

|   |   |   |
|---|---|---|
| <p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor<br/>Employee Benefits Security<br/>Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p style="text-align: center;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p> | <p style="font-size: x-small;">OMB Nos. 1210-0110<br/>1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold; text-align: center;">2024</p> <hr/> <p style="text-align: center; font-weight: bold;">This Form is Open to Public Inspection</p> |
|---|---|---|

**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><b>1a</b> Name of plan<br/><u>CLYDE COMPANIES BENEFITS PLAN</u></p>   | <p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>   |
| <p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br/>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br/>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br/><u>CLYDE COMPANIES</u></p> <p><u>730 N 1500 W</u> <span style="margin-left: 200px;"><u>730 N 1500 W</u></span><br/><u>OREM, UT 84057</u> <span style="margin-left: 200px;"><u>OREM, UT 84057</u></span></p> | <p><b>1c</b> Effective date of plan<br/><u>01/01/2015</u></p> <p><b>2b</b> Employer Identification Number (EIN)<br/><u>87-0260879</u></p> <p><b>2c</b> Plan Sponsor's telephone number<br/><u>801-270-6747</u></p> <p><b>2d</b> Business code (see instructions)<br/><u>551112</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.

|                  |   |            |  |
|------------------|---|------------|--|
| <b>SIGN HERE</b> | Filed with authorized/valid electronic signature. | 10/13/2025 | MICHELLE HILL  |
|                  | Signature of plan administrator                   | Date       | Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> |   |            |  |
|                  | Signature of employer/plan sponsor                | Date       | Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> |   |            |  |
|                  | Signature of DFE                                  | Date       | Enter name of individual signing as DFE                      |

|   |  |      |
|---|--|------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor  | <b>3b</b> Administrator's EIN              |      |
|   | <b>3c</b> Administrator's telephone number |      |
| <b>4</b> 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:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name  | <b>4b</b> EIN                              |      |
|   | <b>4d</b> PN                               |      |
| <b>5</b> Total number of participants at the beginning of the plan year   | <b>5</b>                                   | 2912 |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | <b>6a(1)</b>                               | 2912 |
|   | <b>6a(2)</b>                               | 2974 |
|   | <b>6b</b>                                  |      |
|   | <b>6c</b>                                  |      |
|   | <b>6d</b>                                  | 2974 |
|   | <b>6e</b>                                  |      |
|   | <b>6f</b>                                  |      |
|   | <b>6g(1)</b>                               |      |
| <b>6g(2)</b>  |  |      |
| <b>6h</b>   |  |      |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....  | <b>7</b>                                   |      |

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

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

|   |   |
|---|---|
| <b>9a</b> Plan funding arrangement (check all that apply)               | <b>9b</b> 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)

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

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

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**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.

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**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 \_\_\_\_\_

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|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>CLYDE COMPANIES BENEFITS PLAN</b></p>                           | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>CLYDE COMPANIES</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>87-0260879</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**RECURO HEALTH**

| (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     |
| 86-1571589 | 62199         | 622794                                | 2963  | 01/01/2024              | 12/31/2024 |

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

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

**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.

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

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

**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) ▶ **TELEHEALTH & WELLNESS MEMBERSHIP**

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |       |
|----------|--|------------|-------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 72620 |
| <b>b</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. .... | <b>10b</b> |       |

Specify nature of costs.

**Part IV Provision of Information**

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

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

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>CLYDE COMPANIES BENEFITS PLAN</b></p>                           | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>CLYDE COMPANIES</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>87-0260879</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**COMMENCEMENT BAY RISK MANAGEMENT INSURANCE**

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 91-1571623 | 78879         | 10012928                              | 8193  | 01/01/2024              | 12/31/2024 |

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

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

**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

**BEEHIVE INSURANCE AGENCY INC** **PO BOX 571431**  
**MURRAY, UT 84157**

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

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

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

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|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   |                                 |             |                       |

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|   |                                 |             |                       |

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|   |                                 |             |                       |

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|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
|   |                                 |             |                       |

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

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

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

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

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

**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:

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

**10** Nonexperience-rated contracts:

|          |  |            |         |
|----------|--|------------|---------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 1952642 |
| <b>b</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. .... | <b>10b</b> |         |

Specify nature of costs.

**Part IV Provision of Information**

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

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

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>CLYDE COMPANIES BENEFITS PLAN</b></p>                           | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>CLYDE COMPANIES</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>87-0260879</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**GUARDIAN**

| (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     |
| 13-5123390 | 62424         | 00055294                              | 3722  | 01/01/2024              | 12/31/2024 |

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

|  |  |
|--|--|
| <p><b>(a)</b> Total amount of commissions paid<br/><b>644777</b></p> | <p><b>(b)</b> Total amount of fees paid<br/><b>0</b></p> |
|--|--|

**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  
**BEEHIVE INSURANCE AGENCY INC** **4393 SOUTH RIVERBOAT ROAD, SUI**  
**SALT LAKE CITY, UT 84123**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 644777  |                                 |             |                       |

**(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.

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|   |            |         |
|---|------------|---------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 3636150 |
| <b>b</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. ....<br>Specify nature of costs. | <b>10b</b> |         |

**Part IV Provision of Information**

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

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

|   |  |  |
|---|--|--|
| <p><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|--|

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

|   |  |                   |
|---|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>CLYDE COMPANIES BENEFITS PLAN</b></p>                           | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>CLYDE COMPANIES</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>87-0260879</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**SPRING HEALTH**

| (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     |
| 81-2832914 | 62199         |                                       | 3024  | 01/01/2024              | 12/31/2024 |

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

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

**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.

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

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

**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:

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

**10** Nonexperience-rated contracts:

|          |  |            |        |
|----------|--|------------|--------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 213438 |
| <b>b</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. .... | <b>10b</b> |        |

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**

|   |  |  |
|---|--|--|
| <b>A</b> Name of plan<br><b>CLYDE COMPANIES BENEFITS PLAN</b>                           |  | <b>B</b> Three-digit plan number (PN) ▶ <b>501</b>                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>CLYDE COMPANIES</b> |  | <b>D</b> Employer Identification Number (EIN)<br><b>87-0260879</b> |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**VISION SERVICE PLAN**

| <b>(b)</b> EIN    | <b>(c)</b> NAIC code | <b>(d)</b> Contract or identification number | <b>(e)</b> Approximate number of persons covered at end of policy or contract year | <b>Policy or contract year</b> |                   |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
|                   |                      |  |  | <b>(f)</b> From                | <b>(g)</b> To     |
| <b>06-1227840</b> | <b>39616</b>         | <b>40156499</b>                              | <b>3172</b>  | <b>01/01/2024</b>              | <b>12/31/2024</b> |

**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.

|  |  |
|--|--|
| <b>(a)</b> Total amount of commissions paid<br><b>1584</b> | <b>(b)</b> Total amount of fees paid<br><b>49750</b> |
|--|--|

**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

**EMPLOYEE NAVIGATOR, LLC**  
**7979 OLD GEORGETOWN RD STE 300**  
**BETHESDA, MD 20814-2554**

| <b>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> Purpose |                              |
| <b>1584</b>  | <b>49750</b>                           |                    |                              |

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

| <b>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> 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.

|  |          |  |
|--|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....    | <b>5</b> |  |

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

**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:

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

**10** Nonexperience-rated contracts:

|   |            |        |
|---|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 349710 |
| <b>b</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. ....<br>Specify nature of costs. | <b>10b</b> |        |

**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. ▶

|  |  |   |
|--|--|---|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>▶ File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection.</b> |
|--|--|---|

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

|   |  |            |
|---|--|------------|
| <b>A</b> Name of plan<br><b>CLYDE COMPANIES BENEFITS PLAN</b>                           | <b>B</b> Three-digit plan number (PN) ▶                            | <b>501</b> |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>CLYDE COMPANIES</b> | <b>D</b> Employer Identification Number (EIN)<br><b>87-0260879</b> |            |

**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

**REGENCE BLUECROSS BLUESHIELD OF UTA**                      **2890 EAST COTTOWNWOOD PKWY**  
**SALT LAKE CITY, UT 84121**

**87-0200138**

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

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

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

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

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

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

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

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

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

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

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

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**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)

REGENGE BLUECROSS BLUESHIELD OF UTA

2890 EAST COTTOWNWOOD PKWY  
SALT LAKE CITY, UT 84121

87-0200138

| (b)<br>Service Code(s)     | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|----------------------------|---|--|--|--|---|--|
| 12 13 49<br>50 53 56<br>62 | CLAIMS<br>PROCESSING  | 1743603  | Yes <input type="checkbox"/> No <input type="checkbox"/>   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | 0   | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                          |

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

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>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      |
|---|--|--|
| REGENCE BLUECROSS BLUESHIELD OF UTA   | 12 13 49 50 53 56 62   | 0  |
| (d) Enter name and EIN (address) of source of indirect compensation<br>REGENCE BLUECROSS BLUESHIELD 2890 E COTTONWOOD PKWY SALT LAKE CITY, UT 84121<br>87-0200138 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br>\$1.53 MULTIPLIED BY THE NUMBER OF ELECTRONIC CLAIMS.        |  |
| (a) Enter service provider name as it appears on line 2<br>REGENCE BLUECROSS BLUESHIELD OF UTA  | (b) Service Codes (see instructions)<br>12 13 49 50 53 56 62   | (c) Enter amount of indirect compensation<br>0 |
| (d) Enter name and EIN (address) of source of indirect compensation<br>REGENCE BLUECROSS BLUESHIELD 2890 E COTTONWOOD PKWY SALT LAKE CITY, UT 84121<br>87-0200138 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br>\$2.50 MULTIPLIED BY THE NUMBER OF PAPER CLAIMS              |  |
| (a) Enter service provider name as it appears on line 2<br>REGENCE BLUECROSS BLUESHIELD OF UTA  | (b) Service Codes (see instructions)<br>12 13 49 50 53 56 62   | (c) Enter amount of indirect compensation<br>0 |
| (d) Enter name and EIN (address) of source of indirect compensation<br>REGENCE BLUECROSS BLUESHIELD 2890 E COTTONWOOD PKWY SALT LAKE CITY, UT 84121<br>87-0200138 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br>\$225 MULTIPLIED BY THE NUMBER OF PHARMACY APPEALS - MEDICAL |  |

**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 |
|--|--|---|
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$100 MULTIPLIED BY THE NUMBER OF PHARMACY APPEALS - PHARMACY  |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | A RANGE OF \$40-\$55 MULTIPLIED BY THE NUMBER OF CLINICAL AUDIT.   |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$174 CHARGED PER HOUR IN 15 MINUTE INCREMENTS FOR EXT CLINIC.   |   |

**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 |
|--|--|---|
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$5,000 MULTIPLIED BY THE NUMBER OF PHARMACY DATA EXTRACTION   |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$0.08 MULTIPLIED BY THE NUMBER OF EPREScribe CLAIMS.  |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$6.50 MULTIPLIED BY THE NUMBER OF FOREIGN CLAIMS.   |   |

**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 |
|--|--|---|
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84062<br><br>87-0200138 | \$100 MULTIPLIED BY THE NUMBER OF CLAIMS ADJUSTED  |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$2.50 MULTIPLIED BY THE NUMBER OF TRANSITIONAL FILL LETTERS   |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$1.25 MULTIPLIED BY THE NUMBER OF AUTORENEW NOTIFICATIONS.  |   |

**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 |
|--|--|---|
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$2.25 MULTIPLIED BY THE NUMBER OF SMART RENEW NOTIFICATIONS   |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$13.00 MULTIPLIED BY THE NUMBER OF HIGH COST DRUG EXCLUSION   |   |
| (a) Enter service provider name as it appears on line 2  | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
| REGENCE BLUECROSS BLUESHIELD OF UTA  | 12 13 49 50 53 56 62   | 0   |
| (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. |   |
| REGENCE BLUECROSS BLUESHIELD<br>2890 E COTTONWOOD PKWY<br>SALT LAKE CITY, UT 84121<br><br>87-0200138 | \$0.03 MULTIPLIED BY THE NUMBER OF POINT-OF-SALE REBATES   |   |

**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 |
|---|--|---|
| REGENCE BLUECROSS BLUESHIELD OF UTA   | 12 13 49 50 53 56 62   | 0   |
| (d) Enter name and EIN (address) of source of indirect compensation<br>REGENCE BLUECROSS BLUESHIELD 2890 E COTTONWOOD PKWY SALT LAKE CITY, UT 84121<br>87-0200138 | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.<br>\$13.00 MULTIPLIED BY THE NUMBER OF CONCIERGE OUTREACH PROGRAM CASES |   |
| (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.

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

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

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

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

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

| <b>(a)</b> Enter name and EIN or address of service provider (see instructions) | <b>(b)</b> Nature of Service Code(s) | <b>(c)</b> 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)

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |

Explanation:

|  |  |   |
|--|--|---|
| <b>SCHEDULE H</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|--|--|---|

|  |  |
|--|--|
| For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b> |  |
| <b>A</b> Name of plan<br><b>CLYDE COMPANIES BENEFITS PLAN</b>  | <b>B</b> Three-digit plan number (PN) ▶ <b>501</b>                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>CLYDE COMPANIES</b>                  | <b>D</b> Employer Identification Number (EIN)<br><b>87-0260879</b> |

|               |                                      |
|---------------|--------------------------------------|
| <b>Part I</b> | <b>Asset and Liability Statement</b> |
|---------------|--------------------------------------|

**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 |
|--|-----------------|-----------------------|-----------------|
| <b>Assets</b>  |                 |                       |                 |
| <b>a</b> Total noninterest-bearing cash .....  | <b>1a</b>       | 523730                | 1819961         |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....  | <b>1b(1)</b>    |                       |                 |
| <b>(2)</b> Participant contributions .....   | <b>1b(2)</b>    | 26828                 |                 |
| <b>(3)</b> Other .....   | <b>1b(3)</b>    |                       |                 |
| <b>c</b> General investments:  |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....   | <b>1c(1)</b>    |                       |                 |
| <b>(2)</b> U.S. Government securities .....  | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                            |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....   | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....  | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....   | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                   | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....  | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....   | <b>1c(8)</b>    |                       |                 |
| <b>(9)</b> Value of interest in common/collective trusts .....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                    | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                            | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....        | <b>1c(13)</b>   |                       |                 |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) ..... | <b>1c(14)</b>   |                       |                 |
| <b>(15)</b> Other .....  | <b>1c(15)</b>   |                       |                 |

| 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    | 550558                | 1819961         |
| <b>Liabilities</b>  |       |                       |                 |
| g Benefit claims payable.....                                     | 1g    |                       |                 |
| h Operating payables.....   | 1h    |                       |                 |
| i Acquisition indebtedness.....                                   | 1i    |                       |                 |
| j Other liabilities.....  | 1j    |                       |                 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k    |                       |                 |
| <b>Net Assets</b>   |       |                       |                 |
| l Net assets (subtract line 1k from line 1f).....                 | 1l    | 550558                | 1819961         |

**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.

| <b>Income</b>  |          | (a) Amount | (b) Total |
|--|----------|------------|-----------|
| <b>a Contributions:</b>  |          |            |           |
| (1) Received or receivable in cash from: (A) Employers.....                                  | 2a(1)(A) | 39713340   |           |
| (B) Participants.....  | 2a(1)(B) | 9476699    |           |
| (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)    |            | 49190039  |
| <b>b Earnings on investments:</b>  |          |            |           |
| (1) Interest:  |          |            |           |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) |            |           |
| (B) U.S. Government securities.....  | 2b(1)(B) |            |           |
| (C) Corporate debt instruments.....  | 2b(1)(C) |            |           |
| (D) Loans (other than to participants).....  | 2b(1)(D) |            |           |
| (E) Participant loans.....   | 2b(1)(E) |            |           |
| (F) Other.....   | 2b(1)(F) |            |           |
| (G) Total interest. Add lines 2b(1)(A) through (F).....                                      | 2b(1)(G) |            |           |
| (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) |            |           |
| (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 .....                              | <b>2b(6)</b>  |            |           |
| (7) Net investment gain (loss) from pooled separate accounts .....                              | <b>2b(7)</b>  |            |           |
| (8) Net investment gain (loss) from master trust investment accounts .....                      | <b>2b(8)</b>  |            |           |
| (9) Net investment gain (loss) from 103-12 investment entities .....                            | <b>2b(9)</b>  |            |           |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) ..... | <b>2b(10)</b> |            |           |
| <b>c</b> Other income .....   | <b>2c</b>     |            |           |
| <b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....        | <b>2d</b>     |            | 49190039  |

**Expenses**

|   |               |          |          |
|---|---------------|----------|----------|
| <b>e</b> Benefit payment and payments to provide benefits:                                  |               |          |          |
| (1) Directly to participants or beneficiaries, including direct rollovers .....             | <b>2e(1)</b>  | 38936078 |          |
| (2) To insurance carriers for the provision of benefits .....                               | <b>2e(2)</b>  | 6920671  |          |
| (3) Other .....   | <b>2e(3)</b>  |          |          |
| (4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....                 | <b>2e(4)</b>  |          | 45856749 |
| <b>f</b> Corrective distributions (see instructions) .....                                  | <b>2f</b>     |          |          |
| <b>g</b> Certain deemed distributions of participant loans (see instructions) .....         | <b>2g</b>     |          |          |
| <b>h</b> Interest expense .....   | <b>2h</b>     |          |          |
| <b>i</b> Administrative expenses:   |               |          |          |
| (1) Salaries and allowances .....   | <b>2i(1)</b>  |          |          |
| (2) Contract administrator fees .....   | <b>2i(2)</b>  |          |          |
| (3) Recordkeeping fees .....  | <b>2i(3)</b>  |          |          |
| (4) IQPA audit fees .....   | <b>2i(4)</b>  |          |          |
| (5) Investment advisory and investment management fees .....                                | <b>2i(5)</b>  |          |          |
| (6) Bank or trust company trustee/custodial fees .....                                      | <b>2i(6)</b>  |          |          |
| (7) Actuarial fees .....  | <b>2i(7)</b>  |          |          |
| (8) Legal fees .....  | <b>2i(8)</b>  |          |          |
| (9) Valuation/appraisal fees .....  | <b>2i(9)</b>  |          |          |
| (10) Other trustee fees and expenses .....  | <b>2i(10)</b> |          |          |
| (11) Other expenses .....   | <b>2i(11)</b> | 2063887  |          |
| (12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....        | <b>2i(12)</b> |          | 2063887  |
| <b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | <b>2j</b>     |          | 47920636 |

**Net Income and Reconciliation**

|   |              |  |         |
|---|--------------|--|---------|
| <b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> ..... | <b>2k</b>    |  | 1269403 |
| <b>l</b> Transfers of assets:   |              |  |         |
| (1) To this plan .....  | <b>2l(1)</b> |  |         |
| (2) From this plan .....  | <b>2l(2)</b> |  |         |

**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: **SQUIRE & COMPANY, PC**

(2) EIN: **87-0343246**

**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 |
|--|-----|----|--------|
| <b>a</b> 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>b</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  |        |
| <b>c</b> 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  |        |
| <b>d</b> 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  |        |
| <b>e</b> Was this plan covered by a fidelity bond?   | X   |    | 500000 |
| <b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?  |     | X  |        |
| <b>g</b> 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  |        |
| <b>h</b> 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  |        |
| <b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)   |     | X  |        |
| <b>j</b> 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  |        |
| <b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?  |     | X  |        |
| <b>l</b> Has the plan failed to provide any benefit when due under the plan?   |     | X  |        |
| <b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)   |     | X  |        |
| <b>n</b> 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.)

| <b>5b(1)</b> Name of plan(s) | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> 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 \_\_\_\_\_.

**CLYDE COMPANIES, INC.  
WELFARE BENEFITS PLAN AND TRUST**

**FINANCIAL STATEMENTS**

Years Ended December 31, 2024 and 2023

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## INDEPENDENT AUDITOR'S REPORT

The Trustees  
Clyde Companies, Inc. Welfare Benefits Plan and Trust

### ***Opinion***

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

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial status of Clyde Companies, Inc. Welfare Benefits Plan and Trust as of December 31, 2024 and 2023, and the changes in its financial status for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### ***Basis for Opinion***

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Clyde Companies, Inc. Welfare Benefits Plan and Trust 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 Clyde Companies, Inc. Welfare Benefits Plan and Trust's ability to continue as a going concern for one year after the date that the financial statements are 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 GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Clyde Companies, Inc. Welfare Benefits Plan and Trust'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 Clyde Companies, Inc. Welfare Benefits Plan and Trust'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.

### ***Other Matter—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 assets (held at end of year) is presented for purposes 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 GAAS.

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 supplemental schedule is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

*Squire & Company, PC*

Orem, Utah  
October 13, 2025

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**

December 31, 2024 and 2023

|  | 2024                       | 2023                     |
|--|----------------------------|--------------------------|
| <b>ASSETS</b>                            |                            |                          |
| <b>Cash</b>                              | \$ 1,819,961               | \$ 523,730               |
| <b>Prepaid Expenses</b>                  | <u>-</u>                   | <u>26,828</u>            |
| Total assets                             | 1,819,961                  | 550,558                  |
| <b>LIABILITIES</b>                       |                            |                          |
|  | <u>-</u>                   | <u>-</u>                 |
| <b>Net Assets Available for Benefits</b> | <u><u>\$ 1,819,961</u></u> | <u><u>\$ 550,558</u></u> |

The accompanying notes are an integral part of these financial statements.

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**

Years Ended December 31, 2024 and 2023

|   | 2024         | 2023         |
|---|--------------|--------------|
| <b>Additions to Net Assets:</b>                               |              |              |
| Contributions:  |              |              |
| Participant   | \$ 9,476,699 | \$ 7,853,824 |
| Employer  | 39,713,340   | 38,174,426   |
| Total contributions   | 49,190,039   | 46,028,250   |
| <b>Deductions from Net Assets:</b>                            |              |              |
| Benefits paid to or on behalf of participants                 | 38,936,078   | 38,122,590   |
| Insurance premiums:   |              |              |
| Stop loss policy  | 1,952,642    | 1,809,314    |
| Medical insurance   | 687,102      | 93,141       |
| Life insurance  | 4,280,927    | 2,969,293    |
| Total insurance premiums                                      | 6,920,671    | 4,871,748    |
| Administrative fees - claims processing                       | 2,063,887    | 2,489,890    |
| Total deductions  | 47,920,636   | 45,484,228   |
| <b>Net Increase</b>   | 1,269,403    | 544,022      |
| <b>Net Assets Available for Benefits at Beginning of Year</b> | 550,558      | 6,536        |
| <b>Net Assets Available for Benefits at End of Year</b>       | \$ 1,819,961 | \$ 550,558   |

The accompanying notes are an integral part of these financial statements.

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**STATEMENTS OF BENEFIT OBLIGATIONS**

December 31, 2024 and 2023

|   | 2024                | 2023                |
|---|---------------------|---------------------|
| <b>Amounts Currently Payable:</b>                   |                     |                     |
| Claims payable and claims incurred but not reported | \$ 8,207,519        | \$ 5,173,393        |
| Premiums due to insurers                            | <u>153,242</u>      | <u>346,500</u>      |
| <b>Total Benefit Obligations</b>                    | <u>\$ 8,360,761</u> | <u>\$ 5,519,893</u> |

The accompanying notes are an integral part of these financial statements.

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

Years Ended December 31, 2024 and 2023

|                                   | 2024                       | 2023                       |
|-----------------------------------|----------------------------|----------------------------|
| <b>Amounts Currently Payable:</b> |                            |                            |
| Balance at beginning of year      | \$ 5,519,893               | \$ 4,892,272               |
| Claims and premiums incurred      | 48,697,617                 | 43,621,959                 |
| Claims and premiums paid          | <u>(45,856,749)</u>        | <u>(42,994,338)</u>        |
| <b>Balance at End of Year</b>     | <b><u>\$ 8,360,761</u></b> | <b><u>\$ 5,519,893</u></b> |

The accompanying notes are an integral part of these financial statements.

## **CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**

### **NOTES TO THE FINANCIAL STATEMENTS**

---

#### **NOTE 1 – DESCRIPTION OF PLAN**

The following description of the Clyde Companies, Inc. Welfare Benefits Plan and Trust (the Plan) provides only general information about the Plan's provisions. Participants should refer to the Plan agreement for a more complete description of the provisions of the Plan.

#### **General**

The Plan is a health and welfare benefit plan covering all full-time employees of Clyde Companies, Inc. and Subsidiaries (the Company). The Company is comprised of Clyde Companies, Inc. and its wholly-owned subsidiaries: W. W. Clyde & Co (W. W. Clyde), DDF, Inc. (DDF), Geneva Rock Products, Inc. (Geneva), Interstate Highway Construction (IHC), Bridgesource, LLC (Bridgesource), Scott Contracting, Inc. (Scott), Sunroc Corporation (Sunroc), Beehive Insurance Agency, Inc. (Beehive), Sunpro Corporation (Sunpro), and GWC Capital (GWC). The Company primarily operates in construction services and as a materials manufacturer and supplier.

Certain Plan assets are held in a voluntary employees' beneficiary association (VEBA) trust. The Plan is subject to the provisions of the Employee Retirement Security Act of 1974, as amended (ERISA).

#### **Contributions**

The Plan is funded by the Company and participant contributions. Participants contribute specified amounts based on Company policy and respective benefit elections. The Company makes contributions to the Plan based on Company policy. The Company also contributes to the Plan as needed to fund claims in excess of participant contributions. Any deficiency of the Plan's net assets over benefit obligations is funded by the Company on a pay-as-you-go basis.

#### **Benefits**

Effective June 1, 1979, the Company adopted a group insurance plan which covers medical, dental, vision, life, and accidental death and disability (AD&D) benefits for eligible employees. The Plan provides health, dental, and AD&D benefits to substantially all employees of the Company. The Plan was a partially self-insured program designed to pool and spread health care risks of participants from inception to January 31, 2005. The medical health plan was changed to a fully-insured plan and brought into the Trust from February 1, 2005 through December 31, 2011; the dental plan has always been self-insured and part of the Trust. Effective January 1, 2012, the insurance coverage for medical claims was changed from fully-insured to partially self-insured. There were no changes made to vision, life, and accidental death and disability benefits which remain fully-insured; dental claims remain self-insured. The plan agreement has no provision for postretirement benefits.

The Plan provides health benefits (medical, surgical, limited dental, vision, limited mental illness and hospital care benefits and benefits in the event of sickness, accident, or death) covering participants as described in the Plan's benefit provisions. Life insurance and AD&D coverage is provided by the Company – the benefit amount is based on whether the employee is a corporate officer, exempt employee, or non-exempt employee; additional coverage is available at an individual employee cost.

The claims for self-insured benefits are processed by the Plan's third-party claims processor under administrative services-only arrangements. The claims processor pays claims directly to or on behalf of participants and are then reimbursed by the Plan's VEBA trust or the general assets of the Company. Despite the Plan's utilization of a third-party claims processor, ultimate responsibility for payments to providers and participants is retained by the Plan.

## **CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**

### **NOTES TO THE FINANCIAL STATEMENTS**

---

The Plan entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specified dollar amount, as well as its aggregate exposure for all claims).

#### **Eligibility**

For the entities included in the Company (other than Scott), exempt (salaried) employees become eligible to participate in the health plan and dental care benefits on the first day of full-time employment. Non-exempt (hourly) employees become eligible for benefits the first of the month following 60 days from their first day of full-time regular employment.

Employees of Scott who are scheduled to work at least 30 hours per week are eligible for benefits on the first day of the month following 60 days of employment.

#### **Participant Termination**

Participant coverage will terminate in accordance with the provisions of the Plan as follows: (1) on the day in which enrollment terminates, (2) when average hours worked falls below 30 hours per week, or (3) the date a spouse or child fails to meet the eligibility requirements or the employee is terminated.

### **NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

#### **Basis of Accounting**

The Plan's financial statements are prepared under the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America.

#### **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 reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

#### **Payment of Benefits**

Premiums paid by either the Company or the VEBA trust are recorded as premium payments in the accompanying statement of changes in net assets available for benefits. Claim payments are recorded when paid by the third-party claims processor.

#### **Administrative Expenses**

The Plan pays administrative expenses that consist primarily of administrative fees paid to third-party claims administrators. These expenses are reported on the statement of changes in net assets available for benefits as administrative expenses. All other administrative expenses, such as professional fees, are paid by the Company on behalf of the Plan.

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**NOTES TO THE FINANCIAL STATEMENTS**

---

**Stop Loss**

Premiums for stop-loss insurance are included in premium payments in the accompanying statement of changes in net assets available for benefits. Stop-loss refunds have been netted with claims paid in the accompanying statement of changes in net assets.

**Subsequent Events**

The Plan has evaluated subsequent events through October 13, 2025, the date the financials statements were available to be issued.

**NOTE 3 – RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS**

Regence BlueCross BlueShield of Utah (Regence) is the Plan claims processing service provider and has administrator responsibilities. These functions qualify as party-in-interest transactions of the Plan. Claims processing fees for the Plan related to Regence amounted to \$2,063,887 and \$2,489,890 during the years ended December 31, 2024 and 2023, respectively.

**NOTE 4 – BENEFIT OBLIGATIONS**

The Plan provides for no postretirement benefits. The amount of benefit obligations outstanding as of December 31, 2024 and 2023 was provided by third-party health and dental providers. The amounts were based upon information provided by their actuarial departments. The amount of obligation was equal to the actual claims paid during the seven-month period after year end plus an estimate for incurred but not reported (IBNR) claims. It is at least reasonably possible that these estimates of claim obligations will be different than the actual amount to be incurred. The IBNR claims at December 31, 2024 and 2023 relate to both the health and dental plans.

**NOTE 5 – PLAN TERMINATION**

Although it has not expressed any intention to do so, the Company has the right under the Plan to modify the benefits provided to active employees, to discontinue its contributions at any time, and to terminate the plan subject to the provisions set forth in ERISA.

**NOTE 6 – TAX STATUS**

The VEBA trust funding certain benefits of the Plan received an exemption letter from the Internal Revenue Service dated October 19, 2020, stating that the trust is tax-exempt under the provisions of 501(c)(9) of the Internal Revenue Code (IRC). However, as a result of the Plan's funding policy, from time to time the trust may be subject to income taxes. No federal or state income taxes have been recorded in 2024 or 2023 for unrelated business taxable income.

In addition, the Plan and the trust are required to operate in conformity with the IRC to maintain the tax-exempt status of the trust. The plan administrator believes that the Plan is being operated in compliance with the applicable requirements of the IRC and, therefore, believes that the related trust is tax-exempt.

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**NOTES TO THE FINANCIAL STATEMENTS**

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**NOTE 7 – RISKS AND UNCERTAINTIES**

The Plan's benefit obligations are reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all 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 in the near term could be material to the financial statements.

**SUPPLEMENTAL SCHEDULE**

Schedule provided pursuant to the U.S. Department  
of Labor Rules and Regulations

**CLYDE COMPANIES, INC. WELFARE BENEFITS PLAN AND TRUST**  
**EMPLOYER IDENTIFICATION NUMBER: 87-0260879**  
**PLAN NUMBER: 501**  
**SCHEDULE H, LINE 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**

December 31, 2024

| (a) | (b) Identity of issuer, borrower, lessor, or similar party | (c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value | (d) Cost            | (e) Current value   |
|-----|--|---|---------------------|---------------------|
|     | Wells Fargo Bank   | Cash  | <u>\$ 1,819,961</u> | <u>\$ 1,819,961</u> |

\* Denotes a party-in-interest