

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

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description) _____

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

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>UGSOA HEALTH AND WELFARE TRUST FUND</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>501</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>TRUSTEES - UGSOA HEALTH AND WELFARE FUND</u></p> <p><u>2879 CRANBERRY HIGHWAY</u> <u>EAST WAREHAM, MA 02538</u></p>	<p>1c Effective date of plan <u>07/01/2017</u></p> <p>2b Employer Identification Number (EIN) <u>82-4038622</u></p> <p>2c Plan Sponsor's telephone number <u>774-678-0936</u></p> <p>2d Business code (see instructions) <u>525100</u></p>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	JEFF MILLER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	MATT SIPOS
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number																				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																				
5 Total number of participants at the beginning of the plan year	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">5</td> <td style="text-align: right;">1912</td> </tr> </table>	5	1912																		
5	1912																				
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">6a(1)</td> <td style="text-align: right;">1912</td> </tr> <tr> <td style="width:10%; text-align: center;">6a(2)</td> <td style="text-align: right;">1162</td> </tr> <tr> <td style="width:10%; text-align: center;">6b</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6c</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6d</td> <td style="text-align: right;">1162</td> </tr> <tr> <td style="width:10%; text-align: center;">6e</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6f</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6g(1)</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6g(2)</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6h</td> <td></td> </tr> </table>	6a(1)	1912	6a(2)	1162	6b		6c		6d	1162	6e		6f		6g(1)		6g(2)		6h	
6a(1)	1912																				
6a(2)	1162																				
6b																					
6c																					
6d	1162																				
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">7</td> <td></td> </tr> </table>	7																			
7																					

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

<p>A Name of plan UGSOA HEALTH AND WELFARE TRUST FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - UGSOA HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 82-4038622</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
GREAT MIDWEST INSURANCE COMPANY- SKYWARD INSURANCE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
14-1957288	52421	MSL 2022 10452	1912	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	0

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	791900
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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

A Name of plan UGSOA HEALTH AND WELFARE TRUST FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - UGSOA HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 82-4038622	

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

1 Coverage Information:

(a) Name of insurance carrier
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5123390	64246	000T9339/000T94	1590	07/01/2024	12/31/2024

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

(a) Total amount of commissions paid 0	(b) Total amount of fees paid 125520
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ROBERT HARLING
1 ISBELL CT
GREENVILLE, SC 29607

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	89381	FEES PAID TO BSI	5

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
CONSOLIDATED PLANNING HOLDINGS
3 MONGIN WAY
OKATIE, SC 29909

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	29634	FEES PAID	3

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

CENTRO BENEFITS RESEARCH LLC

325 N KIRKWOOD RD STE 300
KIRKWOOD, MO 63122

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	6505	FEES PAID	3

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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) ▶ AD&D

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	901716	
(2) Increase (decrease) in amount due but unpaid	9a(2)	204376	
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))	9a(4)		1106092
b Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))	9b(3)		0
(4) Claims charged	9b(4)		
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
(2) Claim reserves	9d(2)		
(3) Other reserves	9d(3)		
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

A Name of plan UGSOA HEALTH AND WELFARE TRUST FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - UGSOA HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 82-4038622	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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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)

ROBEIN, URANN, SPENCER, PICARD & CA

72-0999672

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	26599	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)

NEEDLES & ASSOCIATES, LLC.

51-0435869

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	25463	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)

BENEFIT SOURCE, INC

304 RIDGELAND DR
GREENVILLE, SC 29601

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 50	NONE	16481	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.

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ► File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan UGSOA HEALTH AND WELFARE TRUST FUND	B Three-digit plan number (PN) 501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - UGSOA HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 82-4038622

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	1995384	3108650
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	850981	695856
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	414887	373036
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	34858	392276
f Total assets (add all amounts in lines 1a through 1e).....	1f	3296110	4569818
Liabilities			
g Benefit claims payable.....	1g	483401	1618547
h Operating payables.....	1h	239457	5048
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	449876	
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	1172734	1623595
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	2123376	2946223

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	11272266	
(B) Participants.....	2a(1)(B)	9312	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		11281578
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)		
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		0
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		0
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)	
(7) Net investment gain (loss) from pooled separate accounts	2b(7)	
(8) Net investment gain (loss) from master trust investment accounts	2b(8)	
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)	
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)	
c Other income	2c	565560
d Total income. Add all income amounts in column (b) and enter total.....	2d	11847138

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	7875243
(2) To insurance carriers for the provision of benefits	2e(2)	2504000
(3) Other.....	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	10379243
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)	16481
(2) Contract administrator fees	2i(2)	197910
(3) Recordkeeping fees	2i(3)	153818
(4) IQPA audit fees	2i(4)	25463
(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)	26599
(9) Valuation/appraisal fees	2i(9)	
(10) Other trustee fees and expenses	2i(10)	5459
(11) Other expenses.....	2i(11)	219318
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)	645048
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j	11024291

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k	822847
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: **NEEDLES & ASSOCIATES, LLC**

(2) EIN: **51-0435869**

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

UGSOA HEALTH & WELFARE FUND

FINANCIAL STATEMENTS
December 31, 2024 and 2023

UGSOA HEALTH & WELFARE FUND

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December 31, 2024 and 2023

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INDEPENDENT AUDITOR'S REPORT

Plan Participants and Board of Trustees
UGSOA Health & Welfare Fund
East Wareham, MA

Opinion

We have audited the accompanying financial statements of UGSOA Health & Welfare Fund , an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the 18-month period ended December 31, 2024 which includes the short plan year from July 1, 2023 to December 31, 2023, and the subsequent 12-month plan year.

The Board of Trustees elected to defer the audit of the short plan year in accordance with Department of Labor (DOL) guidance, which permits plans with a short year of seven months or fewer to combine the audit with the following full-year period. This approach complies with ERISA requirements and applicable auditing standards.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial status of UGSOA Health & Welfare Fund as of December 31, 2024 and 2023, and the changes in its financial status for the 18-month period ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of UGSOA Health & Welfare Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

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

Needle & Associates, LLC

Broomfield, CO
October 3, 2025

UGSOA HEALTH & WELFARE FUND

***Statements of Net Assets Available for Benefits
December 31, 2024 and 2023***

	<u>12/31/24</u>	<u>12/31/23</u>
<i>Assets</i>		
Cash	\$ 3,108,650	\$ 2,018,907
Receivables		
Employers' contributions	695,856	850,981
Other receivables	<u>373,036</u>	<u>263,788</u>
Total receivables	<u>1,068,892</u>	<u>1,114,769</u>
Property and equipment, net	<u>392,276</u>	<u>439,858</u>
Total assets	<u>\$ 4,569,818</u>	<u>\$ 3,573,534</u>
<i>Liabilities</i>		
Accounts payable		
Due to other funds	\$ 372,723	\$ 197,984
Operating	<u>5,048</u>	<u>6,350</u>
Total liabilities	<u>\$ 377,771</u>	<u>\$ 204,334</u>
<i>Net assets available for benefits</i>	<u>\$ 4,192,047</u>	<u>\$ 3,369,200</u>

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

UGSOA HEALTH & WELFARE FUND

Statements of Changes in Net Assets Available for Benefits
Year Ended December 31, 2024 and Six months ended December 31, 2023

	12 months ended 12/31/24	6-months ended 12/31/23
Additions		
Contributions		
Employers'	\$ 11,272,266	\$ 5,497,507
Participants'	9,312	6,355
Total contributions	<u>11,281,578</u>	<u>5,503,862</u>
Other income	<u>565,560</u>	<u>520,925</u>
Total additions	<u>\$ 11,847,138</u>	<u>\$ 6,024,787</u>
Deductions		
Benefit payments		
Self-funded claims paid, net	\$ 7,875,243	\$ 4,248,018
Insurance premiums paid	<u>2,504,000</u>	<u>1,148,627</u>
Total benefit payments	<u>10,379,243</u>	<u>5,396,645</u>
Operating expenses (Note G)	<u>645,048</u>	<u>497,721</u>
Total deductions	<u>\$ 11,024,291</u>	<u>\$ 5,894,366</u>
Net increase (decrease)	822,847	130,421
Net assets available for benefits		
Beginning of year	<u>\$ 3,369,200</u>	<u>\$ 3,238,779</u>
End of year	<u>\$ 4,192,047</u>	<u>\$ 3,369,200</u>

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

UGSOA HEALTH & WELFARE FUND

***Statements of Benefit Obligations
December 31, 2024 and 2023***

	<u>2024</u>	<u>2023</u>
<i>Other obligations for current benefit coverage, at present value of estimated amounts</i>		
Claims payable and claims incurred but not reported	\$ 1,193,257	\$ 487,933
Participant Accumulated Eligibility	755,172	242,185
Premium obligation	<u>169,084</u>	<u>175,234</u>
Total obligations other than postretirement benefit obligations	<u>\$ 2,117,513</u>	<u>\$ 905,352</u>
Total benefit obligations	<u><u>\$ 2,117,513</u></u>	<u><u>\$ 905,352</u></u>

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

UGSOA HEALTH & WELFARE FUND

Statements of Changes in Benefit Obligations
Year Ended December 31, 2024 and Six months ended December 31, 2024

	<u>2024</u>	<u>2023</u>
<i>Other obligations for current benefits</i>		
<i>at present value of estimated amounts</i>		
Balance at beginning of year	\$ 905,352	\$ 1,383,160
Net change during year:		
Claims incurred, but not reported	705,324	(280,449)
Participant Accumulated Eligibility	512,987	(196,699)
Premium obligation	<u>(6,150)</u>	<u>(660)</u>
Balance at end of year	<u>\$ 2,117,513</u>	<u>\$ 905,352</u>
Total benefit obligations	<u>\$ 2,117,513</u>	<u>\$ 905,352</u>

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

UGSOA HEALTH & WELFARE FUND

Notes to Financial Statements December 31, 2024 and 2023

NOTE A - DESCRIPTION OF PLAN

The following description of UGSOA Health & Welfare Fund (Plan) provides only general information. Participants should refer to the Trust Documents and Plan Documents for a complete description of the Plan's provisions.

- **General**

The Plan is a multiemployer employee welfare benefit plan that started operations on July 1, 2017 and the Trust was formed December 20, 2017 under an agreement between United Government Security Officers International Union and Signatory Employers that perform work under federal contracts subject to the Service Contract Act of 1965. The Plan provides health and other benefits to eligible participants and covered dependents. The Plan is administered by a Board of Trustees with equal representation between union and management.

The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Plan previously contracted with Specialized Contract Administrators, Inc. to manage daily operations but subsequently transitioned to be self-administered by the International Union and TD Bank as custodian of Plan assets.

- **Tax status**

The trust funding benefits of the Plan received an exemption letter from the Internal Revenue Service stating that the trust is tax-exempt under the provision of Section 501(c)9 of the Internal Revenue Code. The Plan and the trust are required to operate in conformity with the Internal Revenue Code to maintain the tax-exempt status of the trust. Plan management believes that the Plan is being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Plan management has evaluated the Plan's tax positions and concluded that the Plan has taken no uncertain tax positions that would require financial statement recognition or disclosure for the years ended December 31, 2024.

The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for the current tax period in progress.

- **Funding**

The Plan is funded by employers' contributions in accordance with formulas set forth in the applicable Collective Bargaining Agreement(s).

UGSOA HEALTH & WELFARE FUND

Notes to Financial Statements December 31, 2024 and 2023

NOTE A - DESCRIPTION OF PLAN (Continued)

Under a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), participants may elect to contribute a specified fixed amount, determined periodically by the Board of Trustees, to temporarily continue health coverage when there is a “qualifying event” that would result in loss of health coverage.

- **Benefits**

The Plan self-insures health benefits (medical and prescription drugs). Additionally, the Plan fully insures vision, dental, life insurance and accidental death and dismemberment benefits through the purchase of annual insurance contracts. The Plan also provides continuation of benefits through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The claims for self-insured benefits are processed by the Plan’s third-party claims processor under an administrative service only (ASO) arrangement. Despite the Plan’s utilization of a third-party claim’s processor, ultimate responsibility for payments to providers and participants is retained by the Plan.

The Plan offers several Benefit options. The Medical Benefit option which is a comprehensive medical and prescription drug benefit that is self-insured by the Fund and there are three “sub-set plans” within this option. The Required Benefit option is an insured Short-Term Disability Benefit plus an insured Basic Life and Accidental Death and Dismemberment Benefit. The Optional Benefit option may include optional welfare benefits like fully insured dental, vision, optional Life and Accidental Death and Dismemberment Benefit, long term disability benefit, accident benefit, critical illness benefits and hospital indemnity benefit.

The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan’s actual utilization pattern of specific drugs. During the year ended December 31, 2024, prescription drug rebates totaling \$565,560, and \$70,925 for the prior six months and have been recorded as other income.

- **Stop-loss insurance**

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits of individual participant claims in excess of \$175,000. During the year and 6-month ended December 31, 2024 and 2023 respectively, stop loss reimbursements totaling \$666,894 and \$141,740 respectively, have been netted against benefit payments.

UGSOA HEALTH & WELFARE FUND

Notes to Financial Statements December 31, 2024 and 2023

NOTE A - DESCRIPTION OF PLAN (Continued)

- **Termination of the Plan**

Although it has not expressed any intention to do so, the Plan's Board of Trustees, as Sponsor, has the right under the Plan to modify the benefits provided to, and contributions required of, participants or to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, remaining assets, after payment of liabilities, will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants, including the transfer of said assets to another Plan established for the same general purpose. No assets of the Plan may revert to a contributing employer or be used for purposes other than for the exclusive benefit of the Plan's participants.

NOTE B - SUMMARY OF ACCOUNTING POLICIES

- **Basis of accounting**

The accompanying financial statements are prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America and presented in a format to coincide with the Form 5500.

- **Use of estimates**

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect reported amounts and disclosures. Actual results could differ from those estimates.

- **Employers' contributions receivable**

Employers' contributions are recorded as income in the month the hours are worked. Employers' contributions receivable represents contributions applicable to work months prior to December 31, 2024 and the six months of 2023, but collected after those dates. Plan management believes these receivables to be fully collectible. The Board of Trustees has a policy of performing procedures on the payroll records of contributing employers on a regular basis. Delinquencies may arise from these procedures, but due to the uncertainty of collections, no estimates of amounts due will be accrued until settlements are reached. Consequently, no allowance for uncollectible receivables is recorded.

- **Plan of continuing eligibility**

The Plan has determined eligibility based on the category of employees which is established by each individual employer. Eligibility for the plan's benefits is dependent on if the employee is Full time, Part Time, Bargaining Unit Employee, Non-Bargaining Unit Employee, or SCA Employee. Full time SCA and Bargaining Unit employees and dependent are required to participate and be covered for the Required benefit and the self-only coverage for the medical benefit. Part time employees and dependents are only eligible for the optional benefits offered by the Plan. During the current year, the plan instituted a process whereby contributions in excess of their monthly premium obligation will give two months of additional coverage.

UGSOA HEALTH & WELFARE FUND

*Notes to Financial Statements
December 31, 2024 and 2023*

NOTE B - SUMMARY OF ACCOUNTING POLICIES (Continued)

- **Claims incurred but not reported**

Plan obligations at December 31, 2024 and 2023 for claims incurred but not reported are estimated using the current claims lag in relation to the total claims paid for the year, based on a rolling 12 months of claims history based on claims data provided by the Plan's third-party claims administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment.

- **Payment of benefits**

Claim payments are recorded when paid by the third-party claim's processor.

- **Subsequent events**

Plan management has evaluated subsequent events through October 3, 2025, the date the financial statements were available to be issued. No subsequent events have occurred requiring accrual or disclosure.

NOTE C - RISKS AND UNCERTAINTIES

Cash consists of non-interest-bearing transaction accounts. The Plan puts its cash with financial institutions deemed to be creditworthy. Balances are insured by FDIC up to \$250,000. As of December 31, 2024 the Plan's cash exceeded the federally insured limits by approximately \$2,858,650.

NOTE D - PARTY-IN-INTEREST TRANSACTIONS

Payments for professional services such as administration, consulting, legal, auditing, and other services rendered by parties-in-interest are considered reasonable and customary for such services.

NOTE E - RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Per financial statements	\$ 4,192,047	\$ 3,369,200
Less: Claims incurred but not reported	(1,193,257)	(487,933)
Less Participant Accumulated Eligibility	(755,172)	(242,185)
Less: Premium obligation	<u>(169,084)</u>	<u>(175,234)</u>
Per Form 5500	<u>\$ 2,074,534</u>	<u>\$ 2,463,848</u>

Claims incurred but not reported, premium obligations and participant accumulated eligibility are not considered liabilities under accounting principles generally accepted in the United States of

UGSOA HEALTH & WELFARE FUND

Notes to Financial Statements December 31, 2024 and 2023

America and, therefore, are not presented as liabilities in the accompanying financial statements, but are recorded on the Form 5500 as liabilities.

NOTE F - OPERATING EXPENSES

The following is a detailed summary of the Plan's operating expenses for the year ended December 31, 2024 and the six months ended December 31, 2023:

	<u>2024</u>	<u>2023</u>
Third party administrator fees	\$ 197,910	\$ 137,548
Network fees	16,481	16,325
Broker fees	153,818	79,310
Custodial fees	4,610	1,378
Legal fees	26,599	9,776
Audit fees	25,463	5,000
Insurance - bonding premiums	7,683	4,263
Office expenses	55,512	28,325
Meeting - conference expenses	5,459	1,195
Payroll and related taxes	76,504	36,472
Fringe benefits	14,180	6,676
Building operations and maintenance	47,584	44,999
Total operating expenses	<u>\$ 645,048</u>	<u>\$ 497,721</u>

NOTE G - AMENDMENTS

During the years ended December 31, 2024 and 2023, plan of benefits were restated by the following amendments. Participants should refer to the Restated Plan Document for more complete information.

- Amendment #5: Effective July 1, 2023, the Plan was amended to update the name, address and telephone number of plan sponsor and plan administrator (as well as type of administration). Effective January 1, 2024, the plan year begins on January 1 and ends on the following December 31. In addition, the eligibility, enrollment and termination of coverage were also revised.

NOTE H - PLAN ADMINISTRATION AND FIXED ASSETS

During the prior plan year there was a gradual transition of the plan's administration from being administered by BSI, Inc. as a third-party administrator to a self-administered function by the International Union. As of 7/1/2022, the International Union completely took over the administration of the plan. Due to this change, there were building capital improvements undertaken to adequately create the space needed to administer the plan. These improvements have

UGSOA HEALTH & WELFARE FUND

**Notes to Financial Statements
December 31, 2024 and 2023**

NOTE H – PLAN ADMINISTRATION AND FIXED ASSETS (continued)

been capitalized and will be depreciated over 15 years straight line, with half-year depreciation in both the first and last years of the life of the asset. The Administrative software that was donated to the Health Fund by the International Union is being depreciated will be depreciated over 10 years useful life .

Fixed assets as of December 31, 2024

<u>Description</u>	<u>Cost</u>	<u>Depreciation Expense</u>	<u>Accumulated Depreciation</u>	<u>Net Book Value</u>
Building and improvements	\$ 488,732	\$ 47,582	\$ 96,455	\$ 392,277
Total fixed assets, at cost	\$ 488,732	\$ 47,582	\$ 96,455	\$ 392,277

Fixed assets as of December 31, 2023

<u>Description</u>	<u>Cost</u>	<u>Depreciation Expense</u>	<u>Accumulated Depreciation</u>	<u>Net Book Value</u>
Building and improvements	\$ 488,732	\$ 45,000	\$ 48,873	\$ 439,859
Total fixed assets, at cost	\$ 488,732	\$ 45,000	\$ 48,873	\$ 439,859

Filing Authorization
for the 2024 Form 5500

Name of Plan: UGSOA Health and Welfare Trust Fund

EIN / PN: 82-4038622

Plan Year Ending: 12/31/2024

PART I Authorization of Practitioner to Electronically Sign and File

I hereby authorize Needles & Associates, LLC to electronically sign and file the above-named return/report through EFAST2.

I understand that in granting this authority that:

- I/we must manually sign and date page 1 of the Form 5500 and provide a scanned copy of that signature page to Needles & Associates, LLC before the electronic filing can be initiated;
- Needles & Associates, LLC will retain a copy of this written authorization in its records;
- Needles & Associates, LLC will notify the individual(s) signing below as plan administrator/employer about any inquiries and information it receives from EFAST2, DOL, IRS, or PBGC regarding this annual return/report; and
- A copy of my signature, as it appears on page 1 of the Form 5500, will be included with the return/report posted by the Department of Labor on the Internet for public disclosure.
- Needles & Associates, LLC shall not be deemed an administrator or other fiduciary with respect to any Plan solely on account of the services performed under this authorization.

This authorization is applicable only to the filing for the above-named Plan and applies only for Plan year end stated above.

Plan Administrator: _____ **Date:** _____

JEFF MILLER

Employer/Plan Sponsor: *Matt Sipos* _____ **Date:** 10/2/2025

(if not the Plan Administrator) **MATT SIPOS**

PART II Acknowledgement of Receipt of Authorization

On behalf of Needles & Associates, LLC, I hereby certify that the firm will use the authority granted only for the express purposes described above; that the firm will not disclose confidential information to any parties other than the DOL, as required for EFAST filing; and that the firm will take reasonable steps to assure that confidential information provided by the Plan Administrator or Plan Sponsor is protected from unauthorized disclosure.

For Needles & Associates, LLC: _____ **Date:** _____
(signature and title)

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: [x] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [x] D Check box if filing under: [x] Form 5558 [] automatic 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 UGSOA HEALTH AND WELFARE TRUST FUND 1b Three-digit plan number (PN) 501 1c Effective date of plan 07/01/2017 2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) TRUSTEES - UGSOA HEALTH AND WELFARE FUND 2879 CRANBERRY HIGHWAY EAST WAREHAM MA 02538 2b Employer Identification Number (EIN) 82-4038622 2c Plan Sponsor's telephone number (774) 678-0936 2d Business code (see instructions) 525100

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes signatures of Jeff Miller and Matt Sipos.

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

Form 5500 (2024) v. 240311