

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

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, a single-employer plan, a DFE (specify) G, B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report, 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, 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 THE CONTRACTORS PLAN TRUST, 1b Three-digit plan number (PN) 501, 1c Effective date of plan 01/01/2004, 2a Plan sponsor's name (employer, if for a single-employer plan) THE CONTRACTORS PLAN TRUST, 2b Employer Identification Number (EIN) 20-0746005, 2c Plan Sponsor's telephone number 800-662-6177, 2d Business code (see instructions)

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.

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

|   |  |       |
|---|--|-------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor  | <b>3b</b> Administrator's EIN              |       |
|   | <b>3c</b> Administrator's telephone number |       |
| <b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name  | <b>4b</b> EIN                              |       |
|   | <b>4d</b> PN                               |       |
| <b>5</b> Total number of participants at the beginning of the plan year   | <b>5</b>                                   | 14701 |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested..... | <b>6a(1)</b>                               | 14701 |
|   | <b>6a(2)</b>                               | 13280 |
|   | <b>6b</b>                                  |       |
|   | <b>6c</b>                                  |       |
|   | <b>6d</b>                                  | 13280 |
|   | <b>6e</b>                                  |       |
|   | <b>6f</b>                                  |       |
|   | <b>6g(1)</b>                               |       |
| <b>6g(2)</b>  |  |       |
| <b>6h</b>   |  |       |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....  | <b>7</b>                                   |       |

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code 167916095

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

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

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>THE CONTRACTORS PLAN TRUST</b></p>   | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>THE CONTRACTORS PLAN TRUST</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>20-0746005</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**ANTHEM BLUE CROSS**

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 95-3760980 | 62825         | 281615H001                            | 246   | 01/01/2024              | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

|  |           |  |
|--|-----------|--|
| <b>a</b> State the basis of premium rates ▶  |           |  |
| <b>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....  | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |
| <b>e</b> Type of contract: (1) <input type="checkbox"/> individual policies                      (2) <input type="checkbox"/> group deferred annuity<br>(3) <input type="checkbox"/> other (specify) ▶         |           |  |
| <b>f</b> If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>   |           |  |

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

|  |              |  |
|--|--------------|--|
| <b>a</b> Type of contract: (1) <input type="checkbox"/> deposit administration                      (2) <input type="checkbox"/> immediate participation guarantee<br>(3) <input type="checkbox"/> guaranteed investment                      (4) <input type="checkbox"/> other ▶ |              |  |
| <b>b</b> Balance at the end of the previous year .....   | <b>7b</b>    |  |
| <b>c</b> Additions: (1) Contributions deposited during the year .....  | <b>7c(1)</b> |  |
|  | <b>7c(2)</b> |  |
|  | <b>7c(3)</b> |  |
|  | <b>7c(4)</b> |  |
|  | <b>7c(5)</b> |  |
|  | <b>7c(6)</b> |  |
| (6) Total additions .....  | <b>7c(6)</b> |  |
| <b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....  | <b>7d</b>    |  |
| <b>e</b> Deductions:<br>(1) Disbursed from fund to pay benefits or purchase annuities during year .....  | <b>7e(1)</b> |  |
|  | <b>7e(2)</b> |  |
|  | <b>7e(3)</b> |  |
|  | <b>7e(4)</b> |  |
|  | <b>7e(5)</b> |  |
| (5) Total deductions .....   | <b>7e(5)</b> |  |
| <b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....   | <b>7f</b>    |  |

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |         |
|----------|--|------------|---------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 3972995 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |         |

**Part IV Provision of Information**

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

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

|   |  |   |
|---|--|---|
| <p style="text-align: center;"><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: small;">Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;"><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|---|

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

|   |   |  |
|---|---|--|
| <p><b>A</b> Name of plan<br/><span style="color: blue;">THE CONTRACTORS PLAN TRUST</span></p>   | <p><b>B</b> Three-digit plan number (PN) ▶</p>  | <p><span style="color: blue;">501</span></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><span style="color: blue;">THE CONTRACTORS PLAN TRUST</span></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><span style="color: blue;">20-0746005</span></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  
KAISER FOUNDATION HEALTH PLAN INC-CA

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 94-1340523 | 99457         | 603817                                | 1347  | 01/01/2024              | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

**b** Balance at the end of the previous year ..... **7b**

**c** Additions: (1) Contributions deposited during the year ..... **7c(1)**  
 (2) Dividends and credits..... **7c(2)**  
 (3) Interest credited during the year..... **7c(3)**  
 (4) Transferred from separate account ..... **7c(4)**  
 (5) Other (specify below)..... **7c(5)**  
 ▶

(6) Total additions ..... **7c(6)**

**d** Total of balance and additions (add lines **7b** and **7c(6)**) ..... **7d**

**e** Deductions:  
 (1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**  
 (2) Administration charge made by carrier..... **7e(2)**  
 (3) Transferred to separate account ..... **7e(3)**  
 (4) Other (specify below)..... **7e(4)**  
 ▶

(5) Total deductions ..... **7e(5)**

**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |          |
|----------|--|------------|----------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 13011939 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |          |

**Part IV Provision of Information**

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

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

|   |  |   |
|---|--|---|
| <p style="text-align: center;"><b>SCHEDULE A</b><br/><b>(Form 5500)</b></p> <p style="font-size: small;">Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor<br/>Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p> | <p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p> | <p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;"><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p> |
|---|--|---|

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

|  |  |  |
|--|--|--|
| <p><b>A</b> Name of plan<br/><b>THE CONTRACTORS PLAN TRUST</b></p>   | <p><b>B</b> Three-digit plan number (PN) ▶ <b>501</b></p>                  |  |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>THE CONTRACTORS PLAN TRUST</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>20-0746005</b></p> |  |

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**METROPOLITAN LIFE INSURANCE COMPANY**

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 13-5581829 | 65978         | 5343645                               | 11200   | 01/01/2024              | 12/31/2024 |

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

|  |  |
|--|--|
| (a) Total amount of commissions paid<br><b>0</b> | (b) Total amount of fees paid<br><b>247982</b> |
|--|--|

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

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**FRINGE BENEFIT GROUP, INC. 11910 ANDERSON MILL ROAD AUSTIN, TX 78726**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                         | (e) Organization code |
|---|---------------------------------|-------------------------|-----------------------|
|   | (c) Amount                      | (d) Purpose             |                       |
| 0   | 247982                          | ADMINISTRATIVE SERVICES | 5                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**FRINGE INSURANCE BENEFITS, INC. 11910 ANDERSON MILL ROAD AUSTIN, TX 78726**

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|---|---------------------------------|-------------|-----------------------|
|   | (c) Amount                      | (d) Purpose |                       |
| 0   |                                 |             | 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 |                       |
|   |                                 |             |                       |

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

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

**b** Premiums paid to carrier ..... **6b**

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

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

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

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

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

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

**b** Balance at the end of the previous year ..... **7b**

**c** Additions: (1) Contributions deposited during the year ..... **7c(1)**  
 (2) Dividends and credits..... **7c(2)**  
 (3) Interest credited during the year..... **7c(3)**  
 (4) Transferred from separate account ..... **7c(4)**  
 (5) Other (specify below)..... **7c(5)**  
 ▶

(6) Total additions ..... **7c(6)**

**d** Total of balance and additions (add lines **7b** and **7c(6)**) ..... **7d**

**e** Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year ..... **7e(1)**  
 (2) Administration charge made by carrier..... **7e(2)**  
 (3) Transferred to separate account ..... **7e(3)**  
 (4) Other (specify below)..... **7e(4)**  
 ▶

(5) Total deductions ..... **7e(5)**

**f** Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |         |
|----------|--|------------|---------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 4959626 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |         |

**Part IV Provision of Information**

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

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

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

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

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>THE CONTRACTORS PLAN TRUST</b></p>   | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>THE CONTRACTORS PLAN TRUST</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>20-0746005</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**UNITED HEALTHCARE OF CALIFORNIA**

| (b) EIN    | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |            |
|------------|---------------|---------------------------------------|---|-------------------------|------------|
|            |               |                                       |   | (f) From                | (g) To     |
| 95-2931460 | 79413         | 148006                                | 20  | 01/01/2024              | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

|  |           |  |
|--|-----------|--|
| <b>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....  | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |        |
|----------|--|------------|--------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 462049 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... | <b>10b</b> |        |

Specify nature of costs.

**Part IV Provision of Information**

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

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

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

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

|  |  |                   |
|--|--|-------------------|
| <p><b>A</b> Name of plan<br/><b>THE CONTRACTORS PLAN TRUST</b></p>   | <p><b>B</b> Three-digit plan number (PN) ▶</p>                             | <p><b>501</b></p> |
| <p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br/><b>THE CONTRACTORS PLAN TRUST</b></p> | <p><b>D</b> Employer Identification Number (EIN)<br/><b>20-0746005</b></p> |                   |

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**UNITED HEALTHCARE 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     |
| 36-2739571 | 79413         | 0710965                               | 315   | 01/01/2024              | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

|  |           |  |
|--|-----------|--|
| <b>b</b> Premiums paid to carrier .....  | <b>6b</b> |  |
| <b>c</b> Premiums due but unpaid at the end of the year .....  | <b>6c</b> |  |
| <b>d</b> 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. ....<br>Specify nature of costs ▶ | <b>6d</b> |  |

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|          |  |            |         |
|----------|--|------------|---------|
| <b>a</b> | Total premiums or subscription charges paid to carrier .....   | <b>10a</b> | 2823667 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |         |

**Part IV Provision of Information**

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

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

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

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

|  |  |            |
|--|--|------------|
| <b>A</b> Name of plan<br><b>THE CONTRACTORS PLAN TRUST</b>   | <b>B</b> Three-digit plan number (PN) ▶                            | <b>501</b> |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>THE CONTRACTORS PLAN TRUST</b> | <b>D</b> Employer Identification Number (EIN)<br><b>20-0746005</b> |            |

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FRINGE BENEFIT GROUP, INC.

74-2124394

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13                     |   | 3892367  | 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)

FRINGE INSURANCE BENEFITS, INC.

74-2616364

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 22                     |   | 3823187  | 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)

HOLIFIELD JANICH, PLLC

84-4425474

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29                     |   | 20625  | 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)

ARMANINO, LLP

33-2514127

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10                     |   | 10707  | 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)

ERISA SMART, INC.

55-1553009

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 25                     |   | 3000   | 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)

ERICKSON DEMEL & CO., PLLC

74-2332708

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

**Part I Service Provider Information (continued)**

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

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

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

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

|   |  |            |
|---|--|------------|
| <b>A</b> Name of plan<br><u>THE CONTRACTORS PLAN TRUST</u>  | <b>B</b> Three-digit plan number (PN)                              | <u>501</u> |
| <b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500<br><u>THE CONTRACTORS PLAN TRUST</u> | <b>D</b> Employer Identification Number (EIN)<br><u>20-0746005</u> |            |

|               |  |
|---------------|--|
| <b>Part I</b> | <b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b><br>(Complete as many entries as needed to report all interests in DFEs) |
|---------------|--|

|   |                      |   |
|---|----------------------|---|
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |
| <b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:    |                      |   |
| <b>b</b> Name of sponsor of entity listed in (a): |                      |   |
| <b>c</b> EIN-PN                                   | <b>d</b> Entity code | <b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) |



**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name

|                               |                                 |                 |             |
|-------------------------------|---------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | A & Y ASPHALT CONTRACTORS, INC. | <b>c</b> EIN-PN | 95-3661169- |
|-------------------------------|---------------------------------|-----------------|-------------|

**a** Plan name

|                               |                      |                 |             |
|-------------------------------|----------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ACCESS PACIFIC, INC. | <b>c</b> EIN-PN | 80-0499951- |
|-------------------------------|----------------------|-----------------|-------------|

**a** Plan name

|                               |                         |                 |             |
|-------------------------------|-------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ACCORD FEDERAL SERVICES | <b>c</b> EIN-PN | 27-2897669- |
|-------------------------------|-------------------------|-----------------|-------------|

**a** Plan name

|                               |   |                 |             |
|-------------------------------|---|-----------------|-------------|
| <b>b</b> Name of plan sponsor | AFFORDABLE ENGINEERING SERVICES, INC. (AES) | <b>c</b> EIN-PN | 59-3812042- |
|-------------------------------|---|-----------------|-------------|

**a** Plan name

|                               |                  |                 |             |
|-------------------------------|------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ALABAMA GOODWILL | <b>c</b> EIN-PN | 63-0288794- |
|-------------------------------|------------------|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ALL CITIES ENGINEERING INC. | <b>c</b> EIN-PN | 61-1772434- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |                              |                 |             |
|-------------------------------|------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ALTERNATE PERSPECTIVES, INC. | <b>c</b> EIN-PN | 20-1498294- |
|-------------------------------|------------------------------|-----------------|-------------|

**a** Plan name

|                               |                                |                 |             |
|-------------------------------|--------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | AMERICAN PLUMBING SYSTEMS INC. | <b>c</b> EIN-PN | 80-0961824- |
|-------------------------------|--------------------------------|-----------------|-------------|

**a** Plan name

|                               |                                  |                 |             |
|-------------------------------|----------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | AMERICA'S STAFFING PARTNER, INC. | <b>c</b> EIN-PN | 74-3215791- |
|-------------------------------|----------------------------------|-----------------|-------------|

**a** Plan name

|                               |                    |                 |             |
|-------------------------------|--------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | AMTEK CONSTRUCTION | <b>c</b> EIN-PN | 90-0937001- |
|-------------------------------|--------------------|-----------------|-------------|

**a** Plan name

|                               |                     |                 |             |
|-------------------------------|---------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ANGUS ASPHALT, INC. | <b>c</b> EIN-PN | 33-0252461- |
|-------------------------------|---------------------|-----------------|-------------|

**a** Plan name

|                               |                                      |                 |             |
|-------------------------------|--------------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | ANOINTED WINGS HEALTHCARE AGENCY LLC | <b>c</b> EIN-PN | 84-2462534- |
|-------------------------------|--------------------------------------|-----------------|-------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor ANYAR INC.**c** EIN-PN 80-0020501-**a** Plan name**b** Name of plan sponsor BANNUM, INC.**c** EIN-PN 61-1063608-**a** Plan name**b** Name of plan sponsor BDR SOLUTIONS, LLC**c** EIN-PN 81-1836628-**a** Plan name**b** Name of plan sponsor BEST DRILLING AND PUMP, INC.**c** EIN-PN 54-2126721-**a** Plan name**b** Name of plan sponsor BLYMYER ENGINEERS, INC.**c** EIN-PN 94-2642614-**a** Plan name**b** Name of plan sponsor BRIGHT HORIZONS CHILDREN'S CENTERS LLC.**c** EIN-PN 04-2949680-**a** Plan name**b** Name of plan sponsor BROWARD BUILDERS, INC**c** EIN-PN 68-0224799-**a** Plan name**b** Name of plan sponsor BUSSCO, INC.**c** EIN-PN 26-1484095-**a** Plan name**b** Name of plan sponsor CAREER MANAGEMENT ASSOCIATES**c** EIN-PN 84-1628825-**a** Plan name**b** Name of plan sponsor CARTER/KELLY, INC.**c** EIN-PN 94-2759544-**a** Plan name**b** Name of plan sponsor CERRUDO**c** EIN-PN 46-0967641-**a** Plan name**b** Name of plan sponsor CLANCYJG INTERNATIONAL**c** EIN-PN 26-0344717-

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name

|                               |                           |                 |             |
|-------------------------------|---------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | CLEAN CUT LANDSCAPE, INC. | <b>c</b> EIN-PN | 46-0627989- |
|-------------------------------|---------------------------|-----------------|-------------|

**a** Plan name

|                               |                           |                 |             |
|-------------------------------|---------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | COFFMAN SPECIALTIES, INC. | <b>c</b> EIN-PN | 33-0483378- |
|-------------------------------|---------------------------|-----------------|-------------|

**a** Plan name

|                               |              |                 |             |
|-------------------------------|--------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | CONTICO CORP | <b>c</b> EIN-PN | 22-2461848- |
|-------------------------------|--------------|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | CONTROL AIR ENTERPRISES LLC | <b>c</b> EIN-PN | 83-3875553- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |                        |                 |             |
|-------------------------------|------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | COOK ENGINEERING, INC. | <b>c</b> EIN-PN | 71-0895247- |
|-------------------------------|------------------------|-----------------|-------------|

**a** Plan name

|                               |                                    |                 |             |
|-------------------------------|------------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | CYBER PROFESSIONAL SOLUTIONS CORP. | <b>c</b> EIN-PN | 20-1930217- |
|-------------------------------|------------------------------------|-----------------|-------------|

**a** Plan name

|                               |                                   |                 |             |
|-------------------------------|-----------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DAVIS CONSTRUCTION PLUMBING, INC. | <b>c</b> EIN-PN | 47-0948853- |
|-------------------------------|-----------------------------------|-----------------|-------------|

**a** Plan name

|                               |  |                 |             |
|-------------------------------|--|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DICKINSON CAMERON CONSTRUCTION COMPANY | <b>c</b> EIN-PN | 33-0602078- |
|-------------------------------|--|-----------------|-------------|

**a** Plan name

|                               |               |                 |             |
|-------------------------------|---------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DIDLAKE, INC. | <b>c</b> EIN-PN | 54-0943833- |
|-------------------------------|---------------|-----------------|-------------|

**a** Plan name

|                               |                          |                 |             |
|-------------------------------|--------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DIEDE CONSTRUCTION, INC. | <b>c</b> EIN-PN | 68-0257126- |
|-------------------------------|--------------------------|-----------------|-------------|

**a** Plan name

|                               |                               |                 |             |
|-------------------------------|-------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DIMENSIONS CONSTRUCTION, INC. | <b>c</b> EIN-PN | 59-3463478- |
|-------------------------------|-------------------------------|-----------------|-------------|

**a** Plan name

|                               |                                  |                 |             |
|-------------------------------|----------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | DYNAMIC SYSTEMS TECHNOLOGY, INC. | <b>c</b> EIN-PN | 54-1780242- |
|-------------------------------|----------------------------------|-----------------|-------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor DZSP 21 LLC**c** EIN-PN 20-1222042-**a** Plan name**b** Name of plan sponsor E&R GLASS CONTRACTORS, INC.**c** EIN-PN 26-0065041-**a** Plan name**b** Name of plan sponsor EDGEWATER FEDERAL SOLUTIONS**c** EIN-PN 71-0928230-**a** Plan name**b** Name of plan sponsor EL-CO CONTRACTORS, INC.**c** EIN-PN 95-2635613-**a** Plan name**b** Name of plan sponsor EMPLOYMENT HORIZONS**c** EIN-PN 22-1612741-**a** Plan name**b** Name of plan sponsor EMPYREAN PLUMBING, INC.**c** EIN-PN 20-5577471-**a** Plan name**b** Name of plan sponsor ENERGY RESOURCES CORPORATION**c** EIN-PN 30-0370985-**a** Plan name**b** Name of plan sponsor FACILITY SERVICES MANAGEMENT, INC.**c** EIN-PN 61-1265365-**a** Plan name**b** Name of plan sponsor FIRST COAST SECURITY SOLUTIONS, INC.**c** EIN-PN 20-0593362-**a** Plan name**b** Name of plan sponsor FISCHER, INC.**c** EIN-PN 20-2020904-**a** Plan name**b** Name of plan sponsor FLORENCE CRITTENTON SERVICES OF ORANGE COUNTY, INC.**c** EIN-PN 94-1156331-**a** Plan name**b** Name of plan sponsor FNF CONSTRUCTION, INC.**c** EIN-PN 86-0474623-

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name

|                               |                            |                 |             |
|-------------------------------|----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | FRINGE BENEFIT GROUP, INC. | <b>c</b> EIN-PN | 74-2124394- |
|-------------------------------|----------------------------|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GA TECHNICAL SERVICES, INC. | <b>c</b> EIN-PN | 32-0019682- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |                           |                 |             |
|-------------------------------|---------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GEMINI TECH SERVICES, LLC | <b>c</b> EIN-PN | 20-5657140- |
|-------------------------------|---------------------------|-----------------|-------------|

**a** Plan name

|                               |                                 |                 |             |
|-------------------------------|---------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GENTRY GENERAL ENGINEERING INC. | <b>c</b> EIN-PN | 47-3813252- |
|-------------------------------|---------------------------------|-----------------|-------------|

**a** Plan name

|                               |                                    |                 |             |
|-------------------------------|------------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GM CONSTRUCTION & DEVELOPERS, INC. | <b>c</b> EIN-PN | 20-2095005- |
|-------------------------------|------------------------------------|-----------------|-------------|

**a** Plan name

|                               |                              |                 |             |
|-------------------------------|------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GOODWILL INDUSTRIAL SERVICES | <b>c</b> EIN-PN | 84-1273701- |
|-------------------------------|------------------------------|-----------------|-------------|

**a** Plan name

|                               |  |                 |             |
|-------------------------------|--|-----------------|-------------|
| <b>b</b> Name of plan sponsor | GOVERNED UNITED SECURITY PROFESSIONALS | <b>c</b> EIN-PN | 46-3155316- |
|-------------------------------|--|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | HAL HAYS CONSTRUCTION, INC. | <b>c</b> EIN-PN | 54-2084366- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |                               |                 |             |
|-------------------------------|-------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | HAMILTON CONSTRUCTION COMPANY | <b>c</b> EIN-PN | 94-0465501- |
|-------------------------------|-------------------------------|-----------------|-------------|

**a** Plan name

|                               |             |                 |             |
|-------------------------------|-------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | HANFORD ARC | <b>c</b> EIN-PN | 94-3347863- |
|-------------------------------|-------------|-----------------|-------------|

**a** Plan name

|                               |   |                 |             |
|-------------------------------|---|-----------------|-------------|
| <b>b</b> Name of plan sponsor | HERITAGE HOMES LLC DBA HERITAGE GENERAL CONTRACTING HERITAGE ROCK AND | <b>c</b> EIN-PN | 38-3686812- |
|-------------------------------|---|-----------------|-------------|

**a** Plan name

|                               |                                 |                 |             |
|-------------------------------|---------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | IMAGE ASPHALT MAINTENANCE, INC. | <b>c</b> EIN-PN | 52-1919201- |
|-------------------------------|---------------------------------|-----------------|-------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor IN AND OUT VALET COMPANY**c** EIN-PN 25-1851406-**a** Plan name**b** Name of plan sponsor INFORMATION SYSTEMS AND NETWORKS CORPORATION**c** EIN-PN 52-1191165-**a** Plan name**b** Name of plan sponsor INNOVATIVE CONSTRUCTION SOLUTIONS**c** EIN-PN 95-4745040-**a** Plan name**b** Name of plan sponsor INQUIP ASSOCIATES, INC.**c** EIN-PN 95-3103923-**a** Plan name**b** Name of plan sponsor INSIGHT ENVIRONMENTAL ENGINEERING & CONSTRUCTION**c** EIN-PN 20-1639719-**a** Plan name**b** Name of plan sponsor INTEGRITY NATIONAL CORPORATION**c** EIN-PN 52-2063943-**a** Plan name**b** Name of plan sponsor INTER-CON SECURITY SYSTEMS, INC.**c** EIN-PN 95-3020192-**a** Plan name**b** Name of plan sponsor INTERIOR DEMOLITION INC.**c** EIN-PN 95-4216657-**a** Plan name**b** Name of plan sponsor IRBY CONSTRUCTION COMPANY, INC.**c** EIN-PN 64-0902002-**a** Plan name**b** Name of plan sponsor ITC FEDERAL LLC**c** EIN-PN 20-5581516-**a** Plan name**b** Name of plan sponsor KONIAG, INCORPORATED**c** EIN-PN 92-0042743-**a** Plan name**b** Name of plan sponsor KOVICILIC CONSTRUCTION COMPANY, INC.**c** EIN-PN 36-2716776-

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name

|                               |                      |                 |             |
|-------------------------------|----------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | KR CONTRACTING, INC. | <b>c</b> EIN-PN | 90-0644901- |
|-------------------------------|----------------------|-----------------|-------------|

**a** Plan name

|                               |                        |                 |             |
|-------------------------------|------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | KTA CONSTRUCTION, INC. | <b>c</b> EIN-PN | 95-3425247- |
|-------------------------------|------------------------|-----------------|-------------|

**a** Plan name

|                               |                                  |                 |             |
|-------------------------------|----------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | LEGACY MANAGEMENT SOLUTIONS, LLC | <b>c</b> EIN-PN | 47-1438699- |
|-------------------------------|----------------------------------|-----------------|-------------|

**a** Plan name

|                               |                |                 |             |
|-------------------------------|----------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | LOGISTIX, INC. | <b>c</b> EIN-PN | 47-3553347- |
|-------------------------------|----------------|-----------------|-------------|

**a** Plan name

|                               |                   |                 |             |
|-------------------------------|-------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | LYONS EXPRESS LLC | <b>c</b> EIN-PN | 47-1726840- |
|-------------------------------|-------------------|-----------------|-------------|

**a** Plan name

|                               |                        |                 |             |
|-------------------------------|------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | M.C.E. DIRTWORKS, INC. | <b>c</b> EIN-PN | 20-2890076- |
|-------------------------------|------------------------|-----------------|-------------|

**a** Plan name

|                               |             |                 |             |
|-------------------------------|-------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MAMCO, INC. | <b>c</b> EIN-PN | 72-1535984- |
|-------------------------------|-------------|-----------------|-------------|

**a** Plan name

|                               |                                     |                 |             |
|-------------------------------|-------------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MANAGEMENT AND TRAINING CORPORATION | <b>c</b> EIN-PN | 87-0365322- |
|-------------------------------|-------------------------------------|-----------------|-------------|

**a** Plan name

|                               |                  |                 |             |
|-------------------------------|------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MARATHON GENERAL | <b>c</b> EIN-PN | 33-0311206- |
|-------------------------------|------------------|-----------------|-------------|

**a** Plan name

|                               |                      |                 |             |
|-------------------------------|----------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MCCLURE & SONS, INC. | <b>c</b> EIN-PN | 91-1411013- |
|-------------------------------|----------------------|-----------------|-------------|

**a** Plan name

|                               |                        |                 |             |
|-------------------------------|------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MCCLURE BROTHERS, INC. | <b>c</b> EIN-PN | 87-4833999- |
|-------------------------------|------------------------|-----------------|-------------|

**a** Plan name

|                               |              |                 |             |
|-------------------------------|--------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | MCX SITE LLC | <b>c</b> EIN-PN | 47-3716495- |
|-------------------------------|--------------|-----------------|-------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor METLANG/METROPOLITAN**c** EIN-PN 27-2172793-**a** Plan name**b** Name of plan sponsor MID-STATE PAVING LLC**c** EIN-PN 23-2999839-**a** Plan name**b** Name of plan sponsor MIDWEST HEAVY CONSTRUCTION, LLC**c** EIN-PN 46-4292738-**a** Plan name**b** Name of plan sponsor MIDWEST TRANSPORT, INC.**c** EIN-PN 71-0930845-**a** Plan name**b** Name of plan sponsor M-TECH GLASS, INC.**c** EIN-PN 11-3688129-**a** Plan name**b** Name of plan sponsor MVC ENTERPRISES, INC.**c** EIN-PN 33-0824793-**a** Plan name**b** Name of plan sponsor NATIVE CONTRACTORS, INC.**c** EIN-PN 74-2922542-**a** Plan name**b** Name of plan sponsor NFI CALIFORNIA CARTAGE HOLDING COMPANY, LLC**c** EIN-PN 82-2307817-**a** Plan name**b** Name of plan sponsor NOBIS ENTERPRISES, INC.**c** EIN-PN 58-1290439-**a** Plan name**b** Name of plan sponsor NORTHERN PACIFIC CORPORATION**c** EIN-PN 37-1530890-**a** Plan name**b** Name of plan sponsor NOVA GROUP, INC.**c** EIN-PN 94-1395180-**a** Plan name**b** Name of plan sponsor OFFICE REMEDIES, INC. DBA ORI**c** EIN-PN 54-1534208-

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor [PACIFIC AVIATION CORPORATION](#)**c** EIN-PN [95-4516709-](#)**a** Plan name**b** Name of plan sponsor [PATTERSON CUSTOM HOMES](#)**c** EIN-PN [75-3016757-](#)**a** Plan name**b** Name of plan sponsor [PRIORITY CONSTRUCTION CORPORATION](#)**c** EIN-PN [52-1972802-](#)**a** Plan name**b** Name of plan sponsor [PROSEGUR SERVICES GROUP, INC.](#)**c** EIN-PN [14-1626307-](#)**a** Plan name**b** Name of plan sponsor [PSC INDUSTRIAL OUTSOURCING, LP](#)**c** EIN-PN [26-1745823-](#)**a** Plan name**b** Name of plan sponsor [RAP ENGINEERING, INC.](#)**c** EIN-PN [26-4678417-](#)**a** Plan name**b** Name of plan sponsor [RC&D, INC.](#)**c** EIN-PN [05-0585667-](#)**a** Plan name**b** Name of plan sponsor [RE-ENGINEERED BUSINESS SOLUTIONS, INC.](#)**c** EIN-PN [54-2022913-](#)**a** Plan name**b** Name of plan sponsor [REYLENN CONSTRUCTION COMPANY, INC.](#)**c** EIN-PN [27-1434535-](#)**a** Plan name**b** Name of plan sponsor [RIVER CITY PAINTING, INC.](#)**c** EIN-PN [68-0101466-](#)**a** Plan name**b** Name of plan sponsor [RO'S PRECISE PAINTING, INC.](#)**c** EIN-PN [77-0495139-](#)**a** Plan name**b** Name of plan sponsor [ROY ALLAN SLURRY SEAL, INC.](#)**c** EIN-PN [95-3297484-](#)

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor S&J SERVICE**c** EIN-PN 52-1985173-**a** Plan name**b** Name of plan sponsor SEA & SHORE CONTRACTING, INC.**c** EIN-PN 04-3433086-**a** Plan name**b** Name of plan sponsor SERVTECH**c** EIN-PN 82-2845507-**a** Plan name**b** Name of plan sponsor SILICON VALLEY PAVING**c** EIN-PN 77-0503684-**a** Plan name**b** Name of plan sponsor SKYWARRIOR FLIGHT TRAINING LLC**c** EIN-PN 87-2093430-**a** Plan name**b** Name of plan sponsor SOILAND RESOURCES, LLC DBA NORTHGATE**c** EIN-PN 27-2559222-**a** Plan name**b** Name of plan sponsor SOLUTION ONE INDUSTRIES INC.**c** EIN-PN 32-0127739-**a** Plan name**b** Name of plan sponsor SOUTHERN CALIFORNIA LANDSCAPE, INC.**c** EIN-PN 33-0800061-**a** Plan name**b** Name of plan sponsor SPECTRUM SECURITY SERVICES, INC.**c** EIN-PN 22-3850072-**a** Plan name**b** Name of plan sponsor SPENCER CONSTRUCTION, LLC**c** EIN-PN 82-4089972-**a** Plan name**b** Name of plan sponsor SPHERE MECHANICAL CORP.**c** EIN-PN 82-4749881-**a** Plan name**b** Name of plan sponsor SSW MECHANICAL CONSTRUCTION, INC.**c** EIN-PN 33-0746573-

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name

|                               |  |                 |             |
|-------------------------------|--|-----------------|-------------|
| <b>b</b> Name of plan sponsor | STARSLIDE SECURITY & INVESTIGATION, INC. | <b>c</b> EIN-PN | 91-2021957- |
|-------------------------------|--|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | STATE ROOFING SYSTEMS, INC. | <b>c</b> EIN-PN | 94-2743961- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |                           |                 |             |
|-------------------------------|---------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | SUMMIT CONSTRUCTION, INC. | <b>c</b> EIN-PN | 20-1807779- |
|-------------------------------|---------------------------|-----------------|-------------|

**a** Plan name

|                               |                                 |                 |             |
|-------------------------------|---------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | SUPREME SECURITY SERVICES, INC. | <b>c</b> EIN-PN | 20-3645297- |
|-------------------------------|---------------------------------|-----------------|-------------|

**a** Plan name

|                               |                          |                 |             |
|-------------------------------|--------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | T.B. PENICK & SONS, INC. | <b>c</b> EIN-PN | 95-2056465- |
|-------------------------------|--------------------------|-----------------|-------------|

**a** Plan name

|                               |                              |                 |             |
|-------------------------------|------------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | TAYLOR BACKHOE SERVICE, INC. | <b>c</b> EIN-PN | 77-0573963- |
|-------------------------------|------------------------------|-----------------|-------------|

**a** Plan name

|                               |                 |                 |             |
|-------------------------------|-----------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | TERRA-CON, INC. | <b>c</b> EIN-PN | 20-3761851- |
|-------------------------------|-----------------|-----------------|-------------|

**a** Plan name

|                               |                      |                 |             |
|-------------------------------|----------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | THE ARC OF SAN DIEGO | <b>c</b> EIN-PN | 95-1863913- |
|-------------------------------|----------------------|-----------------|-------------|

**a** Plan name

|                               |                      |                 |             |
|-------------------------------|----------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | THE EYAK CORPORATION | <b>c</b> EIN-PN | 92-0047433- |
|-------------------------------|----------------------|-----------------|-------------|

**a** Plan name

|                               |                         |                 |             |
|-------------------------------|-------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | THE MORTGAGE LINK, INC. | <b>c</b> EIN-PN | 52-2350821- |
|-------------------------------|-------------------------|-----------------|-------------|

**a** Plan name

|                               |                             |                 |             |
|-------------------------------|-----------------------------|-----------------|-------------|
| <b>b</b> Name of plan sponsor | TRIMMING LAND COMPANY, INC. | <b>c</b> EIN-PN | 95-3930843- |
|-------------------------------|-----------------------------|-----------------|-------------|

**a** Plan name

|                               |  |                 |             |
|-------------------------------|--|-----------------|-------------|
| <b>b</b> Name of plan sponsor | TRINITY ENGINEERING LABORATORIES, INC. | <b>c</b> EIN-PN | 26-4577530- |
|-------------------------------|--|-----------------|-------------|

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

**a** Plan name**b** Name of plan sponsor TRI-POWER ELECTRIC, INC.**c** EIN-PN 33-0983744-**a** Plan name**b** Name of plan sponsor TRI-POWER ELECTRICAL CONTRACTORS, INC.**c** EIN-PN 83-2457783-**a** Plan name**b** Name of plan sponsor USS CAL BUILDERS, INC.**c** EIN-PN 95-4380253-**a** Plan name**b** Name of plan sponsor VALIANT INTEGRATED DEFENSE SERVICES, LLC**c** EIN-PN 33-4649684-**a** Plan name**b** Name of plan sponsor VERO TECHNICAL SUPPORT INC.**c** EIN-PN 65-0277963-**a** Plan name**b** Name of plan sponsor VET PRIDE SERVICES, INC.**c** EIN-PN 86-1155143-**a** Plan name**b** Name of plan sponsor W. HARRIS, GOVERNMENT SERVICES CONTRACTOR, INC.**c** EIN-PN 82-0371553-**a** Plan name**b** Name of plan sponsor WADLEY CONSTRUCTION**c** EIN-PN 86-0858501-**a** Plan name**b** Name of plan sponsor WALDEN SECURITY**c** EIN-PN 62-1448519-**a** Plan name**b** Name of plan sponsor WESTERN WATER CONSTRUCTORS, INC.**c** EIN-PN 94-1457619-**a** Plan name**b** Name of plan sponsor WORRELL CONTRACTING**c** EIN-PN 52-2286265-**a** Plan name**b** Name of plan sponsor ZENETEX**c** EIN-PN 54-1963721-

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

|  |  |
|--|--|
| For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b> |  |
| <b>A</b> Name of plan<br><b>THE CONTRACTORS PLAN TRUST</b>   | <b>B</b> Three-digit plan number (PN) ▶ <b>501</b>                 |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>THE CONTRACTORS PLAN TRUST</b>       | <b>D</b> Employer Identification Number (EIN)<br><b>20-0746005</b> |

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

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

|  |                 | (a) Beginning of Year | (b) End of Year |
|--|-----------------|-----------------------|-----------------|
| <b>Assets</b>  |                 |                       |                 |
| <b>a</b> Total noninterest-bearing cash .....  | <b>1a</b>       | 3570815               | 1838315         |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....  | <b>1b(1)</b>    |                       |                 |
| <b>(2)</b> Participant contributions .....   | <b>1b(2)</b>    |                       |                 |
| <b>(3)</b> Other .....   | <b>1b(3)</b>    | 16449                 | 17819           |
| <b>c</b> General investments:  |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....   | <b>1c(1)</b>    | 6359514               | 4766676         |
| <b>(2)</b> U.S. Government securities .....  | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                            |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....   | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....  | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....   | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                   | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....  | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....   | <b>1c(8)</b>    |                       |                 |
| <b>(9)</b> Value of interest in common/collective trusts .....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                    | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                            | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....        | <b>1c(13)</b>   |                       |                 |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) ..... | <b>1c(14)</b>   |                       |                 |
| <b>(15)</b> Other .....  | <b>1c(15)</b>   |                       |                 |

| <b>1d</b> Employer-related investments:                                  |              | (a) Beginning of Year | (b) End of Year |
|--|--------------|-----------------------|-----------------|
| (1) Employer securities.....   | <b>1d(1)</b> |                       |                 |
| (2) Employer real property.....  | <b>1d(2)</b> |                       |                 |
| <b>e</b> Buildings and other property used in plan operation.....        | <b>1e</b>    |                       |                 |
| <b>f</b> Total assets (add all amounts in lines 1a through 1e).....      | <b>1f</b>    | 9946778               | 6622810         |
| <b>Liabilities</b>   |              |                       |                 |
| <b>g</b> Benefit claims payable.....                                     | <b>1g</b>    |                       |                 |
| <b>h</b> Operating payables.....   | <b>1h</b>    |                       |                 |
| <b>i</b> Acquisition indebtedness.....                                   | <b>1i</b>    |                       |                 |
| <b>j</b> Other liabilities.....  | <b>1j</b>    |                       |                 |
| <b>k</b> Total liabilities (add all amounts in lines 1g through 1j)..... | <b>1k</b>    | 0                     | 0               |
| <b>Net Assets</b>  |              |                       |                 |
| <b>l</b> Net assets (subtract line 1k from line 1f).....                 | <b>1l</b>    | 9946778               | 6622810         |

**Part II Income and Expense Statement**

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

| <b>Income</b>  |                 | (a) Amount | (b) Total |
|--|-----------------|------------|-----------|
| <b>a Contributions:</b>  |                 |            |           |
| (1) Received or receivable in cash from: <b>(A)</b> Employers.....   | <b>2a(1)(A)</b> | 85714502   |           |
| <b>(B)</b> Participants.....   | <b>2a(1)(B)</b> |            |           |
| <b>(C)</b> Others (including rollovers).....   | <b>2a(1)(C)</b> |            |           |
| (2) Noncash contributions.....   | <b>2a(2)</b>    |            |           |
| (3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> ..... | <b>2a(3)</b>    |            | 85714502  |
| <b>b Earnings on investments:</b>  |                 |            |           |
| <b>(1) Interest:</b>   |                 |            |           |
| <b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....        | <b>2b(1)(A)</b> | 272412     |           |
| <b>(B)</b> U.S. Government securities.....   | <b>2b(1)(B)</b> |            |           |
| <b>(C)</b> Corporate debt instruments.....   | <b>2b(1)(C)</b> |            |           |
| <b>(D)</b> Loans (other than to participants).....   | <b>2b(1)(D)</b> |            |           |
| <b>(E)</b> Participant loans.....  | <b>2b(1)(E)</b> |            |           |
| <b>(F)</b> Other.....  | <b>2b(1)(F)</b> |            |           |
| <b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....                              | <b>2b(1)(G)</b> |            | 272412    |
| <b>(2) Dividends:</b>  |                 |            |           |
| <b>(A)</b> Preferred stock.....  | <b>2b(2)(A)</b> |            |           |
| <b>(B)</b> Common stock.....   | <b>2b(2)(B)</b> |            |           |
| <b>(C)</b> Registered investment company shares (e.g. mutual funds).....                                   | <b>2b(2)(C)</b> |            |           |
| <b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....                  | <b>2b(2)(D)</b> |            | 0         |
| (3) Rents.....   | <b>2b(3)</b>    |            |           |
| <b>(4) Net gain (loss) on sale of assets:</b>  |                 |            |           |
| <b>(A)</b> Aggregate proceeds.....   | <b>2b(4)(A)</b> |            |           |
| <b>(B)</b> Aggregate carrying amount (see instructions).....   | <b>2b(4)(B)</b> |            |           |
| <b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....                   | <b>2b(4)(C)</b> |            |           |
| <b>(5) Unrealized appreciation (depreciation) of assets:</b>   |                 |            |           |
| <b>(A)</b> Real estate.....  | <b>2b(5)(A)</b> |            |           |
| <b>(B)</b> Other.....  | <b>2b(5)(B)</b> |            |           |
| <b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....         | <b>2b(5)(C)</b> |            |           |

|   | (a) Amount | (b) Total |
|---|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts .....                              | 2b(6)      |           |
| (7) Net investment gain (loss) from pooled separate accounts .....                              | 2b(7)      |           |
| (8) Net investment gain (loss) from master trust investment accounts .....                      | 2b(8)      |           |
| (9) Net investment gain (loss) from 103-12 investment entities .....                            | 2b(9)      |           |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) ..... | 2b(10)     |           |
| c Other income .....  | 2c         |           |
| d Total income. Add all <b>income</b> amounts in column (b) and enter total.....                | 2d         | 85986914  |

**Expenses**

|   |        |          |
|---|--------|----------|
| e Benefit payment and payments to provide benefits:                                 |        |          |
| (1) Directly to participants or beneficiaries, including direct rollovers.....      | 2e(1)  |          |
| (2) To insurance carriers for the provision of benefits .....                       | 2e(2)  | 81332529 |
| (3) Other.....  | 2e(3)  |          |
| (4) Total benefit payments. Add lines 2e(1) through (3) .....                       | 2e(4)  | 81332529 |
| 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)  | 3892367  |
| (3) Recordkeeping fees .....  | 2i(3)  |          |
| (4) IQPA audit fees .....   | 2i(4)  | 10707    |
| (5) Investment advisory and investment management fees .....                        | 2i(5)  |          |
| (6) Bank or trust company trustee/custodial fees .....                              | 2i(6)  |          |
| (7) Actuarial fees .....  | 2i(7)  |          |
| (8) Legal fees .....  | 2i(8)  | 20625    |
| (9) Valuation/appraisal fees .....  | 2i(9)  |          |
| (10) Other trustee fees and expenses .....  | 2i(10) | 3000     |
| (11) Other expenses.....  | 2i(11) | 4051654  |
| (12) Total administrative expenses. Add lines 2i(1) through (11) .....              | 2i(12) | 7978353  |
| j Total expenses. Add all <b>expense</b> amounts in column (b) and enter total..... | 2j     | 89310882 |

**Net Income and Reconciliation**

|   |       |          |
|---|-------|----------|
| k Net income (loss). Subtract line 2j from line 2d..... | 2k    | -3323968 |
| 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: **ARMANINO, LLP**

(2) EIN: **33-2514127**

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

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

**Part IV Compliance Questions**

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

During the plan year:

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

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

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

| <b>5b(1)</b> Name of plan(s) | <b>5b(2)</b> EIN(s) | <b>5b(3)</b> PN(s) |
|------------------------------|---------------------|--------------------|
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |
|                              |                     |                    |

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

**The Contractors Plan Trust**

Financial Statements  
Modified Cash Basis

December 31, 2024 and 2023



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## INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of Fringe Benefit Group, Inc.  
The Contractors Plan Trust

### **Opinion**

We have audited the accompanying financial statements of The Contractors Plan Trust (the "Trust"), which comprise the statements of net assets available for benefits - modified cash basis as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits - modified cash basis for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits - modified cash basis of The Contractors Plan Trust as of December 31, 2024 and 2023, and the changes in its net assets available for benefits - modified cash basis for the years then ended, in accordance with the basis of accounting the Trust uses for modified cash purposes as described in Note 2.

### **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 Contractors Plan Trust and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### **Basis of Accounting**

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to that matter.

### **Responsibilities of Management for the Financial Statements**

Management is responsible for the preparation and fair presentation of these financial statements in accordance with the modified cash basis of accounting described in Note 2; this includes determining the modified cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

## **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 auditing standards generally accepted in the United States of America will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with auditing standards generally accepted in the United States of America, 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 Contractors Plan Trust's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about The Contractors Plan Trust's ability to continue as a going concern for a reasonable period of time.

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

*Armanino LLP*

Dallas, Texas

October 15, 2025

The Contractors Plan Trust  
 Statements of Net Assets Available for Benefits  
 Modified Cash Basis  
 December 31, 2024 and 2023

|                                   | 2024         | 2023         |
|-----------------------------------|--------------|--------------|
| ASSETS                            |              |              |
| Cash and cash equivalents         | \$ 6,604,992 | \$ 9,930,328 |
| Due from trust sponsor            | 17,819       | 16,449       |
| Net assets available for benefits | \$ 6,622,811 | \$ 9,946,777 |

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

The Contractors Plan Trust  
Statements of Changes in Net Assets Available for Benefits  
Modified Cash Basis  
For the Years Ended December 31, 2024 and 2023

|  | 2024          | 2023          |
|--|---------------|---------------|
| Additions  |               |               |
| Contributions, net of refunds                                | \$ 85,714,502 | \$ 95,294,617 |
| Interest income  | 272,412       | 259,954       |
| Total additions  | 85,986,914    | 95,554,571    |
| Deductions   |               |               |
| Payments to insurance carriers                               | 81,332,528    | 85,415,409    |
| Total deductions   | 81,332,528    | 85,415,409    |
| Administrative expenses                                      |               |               |
| Commission and administrative expenses                       | 7,925,392     | 8,187,859     |
| Professional fees  | 52,960        | 17,424        |
| Total administrative expenses and transfers                  | 7,978,352     | 8,205,283     |
| Net increase (decrease) in net assets available for benefits | (3,323,966)   | 1,933,879     |
| Net assets available for benefits, beginning of year         | 9,946,777     | 8,012,898     |
| Net assets available for benefits, end of year               | \$ 6,622,811  | \$ 9,946,777  |

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

The Contractors Plan Trust  
Notes to Financial Statements  
Modified Cash Basis  
December 31, 2024 and 2023

1. NATURE OF OPERATIONS

The Contractors Plan Trust (the "Trust") was established, effective January 1, 2004, for the purpose of providing fully insured health and welfare benefits for the employees of participating employers subject to the Service Contract Act, the Davis-Bacon Act, and other similar statutes. At December 31, 2024 and 2023, fully insured welfare benefit options available through the Trust included health, life, dental, vision, and chiropractic coverage.

ERISA Smart, Inc. (the "Trustee") is the Trust's trustee. The Trustee's responsibilities include establishing an account to hold the assets of the Trust, to provide for safekeeping and custody of the Trust assets, and to perform the functions and duties assigned to it under the Trust Agreement. The Trustee also provides consent for making available benefit coverage with various insurance carriers. Fringe Benefit Group, Inc. is the master plan sponsor and recordkeeper under the terms of the plan and trust agreement and is responsible for plan maintenance, trust recordkeeping, customer service, and renewals.

In the event the Trust is terminated, the assets of the Trust, after payment of all expenses and liabilities, will first be used to continue insurance coverage on all employees and the families of such employees, as applicable, under existing policies to the extent possible; and apply any remaining balance for the benefit of such employees and their families as to best carry out the purpose for which the Trust was created.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of presentation and use of estimates

As allowed by the Department of Labor, contributions and distributions are recognized on the modified cash basis of accounting. Therefore, the financial statements of the Trust do not purport to represent the net assets available for benefits or the the changes in net assets available for benefits of the trust in accordance with generally accepted accounting principles in the United States of America.

The Contractors Plan Trust  
Notes to Financial Statements  
Modified Cash Basis  
December 31, 2024 and 2023

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Contributions

Participating employers make contributions to the Trust to cover the cost of group insurance programs selected by the employer and the cost of administering the Trust. Employer contributions for covered employees may be determined on the basis of the actual monthly premium or credited hours of service. Contributions are determined based on the contract rates charged by the insurance carriers for selected coverage plus an additional charge for sales compensation and administrative fees. Additional charges for sales compensation and fees average 9% of contributions for the years ended December 31, 2024 and 2023. Some participating employers make contributions in excess of the minimum premiums due. These amounts are held in the Trust and are separately accounted for the benefit of the affected employees of the participating employer's plan ("Dollar Bank"). The Dollar Bank balances are utilized to pay premiums for coverage for periods when the affected employee does not receive sufficient contributions to otherwise continue coverage. The participating employer plan may set limits on the total Dollar Bank balance that may be accumulated for an employee.

Concentration of credit risk

The Trust's cash is maintained in federally insured domestic banking institutions to minimize credit risk. As a part of normal business operations, the Trust maintains cash on deposit in excess of federally insured limits. The Trust has not experienced any losses in such accounts and does not believe it is exposed to any significant risk.

Income taxes

The Trust is a welfare benefit fund as defined in Section 419 of the Internal Revenue Code. As such, contributions to this welfare benefit fund by the various participating employers are subjected to certain limitations. The Trust is subject to federal income tax on unrelated income. For the years ended December 31, 2024 and 2023, the Trust paid no income taxes because there was no unrelated income earned by the Trust. At December 31, 2024 and 2023, no uncertain tax positions have been identified. If applicable, interest and penalties related to uncertain tax positions will be recognized in income tax expense, as incurred. No such amounts were recognized for the years ended December 31, 2024 and 2023.

Subsequent events

The Trust has evaluated subsequent events for recognition or disclosure in the financial statements through October 15, 2025, the date the financial statements were available to be issued and determined that no events have occurred that would require adjustment to our disclosures in the financial statements.

The Contractors Plan Trust  
Notes to Financial Statements  
Modified Cash Basis  
December 31, 2024 and 2023

3. INSURANCE CONTRACTS

All benefits made available to participating employers and their employees are fully insured through insurance contracts with various insurance carriers. All premiums are paid by the Trust to the insurer who services and pays all claims. The Trust's liability is limited to the contributions received and premiums remitted to the insurers.

4. RELATED PARTY TRANSACTIONS

During the years ended December 31, 2024 and 2023, the Trust paid administrative fees of \$3,892,367 and \$4,147,769, respectively, to the plan sponsor, Fringe Benefit Group, Inc. Additionally, the Trust paid sales compensation of \$3,823,187 and \$4,040,090, respectively, to a party related to the plan sponsor through common ownership. The Trust had a receivable due from the plan sponsor of \$17,819 and \$16,449 as of December 31, 2024 and 2023, respectively.