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| <p>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>Annual Return/Report of Employee Benefit Plan</p> <p>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>▶ Complete all entries in accordance with the instructions to the Form 5500.</p> | <p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p> |
|---|---|--|

Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

| | |
|---|--|
| <p>1a Name of plan <u>HEALTH & WELFARE FUND IBEW LOCAL 96</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>BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96</u> <u>96</u></p> <p><u>ASSOCIATED ADMINISTRATORS</u> <u>911 RIDGEBROOK ROAD</u> <u>SPARKS, MD 21152-6966</u></p> | <p>1c Effective date of plan <u>09/01/1974</u></p> <p>2b Employer Identification Number (EIN) <u>04-2177839</u></p> <p>2c Plan Sponsor's telephone number <u>203-269-7741</u></p> <p>2d Business code (see instructions) <u>238210</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. | 10/22/2025 | KEVIN MENARD |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | Filed with authorized/valid electronic signature. | 10/23/2025 | JAMES ARTHUR |
| | 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: | | 4b EIN | |
| a Sponsor's name | | | |
| c Plan Name | | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | | 5 | 378 |
| 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) | 269 |
| a(2) Total number of active participants at the end of the plan year | | 6a(2) | 291 |
| b Retired or separated participants receiving benefits..... | | 6b | 105 |
| c Other retired or separated participants entitled to future benefits | | 6c | |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | | 6d | 396 |
| 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 | 47 |

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 4U

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

| | | |
|---|--|--|
| <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> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96</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 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96</p> | <p>D Employer Identification Number (EIN) 04-2177839</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
TUFTS HEALTH MAINTENANCE ORG INC.

| (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 |
| 04-2674079 | 95688 | 79740000 | 555 | 07/01/2023 | 06/30/2024 |

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

| | | |
|--|---------------------------|--------------|
| b Balance at the end of the previous year | 7b | |
| c Additions: (1) Contributions deposited during the year | 7c(1) | |
| | 7c(2) | |
| | 7c(3) | |
| | 7c(4) | |
| | 7c(5) | |
| | (6) Total additions | 7c(6) |
| d Total of balance and additions (add lines 7b and 7c(6)) | 7d | |
| e Deductions: | | |
| | 7e(1) | |
| | 7e(2) | |
| | 7e(3) | |
| | 7e(4) | |
| (5) Total deductions | 7e(5) | 0 |
| 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 | 4713908 |
| 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 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 HEALTH & WELFARE FUND IBEW LOCAL 96 | | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96 | | D Employer Identification Number (EIN) 04-2177839 |

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
HARTFORD LIFE AND ACCIDENT

| (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 |
| 06-0838648 | 70815 | 804179G | 388 | 10/01/2023 | 09/30/2024 |

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

| | | | | |
|--|---------------------------|--------------|-----------|--|
| b Balance at the end of the previous year | | | 7b | |
| c Additions: (1) Contributions deposited during the year | 7c(1) | | | |
| | 7c(2) | | | |
| | 7c(3) | | | |
| | 7c(4) | | | |
| | 7c(5) | | | |
| | (6) Total additions | | | |
| 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) | 0 | |
| 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) ▶ **ACCIDENTAL DEATH & DISMEMBERMENT**

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 | 53044 |
| 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> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96</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 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96</p> | <p>D Employer Identification Number (EIN) 04-2177839</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
BLUE CROSS BLUE SHIELD OF MASS, INC

| (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 |
| 04-1045815 | 53228 | 4957635 | 123 | 01/01/2024 | 12/31/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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 | 538678 |
| 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> |
|---|--|--|

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

| | | |
|---|--|-------------------|
| <p>A Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96</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 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96</p> | <p>D Employer Identification Number (EIN) 04-2177839</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
TUFTS 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 |
| 04-3319729 | 60117 | | 14 | 07/01/2023 | 06/30/2024 |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| | | |
|--|----------|--|
| 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) | 0 | |
| 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 | 115038 |
| b | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

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

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

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

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

| | | |
|---|--|------------|
| A Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96 | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96 | D Employer Identification Number (EIN) 04-2177839 | |

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

THE VANGUARD GROUP, INC

23-1945930

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

PIMCO

33-0629048

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

ROBERT W. BAIRD & CO INC

39-6037917

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

HARDING LOEVNER LP

27-0684167

(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

(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)

ZENITH AMERICAN SOLUTIONS

52-1590516

| (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? |
|------------------------|---|--|--|--|---|--|
| 13 12 50 | NONE | 102252 | 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)

SEGAL ROITMAN, LLP

04-2489114

| (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 | 39901 | 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)

DELTA DENTAL OF MA

04-6143185

| (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? |
|------------------------|---|--|--|--|---|--|
| 13 50 | NONE | 23826 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

SEGAL CONSULTING GROUP

06-0839113

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 11 50 | NONE | 20257 | 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)

NOVAK FRANCELLA, LLC

61-1436956

| (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 | 12046 | 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)

INTERCONTINENTAL REAL ESTATE

11-3786306

| (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? |
|------------------------|---|--|--|--|---|--|
| 28 51 | NONE | 11060 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

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

MODERN ASSISTANCE

300 CONGRESS ST, STE 104
QUINCY, MA 02169

| (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? |
|------------------------|---|--|--|--|---|--|
| 99 50 | NONE | 10766 | 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)

SEGAL MARCO

13-2626110

| (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? |
|------------------------|---|--|--|--|---|--|
| 27 50 | NONE | 6600 | 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)

THE ANGELL GROUP

04-2530412

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 11 50 | NONE | 5325 | 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 |
|--|--|--|

| | |
|---|--|
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024 | |
| A Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96 | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96 | D Employer Identification Number (EIN) 04-2177839 |

| | |
|---------------|--------------------------------------|
| 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 | 727403 | 1157202 |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 627752 | 888175 |
| (2) Participant contributions | 1b(2) | | |
| (3) Other | 1b(3) | 422190 | 524879 |
| 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) | 794536 | 750784 |
| (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) | 8021211 | 8783773 |
| (14) Value of funds held in insurance company general account (unallocated contracts) | 1c(14) | | |
| (15) Other | 1c(15) | | |

| 1d Employer-related investments: | | (a) Beginning of Year | (b) End of Year |
|---|-------|-----------------------|-----------------|
| (1) Employer securities..... | 1d(1) | | |
| (2) Employer real property..... | 1d(2) | | |
| e Buildings and other property used in plan operation..... | 1e | | |
| f Total assets (add all amounts in lines 1a through 1e)..... | 1f | 10593092 | 12104813 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | 166984 | 14805 |
| h Operating payables..... | 1h | 104261 | 185078 |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | | 73260 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 271245 | 273143 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 10321847 | 11831670 |

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) | 6596031 | |
| (B) Participants..... | 2a(1)(B) | 562247 | |
| (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) | | 7158278 |
| 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) | 34222 | |
| (G) Total interest. Add lines 2b(1)(A) through (F)..... | 2b(1)(G) | | 34222 |
| (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) | 316365 | |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C)..... | 2b(2)(D) | | 316365 |
| (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) | -66914 | |
| (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) | | 446197 |
| c Other income | 2c | | |
| d Total income. Add all income amounts in column (b) and enter total..... | 2d | | 7888148 |

Expenses

| | | | |
|--|--------|---------|---------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers..... | 2e(1) | 76671 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | 6051612 | |
| (3) Other..... | 2e(3) | | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 6128283 |
| 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) | 136844 | |
| (3) Recordkeeping fees | 2i(3) | 2046 | |
| (4) IQPA audit fees | 2i(4) | 10000 | |
| (5) Investment advisory and investment management fees | 2i(5) | 17660 | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | | |
| (7) Actuarial fees | 2i(7) | 25582 | |
| (8) Legal fees | 2i(8) | 39901 | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses..... | 2i(11) | 18009 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 250042 |
| j Total expenses. Add all expense amounts in column (b) and enter total..... | 2j | | 6378325 |

Net Income and Reconciliation

| | | | |
|--|-------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d..... | 2k | | 1509823 |
| 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: **NOVAK FRANCELLA, LLC**

(2) EIN: **61-1436956**

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 | | 3000000 |
| 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.) | | | |
| 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 _____.

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

FINANCIAL STATEMENTS

DECEMBER 31, 2024

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

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INDEPENDENT AUDITOR'S REPORT

Board of Trustees of the
Health and Welfare Fund
IBEW Local 96

Opinion

We have audited the financial statements of the Health and Welfare Fund IBEW Local 96 (the Plan), 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 years then ended, and the related notes to the financial statements.

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America, 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 Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedules of Benefits Paid, Insurance Premiums and Administrative Service Fees, Schedules of Administrative Expenses, and Schedule of Assets Held at End of Year together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The Schedule of Assets Held at End of Year represent supplemental information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. Supplemental 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 GAAS.

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

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

Novak Francella LLC

Killingworth, Connecticut
October 16, 2025

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

| | 2024 | 2023 |
|--|---------------|---------------|
| ASSETS | | |
| INVESTMENTS - at fair value | | |
| Registered investment companies | \$ 8,783,773 | \$ 8,021,211 |
| Limited partnership | 750,784 | 794,536 |
| Total investments | 9,534,557 | 8,815,747 |
| RECEIVABLES | | |
| Employer contributions | 700,171 | 464,368 |
| Reciprocal contributions | 188,004 | 163,384 |
| Total receivables | 888,175 | 627,752 |
| OTHER ASSETS | | |
| Cash | 1,157,202 | 727,403 |
| Prepaid expenses | 491,579 | 387,700 |
| Delta Dental reserves | 33,300 | 33,300 |
| Due from Pension Fund | - | 595 |
| Due from Annuity Fund | - | 595 |
| Total other assets | 1,682,081 | 1,149,593 |
| Total assets | 12,104,813 | 10,593,092 |
| LIABILITIES AND NET ASSETS | | |
| LIABILITIES | | |
| Accounts payable | 18,174 | 20,903 |
| Reciprocals payable | 166,904 | 83,358 |
| Deferred revenue | 73,260 | - |
| Total liabilities | 258,338 | 104,261 |
| NET ASSETS AVAILABLE FOR BENEFITS | \$ 11,846,475 | \$ 10,488,831 |

See accompanying notes to financial statements.

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

STATEMENTS OF CHANGES NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

| | 2024 | 2023 |
|---|---------------|---------------|
| ADDITIONS | | |
| Investment income | | |
| Dividends and capital gains | \$ 350,587 | \$ 291,716 |
| Net appreciation in fair value of investments | 379,283 | 411,760 |
| | 729,870 | 703,476 |
| Less: investment fees | (17,660) | (17,113) |
| Net investment income | 712,210 | 686,363 |
| Contributions | | |
| Employers | 6,672,283 | 5,177,363 |
| Employees | 562,247 | 443,242 |
| Reciprocal agreements, net | (76,252) | 133,246 |
| Total contributions | 7,158,278 | 5,753,851 |
| Other | | |
| Benefits recovered | - | 26,950 |
| Total additions | 7,870,488 | 6,467,164 |
| DEDUCTIONS | | |
| Benefits paid | 228,850 | 182,023 |
| Insurance premiums and administrative service fees | 6,088,076 | 5,081,277 |
| Administrative expenses | 195,918 | 185,374 |
| Total deductions | 6,512,844 | 5,448,674 |
| NET INCREASE | 1,357,644 | 1,018,490 |
| NET ASSETS AVAILABLE FOR BENEFITS | | |
| Beginning of year | 10,488,831 | 9,470,341 |
| End of year | \$ 11,846,475 | \$ 10,488,831 |

See accompanying notes to financial statements.

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

STATEMENTS OF BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

| | 2024 | 2023 |
|---|---------------|---------------|
| AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES AND DEPENDENTS: | | |
| Claims payable | \$ 12,685 | \$ 166,449 |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS: | | |
| Claims incurred but not reported | 2,120 | 535 |
| Accumulated eligibility credits | 4,822,288 | 4,565,265 |
| | 4,824,408 | 4,565,800 |
| Total obligations other than postretirement benefit obligations | 4,837,093 | 4,732,249 |
| POSTRETIREMENT BENEFIT OBLIGATIONS - NET OF AMOUNTS CURRENTLY PAYABLE | | |
| Current retirees, spouses and beneficiaries | 1,047,596 | 1,017,083 |
| Other participants fully eligible for benefits | 975,819 | 1,414,346 |
| Other participants not fully eligible for benefits | 5,259,881 | 6,603,047 |
| Total postretirement benefit obligations | 7,283,296 | 9,034,476 |
| TOTAL BENEFIT OBLIGATIONS | \$ 12,120,389 | \$ 13,766,725 |

See accompanying notes to financial statements.

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

| | 2024 | 2023 |
|---|----------------------|----------------------|
| AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES AND DEPENDENTS | | |
| Balance at beginning of year | \$ 166,449 | \$ 18,741 |
| Claims incurred | 75,086 | 329,731 |
| Claims paid | (228,850) | (182,023) |
| Balance at end of year | 12,685 | 166,449 |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS | | |
| Balance at beginning of year | 4,565,800 | 4,637,549 |
| Net changes during the year: | | |
| Claims incurred but not reported | 1,585 | (1,202) |
| Accumulated eligibility credits | 257,023 | (70,547) |
| Balance at end of year | 4,824,408 | 4,565,800 |
| Total obligations other than postretirement benefit obligations | 4,837,093 | 4,732,249 |
| POSTRETIREMENT BENEFIT OBLIGATIONS | | |
| Balance at beginning of year | 9,034,476 | 8,364,854 |
| Decrease during the year attributable to expected benefit payments | (487,317) | (499,078) |
| Increase from interest due to the decrease in discount period | 417,564 | 401,708 |
| Benefits earned during the year and other actuarial experience | (943,819) | 583,621 |
| Changes in actuarial assumptions | (737,608) | 183,371 |
| Balance at end of year | 7,283,296 | 9,034,476 |
| TOTAL BENEFIT OBLIGATIONS | \$ 12,120,389 | \$ 13,766,725 |

See accompanying notes to financial statements.

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF PLAN

The following description of the Health and Welfare Fund IBEW Local 96 (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

The Plan is a collectively bargained multiemployer plan that was established in 1954 under an agreement between the National Electrical Contractors Association (NECA) and the IBEW Local 96 Labor Union (the Union), with amendments since that time, and is maintained pursuant to collective bargaining agreements which provide for the rate of employer contributions, the type of work and areas of work for which contributions are payable and certain other terms governing contributions. The Plan is administered by a Board of Trustees (Trustees) consisting of both labor and management. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Benefits - The Plan provides medical, prescription, dental, vision, disability, death and accidental death and dismemberment benefits to eligible members and their dependents. Participants are generally eligible upon completion of three hundred (300) hours of work in covered employment in a six consecutive month period. Medical, prescription and life insurance benefits are fully insured while dental, vision and disability benefits are provided on a self-insured basis. The Plan also permits retired members who meet certain qualification requirements and make the required self-payments to maintain eligibility for the Plan's medical, prescription drug and life insurance benefits, and permits Medicare - eligible retirees to pay for coverage under one of two Medicare Supplement Plans.

During each accumulation period (each calendar six-month period, January 1 through June 30 and July 1 through December 31), any hours worked by the participant that are in excess of 800 hours are credited to the participant's bank of surplus hours up to a maximum of eighteen hundred (1,800) hours for participants under the age of 55, and three thousand (3,000) hours for participants at or over the age of 55. A participant's account will be frozen if they opt out, and they may access it at a future date after meeting certain requirements. Non-collectively bargained participants are not eligible to bank surplus hours.

Members who are no longer eligible under normal provisions of the Plan may obtain continuing coverage through self-payment contributions at a fixed premium level, based on coverage selected by the member. The length of self-payment varies.

NOTE 1. DESCRIPTION OF PLAN (continued)

Funding - Contributions to the Plan are made by participating employers in the central Massachusetts area at rates established by the collective bargaining agreement. The collective bargaining agreement (Inside (Basic) Agreement) which was effective for the period September 1, 2020 through August 31, 2023 provides for an hourly contribution rate of \$11.57 effective September 5, 2021 and \$12.20 effective September 4, 2022.

The collective bargaining agreement (Inside (Basic) Agreement) which is effective for the period September 1, 2023 through August 31, 2027 provides for an hourly contribution rate of \$13.00 effective September 3, 2023; \$13.99 effective September 4, 2024; \$14.98 effective September 7, 2025; and \$15.96 effective September 6, 2026.

Contributions from 10 employers comprised 79% percent of total contributions for 2024. Employer contributions are accounted for as exchange transactions.

The Voice-Data-Video Agreement, which is effective for the period September 1, 2020 through August 31, 2023 provides for an hourly contribution rate of \$11.13 effective September 6, 2020; \$11.57 effective September 5, 2021 and \$12.20 effective September 4, 2022.

The Voice-Data-Video Agreement, which is effective for the period September 1, 2023 through August 31, 2027 provides for an hourly contribution rate of \$13.00 effective September 3, 2023; \$13.99 effective September 4, 2024; \$14.98 effective September 7, 2025; and \$15.96 effective September 6, 2026.

Retiree and spouse contribution rates are periodically reset by the Trustees. The annual medical/prescription drug contributions for the years beginning January 1, 2024 and 2023 for Medicare and non-Medicare retirees, respectively, are shown in the following table:

| | <u>January 1, 2024</u> | <u>January 1, 2023</u> |
|--|------------------------|------------------------|
| | <u>Individual</u> | <u>Individual</u> |
| Medicare eligible: | | |
| Blue Cross Blue Shield of Massachusetts | \$ 4,324 | \$ 3,915 |
| Non-Medicare eligible: | | |
| Tufts HMO Plan | \$ 9,725 | \$ 8,752 |

There are no retiree contributions for a member with banked surplus hours.

Teledata participants are required to make co-payments of \$85 per month.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from these estimates.

Valuation of Investments - Subject to an investment policy adopted by the Trustees, the investment manager has discretionary authority concerning purchases and sales of investments which consist of registered investment companies and a limited partnership.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year

See Note 11 for discussion of fair value measurements.

Employer Contributions Receivable - Employer contributions due but not paid prior to year-end are recorded as contributions receivable.

The Plan believes that the receivables are fully collectible; therefore, no allowance for credit losses is recorded for the years ended December 31, 2024 and 2023.

Credit Risk - The Plan maintains its cash with a financial institution deemed to be credit worthy. Cash balance is insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 in a single bank. As of December 31, 2024, cash on deposit with Santander Bank totaling \$1,698,220 exceeded FDIC coverage in a single bank by \$1,448,220.

NOTE 3. POSTRETIREMENT BENEFIT OBLIGATIONS

Postretirement benefits include future benefits expected to be paid to or for eligible (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing participants. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service in the industry rendered to the valuation date.

NOTE 3. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

For measurement purposes, the following health trend rates were assumed:

| | Years Ended December 31, | |
|-----------------|---|---|
| | 2024 | 2023 |
| Pre 65 Medical | 6.00% per year graded down using Getzen model to an ultimate rate of 4.04% per year in 2075. | 6.40% per year graded down using Getzen model to an ultimate rate of 4.04% per year in 2076. |
| Post 65 Medical | 6.00% per year graded down using Getzen model to an ultimate rate of 4.04% per year in 2075. | 6.40% per year graded down using Getzen model to an ultimate rate of 4.04% per year in 2076. |

Valuation assumption changes since the prior valuation are as follows:

- The discount rate of 5.45% (previously, 4.75%).
- The PRI-2012 Mortality Table with MP-2021 Generational Projection (M/F).
- Retirement eligibility:
 - Age 60 & 10 years service
 - Age 65 & 5 years service

The following were other significant assumptions used in the valuations at December 31, 2024 and 2023:

- Valuation Method: The Projected Unit Credit actuarial cost method was used to determine liabilities as required by FASB ASC 965. Under this method, the postretirement health costs are assumed to be earned ratably from date of hire to the participant's full eligibility age.

NOTE 3. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

- Administrative expenses are assumed to be \$25 per member/ per month.
- Withdrawal rates for active participants follow the “T-3” withdrawal table.
- All employees eligible for postretirement benefits have been included in the valuation, including those eligible for a subsidy under Medicare Supplemental Plan. It is assumed that 80% of future eligible retirees and their dependents will elect healthcare coverage upon retirement.
- Per Capita Costs: To determine the assumed per capita claims cost, the per capita claims cost by age based on historical claims costs is adjusted for assumed health care cost trend rates. The resulting assumed per capita claims cost by age reflects expected future costs and is applied with the plan demographics to determine the amount and timing of future gross eligible charges.

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

The Fund indirectly provides post-65 prescription drug coverage through insurance providers and the retiree pays 90% of the cost of the insurance providers’ monthly premium through the Fund. The Fund’s actuary has been told that the prescription drug benefit offered by the Fund is considered to be actuarially equivalent to the Medicare Part D benefit.

The weighted-average health care cost-trend assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rate increased by one percentage point in each year, it would increase the obligation as of December 31, 2024 and 2023 by \$981,687 and \$1,512,387, respectively.

NOTE 4. CLAIMS PAYABLE AND INCURRED BUT NOT REPORTED

Benefit claims currently payable include the Plan’s liability for claims incurred as of December 31, 2024 and 2023 but not reported. The Plan’s liability for claims incurred but not reported is estimated by taking into consideration prior claims experience and the expected time period from the date such claims are incurred to the date that the related claims are submitted and paid, as presented in lag data reports prepared by the third party plan administrator. Health claims incurred by retired participants but not reported at year end are included in claims incurred but not reported.

NOTE 5. LIABILITY FOR ACCUMULATED ELIGIBILITY CREDITS

The liability for accumulated eligibility credits at December 31, 2024 and 2023 has been estimated by the Plan's actuary in accordance with accepted actuarial principles. An obligation for accumulated eligibility credits occurs when a Plan allows for benefit coverage subsequent to covered employment. The calculation used covered active plan population on December 31, 2024. The calculation is based on the understanding that a participant may "bank" up to 3,000 hours to be used at times when the participant would not have met the Plan's eligibility requirement. Also, a participant will have up to 600 hours removed from the bank to provide coverage for six months, if sufficient hours are not worked. In the calculation of the Plan's Accumulated Eligibility Credits, a contribution rate of \$11.57 per hour was used.

NOTE 6. BENEFITS ADMINISTRATION

The Plan has an agreement with Tufts Health Plan to provide medical and prescription drug insurance to eligible members and their dependents. Under the agreement, plan participants are enrolled in the Tufts Health Plan HMO Choice Copay Plan.

The Plan has an agreement with Blue Cross Blue Shield of Massachusetts to provide a Medicare supplement plan for retirees requiring a monthly premium of \$400 and \$363 during the year ended December 2024 and 2023, respectively.

Subsequent to year end, the fund entered into an agreement with Labor First, LLC to provide Retiree Benefit Management Services with Aetna providing the Medicare Advantage and Prescription Drug benefits, effective January 1, 2025 for a monthly rate of \$423.

The Plan provides for accidental death and dismemberment and life insurance through a policy with Aetna Life Insurance Company.

The Plan had a contract with Zenith American Solutions (Zenith), a third-party administrator, to administer the Plan. The contract provides for a monthly fee of \$8,532 effective July 1, 2022. In addition, there is a claims processing fee equal to 6.50% of paid vision, dental, orthodontic, TJD and short term disability benefits payable monthly. These agreements shall be extended automatically for twelve-month periods without further action by either party unless terminated.

The Plan has an agreement with Delta Dental to administer self-insured dental benefits at a monthly fee of \$6.94 per member.

NOTE 7. PLAN TERMINATION

The Trustees expect and intend to continue the Plan indefinitely but reserve the right to amend or terminate it. In the event the Plan terminates, the Trustees shall first apply the net assets to any obligations outstanding and any remaining balance in such manner as will best effectuate the purpose of the Plan. Under no circumstances shall any portion of the Plan, directly or indirectly, revert or accrue to the benefit of any contributing employer or the union.

NOTE 8. TAX STATUS

The Plan obtained its latest determination letter on October 7, 1994, in which the Internal Revenue Service stated that the Plan, as then designed, was exempt from federal income tax under Section 501(c)(9) of the Internal Revenue Code (the Code). The Plan has been amended since receiving this determination letter. However, the Plan's legal counsel believes that the Plan is currently designed, and the Plan administrator believes that the Plan is currently being operated in compliance with the applicable requirements of the Code. Therefore, they believe that the Plan is tax-exempt under Section 501(c)(9) of the Code as of the financial statement date.

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 if the Plan has taken an uncertain position that, more likely than not, would not be sustained upon examination by the U.S. Federal, state, or local taxing authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Typically, plan tax years will remain open for three years; however, this may differ depending upon the circumstances of the Plan.

NOTE 9. RECIPROCAL CONTRIBUTIONS

Reciprocal contributions represent amounts received from other International Brotherhood of Electrical Workers Funds for hours worked by electrical workers who are members of the Union. The contributions are based on the rate stated in the collective bargaining agreement where the work is performed.

NOTE 10. 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:

| | December 31, | |
|--|----------------------|----------------------|
| | 2024 | 2023 |
| Net assets available for benefits per the financial statements | \$ 11,846,475 | \$ 10,488,831 |
| Benefit obligations currently payable | <u>(14,805)</u> | <u>(166,984)</u> |
| Net assets available for benefits per the Form 5500 | <u>\$ 11,831,670</u> | <u>\$ 10,321,847</u> |

NOTE 10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (continued)

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500:

| | <u>Year Ended December 31, 2024</u> |
|--|---|
| Benefits paid to participants per the financial statements | \$ 6,280,462 |
| Add: Amounts currently payable at December 31, 2024 | 14,805 |
| Less: Amounts currently payable at December 31, 2023 | <u>(166,984)</u> |
| Benefits paid to participants per the Form 5500 | <u>\$ 6,128,283</u> |

Amounts currently payable to or for participants, dependents and beneficiaries are recorded on the Form 5500 for benefit claims that have been processed and approved for payment prior to December 31, but not yet paid as of that date and for claims incurred but not reported as of that date.

NOTE 11. FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

Basis of Fair Value Measurement:

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

Level 2 - Inputs to the valuation methodology include: quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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

NOTE 11. FAIR VALUE MEASUREMENTS (continued)

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

The following is a description of the fair valuation methodologies used for assets and liabilities measured at fair value, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Registered Investment Companies - The registered investment companies' investments are valued at their net asset value (NAV) of shares held by the Plan at year end and are classified within level 1 of the valuation hierarchy.

Limited partnership: The partnership invests in equities, fixed income, and debt securities as well as real estate, mortgages below investment grade debt, buy-out and special situation equities, venture/growth capital funds and other partnerships. The partnership is valued using NAV as a practical expedient. The NAV is as determined and reported in good faith by the underlying partnerships investment manager.

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2024:

| | Fair Value Measurements at December 31, 2024 | | | |
|---------------------------------|--|--------------|---------|---------|
| | Total | Level 1 | Level 2 | Level 3 |
| Registered investment companies | \$ 8,783,773 | \$ 8,783,773 | \$ - | \$ - |
| | 8,783,773 | \$ 8,783,773 | \$ - | \$ - |
| Investments measured at NAV(a) | 750,784 | | | |
| Total investments | \$ 9,534,557 | | | |

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2023:

NOTE 11. FAIR VALUE MEASUREMENTS (continued)

| | Fair Value Measurements at December 31, 2023 | | | |
|---------------------------------|--|---------------------|-------------|-------------|
| | Total | Level 1 | Level 2 | Level 3 |
| Registered investment companies | \$ 8,021,211 | \$ 8,021,211 | \$ - | \$ - |
| | 8,021,211 | <u>\$ 8,021,211</u> | <u>\$ -</u> | <u>\$ -</u> |
| Investments measured at NAV(a) | <u>794,536</u> | | | |
| Total investments | <u>\$ 8,815,747</u> | | | |

(a) In accordance with Subtopic 820-10 certain investments that were measured at net asset value per share (or its equivalent) have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the line items in the statements of net assets for benefits.

The following table summarizes an investment measured at fair value based on its equivalent per share at December 31, 2024 and 2023, respectively:

| | 2024 Fair Value | 2023 Fair Value | Unfunded Commitments | Redemption Frequency | Redemption Notice Period |
|---------------------------------------|--------------------|--------------------|-------------------------|-------------------------|-----------------------------|
| Limited partnership: | | | | | |
| U.S. Real Estate Investment Fund, LLC | <u>\$ 750,784</u> | <u>\$ 794,536</u> | <u>\$ -</u> | Quarterly | 90 days |

NOTE 12. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate and market sector risks. Due to the level of risks associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of plan benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and participant demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term could be material to the financial statements.

NOTE 13. RELATED PARTIES

The Annuity Fund IBEW Local 96 and Pension Fund Local 96 IBEW are related to the Plan through common Trustees. The Funds equally share the cost of meeting expenses and fidelity bond coverage.

NOTE 14. PARTY-IN-INTEREST TRANSACTIONS

The Plan paid certain expenses related to plan operations and investment activity to various service providers. These transactions are party-in-interest transactions under ERISA and are denoted on the required supplemental schedule of assets held at end of year and the schedule of reportable transactions.

NOTE 15. SUBSEQUENT EVENTS

Subsequent events have been evaluated through October 16, 2025 which is the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

**SCHEDULES OF BENEFITS PAID, INSURANCE PREMIUMS AND
ADMINISTRATIVE SERVICE FEES**

YEARS ENDED DECEMBER 31, 2024 AND 2023

| | 2024 | 2023 |
|---|--------------|--------------|
| BENEFITS PAID | | |
| Dental claims | \$ 201,803 | \$ 161,020 |
| Disability claims | 9,657 | - |
| Vision benefits | 4,938 | 5,473 |
| Hearing benefits | 12,452 | 13,140 |
| Opt-out reimbursement | - | 2,390 |
| Total benefits paid | \$ 228,850 | \$ 182,023 |
| INSURANCE PREMIUMS AND ADMINISTRATIVE SERVICE FEES | | |
| Insurance premiums: | | |
| Life insurance premiums | \$ 57,883 | \$ 58,421 |
| Health insurance premiums | 5,993,729 | 4,991,128 |
| Dental program administrative service fees | 23,826 | 20,323 |
| Employee assistance administration | 10,766 | 10,283 |
| Claims processing fees | 1,872 | 1,122 |
| Total insurance premiums and administrative service fees | \$ 6,088,076 | \$ 5,081,277 |

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

| | <u>2024</u> | <u>2023</u> |
|----------------------------------|-------------------|-------------------|
| Administration fees | \$ 100,380 | \$ 100,380 |
| Legal | 39,901 | 19,952 |
| Actuarial and consulting | 25,582 | 26,188 |
| Audit | 10,000 | 9,500 |
| Fiduciary and fidelity insurance | 7,978 | 8,405 |
| Bank fees | 4,092 | 4,595 |
| Technology services | 2,480 | 2,480 |
| Printing and office | 2,316 | 819 |
| Payroll audits | 2,046 | 8,931 |
| Conferences and meetings | 1,143 | 4,124 |
| | <u>195,918</u> | <u>185,374</u> |
| Total administrative expenses | <u>\$ 195,918</u> | <u>\$ 185,374</u> |

**HEALTH AND WELFARE FUND
IBEW LOCAL 96**

SCHEDULE OF ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

Form 5500, Schedule H, Item 4i

EIN: 04-2177839
Plan No. 501

| (a) | (b) | (c) | | | (d) | (e) |
|---|---|---------------------------------------|------------------|------------------|---------------------|---------------------|
| Issuer, Borrower | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | | | Cost | Current Value | |
| | Type | Shares/ Principal | Interest Rate | Maturity Date | | |
| | <u>Registered investment companies:</u> | | | | | |
| * PIMCO Short-Term Inst | | 237,078 | | | \$ 2,392,236 | \$ 2,294,917 |
| * Vanguard 500 Index Fund Admiral Shares | | 4,956 | | | 1,221,892 | 2,689,865 |
| * Baird Core Plus Bond Fund | | 323,169 | | | 3,583,988 | 3,234,918 |
| * Int'l Equity Portfolio Inst'l Class | | 23,014 | | | 492,743 | 564,073 |
| | | Total registered investment companies | | | <u>7,690,859</u> | <u>8,783,773</u> |
| | <u>Limited partnership:</u> | | | | | |
| * US Real Estate Investment Fund LLC | | 636 | | | 968,648 | 750,784 |
| | | Total investments | | | <u>\$ 8,659,507</u> | <u>\$ 9,534,557</u> |

* A party-in-interest as defined by ERISA.

**THE FINANCIAL STATEMENTS WILL BE PLACED IN THE
ATTACHMENT FOR THE ACCOUNTANT'S OPINION**

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

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.

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.)

B This return/report is: a single-employer plan the first return/report a DFE (specify) _____
 an amended return/report the final 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)

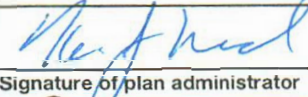
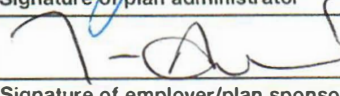
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here

Part II Basic Plan Information - enter all requested information

| | |
|---|--|
| 1a Name of plan HEALTH & WELFARE FUND IBEW LOCAL 96 | 1b Three-digit plan number (PN) ▶ 501 |
| | 1c Effective date of plan 09/01/1974 |
| 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) BOARD OF TRUSTEES-HEALTH & WELFARE FUND IBEW LOCAL 96 ZENITH AMERICAN SOLUTIONS P.O. BOX 5817 WALLINGFORD CT 06492-7617 | 2b Employer Identification Number (EIN) 04-2177839 |
| | 2c Plan Sponsor's telephone number 203-269-7741 |
| | 2d Business code (see instructions) 238210 |

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

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

| | | |
|--|-----------------|--|
| SIGN HERE  | 10/22/25 | KEVIN MENARD |
| Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE  | 10/23/25 | JAMES ARTHUR |
| 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 <div style="background-color: #cccccc; height: 40px; width: 100%;"></div> |
|--|--|

| | |
|--|-----------------------------------|
| 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 | 378 |
| 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) | 269 |
| a (2) Total number of active participants at the end of the plan year | 6a(2) | 291 |
| b Retired or separated participants receiving benefits | 6b | 105 |
| c Other retired or separated participants entitled to future benefits | 6c | |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d | 396 |
| 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) | |
| (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 | 47 |

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 4U

| | |
|--|--|
| 9a Plan funding 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 | 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 |
|--|--|

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> 4 </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) |
|---|---|

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 _____