	41,745	44,139
Audit fees	30,970	16,000
Actuarial services	9,600	9,600
	510,104	442,326
TOTAL DEDUCTIONS	39,554,518	39,048,249
NET INCREASE	7,801,808	7,910,478
NET ASSETS AVAILABLE FOR BENEFITS - Beginning of year	92,625,911	84,715,433
NET ASSETS AVAILABLE FOR BENEFITS - End of year	\$100,427,719	\$92,625,911

See notes to financial statements.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

STATEMENTS OF BENEFIT OBLIGATIONS

	December 31	
	2024	2023
Amounts currently payable:		
Self-funded benefits	\$ 819,461	\$ 344,507
Claims incurred but unreported	4,255,000	2,557,000
	5,074,461	2,901,507
Accumulated eligibility credits, net of amounts currently payable:		
Future benefits	11,066,000	10,440,000
Health reimbursement account	23,987,263	21,420,248
	35,053,263	31,860,248
Total obligations other than post-retirement benefit obligations	40,127,724	34,761,755
Post-retirement benefit obligations, net of amounts currently payable:		
Retired participants and beneficiaries	71,611,027	68,848,521
Active participants fully eligible to receive benefits	37,207,625	38,613,943
Active participants not yet eligible to receive benefits	78,965,492	86,822,532
	187,784,144	194,284,996
Total benefit obligations	\$227,911,868	\$229,046,751

See notes to financial statements.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

	Year Ended December 31	
	2024	2023
Amounts currently payable:		
Balance at beginning of year	\$ 2,901,507	\$ 3,944,711
Reported and approved for payment	36,962,368	35,005,719
Incurred but not reported	4,255,000	2,557,000
Claims paid	<u>(39,044,414)</u>	<u>(38,605,923)</u>
Balance at end of year	<u>5,074,461</u>	<u>2,901,507</u>
Accumulated eligibility credits, net of amounts currently payable:		
Balance at beginning of year	31,860,248	29,161,431
Net change during the year	<u>3,193,015</u>	<u>2,698,817</u>
Balance at end of year	<u>35,053,263</u>	<u>31,860,248</u>
Total obligations other than post-retirement benefit obligations	<u>40,127,724</u>	<u>34,761,755</u>
Post-retirement benefit obligations, net of amounts currently payable:		
Balance at beginning of year	194,284,996	194,849,094
Increase in benefits accumulated	7,457,246	7,094,369
Increase due to passage of time	9,991,850	10,449,551
Benefits paid during the year	(7,069,400)	(7,414,727)
Change in actuarial assumptions	(19,260,459)	7,416,578
Change in expected claims and self-pay rates	(2,513,720)	(22,372,094)
Experience loss (gain)	<u>4,893,631</u>	<u>4,262,225</u>
Balance at end of year	<u>187,784,144</u>	<u>194,284,996</u>
Total benefit obligations	<u>\$227,911,868</u>	<u>\$229,046,751</u>

See notes to financial statements.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

A. General:

The following description of the Steamfitters Local 449 Medical & Benefit Fund (the Plan) provides only general information. Participants should refer to the Plan Agreement for a more complete description of the Plan's provisions.

The Plan was formed in 1953 to provide employees who are members of Steamfitters Local 449 (the Union) with health and other benefits. The Plan provides health benefits (medical, hospital, surgical, major medical, vision, and dental), life insurance coverage, accident and sickness benefits, and death benefits to eligible participants and their beneficiaries and eligible dependents. An eligible retiree and his eligible dependents may use hours earned for continued active eligibility until depleted. For any subsequent eligibility, the retiree must make a retiree contribution for coverage to be extended. If the retiree or retiree's spouse is eligible for Medicare coverage, Part A and Part B, they must enroll for such coverage in order to participate in the retiree coverage offered under the Plan. Retired participants are eligible for reduced benefits. Effective January 1, 2016, the Plan became fully self-insured for current participants. Retired participants remain insured under the group insurance arrangements. Claims are processed by a third party claims processor. The claims processor pays claims on behalf of or directly to participants and is then reimbursed by the Plan. The Plan records these claims as benefits paid in the Statement of Changes in Net Assets Available for Benefits. The Plan has a healthcare reimbursement account program (HRA) that is funded solely through employer contributions. The HRA allows eligible participants to be reimbursed tax free for qualified medical expenses subject to a specified ceiling. Amounts remaining at the end of the year can generally be carried over to the next year. The employer is not permitted to refund any part of the balance to the employee and the account cannot be used for anything other than reimbursements for qualified medical expenses.

The Plan is administered by a Board of Trustees comprised of management and labor representatives. The Board of Trustees has overall responsibility for the operation and administration of the Plan.

An active member of the Union initially becomes eligible for benefits under the Plan as of the first day of February, May, August, or November after working a total of 400 or more credit hours during a qualifying work quarter. Participating employers contribute a fixed amount per hour pursuant to a collective bargaining agreement. Once eligible, employees are permitted to make contributions to make up any shortages during periods of unemployment. An eligible retiree may use the hours earned for continued eligibility until earned contributions are depleted. For any subsequent eligibility, the retiree must make a retiree contribution at the appropriate rate.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

B. Summary of Significant Accounting Policies:

Basis of Accounting - The financial statements of the Plan are prepared on the accrual basis of accounting.

Investment Valuation - Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The net change in fair value of investments consists of the net change in appreciation (depreciation) in fair value and gains and losses on sales of investments. The net appreciation (depreciation) of fair value of investments is determined by the change in fair value from the beginning of the year, if held for the entire year, to the date of sale, or from the date of purchase to the end of the year. Interest and dividend income is recognized on the accrual basis. The Trustees determine the Plan's valuation policies.

Employer Contributions - Employer contributions are recognized as net asset additions based upon the period the members performed the work. Accordingly, contributions receivable represent amounts collected subsequent to the reporting period but applicable to hours worked during the reporting period.

Allowance for Credit Losses - The Plan provides an allowance for credit losses based on Plan management's evaluation of year-end contributions receivable. The evaluation considers historical losses, expected future losses, the financial stability of the employers, and current economic conditions. No allowance was deemed necessary at December 31, 2024 and 2023.

Payment of Benefits - Benefits are recorded when paid by the Plan. Insurance premiums and amounts due to claims processors that have yet to be reimbursed by the Plan are recorded as accounts payable in the Statements of Benefit Obligations.

Reciprocal Agreements - The Plan has reciprocal agreements with other unions when participants perform work for other unions. The contribution rates are based on the Union contract. The agreements require that the contributions follow the employee.

Plan Expenses - The Plan pays administrative expenses that consist primarily of administrative fees, professional services fees and insurance. These expenses are included on the Statements of Changes in Net Assets Available for Benefits.

Estimated Liability for Claims Incurred but not Paid or Reported, Self-Funded Benefits - The estimated liability for claims incurred but not paid or reported, self-funded benefits is an amount computed by the Plan's consulting actuary on the basis of the historical experience relative to the time lag between incurrence of the claim and the reporting of such claim for payment.

Estimated Liability for Future Benefits - The Plan has received contributions that provide participants with coverage in periods subsequent to the end of its reporting period. The estimated cost of this coverage, computed by the Plan's consulting actuary on the basis of earned future eligibility, is recognized in the Statements of Benefit Obligations.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

B. Summary of Significant Accounting Policies (continued):

Cash - Operating cash represents amounts not invested and immediately available to pay benefits and obligations of the Plan. Operating cash consists of non-interest bearing checking accounts and linked interest bearing cash sweep accounts.

Stop Loss Insurance - Premiums for stop loss insurance are included in self-insured benefits payments in the Statements of Changes in Net Assets Available for Benefits. Stop loss premiums are \$900,721 and \$854,277 for the years ended December 31, 2024 and 2023, respectively. There were no stop loss refunds in 2024 or 2023.

Use of Estimates - The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results inevitably will differ from those estimates, and such differences may be material to the financial statements.

C. Fair Value Measurements:

The Plan has adopted the provisions of FASB ASC 820-10, which defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements. FASB ASC 820-10 describes a fair value hierarchy based on three levels of inputs of which the first two are considered observable and the last is considered unobservable.

The levels are defined as:

Level 1 - Quoted prices in active markets for identical assets.

Level 2 - Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets; quoted prices in markets that are not active; or inputs other than quoted prices that are observable.

Level 3 - Unobservable inputs that are supported by little or no market activity.

The following table represents the Plan's fair value hierarchy of investments held at December 31, 2024:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Interest bearing cash	\$ 2,237,539	\$ -	\$ -	\$ 2,237,539
U.S. Government securities	3,410,472	2,746,836	-	6,157,308
Corporate bonds	-	11,342,898	-	11,342,898
Common stocks	9,277,895	-	-	9,277,895
Mutual funds	41,023,668	-	-	41,023,668
	<u>\$55,949,574</u>	<u>\$14,089,734</u>	<u>\$ -</u>	<u>\$70,039,308</u>

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

C. Fair Value Measurements (continued):

Common stocks are valued at closing price reported on the active market on which the individual securities are traded. Corporate bonds are based on quoted market prices of values using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings. Mutual funds are valued at the daily closing price as reported by the fund. U.S. Government securities are valued using pricing models maximizing the use of observable inputs for similar securities. The Plan invests in a number of funds that invest in holdings which are not traded on an exchange and whose fair value is determined by the fund's trustees based on a variety of methods. These methods may include but are not limited to, cost, amortized cost, comparable sales, capitalization of earnings, or discounted cash flow. The funds usually provide the fund's managers and accountants varying levels of flexibility in determining methods used to value the Plan's assets. The fund's managers and accountants are charged with determining methods which are consistent and best reflect the fair value of the underlying investments. In addition, certain funds provide for a review of valuation methods and pricing by a board of trustees with oversight responsibility regarding the fund. However, normally, value determinations by the fund's managers or advisors are deemed final.

In addition, the funds are valued based on predetermined valuation dates which can occur periodically; monthly or yearly. Individuals valuing funds may be faced with a conflict of interest as such values may determine their compensation.

Unfunded Commitments:

The Plan had no unfunded commitments at December 31, 2024 and 2023.

The following table represents the Plan's fair value hierarchy of investments held at December 31, 2023:

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
Interest bearing cash	\$ 1,906,520	\$ -	\$ -	\$ 1,906,520
U.S. Government securities	2,453,920	1,992,194	-	4,446,114
Corporate bonds	-	9,285,157	-	9,285,157
Common stocks	8,431,036	-	-	8,431,036
Mutual funds	<u>32,368,750</u>	<u>-</u>	<u>-</u>	<u>32,368,750</u>
	<u>\$45,160,226</u>	<u>\$11,277,351</u>	<u>\$ -</u>	<u>\$56,437,577</u>

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

C. Fair Value Measurements (continued):

Transfers Between Levels - The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another.

The Plan evaluates the significance of transfers between levels based upon the nature of the financial instrument and size of the transfer relative to total net assets available for benefits. There were no transfers between fair value levels during the years ended December 31, 2024 and 2023.

D. Investments:

The composition of the investments held by the Plan is as follows:

	December 31, 2024	
	Cost	Current Value
Interest bearing cash	\$ 2,237,539	\$ 2,237,539
U.S. Government securities	6,493,035	6,157,308
Corporate bonds	11,558,340	11,342,898
Common stocks	4,914,034	9,277,895
Mutual funds	40,249,812	41,023,668
	\$65,452,760	\$70,039,308
	December 31, 2023	
	Cost	Current Value
Interest bearing cash	\$ 1,906,520	\$ 1,906,520
U.S. Government securities	4,682,627	4,446,114
Corporate bonds	9,805,033	9,285,157
Common stocks	4,671,628	8,431,036
Mutual funds	31,944,233	32,368,750
	\$53,010,041	\$56,437,577

E. Healthcare Reimbursement Account Program:

Participating employers currently contribute \$2.00 per hour worked to a participant's Healthcare Reimbursement Account (HRA). These are individual accounts for the benefit of each member and are available to each member as needed. Total claims paid from these accounts was \$3,782,492 and \$3,372,746 for the years ended December 31, 2024 and 2023, respectively. The total balance of these accounts at December 31, 2024 and 2023 was \$23,987,263 and \$21,420,248, respectively.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

F. Income Tax Status:

The Plan obtained a favorable determination letter in which the Internal Revenue Service stated that the Plan is qualified under Section 501(c)(9) of the Internal Revenue Code and is exempt from income tax under Section 501(a) of the Code. The Trustees believe that the Plan, as amended, continues to qualify and operate as designed.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. The Plan Administrator has analyzed the tax positions taken by the Plan, and has concluded that there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

G. Post-retirement Benefit Obligation:

A post-retirement benefit obligation has been recognized for retiree medical benefits for eligible participants and their dependents upon retirement. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to employee service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current retirees. The obligations represent the amounts that are expected to be funded by contributions and from existing assets of the Plan. Post-retirement benefits include future benefits expected to be paid to or for (a) currently retired or terminated employees and their beneficiaries and dependents, and (b) active employees and their beneficiaries and dependents after retirement from service.

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

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

G. Post-retirement Benefit Obligation (continued):

The Plan is required to provide benefits to certain members, if such members have accumulated credit amounts in excess of that required for current coverage. Participants draw on their accumulated credits whenever they fail to meet the annual requirement. The estimated future liability represents the present value of an extension of future benefits.

The actuary determined the accumulated post-retirement benefit obligation of the Plan, using the following significant actuarial assumptions as of December 31, 2024:

Discount rate	5.66% - 2024; 5.04% - 2023
Health trend rates:	
Non-Medicare Medical & Prescription Drug	Assumed to decrease by .55% for 2025 and then decrease by .60% per year thereafter to 2029, and then .20% in 2030 to an ultimate rate of 4.85% per year.
Medicare Medical & Prescription Drug	Assumed to decrease by .20% for 2025 through 2028 to an ultimate rate of 4.85% per year.
Vision costs	Assumed to increase at a rate of 2% per year.
Dental costs	Assumed to increase at a rate of 2% per year.
Employee Assistance Program	Costs are assumed to increase at a rate of 1.25% per year.
Administrative expense increase rate	Administrative expenses are assumed to be 2.5% of base year claims and will increase at the rate of 2.75% per year.
Retiree contribution increase rate	Retirees who retired prior to 1993 - 1% per year. Retirees who retired during 1993 and after - 2% per year.
Pre-retirement mortality	RP-2014 Blue Collar Sex Distinct Mortality Tables adjusted back to 2006 then projected forward fully generational using Scale MP-2021.
Post-retirement mortality	RP-2014 Blue Collar Sex Distinct Mortality Tables adjusted back to 2006 then projected forward fully generational using Scale MP-2021.
Post-disability mortality	RP-2014 Blue Collar Sex Distinct Mortality Tables adjusted back to 2006 then projected forward fully generational using Scale MP-2021.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

G. Post-retirement Benefit Obligation (continued):

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 2024 by \$41,912,569 and as of December 31, 2023 by \$46,355,689.

H. Risks and Uncertainties:

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the Statement of Net Assets Available for Benefits.

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

Cash consists of checking accounts the Plan maintains with a reputable financial institution that is insured with the Federal Deposit Insurance Corporation (FDIC). All accounts are insured up to \$250,000 by the FDIC. As of December 31, 2024, deposits of \$21,922,888 were in excess of insured amounts. The Plan has not experienced any losses in its cash balances and does not believe it is subject to any significant credit risk.

I. Termination of the Plan:

Although they have not expressed any intent to do so, the Trustees may terminate the Plan in whole or in part at any time and for any reason. In the event of Plan termination, benefits for covered expenses incurred prior to the termination date fixed by the Trustees will be paid to eligible individuals as long as the Plan's assets exceed its liabilities. Full benefits may not be paid if the Plan's liabilities exceed its assets. Excess assets, if any, then remaining after the payment of all the Plan liabilities, will be utilized for purposes similar to the Plan's present purposes.

J. Management Evaluation of Subsequent Events:

Management's representations and estimates include evaluations of subsequent events through September 29, 2025, the date which the financial statements were available to be issued.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

K. Reconciliation of Financial Statements to Schedule H of Form 5500:

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

	December 31	
	2024	2023
Net assets available for benefits per the financial statements	\$100,427,719	\$92,625,911
Benefit obligations currently payable	<u>(5,074,461)</u>	<u>(2,901,507)</u>
Net assets available for benefits per Schedule H of the Form 5500	<u>\$ 95,353,258</u>	<u>\$89,724,404</u>

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

	December 31	
	2024	2023
Benefits paid for participants per the financial statements	\$39,044,414	\$38,605,923
Amounts payable at end of year	5,074,461	2,901,507
Amounts payable at beginning of year	<u>(2,901,507)</u>	<u>(3,944,711)</u>
Benefits paid for participants per Form 5500	<u>\$41,217,368</u>	<u>\$37,562,719</u>

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

	December 31	
	2024	2023
Net increase per the financial statements	\$ 7,801,808	\$ 7,910,478
Subtract change in benefits payable	<u>(2,172,954)</u>	<u>(1,043,204)</u>
Net increase per Form 5500	<u>\$ 5,628,854</u>	<u>\$ 8,953,682</u>

Claims and premiums that have been processed and approved for payment at year end, but not paid and claims incurred but not reported are not considered liabilities under GAAP; therefore these claims and premiums are not presented as liabilities or claims and premiums paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

(Continued)

L. Collective Bargaining Agreement:

The Plan is part of a collective bargaining agreement that requires participating employers to contribute on behalf of their eligible employees certain amounts to the Plan. This collective bargaining agreement expires on May 31, 2026.

M. Concentrations:

There were no concentrations as of and for the year ended December 31, 2024.

As of and for the year ended December 31, 2023, approximately 10% of the Plan's employer contributions and approximately 19% of the Plan's employer contributions receivable are from one contributing employer.

N. Party-in-Interest and Related Party Transactions:

The Plan pays certain administrative, investment, and professional fees to various service providers. The Plan is also administered and transacts with related organizations Steamfitters Local 449 Pension Fund and Steamfitters Local 449 Retirement Security Fund. Certain Plan assets are in a PNC Money Market. PNC is the custodian of the Plan. Therefore, this qualifies as a party-in-interest transaction. None of these transactions are considered ERISA prohibited transactions.

SUPPLEMENTAL INFORMATION

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

EIN 25-6032450 - PLAN NO. 501

SCHEDULE I - ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

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

(a.)	(b.) Identity of Issue, Borrower or Similar Party	(c.) Description of Investments	(d.) Cost	(e.) Fair Value
	Federated Gov Ultrashort Dur Fund	Mutual fund	\$14,924,227	\$14,924,183
	Western Asset Core Plus Bond	Mutual fund	13,738,943	13,118,585
*	PNC Money Market	Interest bearing cash	192,386	192,386
	Chartwell	Interest bearing cash	274,413	274,413
	Chartwell	Corporate bonds	8,107,581	8,076,282
	JP Morgan	Interest bearing cash	1,317,299	1,317,299
	JP Morgan	Mutual fund	7,336,642	6,541,094
	Boyd Watterson	Interest bearing cash	87,430	87,430
	Boyd Watterson	Corporate bonds	3,450,759	3,266,616
	Boyd Watterson	U.S. Government sec.	6,493,035	6,157,308
	Winslow	Interest bearing cash	366,011	366,011
	Winslow	Common stocks	4,914,034	9,277,895
	Blackrock Equity Index	Mutual fund	<u>4,250,000</u>	<u>6,439,806</u>
			<u>\$65,452,760</u>	<u>\$70,039,308</u>

* Party-in-interest.

See independent auditor's report.

STEAMFITTERS LOCAL 449
MEDICAL & BENEFIT FUND

EIN 25-6032450 - PLAN NO. 501

SCHEDULE I - ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

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

(a.)	(b.) Identity of Issue, Borrower or Similar Party	(c.) Description of Investments	(d.) Cost	(e.) Fair Value
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See independent auditor's report.