

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN</u> <u>3601 VINCENNES ROAD</u> <u>INDIANAPOLIS, IN 46268</u>	1c Effective date of plan <u>07/01/1966</u> 2b Employer Identification Number (EIN) <u>23-7258552</u> 2c Plan Sponsor's telephone number <u>317-875-5250</u> 2d Business code (see instructions) <u>525100</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2025	RON CASSESSO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

For Paperwork Reduction Act Notice, see the Instructions for Form 5500.

Form 5500 (2024)
v. 240311

<p>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p style="color: blue;">THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN</p> <p style="color: blue;">3601 VINCENNES ROAD INDIANAPOLIS, IN 46268</p>	<p>3b Administrator's EIN 23-7258552</p> <p>3c Administrator's telephone number 317-875-5250</p>
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<p>4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:</p> <p>a Sponsor's name</p> <p>c Plan Name</p>	<p>4b EIN</p> <p>4d PN</p>
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5 Total number of participants at the beginning of the plan year	5	1107
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6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	663
a(2) Total number of active participants at the end of the plan year	6a(2)	745
b Retired or separated participants receiving benefits.....	6b	457
c Other retired or separated participants entitled to future benefits	6c	0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d	1202
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f Total. Add lines 6d and 6e	6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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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 4H 4L

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

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

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

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

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

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

Receipt Confirmation Code _____

(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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	64936
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN</p>	<p>D Employer Identification Number (EIN) 23-7258552</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
DELTA DENTAL OF INDIANA

(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
35-1545647	52634	0000891	915	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 34700</p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GIBSON INSURANCE AGENCY, INC. 130 S MAIN ST STE 400 SOUTH BEND, IN 46601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
34700			3

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

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(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.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	379980	
(2) Increase (decrease) in amount due but unpaid	9a(2)	-43	
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))	9a(4)		379937
b Benefit charges (1) Claims paid	9b(1)	287131	
(2) Increase (decrease) in claim reserves	9b(2)	-227	
(3) Incurred claims (add (1) and (2))	9b(3)		286904
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)	34700	
(B) Administrative service or other fees	9c(1)(B)	18681	
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)	9498	
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		62879
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
(2) Claim reserves	9d(2)		7506
(3) Other reserves	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN</p>	<p>D Employer Identification Number (EIN) 23-7258552</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
SYMETRA LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
91-0742147	68608	01-017092-00	1771	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 199132</p>	<p>(b) Total amount of fees paid 50924</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
GIBSON INSURANCE AGENCY INC **11801 N TATUM BLVD STE 124**
PHOENIX, AZ 85028

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
199132	50924	GROUP VOLUME BONUS	3

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	1068876
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p>A Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN</p>	<p>D Employer Identification Number (EIN) 23-7258552</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
UNUM LIFE INSURANCE COMPANY OF AMERICA

(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
01-0278678	62235	R0829135	315	01/01/2024	01/01/2025

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">21740</p>	<p>(b) Total amount of fees paid</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
GIBSON INSURANCE AGENCY, INC. 202 S MICHIGAN ST STE 1400 SOUTH BEND, IN 46601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
21740			3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	92566
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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

A Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN	D Employer Identification Number (EIN) 23-7258552	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

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

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

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

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)

NAMIC INSURANCE AGENCY

3601 VINCENNES ROAD
INDIANAPOLIS, IN 46268

35-1469772

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	228616	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

BOARDMAN & CLARK

15 PINCKNEY ST STE 410
MADISON, WI 53701-0927

45-3866466

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	9450	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

L.M. HENDERSON & COMPANY, LLP

450 E 96TH STREET STE 200
INDIANAPOLIS, IN 46240

20-5520612

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	21800	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

THE SEGAL COMPANY

30 WATERSIDE DR, STE 300
FARMINGTON, CT 06032

13-1835864

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 16 50	NONE	18565	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PNC BANK NA

1900 E. 9TH STREET 8TH FL
CLEVELAND, OH 44114

22-1146430

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 50	NONE	24061	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EXTEND HEALTH, INC

38 EAST SCENIC POINTE DR
DRAPER, UT 84020

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	16064	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

CLARITY BENEFIT SOLUTIONS FSA

90 WOODBRIDGE CENTER DR.
WOODBRIDGE, NJ 07095

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	11320	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ICSO HUMAN RESOURCES ASSOCTN INC.

3601 VINCENNES ROAD
INDIANAPOLIS, IN 46268

46-5048228

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	14000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RON CASSESSO

3601 VINCENNES ROAD
INDIANAPOLIS, IN 46268

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
31 50	NONE	20000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

IRON MOUNTAIN

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
64 50	NONE	10258	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2024 or fiscal plan year beginning <u>01/01/2024</u> and ending <u>12/31/2024</u>	
A Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN	B Three-digit plan number (PN) ▶ <u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 THE BOARD OF TRUSTEES OF THE ICSO GROUP HEALTH & WELFARE PLAN	D Employer Identification Number (EIN) <u>23-7258552</u>

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	2343917	2137127
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	90345	65142
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	157596	214665
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	2018911	1944695
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	4610769	4361629
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h	75117	168032
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	2805361	2191674
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	2880478	2359706
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	1730291	2001923

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	13104722	
(B) Participants.....	2a(1)(B)	318622	
(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)		13423344
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	94803	
(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)		94803
(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	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		343584
d Total income. Add all income amounts in column (b) and enter total	2d		13861731

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	334250	
(2) To insurance carriers for the provision of benefits	2e(2)	12704751	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		13039001
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	21800	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	24061	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	20160	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	485077	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		551098
j Total expenses. Add all expense amounts in column (b) and enter total	2j		13590099

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		271632
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **L.M. HENDERSON & COMPANY LLP**

(2) EIN: **20-5520612**

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

ICSO Group Benefit Plan

FINANCIAL STATEMENTS

Years Ended December 31, 2024 and December 31, 2023



L. M. HENDERSON & COMPANY LLP
CERTIFIED PUBLIC ACCOUNTANTS / ADVISORS

ICSO Group Benefit Plan

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Note: All other schedules required by Section 2520.103-10 of the Department of Labor’s Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.



"Serving Our Clients Since 1948"

L. M. HENDERSON & COMPANY LLP
CERTIFIED PUBLIC ACCOUNTANTS / ADVISORS

James J. Cline, Jr.
Jason L. Confer
Jude A. Thompson
Michelle L. Zimmerman

450 E. 96th Street, Suite 200
Indianapolis, IN 46240
Telephone: 317.566.1000
Fax: 317.566.1700

Independent Auditor's Report

To the Board of Trustees of
ICSO Group Benefit Plan

Opinion

We have audited the accompanying financial statements of net assets available for benefits of the ICSO Group Benefit Plan, an Indiana employee benefit plan, which comprise the statements of net assets available for benefits as of December 31, 2024 and December 31, 2023, and the related statements of changes in net assets available for benefits, accumulated postretirement benefit obligations, and changes in benefit obligations for the years then ended and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of the ICSO Group Benefit Plan as of December 31, 2024 and December 31, 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the ICSO Group Benefit Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Management's Responsibility for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the ICSO Group Benefit Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

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

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

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

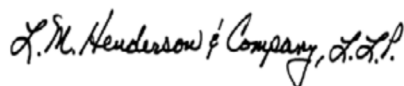
We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Report on Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules as listed in the accompanying index of the ICSO Group Benefit Plan, together referred to as "supplementary information," are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 (ERISA). Such information is the responsibility of the Plan's 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 audit 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 auditing standards generally accepted in the United States of America.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

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



Certified Public Accountants
Indianapolis, Indiana

July 21, 2025

ICSO Group Benefit Plan

Statements of Net Assets Available for Benefits

at December 31, 2024 and December 31, 2023

	December 31, 2024	December 31, 2023
<u>ASSETS:</u>		
Cash and cash equivalents	\$ 2,137,127	\$ 2,343,917
Investments	1,944,695	2,018,911
Prepaid expenses	206,196	150,515
Interest receivable	7,119	7,081
Employer contributions receivable	43,834	50,071
FSA deposits/receivables	21,308	40,274
Other receivables	1,350	-
	<u>4,361,629</u>	<u>4,610,769</u>
Total assets		
<u>LIABILITIES:</u>		
Advanced contributions	176,594	690,590
Retiree program liability - Post 65	1,976,296	2,085,343
Retiree program liability - Pre 65	18,236	25,694
Income taxes payable	20,548	3,734
Accrued expenses	168,032	75,117
	<u>2,359,706</u>	<u>2,880,478</u>
Total liabilities		
<u>NET ASSETS AVAILABLE FOR BENEFITS</u>	<u>\$ 2,001,923</u>	<u>\$ 1,730,291</u>

ICSO Group Benefit Plan

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and December 31, 2023

	Year Ended	
	December 31, 2024	December 31, 2023
ADDITIONS:		
Contributions	\$ 13,423,344	\$ 12,557,126
Administrative fee income	333,584	319,601
Marketing support income	10,000	10,000
Interest income	94,803	51,925
Total additions	<u>13,861,731</u>	<u>12,938,652</u>
DEDUCTIONS:		
Benefits paid to participants	334,250	254,908
Insurance premiums	12,704,751	11,865,643
Administrative expenses	399,498	360,061
Legal fees	20,160	2,145
Audit and tax preparation fees	21,814	20,750
Fiduciary expense	21,862	30,201
Income tax expense	80,232	63,882
Postage, storage, software and miscellaneous	7,532	5,579
Total deductions	<u>13,590,099</u>	<u>12,603,169</u>
NET INCREASE IN NET ASSETS AVAILABLE FOR BENEFITS	271,632	335,483
NET ASSETS AVAILABLE FOR BENEFITS:		
Balance, beginning of year	<u>1,730,291</u>	<u>1,394,808</u>
Balance, end of year	<u>\$ 2,001,923</u>	<u>\$ 1,730,291</u>

ICSO Group Benefit Plan

Statements of Accumulated Postretirement Benefit Obligations

at December 31, 2024 and December 31, 2023

	December 31, 2024	December 31, 2023
<u>ACCUMULATED POSTRETIREMENT BENEFIT OBLIGATIONS:</u>		
Vested benefits:		
Current retirees, beneficiaries, and dependents	\$ 24,246,770	\$ 24,303,959
Other participants fully eligible for benefits	12,086,012	13,161,567
Other participants not yet fully eligible for benefits	<u>8,805,175</u>	<u>9,202,262</u>
Total actuarial present value of postretirement benefit obligations	<u>45,137,957</u>	<u>46,667,788</u>
<u>TOTAL ACCUMULATED POSTRETIREMENT BENEFIT OBLIGATIONS AT END OF YEAR</u>	<u>\$ 45,137,957</u>	<u>\$ 46,667,788</u>

ICSO Group Benefit Plan

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and December 31, 2023

	Year Ended	
	December 31, 2024	December 31, 2023
<u>ACCUMULATED POSTRETIREMENT BENEFIT OBLIGATIONS:</u>		
Balance at beginning of year	\$ 46,667,788	\$ 44,719,212
Increase (decrease) during year attributable to:		
Benefits earned net of benefits paid	987,163	696,341
Plan amendments	(46,864)	-
Actuarial experience loss	134,147	114,608
Changes in actuarial assumptions	(2,604,277)	1,137,627
	<u>(1,529,831)</u>	<u>1,948,576</u>
<u>TOTAL ACCUMULATED POSTRETIREMENT BENEFIT OBLIGATIONS AT END OF THE YEAR</u>	<u>\$ 45,137,957</u>	<u>\$ 46,667,788</u>

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Significant accounting policies followed by the ICSO Group Benefit Plan (the Plan) are listed below:

Basis of Accounting:

Assets and liabilities and income and expense are recognized on the accrual basis of accounting.

Cash and Cash Equivalents:

The Plan maintains cash balances with financial institutions which may exceed the Federal Deposit Insurance Corporation coverage limit of \$250,000.

Postretirement Benefit Obligations:

A postretirement benefit obligation has been recognized for the retiree medical benefits for eligible participants and their dependents upon retirement. In addition, a postemployment benefit obligation has been recognized for health and welfare benefits for individuals currently on long-term disability or COBRA. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to employee service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current retirees of the Plan. The obligations represent the amounts that are expected to be funded by contributions from the participating employers and from the existing assets of the Plan. Postretirement benefits include future benefits expected to be paid to or for (a) currently retired or terminated employees and their beneficiaries and dependents and (b) active employees and their beneficiaries and dependents after retirement from service with the employer.

The actuarial present value of the expected postretirement benefit obligations is determined by an actuary and is based on actuarial assumptions and historical claims-cost data. The process estimates future annual incurred claims-cost per participant and adjusts such estimates for the time value of money (through discounts for interest) and probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and date of payment.

Actuarial Assumptions:

The following were other significant assumptions used in the valuation as of December 31, 2024 and December 31, 2023:

December 31, 2024

Discount rate:	5.50%
Healthcare trend rates:	7.50% graded to 4.50% over 12 years
Salary increases:	3.00 - 4.00% depending on the participating employer
Administrative expenses:	An administrative expense load of \$500 per pre-65 and post-65 retiree and beneficiary receiving an HRA with no future increase expected per year
Mortality rate:	Headcount-Weighted Pri-2012 with Scale MP - 2021

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

December 31, 2023

Discount rate:	5.00%
Healthcare trend rates:	7.00% graded to 4.50% over 10 years
Salary increases:	3.00 - 4.00% depending on the participating employer
Administrative expenses:	An administrative expense load of \$500 per pre-65 and post-65 retiree and beneficiary receiving an HRA with no future increase expected per year
Mortality rate:	Headcount-Weighted Pri-2012 with Scale MP - 2021

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

Contributions Receivable:

The Plan follows Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2016-13, *Measurement of Credit Losses on Financial Instruments*. The standard requires recognition of an allowance that reflects a current estimate of credit losses expected to be incurred over the life of the asset. Collections and payments from the Adopting Employers are continuously monitored and credit losses are estimated relating to the Plan's receivables based on a number of factors, including the age of receivable balances, history of losses, expectations of future credit losses, and the Adopting Employers' ability to pay their obligations. As of December 31, 2024 and December 31, 2023, all receivables were deemed fully collectible and no allowances for uncollectible receivables were recorded.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Trustees 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 revenue and expenses during the reporting period. Actual results could differ from those estimates.

Subsequent Events:

Management has evaluated subsequent events through July 21, 2025, the date that the financial statements were available to be issued.

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 2: PLAN DESCRIPTION

The following description of 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 Plan's provisions.

General

The Plan provides various forms of health, disability, death, and reimbursement accounts for health care (HCRA) benefits to substantially all employees and eligible dependents of the various insurance service organizations (the Adopting Employees) that have entered into participation agreements with the Plan. The Plan is a multiple employer plan and is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, and the underlying trust is organized as a trust under the laws of Indiana.

The Trustees of the Plan consist of executive officers of certain insurance service organizations who have adopted the Plan. Effective during the year ended December 31, 2022, NAMIC Insurance Agency (NIA) was named the Plan administrator.

The Plan's primary insurance carrier through December 31, 2013 was Aetna. Aetna provided the majority of health benefits under the Plan except for various insurance carriers who also provide health maintenance organization (HMO) and preferred provider organization (PPO) coverage under the Plan. In 2014, the Plan expanded their use of other health insurance providers. In 2024, the Plan used approximately 21 health insurance carriers. Dental coverage is provided by Delta Dental of Indiana, vision coverage is provided by Vision Service Plan and the life insurance carrier is Symetra. All benefits offered under the Plan are fully insured.

Effective July 1, 2013, the Plan added a Post-65 HRA program for retired employees of the participating employers who are eligible to participate in the Plan to reimburse retirees for certain medical expenses not otherwise reimbursed. The Post-65 HRA program is not funded, but paid from the general assets of the participating employers.

Effective January 1, 2014, the Plan added a Pre-65 HRA program for retirees of the participating employers who are eligible to participate in the Plan to reimburse retirees for health care premiums. The Pre-65 HRA program is not funded, but paid from the general assets of the participating employers.

Effective January 1, 2016, the Plan was restated in its entirety.

Eligibility

Each employee of an Adopting Employer who is regularly scheduled to work at least 30 hours per week for medical benefits, or as determined by an Adopting Employer is eligible to participate in medical benefits. For all other benefits, employees scheduled 20 hours per week are eligible to participate in the Plan. Retired employees of an Adopting Employer who elected to provide retiree coverage may be eligible for basic life, supplemental life, dental, vision, and HRA benefits if they have attained the service years required by the employer (if they meet service requirements). Participants should refer to the Adopting Employer's Plan agreement for a list of available benefits.

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 2: PLAN DESCRIPTION (continued)

Benefits

Subject to a reservation of rights to amend all benefits, the Plan provides health (medical, dental, and vision), long-term disability, identity theft, and death (basic, accidental death & dismemberment, and supplemental life insurance) benefits for active employees and their eligible dependents. The Plan provides death and HRA benefits for eligible retirees. The Plan also provides employees with reimbursement accounts for FSA. Employee contributions withheld from each paycheck are placed into the employee's account in the Plan.

Funding Policy

The Plan agreement provides that the Adopting Employers make premium contributions to the Plan for insurance benefits and administrative expenses. Employers provide basic life, long-term disability and accidental death and dismemberment benefits to active employees. Active employees have the opportunity to pay health, dental, and vision premiums on a pre-tax basis by means of a salary reduction agreement. Supplemental life insurance premiums are paid on a post-tax basis through the salary reduction agreement. Eligible former employees can elect continuation of health benefits under COBRA and pay 102% of premiums. Each Adopting Employer determines the cost-sharing provisions for active employees and retirees for health benefits.

It is the present intention of the Adopting Employers and the Plan to continue obtaining insurance coverage for benefits. Insurance premiums for future years with respect to the Plan's postretirement benefit obligation will be funded by employer contributions to the Plan in those later years.

Note 3: CONTRIBUTIONS AND PREMIUM PAYMENT

Premiums paid by employers are recorded as premium payments in the accompanying statement of changes in net assets available for benefits.

Claim payments are recorded when paid. Amounts due that have yet to be reimbursed by the Plan are recorded as accrued expenses in the accompanying statements of net assets available for benefits. Reimbursement of claims paid for the HCRA are recorded as claims paid in the accompanying statements of changes in net assets available for benefits.

Note 4: TAX STATUS

The Plan is funded by a trust that has received a determination letter on July 18, 2019, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code (the Code).

In accordance with Section 419A of the Code, the Plan is subject to trust tax rates on net income earned from unrelated business activities. As the Plan is a fully insured Voluntary Employee Beneficiary Association, management fee income related to the retiree programs (as described in Note 8) is subject to tax.

	December 31, 2024	December 31, 2023
Federal income tax expense - current	\$ 69,857	\$ 56,199
State income tax expense - current	<u>10,375</u>	<u>7,683</u>
Total income tax expense - current	<u>\$ 80,232</u>	<u>\$ 63,882</u>

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 4: TAX STATUS (continued)

The following were income taxes recoverable (payable) for the years ended:

	December 31, 2024	December 31, 2023
Federal	\$ (18,093)	\$ (3,890)
State	(2,455)	156
Total net income tax recoverable (payable)	<u>\$ (20,548)</u>	<u>\$ (3,734)</u>

Management evaluates all significant income tax positions that it takes. For the years ended December 31, 2024 and December 31, 2023, management does not believe that it has taken any tax positions that would require the recording of any additional tax liability nor does it believe that there are any unrealized tax benefits that would either increase or decrease within the next twelve months. The Plan recognizes interest and penalties, if any, related to unrecognized tax benefits in interest expense. No interest or penalties have been accrued or charged to expense for uncertain tax positions for the years ended December 31, 2024 and December 31, 2023.

The Plan is subject to routine audits by taxing jurisdictions, however, there are no current audits for any tax periods in progress. The annual information returns for the Plan are subject to examination by taxing authorities for a period of three years from the date they are filed.

Note 5: RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

As of December 31, 2024 and December 31, 2023, no differences existed between the Form 5500 and the financial statements for net assets available for benefits.

Note 6: PLAN BENEFIT OBLIGATIONS

Accumulated Postretirement Benefit Obligations:

Accumulated postretirement benefit obligations were computed by an actuary as required by FASB Accounting Standards Codification (ASC) 965-30 and in accordance with FASB ASC 715 for the years ended December 31, 2024 and December 31, 2023. The postretirement benefit obligations at December 31, 2024 and December 31, 2023, principally health benefits, relates to the following categories of participants (including their beneficiaries and dependents) as follows:

	Postretirement Benefit Obligations			
	December 31, 2024		December 31, 2023	
	Number of Participants	Net Liability	Number of Participants	Net Liability
Current retirees, beneficiaries & dependents	542	\$ 24,246,770	526	\$ 24,303,959
Other participants fully eligible for benefits	152	12,086,012	160	13,161,567
Other participants not yet fully eligible for benefits	593	8,805,175	569	9,202,262
Total accumulated postretirement benefit obligations	<u>1,287</u>	<u>\$ 45,137,957</u>	<u>1,255</u>	<u>\$ 46,667,788</u>

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 6: PLAN BENEFIT OBLIGATIONS (continued)

If the assumed health care cost-trend rates increase by one percentage point each year, the postretirement benefit obligation would increase by approximately \$202,591 and \$204,722 for the years ended December 31, 2024 and December 31, 2023, respectively.

The Plan's deficiency of net assets over benefit obligations at December 31, 2024 and December 31, 2023 is related to the postretirement benefit obligations, the funding of which is not covered by the contributions from the members. It is expected that the deficiency will be funded through future increases in the contribution rates from the members.

Note 7: PARTY-IN-INTEREST TRANSACTIONS

Fees paid by the Plan during the years ended December 31, 2024 and December 31, 2023, for services rendered by parties-in-interest, as defined by ERISA, were based on contractual rates for their services.

Note 8: RETIREE PROGRAM LIABILITIES

The Plan, on behalf of the participating employers, collects contributions and makes distributions for the Pre-65 and Post-65 retiree programs. The money collected for these programs still belongs to the participating employers and is not revenue to the Plan. At December 31, 2024 and December 31, 2023, the Plan owed back to the participating employers \$1,994,532 and \$2,111,037, respectively, for the Pre-65 and Post-65 retiree programs.

Note 9: CREDIT RISK

In accordance with FASB ASC 825-10-50-20, credit risk is the possibility that a loss may occur from the failure of another party to perform according to the terms of a contract. Bank deposits are federally insured up to \$250,000 for each account owned at a federally insured bank. The following are deposits in excess of federally insured limits for the years ended December 31, 2024 and December 31, 2023, respectively:

	December 31, 2024	December 31, 2023
Deposits	\$ 2,137,127	\$ 2,343,917
Federally insured	250,000	250,000
Deposits in excess of federally insured limits	<u>\$ 1,887,127</u>	<u>\$ 2,093,917</u>

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 10: INVESTMENTS

The following represents the fair value of investments at December 31, 2024 and December 31, 2023 held at PNC Bank:

	Fair Value	
	December 31, 2024	December 31, 2023
U.S. Treasury Cash Reserve Fund	\$ 1,944,695	\$ 2,018,911
Total investments at fair value	\$ 1,944,695	\$ 2,018,911

The Plan's investments had no realized or unrealized gain (loss) at December 31, 2024 or December 31, 2023, as cost approximates fair value. The U.S. Treasury Cash Reserve Fund had an approximate interest rate of 4.15% at December 31, 2024.

Note 11: FAIR VALUE MEASUREMENTS

FASB ASC 820-10, *Fair Value Measurements*, establishes a framework for measuring fair value. The framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820-10 are described as follows:

Level 1 - Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access at the measurement date.

Level 2 - Inputs to the valuation methodology include:

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

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

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

The assets or liabilities fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

ICSO Group Benefit Plan

Notes to the Financial Statements

December 31, 2024 and December 31, 2023

Note 11: FAIR VALUE MEASUREMENTS (continued)

Following is a description of the valuation methodology used for assets measured at fair value. There have been no changes in the methodology used at December 31, 2024 and December 31, 2023.

U.S. Treasury Cash Reserve Fund: Valued at the closing price reported in the active market in which the individual security is traded.

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

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and December 31, 2023:

Assets at Fair Value as of December 31, 2024

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
U.S. Treasury Cash Reserve Fund	<u>\$ 1,944,695</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 1,944,695</u>
Total assets at fair value	<u><u>\$ 1,944,695</u></u>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>	<u><u>\$ 1,944,695</u></u>

Assets at Fair Value as of December 31, 2023

	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Total</u>
U.S. Treasury Cash Reserve Fund	<u>\$ 2,018,911</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 2,018,911</u>
Total assets at fair value	<u><u>\$ 2,018,911</u></u>	<u><u>\$ -</u></u>	<u><u>\$ -</u></u>	<u><u>\$ 2,018,911</u></u>

ICSO Group Benefit Plan

SUPPLEMENTARY INFORMATION

Year Ended December 31, 2024

ICSO Group Benefit Plan

EIN: 23-7258552 PN: 501

Schedule H line 4i - Schedule of Assets (Held at End of Year) at December 31, 2024

(a)	(b)	(c)	(d)	(e)
	Identity of issuer, borrower, lessor, or similar party	Description of investment including interest rate, maturity date, par or quantity	Cost	Current Value
INVESTMENTS				
	U.S. Treasury Cash Reserve Fund	Various On Demand	1,944,695	1,944,695
	Total Investments		<u>\$ 1,944,695</u>	<u>\$ 1,944,695</u>

ICSO Group Benefit Plan

EIN: 23-7258552 PN: 501

Schedule H line 4j - Schedule of Reportable Transactions During Year Ended December 31, 2024**

<u>Identity of Party Involved</u>	<u>Description</u>	<u>Number of Transactions</u>	<u>Purchase Price</u>	<u>Selling Price</u>	<u>Cost of Asset</u>	<u>Current Value on Transaction Date</u>	<u>Net Gain (Loss)</u>
Single Transactions							
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* \$ 463,307	\$ -	\$ -	\$ -	\$ -
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 329,721	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 256,799	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 333,564	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 266,406	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 342,299	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 295,022	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 243,902	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 327,857	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 395,547	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 345,912	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	352,423	352,423	352,423	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	280,146	280,146	280,146	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	251,271	251,271	251,271	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	298,542	298,542	298,542	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	259,689	259,689	259,689	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	322,884	322,884	322,884	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	283,024	283,024	283,024	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	299,841	299,841	299,841	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	232,552	232,552	232,552	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	302,165	302,165	302,165	-
Series of Transactions							
U.S. Treasury Cash Reserve Fund	Investments	141 purchases	8,878,757				
U.S. Treasury Cash Reserve Fund	Investments	105 sales		8,952,973	5,321,629	5,321,629	-

* Single transaction also included in series of transactions for securities of the same issue

** A reportable transaction is any transaction during the Plan year, with respect to any Plan asset, involving an amount in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year. This schedule includes securities transactions involving a single transaction within the Plan year in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year, and also includes securities transactions involving securities of the same issue during the Plan year where the aggregate amount involved in the transactions exceeds five percent (5%) of the current value of Plan assets at the beginning of the year

ICSO Group Benefit Plan

EIN: 23-7258552 PN: 501

Schedule H line 4i - Schedule of Assets (Held at End of Year) at December 31, 2024

(a)	(b)	(c)		(d)	(e)
Identity of issuer, borrower, lessor, or similar party	Description of investment including interest rate, maturity date, par or quantity			Cost	Current Value
INVESTMENTS					
U.S. Treasury Cash Reserve Fund	Various	On Demand	1,944,695	\$ 1,944,695	\$ 1,944,695
Total Investments				<u>\$ 1,944,695</u>	<u>\$ 1,944,695</u>

ICSO Group Benefit Plan

EIN: 23-7258552 PN: 501

Schedule H line 4j - Schedule of Reportable Transactions During Year Ended December 31, 2024**

<u>Identity of Party Involved</u>	<u>Description</u>	<u>Number of Transactions</u>	<u>Purchase Price</u>	<u>Selling Price</u>	<u>Cost of Asset</u>	<u>Current Value on Transaction Date</u>	<u>Net Gain (Loss)</u>
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U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* \$ 463,307	\$ -	\$ -	\$ -	\$ -
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 329,721	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 256,799	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 333,564	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 266,406	-	-	-	-
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U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 327,857	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 395,547	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 purchase	* 345,912	-	-	-	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	352,423	352,423	352,423	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	280,146	280,146	280,146	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	251,271	251,271	251,271	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	298,542	298,542	298,542	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	259,689	259,689	259,689	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	322,884	322,884	322,884	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	283,024	283,024	283,024	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	299,841	299,841	299,841	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	232,552	232,552	232,552	-
U.S. Treasury Cash Reserve Fund	Investments	1 sale	* -	302,165	302,165	302,165	-
Series of Transactions							
U.S. Treasury Cash Reserve Fund	Investments	141 purchases	8,878,757				
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* Single transaction also included in series of transactions for securities of the same issue

** A reportable transaction is any transaction during the Plan year, with respect to any Plan asset, involving an amount in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year. This schedule includes securities transactions involving a single transaction within the Plan year in excess of five percent (5%) of the current value of Plan assets at the beginning of the Plan year, and also includes securities transactions involving securities of the same issue during the Plan year where the aggregate amount involved in the transactions exceeds five percent (5%) of the current value of Plan assets at the beginning of the year

Member Co.	EIN	% of total
002 GEORGIA UNDERWRITING ASSOCIATION	58-6122627	3.22%
003 ALABAMA INSURANCE GUARANTY ASSOCIATION	63-0810507	0.20%
005 SOUTH CAROLINA WIND & HAIL UNDERWRITING ASSN	57-0629683	4.22%
006 NEVADA INSURANCE GUARANTY ASSOCIATION	88-0134332	0.03%
010 NATIONAL CONFERENCE OF INSURANCE GUARANTY FUNDS	36-3678111	1.84%
015 KANSAS ALL-INDUSTRY PLACEMENT FACILITY	48-6149270	1.15%
016 Tennessee Insurance Guaranty Association	23-7182287	0.51%
018 PROPERTY INSURANCE ASSOCIATION OF LOUISIANA	72-0246020	5.29%
022 MISSISSIPPI STATE RATING BUREAU	64-0766391	8.53%
023 TEXAS MEDICAL JOINT UNDERWRITING ASSOCIATION	74-1854731	1.10%
032 ALABAMA INSURANCE UNDERWRITING ASSOCIATION	63-0692922	2.73%
034 CALIFORNIA FAIR PLAN	95-2553538	28.80%
038 PENNSYLVANIA INSURANCE GUARANTY ASSOCIATION (PP&CIGA)	23-1965995	1.53%
040 UNDERWRITERS SERVICE ASSOCIATION	20-0487810	0.01%
045 MISSOURI PROPERTY INSURANCE PLACEMENT FACILITY	43-0969898	1.15%
048 ADVOCATES FOR HIGHWAY & AUTO SAFETY	52-1648962	1.41%
050 NEW JERSEY INSURANCE UNDERWRITING ASSOCIATION	23-7055995	1.70%
054 NEW YORK PROPERTY INSURANCE UNDERWRITING ASSOCIATION	11-6127767	10.25%
055 AMERICAN NUCLEAR INSURERS	13-6112062	0.32%
057 The Surety & Fidelity Association of America	26-0003391	0.02%
058 WASHINGTON INSURANCE FAIR PLAN	91-0838429	0.04%
061 ILLINOIS FAIR PLAN ASSOCIATION	36-2754597	1.34%
064 ILLINOIS MINE SUBSIDENCE INSURANCE FUND	36-3135858	2.68%
065 JOINT INSURANCE ASSOCIATION	52-0983562	1.03%
066 OHIO FAIR PLAN	23-7024436	0.44%
070 VIRGINIA PROPERTY INSURANCE ASSOCIATION	23-7097511	1.53%
072 FLORIDA MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION	59-1625412	0.67%
076 CONNECTICUT FAIR PLAN	06-0957536	0.68%
079 ILLINOIS INSURANCE GUARANTY FUND	36-2737437	2.68%
085 MISSISSIPPI INSURANCE GUARANTY ASSOCIATION	23-7366411	0.20%
086 WISCONSIN INSURANCE PLAN	39-1125929	0.42%
091 WISCONSIN INSURANCE SECURITY FUND	39-1125929	0.12%
095 FAIR Plan Cost Sharing Alliance (The Alliance)	61-0408077	2.56%
099 PENNSYLVANIA FINANCIAL RESPONSIBILITY ASSIGNED CLAIMS PLAN	23-2315555	3.07%
101 PA Fair	23-1884377	1.99%
105 PA JOINT UNDERWRITING ASSOCIATION	23-1924852	0.10%
106 Property Insurance Plans Service Office INC (PIPSO)	04-3253510	0.64%
110 Michigan Automobile Placement Facility (MAIPF)	38-6090344	4.86%
112 KENTUCKY INSURANCE GUARANTY ASSOCIATION	61-0849486	0.90%
113 Colorado FAIR Plan	99-0466446	0.04%

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

For calendar plan year 2024 or fiscal plan year beginning _____ and ending _____

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

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

C If the plan is a collectively-bargained plan, check here _____ ▶ the DFVC program

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan INSURANCE COMPANY SUPPORTED ORGANIZATIONS GROUP HEALTH & WELFARE PLAN	1b Three-digit plan number (PN) ▶	501
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) THE BOARD OF TRUSTEES OF THE ICSSO GROUP HEALTH & WELFARE PLAN 3601 VINCENNES ROAD INDIANAPOLIS IN 46268	1c Effective date of plan 07/01/1966	2b Employer Identification Number (EIN) 23-7258552
	2c Plan Sponsor's telephone number 317-875-5250	2d Business code (see instructions) 525100

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

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

SIGN HERE		10/8/25	RON CASESSO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address Same as Plan Sponsor

THE BOARD OF TRUSTEES OF THE IC SO
GROUP HEALTH & WELFARE PLAN

3601 VINCENNES ROAD

INDIANAPOLIS IN 46268

3b Administrator's EIN

23-7258552

3c Administrator's telephone number

317-875-5250

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5 Total number of participants at the beginning of the plan year

5 1107

6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).

a(1) Total number of active participants at the beginning of the plan year

6a(1) 663

a(2) Total number of active participants at the end of the plan year

6a(2) 745

b Retired or separated participants receiving benefits

6b 457

c Other retired or separated participants entitled to future benefits

6c 0

d Subtotal. Add lines 6a(2), 6b, and 6c.

6d 1202

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.

6e

f Total. Add lines 6d and 6e.

6f

g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)

6g(1)

g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

6g(2)

h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested

6h

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)

7

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 4H 4L

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code _____