Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
CHAMBER ASSOCIATION BENEFIT PLAN TRUST

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan

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)
CHAMBER ASSOCIATION BENEFIT PLAN

1100 MAIN ST- 2ND FLOOR
WHEELING, WV 26003

2b Employer Identification Number (EIN)
82-2769605

2c Plan Sponsor's telephone number
304-233-2575

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.

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

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

3b Administrator's EIN

3c Administrator's telephone number

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

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	0
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

9a Plan funding arrangement (check all that apply)

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

9b Plan benefit arrangement (check all that apply)

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

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

a Pension Schedules

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

b General Schedules

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

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

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... [X] 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.) ..... [X] 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 160357714

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
CHAMBER ASSOCIATION BENEFIT PLAN TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CHAMBER ASSOCIATION BENEFIT PLAN

D Employer Identification Number (EIN)
82-2769605

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
THP 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
55-0765726	95677	0000	1196	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
65219	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

ADVANTAGE CONSULTING
5005 ROCKSIDE RD,5TH FLOOR, STE 530
CLEVELAND, OH 44131

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
65219			3

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			7b	0
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)	0
d	Total of balance and additions (add lines **7b** and **7c(6)**).			7d	0
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)	0
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			7f	0

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] 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)	0
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 [ ] paid in cash, or [ ] 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	1022354
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 [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan	**B** Three-digit plan number (PN) ▶
CHAMBER ASSOCIATION BENEFIT PLAN TRUST	501

C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)
CHAMBER ASSOCIATION BENEFIT PLAN	82-2769605

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

(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

(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

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

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

THE HEALTH PLAN

55-0765726

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12	NONE	646716	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CONSOLIPLEX WEST VIRGINIA

35-2597759

(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 15 16	NONE	170035	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MALONEY + NOVOTNY LLC

34-0677006

(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 16	NONE	26956	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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)

ERIKKA L. STORCH

5 EDGWOOD ST.
WHEELING, WV 26003

(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	NONE	13976	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

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

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

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 D (Form 5500)	DFE/Participating Plan Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
CHAMBER ASSOCIATION BENEFIT PLAN TRUST

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
CHAMBER ASSOCIATION BENEFIT PLAN

D Employer Identification Number (EIN)
82-2769605

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

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	**d** Entity code	**e** 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	ADVANCED PHYSICAL THERAPY CBWV BENEFIT PLAN		
b Name of plan sponsor	ADVANCED PHYSICAL THERAPY	**c** EIN-PN	76-0754593-501
a Plan name	AG HEATING & AIR CBWV BENEFIT PLAN		
b Name of plan sponsor	AG HEATING & AIR	**c** EIN-PN	82-4795157-501
a Plan name	AIR SERVICE OF WEST VIRGINIA, LTD. CO. CBWV BENEFIT PLAN		
b Name of plan sponsor	AIR SERVICE OF WV, LTD. CO.	**c** EIN-PN	55-0774741-501
a Plan name	ALFRED CONSTRUCTION, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	ALFRED CONSTRUCTION, INC	**c** EIN-PN	55-0529376-501
a Plan name	ALMOST HEAVEN FAMILY DENTISTRY CBWV BENEFIT PLAN		
b Name of plan sponsor	ALMOST HEAVEN FAMILY DENTISTRY	**c** EIN-PN	85-1223047-501
a Plan name	AMANDA SPRINGER DDS PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	AMANDA SPRINGER DDS PLLC	**c** EIN-PN	88-3393130-501
a Plan name	AMERICAN PLATE GLASS, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	AMERICAN PLATE GLASS, INC	**c** EIN-PN	55-0770875-501
a Plan name	AMERICAN TIRE, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	AMERICAN TIRE, INC.	**c** EIN-PN	55-0563934-501
a Plan name	AMOS CARVELLI FUNERAL HOME LL CBWV BENEFIT PLAN		
b Name of plan sponsor	AMOS CARVELLI FUNERAL HOME LL	**c** EIN-PN	26-3842575-501
a Plan name	ANDREA PECORA AND ASSOCIATES CBWV BENEFIT PLAN		
b Name of plan sponsor	ANDREA PECORA AND ASSOCIATES	**c** EIN-PN	55-0746921-501
a Plan name	ANIMAL WELLNESS INC CBWV BENEFIT PLAN		
b Name of plan sponsor	ANIMAL WELLNESS INC	**c** EIN-PN	55-0726853-501
a Plan name	ANISSA M ANDERSON DDS MS CBWV BENEFIT PLAN		
b Name of plan sponsor	ANISSA M ANDERSON DDS MS	**c** EIN-PN	55-0783463-501

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	APO COUNSELING L.L.C. CBWV BENEFIT PLAN		
b Name of plan sponsor	APO COUNSELING, L.L.C.	**c** EIN-PN	55-0785194-501
a Plan name	APPALACHIAN OFFICE PRODUCTS CBWV BENEFIT PLAN		
b Name of plan sponsor	APPALACHIAN OFFICE PRODUCTS	**c** EIN-PN	31-1492336-501
a Plan name	AUGUSTA LEVY LEARNING CENTER CBWV BENEFIT PLAN		
b Name of plan sponsor	AUGUSTA LEVY LEARNING CENTER	**c** EIN-PN	20-2628216-501
a Plan name	B&B HAULING LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	B&B HAULING LLC	**c** EIN-PN	85-0754602-501
a Plan name	B&B MART INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	B&B MART INC.	**c** EIN-PN	55-0702480-501
a Plan name	BC BANK INC CBWV BENEFIT PLAN		
b Name of plan sponsor	BC BANK INC	**c** EIN-PN	55-0519325-501
a Plan name	BEAVER COAL COMPANY, LIMITED CBWV BENEFIT PLAN		
b Name of plan sponsor	BEAVER COAL COMPANY, LIMITED	**c** EIN-PN	23-1689810-501
a Plan name	BENWOOD-MCMECHEN HOUSING AUTHORITY CBWV BENEFIT PLAN		
b Name of plan sponsor	BENWOOD-MCMECHEN HOUSING AUTHORITY	**c** EIN-PN	55-0464563-501
a Plan name	BEST BUSINESS STRATEGIES CBWV BENEFIT PLAN		
b Name of plan sponsor	BEST BUSINESS STRATEGIES	**c** EIN-PN	73-1719093-501
a Plan name	BIAFORA HOLDING LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	BIAFORA HOLDING LLC	**c** EIN-PN	55-0768326-501
a Plan name	BIZTEC, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	BIZTEC, LLC	**c** EIN-PN	82-2898476-501
a Plan name	BLATTNER & HOWARD LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	BLATTNER & HOWARD LLC	**c** EIN-PN	27-4492228-501

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	BLUE GOLD DEVELOPMENT CBWV BENEFIT PLAN		
b Name of plan sponsor	BLUE GOLD DEVELOPMENT	**c** EIN-PN	84-4295582-501
a Plan name	BOLTS & QUARTERS QUILT SHOP CBWV BENEFIT PLAN		
b Name of plan sponsor	BOLTS & QUARTERS QUILT SHOP	**c** EIN-PN	46-3114879-501
a Plan name	BROKE GIRLS INC CBWV BENEFIT PLAN		
b Name of plan sponsor	BROKE GIRLS INC	**c** EIN-PN	81-4251174-501
a Plan name	BUCKY'S LTD AUTO BODY CBWV BENEFIT PLAN		
b Name of plan sponsor	BUCKYS LTD AUTO BODY	**c** EIN-PN	55-0723728-501
a Plan name	BUTCHER'S BLACK ANGUS LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	BUTCHERS BLACK ANGUS LLC	**c** EIN-PN	80-0964431-501
a Plan name	CANAAN REALTY CBWV BENEFIT PLAN		
b Name of plan sponsor	CANAAN REALTY	**c** EIN-PN	82-2180203-501
a Plan name	CARLINE HAULING AND EXCAVATION CBWV BENEFIT PLAN		
b Name of plan sponsor	CARLINE HAULING AND EXCAVATION	**c** EIN-PN	82-3645318-501
a Plan name	CARNEY & SLOAN, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	CARNEY & SLOAN, INC.	**c** EIN-PN	31-1491054-501
a Plan name	CARTE HALL CPAS CBWV BENEFIT PLAN		
b Name of plan sponsor	CARTE HALL CPAS	**c** EIN-PN	80-0773051-501
a Plan name	CGL DDS MORGANTOWN INC CBWV BENEFIT PLAN		
b Name of plan sponsor	CGL DDS MORGANTOWN INC	**c** EIN-PN	47-5391287-501
a Plan name	CIRA & ASSOCIATES CONSULTING CBWV BENEFIT PLAN		
b Name of plan sponsor	CIRA & ASSOCIATES CONSULTING	**c** EIN-PN	11-3735926-501
a Plan name	CLARKSBURG CARDIOVASCULAR PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	CLARKSBURG CARDIOVASCULAR PLLC	**c** EIN-PN	47-3906490-501

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	CORNERSTONE DRILLING LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	CORNERSTONE DRILLING LLC	**c** EIN-PN	83-3892702-501
a Plan name	COUNTRY ROADS DINING, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	COUNTRY ROADS DINING, LLC	**c** EIN-PN	47-4051138-501
a Plan name	CRANBERRY MEDICAL CLINIC CBWV BENEFIT PLAN		
b Name of plan sponsor	CRANBERRY MEDICAL CLINIC	**c** EIN-PN	55-0612718-501
a Plan name	CURRY TRANSFER & STORAGE CO. CBWV BENEFIT PLAN		
b Name of plan sponsor	CURRY TRANSFER & STORAGE CO.	**c** EIN-PN	55-0493637-501
a Plan name	DANIEL I. JOSPEH, DDS CBWV BENEFIT PLAN		
b Name of plan sponsor	DANIEL I. JOSPEH, DDS	**c** EIN-PN	55-0665185-501
a Plan name	DESAI LAW, PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	DESAI LAW, PLLC	**c** EIN-PN	92-1294276-501
a Plan name	DR. JAMIE M. DAY, DDS, MS PLL CBWV BENEFIT PLAN		
b Name of plan sponsor	DR. JAMIE M. DAY, DDS, MS PLL	**c** EIN-PN	84-1715622-501
a Plan name	DYNAMIC PHYSICAL THERAPY CBWV BENEFIT PLAN		
b Name of plan sponsor	DYNAMIC PHYSICAL THERAPY	**c** EIN-PN	45-0511449-501
a Plan name	ED SWIERKOS ENTERPRISES, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	ED SWIERKOS ENTERPRISES, INC	**c** EIN-PN	55-0515833-501
a Plan name	ELEVATE PHYSICAL THERAPY CBWV BENEFIT PLAN		
b Name of plan sponsor	ELEVATE PHYSICAL THERAPY	**c** EIN-PN	88-2285489-501
a Plan name	ENVIROCLEAN, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	ENVIROCLEAN, LLC	**c** EIN-PN	42-2354983-501
a Plan name	FAZALARE ENGINEERING CBWV BENEFIT PLAN		
b Name of plan sponsor	FAZALARE ENGINEERING	**c** EIN-PN	82-4389150-501

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	FIEST FINANCIAL, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	FIEST FINANCIAL, LLC	**c** EIN-PN	93-3035768-501
a Plan name	FISH HAWK ACRES, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	FISH HAWK ACRES, LLC	**c** EIN-PN	45-4023920-501
a Plan name	FORT HENRY CAPITAL CBWV BENEFIT PLAN		
b Name of plan sponsor	FORT HENRY CAPITAL	**c** EIN-PN	46-4781142-501
a Plan name	FROHNAPFEL & BURKETT INSURANCE CBWV BENEFIT PLAN		
b Name of plan sponsor	FROHNAPFEL & BURKETT INSURANCE	**c** EIN-PN	82-2193530-501
a Plan name	GENERATION WEST VIRGINIA, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	GENERATION WEST VIRGINIA, INC	**c** EIN-PN	81-3004556-501
a Plan name	GLESSNER, WHARTON & ANDREWS INSURANCE CBWV BENEFIT PLAN		
b Name of plan sponsor	GLESSNER, WHARTON & ANDREWS INSURANCE	**c** EIN-PN	27-0746759-501
a Plan name	GOOD LIFE FINANCIAL ADVISORS OF WEST VIRGINIA CBWV BENEFIT PLAN		
b Name of plan sponsor	GOOD LIFE FINANCIAL ADVISORS OF WEST VIRGINIA	**c** EIN-PN	84-1877378-501
a Plan name	GREENWOOD CEMETERY ASSOCIATION CBWV BENEFIT PLAN		
b Name of plan sponsor	GREENWOOD CEMETERY ASSOCIATION	**c** EIN-PN	55-0184540-501
a Plan name	GS MILLWORK, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	GS MILLWORK, LLC	**c** EIN-PN	84-4387772-501
a Plan name	HARTSOCK AUTOMOTIVE LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	HARTSOCK AUTOMOTIVE LLC	**c** EIN-PN	46-3449582-501
a Plan name	HILLCREST VETERINARY CLINIC CBWV BENEFIT PLAN		
b Name of plan sponsor	HILLCREST VETERINARY CLINIC	**c** EIN-PN	30-0672603-502
a Plan name	HOLE N RUN, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	HOLE N RUN, INC.	**c** EIN-PN	55-0597806-501

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	HOMETOWN CARE CBWV BENEFIT PLAN		
b Name of plan sponsor	HOMETOWN CARE	**c** EIN-PN	30-0608900-501
a Plan name	HP EXCAVATING, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	HP EXCAVATING, INC	**c** EIN-PN	55-0606154-501
a Plan name	HULS CHIROPRACTIC PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	HULS CHIROPRACTIC PLLC	**c** EIN-PN	77-0709463-501
a Plan name	HUNTINGTON REGIONAL CHAMBER OF COMMERCE CBWV BENEFIT PLAN		
b Name of plan sponsor	HUNTINGTON REGIONAL CHAMBER OF COMMERCE	**c** EIN-PN	55-0199470-501
a Plan name	IMPACT MEDIA CBWV BENEFIT PLAN		
b Name of plan sponsor	IMPACT MEDIA	**c** EIN-PN	82-3394589-501
a Plan name	J & R EXCAVATING INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	J & R EXCAVATING INC.	**c** EIN-PN	55-0565719-501
a Plan name	JHGKL ENTERPRISES, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	JHGKL ENTERPRISES, INC.	**c** EIN-PN	85-4145305-501
a Plan name	JIM ROBINSON GROUP INC CBWV BENEFIT PLAN		
b Name of plan sponsor	JIM ROBINSON GROUP INC	**c** EIN-PN	26-3448928-502
a Plan name	JNB SERVICES, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	JNB SERVICES, LLC	**c** EIN-PN	47-3478423-501
a Plan name	JOE DEFAZIO OIL CO. CBWV BENEFIT PLAN		
b Name of plan sponsor	JOE DEFAZIO OIL CO.	**c** EIN-PN	55-0608001-501
a Plan name	JOE'S PREOWNED AUTO SALES, LL CBWV BENEFIT PLAN		
b Name of plan sponsor	JOES PREOWNED AUTO SALES, LL	**c** EIN-PN	41-2127229-501
a Plan name	JOSHUA DOLIN PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	JOSHUA DOLIN PLLC	**c** EIN-PN	82-3980922-501

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	JPE HARDWOOD LUMBER INC CBWV BENEFIT PLAN		
b Name of plan sponsor	JPE HARDWOOD LUMBER INC	**c** EIN-PN	55-0644419-501
a Plan name	KENNETH P. HICKS L.C. CBWV BENEFIT PLAN		
b Name of plan sponsor	KENNETH P. HICKS L.C.	**c** EIN-PN	55-0711871-501
a Plan name	KOZICKI HUGHES TICKERHOOF PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	KOZICKI HUGHES TICKERHOOF PLLC	**c** EIN-PN	55-0526247-502
a Plan name	LAW OFFICES OF NEISWONGER & WHITE CBWV BENEFIT PLAN		
b Name of plan sponsor	LAW OFFICES OF NEISWONGER & WHITE	**c** EIN-PN	55-0763898-501
a Plan name	LESLIE W ELSON CBWV BENEFIT PLAN		
b Name of plan sponsor	LESLIE W ELSON	**c** EIN-PN	52-1359193-501
a Plan name	LEVELTEK PROCESSING LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	LEVELTEK PROCESSING LLC	**c** EIN-PN	55-0955928-501
a Plan name	LEWIS GLASSER PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	LEWIS GLASSER PLLC	**c** EIN-PN	55-0486513-501
a Plan name	LIBERA, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	LIBERA, INC.	**c** EIN-PN	47-1601546-501
a Plan name	LONE PINE BUS LINES INC CBWV BENEFIT PLAN		
b Name of plan sponsor	LONE PINE BUS LINES INC	**c** EIN-PN	92-3306483-501
a Plan name	LPL DAVIS & SONS LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	LPL DAVIS & SONS LLC	**c** EIN-PN	26-2434698-501
a Plan name	MAIN STREET FAIRMONT CBWV BENEFIT PLAN		
b Name of plan sponsor	MAIN STREET FAIRMONT	**c** EIN-PN	55-0719007-501
a Plan name	MARSHALL COUNTY CONVENTION & VISITORS BUREAU CBWV BENEFIT PLAN		
b Name of plan sponsor	MARSHALL COUNTY CONVENTION & VISITORS BUREAU	**c** EIN-PN	47-1170203-501

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	METTLER PACKAGING, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	METTLER PACKAGING, LLC	**c** EIN-PN	37-1429708-501
a Plan name	MFD INC CBWV BENEFIT PLAN		
b Name of plan sponsor	MFD INC	**c** EIN-PN	55-0767441-501
a Plan name	MICHAEL J TUPTA DDS INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	MICHAEL J TUPTA DDS INC.	**c** EIN-PN	55-0607549-501
a Plan name	MIDDLETOWN ANIMAL CLINIC CBWV BENEFIT PLAN		
b Name of plan sponsor	MIDDLETOWN ANIMAL CLINIC	**c** EIN-PN	55-0571630-501
a Plan name	MILLER ORTHOTICS & PROSTHETIC CBWV BENEFIT PLAN		
b Name of plan sponsor	MILLER ORTHOTICS & PROSTHETIC	**c** EIN-PN	46-1805615-501
a Plan name	MOLLY JOE INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	MOLLY JOE INC.	**c** EIN-PN	20-8161682-501
a Plan name	MOORE VISION CENTER, PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	MOORE VISION CENTER, PLLC	**c** EIN-PN	27-1829986-501
a Plan name	MORGANTOWN AREA PARTNERSHIP CBWV BENEFIT PLAN		
b Name of plan sponsor	MORGANTOWN AREA PARTNERSHIP	**c** EIN-PN	55-0237464-501
a Plan name	MORGANTOWN SEPTIC TANK SERVICE CBWV BENEFIT PLAN		
b Name of plan sponsor	MORGANTOWN SEPTIC TANK SERVICE	**c** EIN-PN	47-4056901-501
a Plan name	MORRIS MOUNTAINEER OIL & GAS CBWV BENEFIT PLAN		
b Name of plan sponsor	MORRIS MOUNTAINEER OIL & GAS	**c** EIN-PN	81-2093350-501
a Plan name	MOUNTAIN COMMUNICATIONS, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	MOUNTAIN COMMUNICATIONS, LLC	**c** EIN-PN	14-1844408-501
a Plan name	MOUNTAIN TECHNOLOGY RESOURCES CBWV BENEFIT PLAN		
b Name of plan sponsor	MOUNTAIN TECHNOLOGY RESOURCES	**c** EIN-PN	20-3308391-501

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	MOUNTAINEER RV & OUTDOOR CENTER CBWV BENEFIT PLAN		
b Name of plan sponsor	MOUNTAINEER RV & OUTDOOR CENTER	**c** EIN-PN	82-5129518-501
a Plan name	MOUNTAINEER TECHNOLOGY CONSULTANTS CBWV BENEFIT PLAN		
b Name of plan sponsor	MOUNTAINEER TECHNOLOGY CONSULTANTS	**c** EIN-PN	81-3157656-501
a Plan name	MT PROPERTIES, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	MT PROPERTIES, INC.	**c** EIN-PN	55-0745483-501
a Plan name	MY VEIN CARE, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	MY VEIN CARE, INC	**c** EIN-PN	82-2597952-501
a Plan name	N. S. ELECTRIC LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	N. S. ELECTRIC LLC	**c** EIN-PN	85-1225028-501
a Plan name	NATASHA HARRIS ENTERPRISES INC CBWV BENEFIT PLAN		
b Name of plan sponsor	NATASHA HARRIS ENTERPRISES INC	**c** EIN-PN	93-3526451-501
a Plan name	NEW MARTINSVILLE SUPPLY CO CBWV BENEFIT PLAN		
b Name of plan sponsor	NEW MARTINSVILLE SUPPLY CO	**c** EIN-PN	55-0569351-501
a Plan name	OAKWOOD TERRACE APARTMENTS CBWV BENEFIT PLAN		
b Name of plan sponsor	OAKWOOD TERRACE APARTMENTS	**c** EIN-PN	55-0673518-501
a Plan name	OHIO VALLEY ASTHMA AND ALLERGY CBWV BENEFIT PLAN		
b Name of plan sponsor	OHIO VALLEY ASTHMA AND ALLERGY	**c** EIN-PN	55-0567486-501
a Plan name	OHIO VALLEY VETERINARY CARE CENTER PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	OHIO VALLEY VETERINARY CARE CENTER PLLC	**c** EIN-PN	82-2800910-501
a Plan name	ON-POINT HEALTH & WELLNESS CBWV BENEFIT PLAN		
b Name of plan sponsor	ON-POINT HEALTH & WELLNESS	**c** EIN-PN	46-4575711-501
a Plan name	P.A.M.S. INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	P.A.M.S. INC.	**c** EIN-PN	55-0654085-501

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	PARKERSBURG COUNTRY CLUB CBWV BENEFIT PLAN		
b Name of plan sponsor	PARKERSBURG COUNTRY CLUB	**c** EIN-PN	55-0249680-501
a Plan name	PARKERSBURG MARIETTA CONTRACTORS ASSOCIATION CBWV BENEFIT PLAN		
b Name of plan sponsor	PARKERSBURG MARIETTA CONTRACTORS ASSOCIATION	**c** EIN-PN	55-0619428-501
a Plan name	PARKERSBURG PLUMBING SUPPLIES CBWV BENEFIT PLAN		
b Name of plan sponsor	PARKERSBURG PLUMBING SUPPLIES	**c** EIN-PN	86-3005332-501
a Plan name	PDGC BRIDGEPORT LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	PDGC BRIDGEPORT LLC	**c** EIN-PN	81-3315539-501
a Plan name	POTOMAC NORTH CBWV BENEFIT PLAN		
b Name of plan sponsor	POTOMAC NORTH	**c** EIN-PN	83-1810114-501
a Plan name	PRESTON URGENT CARE FAMILY PRACTICE CBWV BENEFIT PLAN		
b Name of plan sponsor	PRESTON URGENT CARE FAMILY PRACTICE	**c** EIN-PN	80-0768402-501
a Plan name	PROFESSIONAL HOME CARE LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	PROFESSIONAL HOME CARE LLC	**c** EIN-PN	59-3804097-501
a Plan name	RANDOLPH FUNERAL HOME & CREMATORIUM CBWV BENEFIT PLAN		
b Name of plan sponsor	RANDOLPH FUNERAL HOME & CREMATORIUM	**c** EIN-PN	26-3096385-502
a Plan name	RBCH VENTURES CBWV BENEFIT PLAN		
b Name of plan sponsor	RBCH VENTURES	**c** EIN-PN	46-1505030-501
a Plan name	RIDGE KIDS ACADEMY CBWV BENEFIT PLAN		
b Name of plan sponsor	RIDGE KIDS ACADEMY	**c** EIN-PN	87-4006094-501
a Plan name	RITCHIE COUNTY PRIMARY CARE ASSOCIATION, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	RITCHIE COUNTY PRIMARY CARE ASSOCIATION, INC.	**c** EIN-PN	55-0737963-501
a Plan name	RUCKMAN EXCAVATING, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	RUCKMAN EXCAVATING, INC.	**c** EIN-PN	55-0777034-501

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	S & V OLEARY, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	S & V OLEARY, LLC	**c** EIN-PN	83-2356694-501
a Plan name	SEDOSKY & ASSOCIATES PLLC CBWV BENEFIT PLAN		
b Name of plan sponsor	SEDOSKY & ASSOCIATES PLLC	**c** EIN-PN	46-4262621-501
a Plan name	SHINNSTON PLUMBING COMPANY CBWV BENEFIT PLAN		
b Name of plan sponsor	SHINNSTON PLUMBING COMPANY	**c** EIN-PN	55-0622568-501
a Plan name	SIR SPEEDY PRINTING CBWV BENEFIT PLAN		
b Name of plan sponsor	SIR SPEEDY PRINTING	**c** EIN-PN	82-2031251-501
a Plan name	SOLAR HOLLER LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	SOLAR HOLLER LLC	**c** EIN-PN	46-3187775-501
a Plan name	SOUTHERN WV ORAL & MAXILLOFACIAL SURGEONS CBWV BENEFIT PLAN		
b Name of plan sponsor	SOUTHERN WV ORAL & MAXILLOFACIAL SURGEONS	**c** EIN-PN	55-0757108-501
a Plan name	STATEWIDE SERVICE CBWV BENEFIT PLAN		
b Name of plan sponsor	STATEWIDE SERVICE	**c** EIN-PN	55-0640541-501
a Plan name	STEPPING STONE, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	STEPPING STONE, INC.	**c** EIN-PN	55-0579420-503
a Plan name	STUDIO MK, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	STUDIO MK, LLC	**c** EIN-PN	46-3285889-501
a Plan name	SUNSHINE RECLAMATION INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	SUNSHINE RECLAMATION INC.	**c** EIN-PN	25-1838736-501
a Plan name	T-BODY AUTO BODY REPAIR CBWV BENEFIT PLAN		
b Name of plan sponsor	T-BODY AUTO BODY REPAIR	**c** EIN-PN	51-0499774-501
a Plan name	THE AUTO SHOP CBWV BENEFIT PLAN		
b Name of plan sponsor	THE AUTO SHOP	**c** EIN-PN	13-4260661-501

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	THE DIRT DOCTOR INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	THE DIRT DOCTOR INC.	**c** EIN-PN	83-1100326-501
a Plan name	THE FLOORING CENTER, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	THE FLOORING CENTER, LLC	**c** EIN-PN	20-1014431-501
a Plan name	THE JAMES AND LAW COMPANY CBWV BENEFIT PLAN		
b Name of plan sponsor	THE JAMES AND LAW COMPANY	**c** EIN-PN	55-0202740-501
a Plan name	THE STICK COMPANY CBWV BENEFIT PLAN		
b Name of plan sponsor	THE STICK COMPANY	**c** EIN-PN	33-1129952-501
a Plan name	THREE-D DRILLING, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	THREE-D DRILLING, INC	**c** EIN-PN	31-1562527-501
a Plan name	TJD FOODS, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	TJD FOODS, INC.	**c** EIN-PN	55-0815227-501
a Plan name	TOP NOTCH LANDSCAPING & SUPPLY LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	TOP NOTCH LANDSCAPING & SUPPLY LLC	**c** EIN-PN	90-1021218-501
a Plan name	TRACTOR PROS, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	TRACTOR PROS, INC.	**c** EIN-PN	35-2304425-501
a Plan name	TRAVIS PHYSICAL THERAPY & SPORTS MEDICINE, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	TRAVIS PHYSICAL THERAPY & SPORTS MEDICINE, INC.	**c** EIN-PN	55-0743660-501
a Plan name	TRIPLE S MOTORCYCLE COMPANY CBWV BENEFIT PLAN		
b Name of plan sponsor	TRIPLE S MOTORCYCLE COMPANY	**c** EIN-PN	30-0048818-501
a Plan name	TYGART VALLEY UNITED WAY INC CBWV BENEFIT PLAN		
b Name of plan sponsor	TYGART VALLEY UNITED WAY INC	**c** EIN-PN	55-0368459-501
a Plan name	UNIGLOBE OHIO VALLEY TRAVEL CBWV BENEFIT PLAN		
b Name of plan sponsor	UNIGLOBE OHIO VALLEY TRAVEL	**c** EIN-PN	55-0562341-501

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	UNITED FINANCIAL CENTER, LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	UNITED FINANCIAL CENTER, LLC	**c** EIN-PN	45-2488311-501
a Plan name	UNITED SOUND & ELECTRONICS LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	UNITED SOUND & ELECTRONICS LLC	**c** EIN-PN	26-0168305-501
a Plan name	UNITED WAY ALLIANCE OF THE MID-OHIO VALLEY CBWV BENEFIT PLAN		
b Name of plan sponsor	UNITED WAY ALLIANCE OF THE MID-OHIO VALLEY	**c** EIN-PN	55-0403123-501
a Plan name	UNITED WAY OF THE UPPER OHIO VALLEY, INC. CBWV BENEFIT PLAN		
b Name of plan sponsor	UNITED WAY OF THE UPPER OHIO VALLEY, INC.	**c** EIN-PN	55-0479446-501
a Plan name	VAST VENDING, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	VAST VENDING, INC	**c** EIN-PN	55-0765643-501
a Plan name	WELLNESS ON THE MON LLC CBWV BENEFIT PLAN		
b Name of plan sponsor	WELLNESS ON THE MON LLC	**c** EIN-PN	84-1851573-501
a Plan name	WEST VIRGINIA WOMEN WORK, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	WEST VIRGINIA WOMEN WORK, INC	**c** EIN-PN	55-0775351-501
a Plan name	WETZEL COUNTY CENTER FOR CHILDREN AND FAMILY, INC CBWV BENEFIT PLAN		
b Name of plan sponsor	WETZEL COUNTY CENTER FOR CHILDREN AND FAMILY, INC	**c** EIN-PN	55-0755137-501
a Plan name	WHEELING SYMPHONY SOCIETY CBWV BENEFIT PLAN		
b Name of plan sponsor	WHEELING SYMPHONY SOCIETY	**c** EIN-PN	55-6000958-501
a Plan name	WHITE HALL PHARMACY CBWV BENEFIT PLAN		
b Name of plan sponsor	WHITE HALL PHARMACY	**c** EIN-PN	42-1699265-501
a Plan name	WILLIAMS PHARMACY HOLDINGS CBWV BENEFIT PLAN		
b Name of plan sponsor	WILLIAMS PHARMACY HOLDINGS	**c** EIN-PN	46-3535669-501
a Plan name	WITHROW'S AUTO SERVICE CBWV BENEFIT PLAN		
b Name of plan sponsor	WITHROWS AUTO SERVICE	**c** EIN-PN	55-0605486-501

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

▶ **File as an attachment to Form 5500.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
CHAMBER ASSOCIATION BENEFIT PLAN TRUST

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
CHAMBER ASSOCIATION BENEFIT PLAN

D Employer Identification Number (EIN)
82-2769605

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.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	148469	657890
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	430530	28853
(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)	14211	1148

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e		
f Total assets (add all amounts in lines 1a through 1e)	1f	593210	687891
Liabilities			
g Benefit claims payable	1g		
h Operating payables	1h	86088	95385
i Acquisition indebtedness	1i		
j Other liabilities	1j	282085	0
k Total liabilities (add all amounts in lines 1g through1j)	1k	368173	95385
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	225037	592506

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)		
(B) Participants	2a(1)(B)		
(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)		0
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	11928	
(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)		11928
(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)		0
(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)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		11928
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)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		0
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)	895946	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	26956	
(5) Investment advisory and investment management fees	2i(5)	1724	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	18511	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		943137
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		943137
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-931209
l Transfers of assets:			
(1) To this plan	2l(1)		11322967
(2) From this plan	2l(2)		10024289

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) [X] 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)** [X] 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: MALONEY + NOVOTNY LLC **(2)** EIN: 34-0677006

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.)	4a			
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.)	4b		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.)	4c		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.)	4d		X	
e Was this plan covered by a fidelity bond?	4e			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f			
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?	4g			
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?	4h			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i		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.)	4j			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k			
l Has the plan failed to provide any benefit when due under the plan?	4l			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
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.	4n			

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 _____.

CHAMBER ASSOCIATION BENEFIT PLAN TRUST

FINANCIAL REPORT

DECEMBER 31, 2024 and 2023

CHAMBER ASSOCIATION BENEFIT PLAN TRUST

CONTENTS

	Page
INDEPENDENT AUDITORS' REPORT	1-2
FINANCIAL STATEMENTS	
Statements of net assets	3
Statement of changes in net assets	4
Notes to financial statements	5-7
SUPPLEMENTAL SCHEDULE	
Schedule of operating expenses for the year ended December 31, 2024	8

MALONEY + NOVOTNY LLC

+ 1111 Superior Avenue, Suite 700, Cleveland, Ohio 44114
+ p 216.363.0100 | f 216.363.0500
+ www.maloneynovotny.com

Independent Auditors' Report

To the Board of Trustees of
Chamber Association Benefit Plan Trust
Wheeling, West Virginia

Opinion

We have audited the financial statements of the Chamber Association Benefit Plan Trust (the "Trust"), which comprise the statements of net assets as of December 31, 2024 and 2023, and the related statement of changes in net assets for the year ended December 31, 2024, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets of the Trust as of December 31, 2024 and 2023, and the changes in its net assets for the year ended December 31, 2024 in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audits of the Financial Statements section of our report. We are required to be independent of the 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.

Other Matter

The accompanying financial statements are those of the Trust. These financial statements do not purport to present the net assets available for benefits and plan benefit obligations or the changes in net assets available for benefits or changes in plan benefit obligations of the participating plans and do not contain certain information and other disclosures necessary for a fair presentation of the financial statements of the participating plans in accordance with accounting principles generally accepted in the United States of America. Further, these financials statements do not purport to satisfy the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("ERISA") relating to the financial statements of employee benefit plans.

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 the Trust's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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 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 audits, significant audit findings, and certain internal control related matters that we identified during the audits.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of operating expenses for the year ended December 31, 2024 is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In our opinion, the information in the accompanying schedule is fairly stated in all material respects, in relation to the financial statements as a whole.

Maloney + Novotny LLC

Cleveland, Ohio
October 9, 2025

CHAMBER ASSOCIATION BENEFIT PLAN TRUST

STATEMENTS OF NET ASSETS

December 31, 2024 and 2023

	2024	2023
ASSETS		
Cash	$ 28,853	$ 430,530
Receivables:		
Net reinsurance receivable	308,673	-
Healthcare receivable	341,247	138,909
Other receivables	7,970	9,560
Total receivables	657,890	148,469
Prepaids	1,148	14,211
Total assets	687,891	593,210
LIABILITIES		
Accounts payable and other	95,385	86,088
Net reinsurance payable	-	282,085
Total liabilities	95,385	368,173
NET ASSETS	$ 592,506	$ 225,037

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

CHAMBER ASSOCIATION BENEFIT PLAN TRUST

STATEMENT OF CHANGES IN NET ASSETS

Year Ended December 31, 2024

ADDITIONS	
Contributions from participating plans	$ 9,201,967
Interest income	11,928
Total additions	9,213,895
DEDUCTIONS	
Distributions to participating plans for benefit claims paid, net of reinsurance recoveries	9,001,935
Distributions to participating plans for premiums paid for the provision of benefits, net of ceding allowances	1,022,354
Total distributions to participating plans	10,024,289
Operating expenses	943,137
Total deductions	10,967,426
DECREASE IN NET ASSETS	(1,753,531)
NET ASSETS	
BEGINNING OF YEAR	225,037
Capital contribution	2,121,000
END OF YEAR	$ 592,506

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

Note 1. Description of the Trust

The following description of the Chamber Association Benefit Plan Trust (the "Trust") provides only general information. Participating plans should refer to the Trust agreement for a more complete description of the Trust's provisions.

General:

The Trust is intended to be a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code (the "IRC"). The purpose of the Trust is to hold Plan assets of a non-plan multiple employer welfare arrangement ("MEWA") as described in the Code and Regulations of the State of West Virginia and to pay those Plans' benefits and expenses. Employers of plans participating in this Trust (the "Plans") are employers in good standing with the Wheeling Chamber of Commerce ("WCC") and affiliates.

Contributions:

The Trust receives contributions for health and welfare coverage from participating Plans. Such funds are utilized for the payment of premiums to IOA Re, LLC ("IOA") for the provision of benefits on behalf of the Plans.

Distributions:

In addition to distributions for the premium payments to IOA described above, distributions are made for the payment of benefit claims. These benefit claims are paid out of the Trust, on behalf of the participating Plans, to IOA. THP Insurance Company ("THP") administers payment of hospital charges, medical/surgical claims and prescription coverage.

Operating Expenses:

All administrative fees are paid by the Trust or the participating Plans at the option of the trustees of the Trust.

Note 2. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by the Trust:

Basis of Presentation:

The accompanying financial statements have been prepared on the accrual basis of accounting.

Net Reinsurance Receivable or Payable:

Net reinsurance receivable or payable represents the net of amounts recoverable for claims paid (including stop loss recoveries) and amounts recoverable for administrative expenses under the quota share reinsurance agreement offset by the amounts payable for premiums ceded under the quota share and stop loss agreements.

Note 2. Summary of Significant Accounting Policies (Continued)

Recognition of Contribution Revenue:

Contribution revenue is recognized in the month for which coverage is being paid. Contributions received after the coverage months are recorded as receivables. Management has estimated an allowance of $-0- for past due accounts for contributions receivable from participating plans as of December 31, 2024 and 2023.

Healthcare Receivable:

Healthcare receivables include pharmacy rebates earned by the Plan. As of December 31, 2024 and December 31, 2023, the Plan had pharmacy rebates receivable of $341,247 and $138,909, respectively. The pharmacy rebates were netted against claims paid.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the trust administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Distributions for the Payment of Premiums and Benefits:

Distributions for the payment of premiums and benefit claims are recorded when processed and approved for payment to IOA.

Subsequent Events:

The Trust has evaluated subsequent events through October 9, 2025, the date the financial statements were available to be issued. Refer to Note 8.

Note 3. Cash

The Trust holds its temporary cash with a national financial institution which at times may exceed federally insured amounts. The actual balance may exceed reported balances due to outstanding checks.

Note 4. Reinsurance

During 2024, the participating Plans were subject to a stop loss reinsurance agreement with IOA for medical and prescription drug coverage. The individual specific stop loss threshold per covered person is $250,000 for the year ended December 31, 2024. The IOA aggregate stop loss threshold is approximately $11,300,000 per policy period for claimants under the individual specific stop loss threshold. The maximum aggregate reimbursement is $10,000,000 per policy period. The total amount of reinsurance recovered due to stop loss was $1,141,545 for the year ended December 31, 2024.

Note 5. Related Party/Party-in-Interest Transactions

The Trust has entered into an administrative services contract with THP, whereby THP collects premiums on behalf of participating Plans, provides quoting, servicing and renewing employers of participating Plans and administers payment of hospital charges, medical/surgical claims and prescription coverage on behalf of participating Plans. These transactions qualify as party-in-interest. Total fees paid from the Trust to THP for these services amounted to $404,474 for 2024.

The Trust has appointed Consoliplex to act as plan manager of the participating Plans and Trust. Fees paid to Consoliplex in 2024 were $170,035. In addition, in the event of insolvency of the Trust, Consoliplex has guaranteed to fund any claims deficit as reasonably determined by the Trust's liquidator or statutory receiver. There is no expiration on the guarantee, however, during December 31, 2024, Consoliplex has paid in $2,121,000 in accordance with the guarantee.

Note 6. Tax Status

The Trust established to hold the participating Plans' net assets is qualified pursuant to Section 501(c)(9) of the IRC. In December 2019, the Internal Revenue Service finalized regulations under IRC Section 512(a)(3)(E)(i) which specified that net investment income earned by a VEBA is taxable as unrelated business income. The Trust's management has analyzed the tax positions taken by the Trust and has concluded that, as of December 31, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Trust is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

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

Note 7. Plan and Trust Termination

On June 16, 2025, the Board of Trustees of the Trust adopted a motion to proceed with steps necessary to wind down operation of the Trust by December 31, 2025. Any Trust assets at the time of termination will be distributed or will be transferred to another trust that complies with the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

The participating Plans' sponsors have the right under the Plans to discontinue their contributions at any time and to terminate the Plans, subject to provisions set forth in ERISA.

SUPPLEMENTAL SCHEDULE

CHAMBER ASSOCIATION BENEFIT PLAN TRUST

SCHEDULE OF OPERATING EXPENSES

Year Ended December 31, 2024

Outsourced services	$ 895,946
Professional services	26,956
Insurance	11,931
Regulatory	3,929
Other	2,651
Bank fees	1,724
Total operating expenses	$ 943,137