

<p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025

**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><b>1a</b> Name of plan <u>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> 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, IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</u></p> <p><u>7180 KOLL CENTER PKWY STE 200</u> <u>PLEASANTON, CA 94566</u></p>	<p><b>1c</b> Effective date of plan <u>12/12/1955</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>94-6085740</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>925-208-9999</u></p> <p><b>2d</b> 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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	11/17/2025	MILLER KAPLAN ARASE LLP
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	1862
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	1321
	<b>6a(2)</b>	1393
	<b>6b</b>	546
	<b>6c</b>	0
	<b>6d</b>	1939
	<b>6e</b>	
	<b>6f</b>	1939
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	230

**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 4Q

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

<b>a Pension Schedules</b>	<b>b General Schedules</b>
(1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)
(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)
(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>9</u>
(4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)
(5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code \_\_\_\_\_

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<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**UNITEDHEALTHCARE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	718716	97	02/01/2024	01/31/2025

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	4215742
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**UNITEDHEALTHCARE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2739571	79413	0711865	152	02/01/2024	01/31/2025

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

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

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

(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	

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	41696
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

**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 **02/01/2024** and ending **01/31/2025**

<b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6085740</b>

**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  
**U.S. BEHAVIORAL HEALTH PLAN OF CALIFORNIA DBA OPTUM**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>94-3077084</b>	<b>N/A</b>	<b>15198</b>	<b>1816</b>	<b>02/01/2024</b>	<b>01/31/2025</b>

**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	63728
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**DELTA DENTAL OF CALIFORNIA**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1461312	N/A	03374	4715	02/01/2024	01/31/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	3154776
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>	
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>	
	(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>	3154776
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	2505678
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	-18630
	(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>	2487048
	(4) Claims charged .....	<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions .....	<b>9c(1)(A)</b>	
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	315468
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>	
	(D) Other expenses .....	<b>9c(1)(D)</b>	
	(E) Taxes .....	<b>9c(1)(E)</b>	
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	
	(G) Other retention charges .....	<b>9c(1)(G)</b>	
	(H) Total retention .....	<b>9c(1)(H)</b>	315468
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>	
	(2) Claim reserves .....	<b>9d(2)</b>	
	(3) Other reserves .....	<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>	

**10** Nonexperience-rated contracts:

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

Specify nature of costs.

**Part IV Provision of Information**

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

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

**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 **02/01/2024** and ending **01/31/2025**

<b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b>		<b>D</b> Employer Identification Number (EIN) <b>94-6085740</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**KAISER FOUNDATION HEALTH PLAN INC.**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>94-1340523</b>	<b>00000</b>	<b>750</b>	<b>385</b>	<b>02/01/2024</b>	<b>05/31/2024</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
---	--------------------------------------

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	2111674
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**KAISER FOUNDATION HEALTH PLAN 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
94-1340523	00000	877	3194	02/01/2024	05/31/2024

**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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	25732479
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**VISION SERVICE PLAN**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-1632821	N/A	00409401	1496	02/01/2024	01/31/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>		0	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
(6) Total additions .....	<b>7c(6)</b>		0	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>			
<b>e</b> Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	<b>7e(1)</b>		
	(2) Administration charge made by carrier.....	<b>7e(2)</b>		
	(3) Transferred to separate account .....	<b>7e(3)</b>		
	(4) Other (specify below) .....	<b>7e(4)</b>		
(5) Total deductions .....	<b>7e(5)</b>		0	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>		0	

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

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

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	166645	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		166645
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	129479	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		129479
	(4) Claims charged .....	<b>9b(4)</b>		
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	26663	
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....	<b>9c(1)(H)</b>		26663
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
	(2) Claim reserves .....	<b>9d(2)</b>		
	(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

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

Specify nature of costs.

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**UNITEDHEALTHCARE 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
94-0734860	71420	H2001	594	02/01/2024	01/31/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	3545159
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<p><b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>94-6085740</b></p>	

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

**1 Coverage Information:**

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-1817054	92711	HCCL32230	143	02/01/2024	01/31/2025

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

<p><b>(a)</b> Total amount of commissions paid <b>27140</b></p>	<p><b>(b)</b> Total amount of fees paid</p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**STEALTH PARTNER GROUP LLC** **18700 N HAYDEN RD STE 405**  
**SCOTTSDALE, AZ 85255**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
27140			3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	387709
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **02/01/2024** and ending **01/31/2025**

<b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6085740</b>	

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

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

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

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

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

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

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

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

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

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

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

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

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

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**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)

OPTUMRX, INC

33-0441200

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50 99	NONE	2099209	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2833	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

BAYSPORT INC

14830 LOS GATOS BLVD STE 101  
LOS GATOS, CA 95032

(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?
49 50	NONE	156871	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)

RAEL & LETSON

94-1701048

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	85911	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)

WEDGE CAPITAL MANAGEMENT

56-1557450

(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?
51	NONE	106007	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)

MILLER KAPLAN ARASE LLP

95-2036255

(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	52515	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)

CHARTWELL INVESTMENT PARTNERS, LLC

36-4776242

(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 31 51	NONE	62598	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)

LIFEWORKS

52-1883918

(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?
49 50	NONE	56745	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)

ANTHEM BLUE CROSS

95-4331852

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 49 62	NONE	37351	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)

SAN JOAQUIN & CALAVERAS CTY JATC

94-6411032

(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?
49 50	NONE	22025	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)

LEONARD CARDER, LLP

94-2819269

(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	43496	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)

INVESTMENT PERFORMANCE SERVICES LLC

58-2432390

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 27 50	NONE	15000	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)

BENESYS, INC.

38-2383171

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 50	NONE	1081744	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)

ELECTRICAL INDUSTRY SERVICE CORP.

94-3053367

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 50	RELATED ORGANIZATION	166555	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)

SMARTSOURCE

30-0830429

(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?
49 50	NONE	25831	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)

AMALGAMATED BANK

13-4920330

(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?
19 52	NONE	10000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

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

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

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

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

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

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

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

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

<b>a</b> Name: RAE & LETSON	<b>b</b> EIN: 94-1701048
<b>c</b> Position: ACTUARY	
<b>d</b> Address: 160 BOVET RD STE 203 SAN MATEO, CA 94402	<b>e</b> Telephone: 650-341-3311

Explanation: DUE TO A COMPETATIVE BID PROCESS.

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>02/01/2024</b> and ending <b>01/31/2025</b>	
<b>A</b> Name of plan <b>IBEW LOCAL 595 HEALTH &amp; WELFARE TRUST</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BOARD OF TRUSTEES, IBEW LOCAL 595 HEALTH &amp; WELFARE</b>	<b>D</b> Employer Identification Number (EIN) <b>94-6085740</b>

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

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	7119428	4643077
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	4228548	4316595
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	478895	549400
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	7327729	5126846
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>	26839226	28265864
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>	19643071	23997139
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	5729566	5090187
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	681189	562523
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>	4674982	3911677

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>	21679	20549
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	76744313	76483857
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>	16133991	17195877
<b>h</b> Operating payables.....	<b>1h</b>	95648	16675
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>	33504	0
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	16263143	17212552
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	60481170	59271305

**Part II Income and Expense Statement**

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

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	42559727	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	2801840	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		45361567
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	32189	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>	830803	
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>	1037809	
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>	104044	
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		2004845
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>	44328	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		44328
<b>(3)</b> Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	34737282	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	34926984	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		-189702
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>	415412	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<b>c</b> Other income .....	<b>2c</b>		
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	<b>2d</b>		47636450

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	<b>2e(1)</b>	8108298	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	38934201	
(3) Other.....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		47042499
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	<b>2g</b>		
<b>h</b> Interest expense.....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>		
(2) Contract administrator fees .....	<b>2i(2)</b>	1081744	
(3) Recordkeeping fees .....	<b>2i(3)</b>	10975	
(4) IQPA audit fees .....	<b>2i(4)</b>	41540	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	183730	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	10000	
(7) Actuarial fees .....	<b>2i(7)</b>	9711	
(8) Legal fees .....	<b>2i(8)</b>	43496	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses.....	<b>2i(11)</b>	422620	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		1803816
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	<b>2j</b>		48846315

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		-1209865
<b>l</b> Transfers of assets:			
(1) To this plan.....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**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: **MILLER KAPLAN ARASE LLP**

(2) EIN: **95-2036255**

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		2000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	X		5090187
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**

FINANCIAL STATEMENTS

JANUARY 31, 2025 AND 2024



## INDEPENDENT AUDITOR'S REPORT

Board of Trustees  
IBEW Local 595 Health & Welfare Trust  
7180 Koll Center Parkway, Suite 200  
Pleasanton, California 94566

Members of the Board:

### **Opinion**

We have audited the accompanying financial statements of IBEW Local 595 Health & Welfare Trust (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 January 31, 2025 and 2024, 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 financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of January 31, 2025 and 2024, and the changes in its net assets available for benefits and 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the 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 the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Management is also responsible for maintaining a current plan instrument, including all plan amendments; administering the plan; and determining that the plan's transactions that are presented and disclosed in the financial statements are in conformity with the plan's provisions, including maintaining sufficient

records with respect to each of the participants, to determine the benefits due or which may become due to such participants.

### **Auditor's Responsibilities for the Audit of the Financial Statements**

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

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

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

*Miller Kaplan Arase LLP*

MILLER KAPLAN ARASE LLP

San Francisco, California

November 14, 2025

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**

<b>ASSETS</b>	January 31, 2025	January 31, 2024
INVESTMENTS, AT FAIR VALUE		
Corporate Debt Securities	\$ 21,759,928	\$ 19,643,071
Government Debt Securities	34,414,750	31,514,208
Limited Partnership	5,090,187	5,729,566
Short Term Investment Funds	562,524	681,189
	\$ 61,827,389	\$ 57,568,034
CASH AND CASH EQUIVALENTS	9,769,923	14,447,157
TOTAL CASH, CASH EQUIVALENTS AND INVESTMENTS	71,597,312	72,015,191
RECEIVABLES		
Employer Contributions	4,316,595	4,228,548
Accrued Investment Income	411,788	411,953
Prescription Rebates	32,091	40,394
Cobra Subsidy	580	975
Stop Loss	93,014	-
Due From Other Trusts	11,928	25,573
TOTAL RECEIVABLES	4,865,996	4,707,443
PREPAID EXPENSES	20,549	21,679
TOTAL ASSETS	76,483,857	76,744,313
 <b>LIABILITIES</b>		
Accrued Expenses	16,675	95,648
Payable for Investments Purchased	-	33,504
TOTAL LIABILITIES	16,675	129,152
NET ASSETS AVAILABLE FOR BENEFITS	76,467,182	76,615,161
MEMORANDUM:		
Benefit Obligations Other Than Postretirement		
Benefit Obligations:		
Benefit Obligations	17,195,877	16,133,991
Drug-Free Workplace Program - Note 6	149,696	289,808
Health Reimbursement Accounts - Note 7	36,281,574	33,962,340
Excess of Net Assets Available for Benefits Over Benefit Obligations	\$ 22,840,035	\$ 26,229,022

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**

	February 1, 2024 to January 31, 2025	February 1, 2023 to January 31, 2024
<b>ADDITIONS</b>		
NET INVESTMENT INCOME		
Interest and Dividends	\$ 2,049,173	\$ 1,961,563
Net Appreciation of Investments	225,710	321,427
Less: Investment Expenses	<u>(193,730)</u>	<u>(178,667)</u>
	\$ 2,081,153	\$ 2,104,323
CONTRIBUTIONS		
Employers	36,358,063	35,844,430
HRA	6,089,610	6,236,115
Retiree Co-Payments	1,974,790	1,800,293
Participant Self-Payments	827,050	431,998
Drug-Free Workplace	<u>112,054</u>	<u>109,512</u>
	45,361,567	44,422,348
TOTAL ADDITIONS	<u>47,442,720</u>	<u>46,526,671</u>
<b>DEDUCTIONS</b>		
NET BENEFITS PAID		
Premiums	38,840,630	36,676,314
Claims	7,405,106	7,641,489
Less: Stop-Loss Reimbursements	(96,103)	-
Refunds	(16,903)	(1,184,112)
Prescription Rebates	<u>(152,117)</u>	<u>(127,524)</u>
	45,980,613	43,006,167
EXPENSES		
Administration Fees	970,622	930,081
Administration Fees - Stockton	22,025	25,815
Service Corp Fees	166,555	157,657
Consulting Fees	76,200	73,200
Actuary Fees	9,711	4,800
Legal Fees	43,496	17,156
Audit Fees	52,515	54,940
HRA Administration Fees	111,122	108,544
Printing, Postage and Office Expenses	58,790	57,366
Conferences and Meetings	11,531	5,865
Insurance	26,206	25,707
Rent	2,760	2,300
PCORI Fee	16,261	714
Miscellaneous	<u>42,292</u>	<u>12,005</u>
	1,610,086	1,476,150
TOTAL DEDUCTIONS	<u>47,590,699</u>	<u>44,482,317</u>
NET INCREASE (DECREASE) FOR THE YEAR	(147,979)	2,044,354
NET ASSETS AVAILABLE FOR BENEFITS		
Balance, Beginning of Year	<u>76,615,161</u>	<u>74,570,807</u>
Balance, End of Year	<u>\$ 76,467,182</u>	<u>\$ 76,615,161</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**STATEMENTS OF BENEFIT OBLIGATIONS**

	January 31, 2025	January 31, 2024
AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Premiums Payable (Prepaid)	\$ 79,160	\$ (14,411)
Claims Payable	103,655	84,645
	182,815	70,234
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Claims Incurred But Not Reported	156,500	231,000
Accumulated Eligibility Credits (Two Month Lag)	6,064,639	5,330,150
Dollar Bank Liability	10,791,923	10,502,607
	17,013,062	16,063,757
TOTAL OBLIGATIONS OTHER THAN POST- RETIREMENT BENEFIT OBLIGATIONS	17,195,877	16,133,991
POSTRETIREMENT BENEFIT OBLIGATIONS*		
Retirees	105,580,591	97,702,977
Active Fully Eligible Participants	49,944,149	32,888,192
Active Not Yet Fully Eligible Participants	67,506,588	61,844,480
NET POSTRETIREMENT BENEFIT OBLIGATIONS	223,031,328	192,435,649
PLAN'S TOTAL BENEFIT OBLIGATIONS	\$ 240,227,205	\$ 208,569,640

\* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

	<u>February 1, 2024 to January 31, 2025</u>	<u>February 1, 2023 to January 31, 2024</u>
<b>AMOUNTS CURRENTLY PAYABLE TO OR ON BEHALF OF PARTICIPANTS, BENEFICIARIES AND DEPENDENTS</b>		
Premiums Payable (Prepaid) at Beginning of Year	\$ (14,411)	\$ 23,237
Premiums for Participants Eligible for Coverage During the Year	38,934,201	36,638,666
Premiums Paid	<u>(38,840,630)</u>	<u>(36,676,314)</u>
Premiums Payable (Prepaid) at End of Year	<u>79,160</u>	<u>(14,411)</u>
Claims Payable at Beginning of Year	84,645	299,978
Claims Reported and Approved for Payment	7,158,993	6,114,520
Claims Paid, Net	<u>(7,139,983)</u>	<u>(6,329,853)</u>
Claims Payable at End of Year	<u>103,655</u>	<u>84,645</u>
<b>OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS</b>		
Balance at Beginning of Year	16,063,757	17,563,369
Net Change During the Year:		
Claims Incurred But Not Reported	(74,500)	(372,000)
Accumulated Eligibility Credits (Two Month Lag)	734,489	(398,402)
Dollar Bank Liability	<u>289,316</u>	<u>(729,210)</u>
Balance at End of Year	<u>17,013,062</u>	<u>16,063,757</u>
<b>TOTAL OBLIGATIONS OTHER THAN POSTRETIREMENT BENEFIT OBLIGATIONS</b>	<u><b>17,195,877</b></u>	<u><b>16,133,991</b></u>
<b>POSTRETIREMENT BENEFIT OBLIGATIONS*</b>		
Balance at Beginning of Year	192,435,649	150,147,088
Net Changes During the Year:		
Benefits Accumulated During The Year	5,970,915	12,011,767
Change In Expected Premiums Assumption	47,005,083	-
Benefits Paid (Estimated)	(4,995,818)	(4,848,045)
Increase For Passage Of Time - Interest	9,621,782	9,584,090
Changes In Actuarial Assumptions	(25,040,717)	25,540,749
Actuarial Experience Due To Passage of Time	<u>(1,965,566)</u>	<u>-</u>
	<u>223,031,328</u>	<u>192,435,649</u>
<b>PLAN'S TOTAL BENEFIT OBLIGATIONS AT END OF YEAR</b>	<u><b>\$ 240,227,205</b></u>	<u><b>\$ 208,569,640</b></u>

\* The calculation of the postretirement benefit obligations does not imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Plan is required to implement a funding policy to satisfy the projected expense.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**

**NOTES TO FINANCIAL STATEMENTS**

**JANUARY 31, 2025 AND 2024**

**NOTE 1 - DESCRIPTION OF THE PLAN**

The IBEW Local 595 Health & Welfare Trust (the “Plan”) is a multiemployer welfare benefit plan providing medical, vision, dental, prescription, life, disability, chemical dependency and accidental death and dismemberment insurance benefits to participants on whose behalf employers contribute to the Plan in accordance with their collective bargaining agreements. Chemical dependency, vision and death benefits are provided on a self-insured basis. Medical and prescription drug benefits are provided on either an insured or self-insured basis. All other benefits are provided on an insured basis through insurance contracts. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan was created on November 12, 1953, as provided by the collective bargaining agreement between Local Union No. 595 of the International Brotherhood of Electrical Workers and the Northern California Chapter of the Electrical Contractors Association.

THE PLAN DOCUMENT INCLUDES DETAILED RULES FOR EACH SITUATION. PARTICIPANTS SHOULD REFER TO THE PLAN AGREEMENT AND ANY AMENDMENTS REGARDING SPECIFIC PROVISIONS OF THE PLAN.

**NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**A. Basis of Accounting**

The financial statements of the Plan are prepared on the accrual basis of accounting.

**B. 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 those estimates.

**C. Postretirement Benefits**

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered to January 31. Postretirement benefits include future benefits expected to be paid to or for (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. Prior to an active employee’s full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee’s service in the industry rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation was determined by actuaries from NWPS for year ended January 31, 2025 and Rael & Letson for year ended January 31, 2024, and is the amount that results from applying actuarial assumptions to historical benefit cost data to estimate future annual benefit 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.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
NOTES TO FINANCIAL STATEMENTS  
JANUARY 31, 2025 AND 2024

**NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

**C. Postretirement Benefits (Continued)**

The significant actuarial assumptions and methods used for the January 31, 2025 (2024), valuation were: (a) Discount Rate: 5.5% (5.0%), (b) Postretirement Mortality Rates: PRI-2012 Private Retirement Plans Mortality Tables with Blue Collar adjustment, sex-distinct, projected generationally using Scale MP-2021 (RP-2000 Mortality Table projected to 2022 for Blue Collar Annuitants for males and females after retirement), (c) Medical Inflation Rate: based on the Getzen model (assumed 5% annual increases for medical and 2% for dental and vision benefits), (d) Election Rate: 100% (60% Kaiser/40% UnitedHealthcare) of active employees are assumed to elect coverage with the same provider upon retirement, (e) Retirement Age: based on percentage rate retiring between 55-67. Future medical costs and self pay rates assumptions were also updated.

The health care cost-trend rate and retiree contribution trend rate have a significant effect on the postretirement benefit obligations. A 1% increase in the health care cost-trend rate would increase the net postretirement benefit obligation as of January 31, 2025 and 2024 by \$38,194,514 and \$40,532,243, respectively.

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 postretirement benefit obligations.

**D. Contributions**

Employer contributions, including HRA and drug-free workplace as reported are contributions made on behalf of employees for hours worked during the year. Employer contributions receivable is estimated based on contributions received subsequent to the end of the year. No allowance is provided for uncollectible accounts. Retiree co-payments and participant self-payments are contributions made by participants for coverage during the year.

**E. Payroll Compliance Program**

Employer remittance reports were accepted as submitted, without examination or verification of employers' payroll records. The system of internal control provides for examination of employers' records under a separate payroll compliance program.

**F. Investment Valuation and Income Recognition**

The Plan's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Purchases and sales of securities are recorded on the trade date basis. Dividends are recorded on the ex-dividend date and interest income is recorded on the accrual basis. Realized and unrealized gains and losses are computed using investments' costs for financial statement purposes. For Form 5500 reporting, realized and unrealized gains and losses are computed using investments' market values as of the beginning of the year.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**NOTES TO FINANCIAL STATEMENTS**  
**JANUARY 31, 2025 AND 2024**

**NOTE 2 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

**G. Tax-Exempt Status**

No provision for federal or state income tax is made. The Plan has received tax-exempt status from the federal government under Internal Revenue Code Section 501(c)(9) and the state of California under Revenue and Taxation Code Section 23701i. However, the plan administrator and the Plan's legal counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken a tax position that more likely than not would not be sustained upon examination by a tax authority. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

**H. Plan Termination**

Upon termination of the Plan, per the Agreement and Declaration of the Trust, any and all monies remaining in the Plan after payment of all expenses and obligations of the Plan shall be either expended and used for the continuance of purposes of the Plan until such monies have been exhausted, or transferred to another trust or trusts providing similar benefits.

**I. Cash and Cash Equivalents**

Cash and cash equivalents consist of checking, savings and money market funds.

**J. Risks and Uncertainties**

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

The actuarial present value of benefit obligations, including postretirement benefit obligations are reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee 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 would be material to the financial statements.

**NOTE 3 - RELATED PARTY TRANSACTIONS**

The Plan shares common expenses with four related entities (IBEW Local 595 Pension Plan, IBEW Local 595 Money Purchase Pension Plan, IBEW Local 595 Vacation Trust and Electrical Industry Service Corporation). Each entity pays its direct costs and an allocated percentage of common expenses periodically approved by the Board of Trustees. The Service Corporation serves as the custodial agent for the collection and disbursement of the regular monthly employer contributions under collective bargaining agreements. The Service Corporation also monitors and pursues collection of delinquent contributions from employers. To maintain the operations of the Service Corporation, the Plan contributed to the Service Corporation \$0.07 per reported hour.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**NOTES TO FINANCIAL STATEMENTS**  
**JANUARY 31, 2025 AND 2024**

**NOTE 4 - FAIR VALUE MEASUREMENTS**

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

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

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; and
- 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.

The asset 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 used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at January 31, 2025 and 2024. Level 1 investments include U.S. treasury securities valued at the closing price reported in active markets. Level 2 investments consist of corporate debt securities, non-U.S. Treasury securities, government agency obligations, and short term investment funds valued at fair value at the closing price reported on the active market on which the individual securities are traded. If a closing price is not noted on an active market, valuation is subject to other observable inputs such as the last bid or settlement price.

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

The following tables summarize the Plan's investments at January 31 based on the inputs used to value them:

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**NOTES TO FINANCIAL STATEMENTS**  
**JANUARY 31, 2025 AND 2024**

**NOTE 4 - FAIR VALUE MEASUREMENTS (Continued)**

	January 31, 2025			
	Level 1	Level 2	Level 3	Total
Corporate Debt Securities	\$ -	\$ 21,759,928	\$ -	\$ 21,759,928
Government Debt Securities	9,570,678	24,844,072	-	34,414,750
Short Term Investment Funds	-	562,524	-	562,524
<b>Total Assets in the Fair Value Hierarchy</b>	<b>\$ 9,570,678</b>	<b>\$ 47,166,524</b>	<b>\$ -</b>	<b>56,737,202</b>
Investment Measured at Net Asset Value <sup>A</sup>				5,090,187
				<b>\$ 61,827,389</b>

	January 31, 2024			
	Level 1	Level 2	Level 3	Total
Corporate Debt Securities	\$ -	\$ 19,643,071	\$ -	\$ 19,643,071
Government Debt Securities	9,570,678	21,943,530	-	31,514,208
Short Term Investment Funds	-	681,189	-	681,189
<b>Total Assets in the Fair Value Hierarchy</b>	<b>\$ 9,570,678</b>	<b>\$ 42,267,790</b>	<b>\$ -</b>	<b>51,838,468</b>
Investment Measured at Net Asset Value <sup>A</sup>				5,729,566
				<b>\$ 57,568,034</b>

<sup>A</sup> In accordance with ASC 820, the investment measured at net asset value per share (or its equivalent) has 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 statements of net assets available for benefits.

The following table presents the fair value, unfunded commitments, and information about redemptions for the investment where the fair value is determined by the NAV per share or its equivalent as of January 31, 2025 and 2024:

	January 31,		Unfunded Commitments	Redemption Frequency	Redemption Notice Period
	2025	2024			
Boyd Watterson GSA Fund LP	\$ 5,090,187	\$ 5,729,566	None	Quarterly	60 days

The investment strategy for the investment valued at net asset value is as follows:

Boyd Watterson GSA Fund LP's primary objective is to generate a high, stable stream of current income while providing the preservation of capital with the opportunity for longer-term capital appreciation through the purchase of real estate assets that are primarily leased to federal agencies.

The Plan did not have any transfers into or out of Levels 1, 2 or 3 for the year ended January 31, 2025.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**NOTES TO FINANCIAL STATEMENTS**  
**JANUARY 31, 2025 AND 2024**

**NOTE 5 - CONCENTRATION OF CREDIT RISK**

During the year ended January 31, 2025, the Plan maintained bank accounts with cash balances in excess of the federally insured limit of \$250,000 per bank. The amount in excess of the limit was subject to risk if the financial institution did not perform. The Plan has not incurred any losses on the uninsured balances.

**NOTE 6 - DRUG-FREE WORKPLACE PROGRAM (MAP)**

Contributing employers contribute an additional \$0.06 per hour worked to fund the Plan's substance abuse program. In May 2019, the Board of Trustees approved using surplus MAP contributions to establish a Wellness Program for plan participants.

The following is a reconciliation of the MAP activity at January 31:

	<u>2025</u>	<u>2024</u>
Beginning of Year - February 1	\$ 289,808	\$ 451,057
Contributions:		
West	87,906	89,898
East	24,148	19,614
Wellness Program Fees	(156,871)	(156,871)
Reimbursements and Fees	<u>(95,295)</u>	<u>(113,890)</u>
End of Year - January 31	<u>\$ 149,696</u>	<u>\$ 289,808</u>

**NOTE 7 - HEALTH REIMBURSEMENT ACCOUNTS (HRA)**

The IBEW Local 595 Health Reimbursement Account Plan (HRA Plan) is a health-care reimbursement account funded solely by employer contributions to cover qualified medical expenses for the participant and their qualified dependents. They may use their HRA Plan account to receive reimbursement for health-care expenses, such as co-payments and prescription drugs, and self-payments for continued coverage under the Plan.

The HRA account balance must be at least \$500 to be eligible for the participant to access their account for immediate use for qualified health-care reimbursements.

The following is a reconciliation of the HRA Plan activity at January 31:

	<u>2025</u>	<u>2024</u>
Beginning of Year - February 1	\$ 33,962,340	\$ 31,096,926
Contributions	6,089,610	6,236,115
Dividends and Interest	984,004	910,786
Net Appreciation of Investments	266,798	247,617
Benefits	(3,426,099)	(3,174,712)
Buy Up	(1,483,957)	(1,245,848)
Administrative Charge	<u>(111,122)</u>	<u>(108,544)</u>
End of Year - January 31	<u>\$ 36,281,574</u>	<u>\$ 33,962,340</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**NOTES TO FINANCIAL STATEMENTS**  
**JANUARY 31, 2025 AND 2024**

**NOTE 8 - RECONCILIATION OF FINANCIAL STATEMENTS TO THE FORM 5500**

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

	<u>January 31, 2025</u>	<u>January 31, 2024</u>
Net Assets Available for Benefits Per the Financial Statements	\$ 76,467,182	\$ 76,615,161
Less: Plan's Benefit Obligations Other Than Postretirement Benefit Obligations	<u>(17,195,877)</u>	<u>(16,133,991)</u>
Net Assets Per the Form 5500	<u>\$ 59,271,305</u>	<u>\$ 60,481,170</u>

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

	<u>February 1, 2024 to January 31, 2025</u>
Benefits Paid Per the Financial Statements	\$ 45,980,613
Add: Benefit Obligations Other Than Postretirement Benefit Obligations at January 31, 2025	17,195,877
Less: Benefit Obligations Other Than Postretirement Benefit Obligations at January 31, 2024	<u>(16,133,991)</u>
Benefits Paid Per the Form 5500	<u>\$ 47,042,499</u>

Amounts currently payable to or for participants, dependents, and beneficiaries are reported on the Form 5500 for benefits that have been incurred prior to January 31, but not yet paid as of that date.

**NOTE 9 - SUBSEQUENT EVENTS**

Management has evaluated subsequent events through November 14, 2025, the date on which the financial statements were available to be issued. There were no material subsequent events that required recognition or additional disclosures in these financial statements.

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
FORM 5500  
SCHEDULE H, LINE 4  
E.I.N. 94-6085740; PLAN NO. 501

SUPPLEMENTAL SCHEDULES REQUIRED  
BY THE DEPARTMENT OF LABOR



Independent Auditor's Report on Supplemental  
Schedules Required by the Department of Labor

Board of Trustees  
IBEW Local 595 Health & Welfare Trust  
7180 Koll Center Parkway, Suite 200  
Pleasanton, California 94566

Members of the Board:

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) as of January 31, 2025 and reportable transactions for the year ended January 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

*Miller Kaplan Arase LLP*

MILLER KAPLAN ARASE LLP

San Francisco, California

November 14, 2025

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

No. of Shares	<u>Short Term Investment Funds</u>	Fair Value	Cost
281,312	DREYFUS TREASURY & AGENCY CASH MGMT	\$ 281,312	\$ 281,312
281,212	JPMORGAN 100% US TREASURY MONEY MARKET	281,212	281,212
	<u>TOTALS - SHORT TERM INVESTMENT FUNDS</u>	<u>\$ 562,524</u>	<u>\$ 562,524</u>
	<u>Limited Partnership</u>		
5,161	BOYD WATTERSON GSA FUND LP	<u>\$ 5,090,187</u>	<u>\$ 5,284,801</u>
Face Value	<u>Corporate Debt Securities</u>		
\$ 179,167	AADVANTAGE LOYALTY IP 5.5% 04/20/2026	\$ 179,055	\$ 176,332
95,000	AADVANTAGE LOYALTY IP 5.75% 04/20/2029	94,768	93,606
330,000	ADOBE INC SR GLBL 4.8% 04/04/2029	332,056	338,521
260,000	ALBERTSONS COS-SAFEWAY 3.25% 03/15/2026	255,159	258,700
30,000	ALBERTSONS COS-SAFEWAY 4.625% 01/15/2027	29,466	29,419
705,000	AT&T INC 2.3% 06/01/27	667,755	653,159
130,000	AT&T INC 4.10% 02/15/2028	127,605	142,095
965,000	BANK OF AMERICA CORP FLTG 04/23/2027	950,824	1,016,268
95,000	BLACKROCK INC 2.4% 04/30/2030	84,697	90,114
290,000	BOYD GAMING CORP 4.75% 12/01/27	284,551	273,614
140,000	BRINKS CO SR 6.5% 06/15/2029	142,708	141,638
25,000	BRINK'S CO/THE 4.625% 10/15/2027	24,410	24,310
335,000	CATERPILLAR FINL SVCS 4.7% 11/15/2029	334,635	334,682
300,000	CENTENE CORP 4.25% 12/15/27	290,727	279,595
285,000	CHARTER COMM OPT LLC CAP 4.908% 07/23/25	284,826	287,453
835,000	CITIGROUP INC SR VAR 02/24/2028	806,051	826,254
200,000	CLEARWAY ENERGY OP LLC 4.75% 3/15/28	193,494	193,794
30,000	CLEVELAND-CLIFFS INC 6.875% 11/01/2029	30,093	30,000
710,000	CONOCOPHILLIPS SR NT 4.7% 01/15/2030	704,079	706,374
280,000	CROWN AMERS LLC / CROWN 4.75% 02/01/2026	279,266	274,485
70,000	DEERE JOHN CAPITAL 3.45% 03/07/2029	66,765	75,939
635,000	DUKE ENERGY CAROLINAS 2.95% 12/01/2026	617,919	609,263
160,000	DUKE ENERGY CAROLINAS 3.95% 11/15/2028	155,970	178,085
285,000	ESAB CORPORATION 6.25% 04/15/2029	288,836	286,733
305,000	FORTRESS TRANSN & INFRA 5.5% 05/01/2028	298,122	290,357
105,000	GENTING NEW YORK LLC 7.25% 10/01/2029	107,939	105,456
195,000	GFL ENVIRONMENTAL INC 3.75% 08/01/2025	193,760	200,853
105,000	GGAM FIN LTD SR 144A 8.00% 02/15/2027	108,427	106,184
180,000	GGAM FIN LTD SR GLBL 7.75% 05/15/2026	182,821	180,000
85,000	GLP CAPITAL LP / FIN II 5.25% 6/1/2025	84,890	88,360
195,000	GLP CAPITAL LP-FIN II 5.375% 04/15/2026	195,320	190,925
35,000	HAT HLDGS I LLC / HAT 8.00% 06/15/2027	36,385	35,644
270,000	HAT HLDGS I LLC 3.375% 06/15/2026	261,595	253,530
190,000	HERC HLDGS INC SR 6.625% 06/15/2029	194,186	191,594
90,000	HERC HOLDINGS INC 5.5% 07/15/2027	89,655	89,542
140,000	HILTON DOMESTIC OPER 5.375% 05/01/2025	139,481	141,196
	<u>Forward</u>	<u>\$ 9,118,296</u>	<u>\$ 9,194,074</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

Face Value	Corporate Debt Securities (Continued)	Fair Value	Cost
	<u>Forwarded</u>	\$ 9,118,296	\$ 9,194,074
\$ 60,000	HILTON WORLDWIDE FIN LLC 4.875% 04/01/2	59,567	58,350
60,000	HOME DEPOT INC 2.95% 6/15/2029	55,922	52,759
115,000	HOME DEPOT INC SR 4.85% 06/25/2031	115,084	114,359
185,000	ICHAN ENTERPRISES FIN 525% 05/15/2027	179,309	171,631
72,000	ICHAN ENTERPRISES- FIN 6.25% 05/15/26	71,900	69,660
285,000	INTERNATIONAL GAME TECH 6.25% 01/15/2027	288,959	288,975
320,000	JAZZ SECURITIES 4.375% 01/15/2029	304,819	296,536
115,000	JOHN DEERE CAPITAL 4.4% 09/08/2031	111,754	115,159
575,000	JOHN DEERE CAPITAL 4.75% 06/08/2026	577,599	574,273
295,000	JPMORGAN CHASE & CO FLTG 04/23/2029	287,554	315,986
655,000	JPMORGAN CHASE & CO VAR 01/29/2027	650,598	700,495
285,000	KINETIK HLDGS LP SR 6.625% 12/15/2028	291,427	287,400
35,000	MACQUARIE AIRFINANCE 6.4% 03/26/2029	36,066	35,700
180,000	MACQUARIE AIRFINANCE 8.375% 05/01/2028	188,660	184,642
85,000	MARSH & MCLENNAN COS 5.15% 03/15/2034	84,388	84,934
75,000	MIDAMERICAN ENERGY CO 3.65% 4/15/2029	71,677	81,779
125,000	ONEMAIN FINANCIAL 3.5% 01/15/2027	120,264	116,897
100,000	ONEMAIN FINANCIAL 3.875% 09/15/2028	93,412	92,497
130,000	PARK INTER HLDGS LLC 4.875% 05/15/2029	124,194	122,144
170,000	PARK INTERMED HOLDINGS 5.875% 10/01/28	168,054	167,400
210,000	PHINIA INC SR SEC 6.75% 04/15/2029	215,733	212,523
280,000	PRIME SEC SVCS 5.75% 04/15/2026	280,678	275,414
125,000	REPUBLIC SVCS 2.375% 03/15/2033	101,709	100,958
290,000	SBA COMMUNICATIONS 3.875% 02/15/2027	280,604	292,354
295,000	SIRIUS XM RADIO INC 3.125% 09/01/2026	285,224	294,283
170,000	SLM CORP 4.2% 10/29/25	169,653	178,326
25,000	SLM CORP SR 6.5% 01/31/2030	25,235	24,944
120,000	SLM CORP SR GBL 3.125% 11/02/2026	115,367	107,960
70,000	SPRINGLEAF FINANCE CORP 7.125% 03/15/26	71,399	71,225
130,000	SS&C TECHNOLOGIES INC 5.5% 09/30/2027	129,661	129,650
315,000	STARWOOD PPTY TR INC 3.625% 07/15/2026	306,067	311,176
535,000	STATE STR CORP SR NT VAR 11/21/2029	551,253	536,109
45,000	SUNOCO LP -FINANCE CORP 6% 04/15/2027	44,942	44,480
235,000	SUNOCO LP-FINANCE CORP 5.875% 03/15/28	235,226	232,650
110,000	TALLGRASS ENERGY 5.5% 01/15/2028	107,602	105,294
130,000	TALLGRASS ENERGY 7.375% 02/15/2029	132,323	130,000
60,000	TALLGRASS NRG PRTNR -FIN 6% 03/01/2027	59,720	58,825
30,000	TEGNA INC 4.625% 03/15/28	28,734	27,906
255,000	TEGNA INC 4.75% 03/15/26	253,498	263,836
170,000	TENET HEALTHCARE CORP 4.25% 06/01/2029	160,618	156,938
125,000	TENET HEALTHCARE CORP 5.125% 11/01/2027	123,644	122,870
90,000	TEVA PHARMACEUTICAL 4.75% 05/09/2027	88,558	86,713
15,000	TEVA PHARMACEUTICAL 6.75% 03/01/2028	15,435	15,113
185,000	TEVA PHARMACEUTICALS NE 3.15% 10/01/2026	179,261	165,516
70,000	TEXAS CHILDRENS HOSPITAL 3.368% 10/01/29	67,740	69,734
65,000	TOYOTA MTR CR CORP FR 0.8% 10/16/2025	63,370	64,257
490,000	TOYOTA MTR CR CORP FR 5.05% 05/16/2029	494,792	489,068
125,000	TRANSDIGM INC SR SEC 6.375% 03/01/2029	126,253	125,039
	<u>Forward</u>	\$ 17,713,802	\$ 17,818,811

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

Face Value	Corporate Debt Securities (Continued)	Fair Value	Cost
	<u>Forwarded</u>	\$ 17,713,802	\$ 17,818,811
\$ 170,000	TRANSDIGM INC SR SEC 6.75% 08/15/2028	173,012	172,350
215,000	TRAVEL PLUS LEISURE CO VAR 10/01/2025	215,561	230,585
165,000	TRUIST BANK 2.25% 03/11/2030	142,987	139,104
490,000	TRUIST FINL CORP FR VAR 07/28/2026	488,657	488,416
580,000	VERIZON COMMUNICATIONS 4.125% 03/16/2027	574,333	578,451
230,000	VERIZON COMMUNICATIONS 4.329% 9/21/2028	226,884	259,064
665,000	VIRGINIA PWR FUEL 4.877% 05/01/2033	665,160	683,717
280,000	VISTRA OPERATIONS CO 5.5% 09/01/2026	279,885	272,902
345,000	WASTE MGMT INC DEL SR 0.75% 11/15/2025	335,281	317,583
170,000	WASTE MGMT INC DEL SR 1.15% 03/15/2028	153,286	162,102
155,000	WESCO DISTR INC SR 6.375% 03/15/2029	157,903	155,769
280,000	WESTERN DIGITAL CORP 4.75% 02/15/2026	278,351	302,478
70,000	WYNDHAM WORLDWIDE 6.625% 7/31/2026	71,124	69,756
280,000	XPO INC SR SEC 6.25% 06/01/2028	283,702	280,936
	<u>TOTALS - CORPORATE DEBT SECURITIES</u>	<u>\$ 21,759,928</u>	<u>\$ 21,932,024</u>
	<u>Government Debt Securities</u>		
\$ 115,000	CHICAGO ILL SALES TAX 0.00% 01/01/2032	\$ 80,127	\$ 87,206
70,000	CHICAGO ILL SALES TAX 0.00% 01/01/2033	46,003	51,987
1,834,924	FANNIE MAE 2019-M11 2.65% 06/25/2029	1,706,441	1,700,243
82,017	FHLMC MULTIFAM STRU CMO 2.896% 04/25/26	81,088	80,895
452,073	FHLMC MULTIFAMILY CMO 3.284% 06/25/2025F	449,677	465,641
669,870	FANNIE MAE REMIC TRUST 2.937% 06/25/2029	627,363	629,678
62,447	FHLMC GOLD POOL #WN0007 3.42% 10/01/2033	56,388	69,268
251,460	FHLMC GLD PL #WA2801 3.49% 10/01/2033	242,816	263,512
638,530	FHLMC POOL # SA-0088 1.5% 01/01/2032	573,811	587,149
487,565	FHLMC POOL #SB-0308 2.5% 01/01/2035	448,788	471,732
196,870	FHLMC POOL #SD-4154 3.5% 08/01/2045	179,183	179,280
265,102	FHLMC POOL #SI-2036 5.00% 12/01/2047	263,652	268,721
158,595	FHLMC POOL #WA-1625 3.4499999% 08/01/32	145,511	146,653
229,585	FHLMC POOL #ZA5113 4.00% 12/01/2047	217,317	245,208
21,291	FHLMC POOL #ZS-9446 3.5% 08/01/2045	19,401	19,700
41,287	FHLMC REMIC SERIES 0.681% 06/25/2026	40,899	38,618
25,000	FHLMC REMIC SERIES 1.47% 09/25/2027	23,125	22,772
1,605,000	FHLMC REMIC SERIES 2.77% 05/25/2025	1,593,259	1,595,161
440,000	FHLMC REMIC SERIES 2.995% 12/25/2025	434,476	431,610
25,000	FHLMC REMIC SERIES 3.465% 02/25/2031	23,427	23,296
432,904	FHLMC REMIC SERIES 3.902% 07/25/2029	423,425	432,346
190,000	FHLMC REMIC SERIES VAR 01/25/2029	194,832	197,363
450,000	FHLMC REMIC SERIES VAR 03/25/2029	409,865	395,204
155,000	FHLMC REMIC SERIES VAR 11/25/2032	141,427	137,770
33,103	FNMA PL #FM2993 3.5% 07/01/44	30,299	36,227
341,027	FNMA POOL #AL2893 3.5% 12/01/2042	310,867	341,897
246,823	FNMA POOL #AL3495 3.2% 04/01/2028	238,030	266,038
5,000	FNMA POOL #AN9316 3.46% 05/01/2028	4,826	4,661
159,704	FNMA POOL #BM4567 VAR 07/01/2044	164,695	162,779
87,071	FNMA POOL #BM4870 3.5% 03/01/2033	84,500	93,318
478,074	FNMA POOL #BM7277 VAR 08/01/2051	424,813	413,750
	<u>Forward</u>	<u>\$ 9,680,331</u>	<u>\$ 9,859,683</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

Face Value	Government Debt Securities (Continued)	Fair Value	Cost
	<u>Forwarded</u>	\$ 9,680,331	\$ 9,859,683
\$ 505,000	FNMA POOL #BS9744 5.27% 10/01/2028	515,179	521,178
340,000	FNMA POOL #BZ1048 5.13% 06/01/2029	346,109	347,650
255,156	FNMA POOL #FM3066 4.5% 11/01/2038	253,761	276,749
410,291	FNMA POOL #FM3228 3.5% 09/01/2047	373,878	413,267
229,046	FNMA POOL #FM3244 5.00% 07/01/2045	227,794	257,167
168,314	FNMA POOL #FM8873 3.5% 07/01/2034	164,527	179,903
294,036	FNMA POOL #FS1116 5.00% 12/01/2047	291,739	316,975
228,165	FNMA POOL #FS1485 3.00% 11/01/2046	201,320	219,222
596,422	FNMA POOL #FS7952 6.00% 02/01/2049	618,136	615,926
273,408	FNMA POOL #FS7981 2.5% 04/01/2036	259,567	260,464
1,216,051	FNMA POOL #FS8559 5.5% 11/01/2052	1,233,342	1,243,982
207,064	FNMA POOL #FS9640 5.5% 11/01/2052	209,070	211,658
182,677	FNMA POOL #FS9946 6.00% 02/01/2049	189,327	191,475
1,513,878	FNMA REMIC TRUST 0.96% 01/25/2031	1,317,576	1,331,739
301,832	FNMA REMIC TRUST 2.00% 02/25/2033	278,538	282,345
98,538	FNMA REMIC TRUST 2.5% 09/25/2045	88,080	97,848
330,000	FNMA REMIC TRUST VAR 04/25/2032	275,099	257,136
682,980	FNMA REMIC TRUST VAR 07/25/2028	671,099	664,179
360,925	FNMA REMIC TRUST VAR 10/25/2027	347,109	361,822
577,912	FNMA SUPER POOL #FS9260 2.5% 08/01/2035	547,571	547,571
716,396	FNMA UMBS POOL #MA4389 1.5% 07/01/2031	661,435	659,980
260,812	GNMA I POOL #BX7719X 1.97% 09/15/2041	208,772	242,465
459,965	GNMA PL #AC1428 2.690% 06/15/2033	420,077	448,100
22,941	GNMA PL #AC3667 1.660% 08/15/2026	22,389	23,120
519,645	GNMA PL #AI8404 3.310% 05/15/2030	505,111	538,898
591,647	GNMA PL #AU4920 3.020% 09/15/2041	504,933	595,829
105,161	GNMA PL #BB2949 3.63% 9/15/2037	98,391	114,385
320,188	GNMA POOL #786470X 5.00% 11/15/2040	319,338	327,270
282,711	GNMA POOL #787712X 5.5% 11/15/2045	288,056	289,959
359,181	GNMA POOL #BB5549X 3.59% 12/15/2034	342,906	374,783
470,000	HUNTSVILLE ALA WTR SYS 1.337% 11/01/2028	420,298	388,831
145,000	MASSACHUSETTS ST SCH 1.753% 08/15/2030	127,825	122,164
110,000	METRO WSTWTR RECLAMATION 2.413% 04/01/28	103,727	115,987
330,000	NEW YORK ST 1.538% 03/15/2027	310,834	291,629
405,000	NEW YORK ST DORM AUTH 2.738% 03/15/2026	397,670	404,218
325,000	NEW YORK ST URBAN DEV 1.00% 03/15/2026	313,138	295,338
445,000	NEW YORK ST URBAN DEV 1.31% 03/15/2026	430,101	406,746
235,000	NEW YORK ST URBAN DEV 3.25% 03/15/2025	234,640	228,434
90,000	NORFOLK VA TAXABLE GO 1.704% 10/01/2030	76,678	73,523
200,000	OKLAHOMA DEV FIN AUTH 4.38% 11/01/2045	183,036	190,355
270,000	OREGON ED DIST FULL 0.874% 06/30/2025	266,217	261,586
10,000	OREGON ST CMNTY CLG DIST 5.68% 06/30/26	10,179	12,218
255,000	RFCSP STRIP PRINCIPAL ZERO CPN 04/15/2030	201,057	205,752
90,000	ST JOHNS CNTY FL 5% 08/15/47	90,839	105,267
815,677	TEXAS NAT GAS 5.102% 04/01/2035	820,367	821,332
1,610,000	U.S. TREASURY NOTE 1.25% 03/31/2028	1,468,562	1,422,269
2,175,000	U.S. TREASURY NOTE 2.25% 02/15/2027	2,092,589	2,047,463
25,000	U.S. TREASURY NOTE 2.25% 11/15/2025	24,611	23,652
	<u>Forward</u>	\$ 29,032,928	\$ 29,489,492

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

<u>Face Value</u>	<u>Government Debt Securities (Continued)</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>	\$ 29,032,928	\$ 29,489,492
\$ 1,305,000	U.S. TREASURY NOTE 2.375% 03/31/2029	1,209,109	1,200,068
610,000	U.S. TREASURY NOTES 1.375% 08/31/2026	583,959	582,328
1,470,000	U.S. TREASURY NOTES 1.625% 11/30/2026	1,404,026	1,394,198
1,525,000	U.S. TREASURY NOTES 2.25% 08/15/2027	1,453,569	1,413,618
325,000	U.S. TREASURY NTS 0.625% 08/15/30	265,522	265,352
375,000	U.S. TREASURY NTS 1.375% 11/15/2031	308,029	304,563
165,000	US TREASURY NOTE 3.875% 08/15/2033	157,608	161,453
	<u>TOTALS - GOVERNMENT DEBT SECURITIES</u>	<u>\$ 34,414,750</u>	<u>\$ 34,811,072</u>
<u>Par Value</u>	<u>INTEREST BEARING CASH</u>		
\$ 5,126,846	COMERICA MONEY MARKET 1.00%	<u>\$ 5,126,846</u>	<u>\$ 5,126,846</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**FEBRUARY 1, 2024 TO JANUARY 31, 2025**

Description of Asset	Transaction	Purchase Price	Selling Price	Cost of Asset	Net Gain or (Loss)
JPMORGAN 100% US TREASURY MONEY MARKET	Purchases	\$ 14,297,041	\$ -	\$ 14,297,041	\$ -
	Sales	-	14,328,180	14,328,180	-
DREYFUS TREASURY & AGENCY CASH MGMT	Purchases	5,468,521	-	5,468,521	-
	Sales	-	5,556,048	5,556,048	-
AB INTEREST BEARING ACCT	Purchases	6,086,946	-	6,086,946	-
	Sales	-	6,086,946	6,086,946	-
U.S. TREASURY NOTE 2.375% 03/31/2029	Purchases	4,243,120	-	4,243,120	-
	Sales	-	3,676,734	3,641,154	35,580

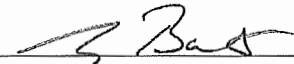
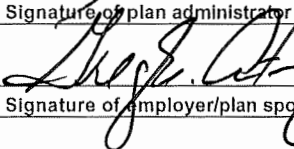
<b>Form 5500</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b> This form is required to be filed for employee benefit plans under sections 104 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).  <b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB Nos. 1210-0110 1210-0089  <b>2024</b>  This Form is Open to Public Inspection
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<b>Part I Annual Report Identification Information</b>	
For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 01/31/2025	
<b>A</b> This return/report is for: <input checked="" type="checkbox"/> a multiemployer plan  <input type="checkbox"/> a single-employer plan <b>B</b> This return/report is: <input type="checkbox"/> the first return/report <input type="checkbox"/> an amended return/report  <b>C</b> If the plan is a collectively-bargained plan, check here <input checked="" type="checkbox"/> <b>D</b> Check box if filing under: <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> special extension (enter description)	<input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the final return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)  <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program  <b>E</b> If this is a retroactively adopted plan permitted by SECURE Act section 201, check here <input type="checkbox"/>

<b>Part II Basic Plan Information - enter all requested information</b>											
<b>1a</b> Name of plan IBEW LOCAL 595 HEALTH & WELFARE TRUST  <b>2a</b> 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, IBEW LOCAL 595 HEALTH & WELFARE TRUST  7180 KOLL CENTER PKWY STE 200 PLEASANTON, CA 94566	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td><b>1c</b> Effective date of plan</td> <td style="text-align: center;">12/12/1955</td> </tr> <tr> <td><b>2b</b> Employer Identification Number (EIN)</td> <td style="text-align: center;">94-6085740</td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number</td> <td style="text-align: center;">925-208-9999</td> </tr> <tr> <td><b>2d</b> Business code (see instructions)</td> <td style="text-align: center;">238210</td> </tr> </table>	<b>1b</b> Three-digit plan number (PN) ▶	501	<b>1c</b> Effective date of plan	12/12/1955	<b>2b</b> Employer Identification Number (EIN)	94-6085740	<b>2c</b> Plan Sponsor's telephone number	925-208-9999	<b>2d</b> Business code (see instructions)	238210
<b>1b</b> Three-digit plan number (PN) ▶	501										
<b>1c</b> Effective date of plan	12/12/1955										
<b>2b</b> Employer Identification Number (EIN)	94-6085740										
<b>2c</b> Plan Sponsor's telephone number	925-208-9999										
<b>2d</b> 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		11/05/2025	Greg Bonato
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		11/05/2025	Greg Armstrong
	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

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN 94-6085740
	<b>3c</b> Administrator's telephone number 925-208-9999

<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:  <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN		
<b>5</b> Total number of participants at the beginning of the plan year	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>5</b></td> <td style="text-align: right;">1862</td> </tr> </table>	<b>5</b>	1862
<b>5</b>	1862		
<b>6</b> 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).			
<b>a(1)</b> Total number of active participants at the beginning of the plan year . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6a(1)</b></td> <td style="text-align: right;">1321</td> </tr> </table>	<b>6a(1)</b>	1321
<b>6a(1)</b>	1321		
<b>a(2)</b> Total number of active participants at the end of the plan year . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6a(2)</b></td> <td style="text-align: right;">1393</td> </tr> </table>	<b>6a(2)</b>	1393
<b>6a(2)</b>	1393		
<b>b</b> Retired or separated participants receiving benefits . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6b</b></td> <td style="text-align: right;">546</td> </tr> </table>	<b>6b</b>	546
<b>6b</b>	546		
<b>c</b> Other retired or separated participants entitled to future benefits. . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6c</b></td> <td style="text-align: right;">0</td> </tr> </table>	<b>6c</b>	0
<b>6c</b>	0		
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c. . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6d</b></td> <td style="text-align: right;">1939</td> </tr> </table>	<b>6d</b>	1939
<b>6d</b>	1939		
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6e</b></td> <td style="text-align: right;">0</td> </tr> </table>	<b>6e</b>	0
<b>6e</b>	0		
<b>f</b> Total. Add lines 6d and 6e. . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6f</b></td> <td style="text-align: right;">1939</td> </tr> </table>	<b>6f</b>	1939
<b>6f</b>	1939		
<b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6g(1)</b></td> <td style="text-align: right;">0</td> </tr> </table>	<b>6g(1)</b>	0
<b>6g(1)</b>	0		
<b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6g(2)</b></td> <td style="text-align: right;">0</td> </tr> </table>	<b>6g(2)</b>	0
<b>6g(2)</b>	0		
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>6h</b></td> <td style="text-align: right;">0</td> </tr> </table>	<b>6h</b>	0
<b>6h</b>	0		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) . . . . .	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;"><b>7</b></td> <td style="text-align: right;">230</td> </tr> </table>	<b>7</b>	230
<b>7</b>	230		

**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 4Q

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance (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	(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)

<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)	<b>b General Schedules</b> (1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) - Number Attached <u>  9  </u> (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)
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**Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)**

**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 \_\_\_\_\_

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**FEBRUARY 1, 2024 TO JANUARY 31, 2025**

Description of Asset	Transaction	Purchase Price	Selling Price	Cost of Asset	Net Gain or (Loss)
JPMORGAN 100% US TREASURY MONEY MARKET	Purchases	\$ 14,297,041	\$ -	\$ 14,297,041	\$ -
	Sales	-	14,328,180	14,328,180	-
DREYFUS TREASURY & AGENCY CASH MGMT	Purchases	5,468,521	-	5,468,521	-
	Sales	-	5,556,048	5,556,048	-
AB INTEREST BEARING ACCT	Purchases	6,086,946	-	6,086,946	-
	Sales	-	6,086,946	6,086,946	-
U.S. TREASURY NOTE 2.375% 03/31/2029	Purchases	4,243,120	-	4,243,120	-
	Sales	-	3,676,734	3,641,154	35,580

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

No. of Shares	<u>Short Term Investment Funds</u>	Fair Value	Cost
281,312	DREYFUS TREASURY & AGENCY CASH MGMT	\$ 281,312	\$ 281,312
281,212	JPMORGAN 100% US TREASURY MONEY MARKET	281,212	281,212
	<u>TOTALS - SHORT TERM INVESTMENT FUNDS</u>	<u>\$ 562,524</u>	<u>\$ 562,524</u>
	<u>Limited Partnership</u>		
5,161	BOYD WATTERSON GSA FUND LP	<u>\$ 5,090,187</u>	<u>\$ 5,284,801</u>
Face Value	<u>Corporate Debt Securities</u>		
\$ 179,167	AADVANTAGE LOYALTY IP 5.5% 04/20/2026	\$ 179,055	\$ 176,332
95,000	AADVANTAGE LOYALTY IP 5.75% 04/20/2029	94,768	93,606
330,000	ADOBE INC SR GLBL 4.8% 04/04/2029	332,056	338,521
260,000	ALBERTSONS COS-SAFEWAY 3.25% 03/15/2026	255,159	258,700
30,000	ALBERTSONS COS-SAFEWAY 4.625% 01/15/2027	29,466	29,419
705,000	AT&T INC 2.3% 06/01/27	667,755	653,159
130,000	AT&T INC 4.10% 02/15/2028	127,605	142,095
965,000	BANK OF AMERICA CORP FLTG 04/23/2027	950,824	1,016,268
95,000	BLACKROCK INC 2.4% 04/30/2030	84,697	90,114
290,000	BOYD GAMING CORP 4.75% 12/01/27	284,551	273,614
140,000	BRINKS CO SR 6.5% 06/15/2029	142,708	141,638
25,000	BRINK'S CO/THE 4.625% 10/15/2027	24,410	24,310
335,000	CATERPILLAR FINL SVCS 4.7% 11/15/2029	334,635	334,682
300,000	CENTENE CORP 4.25% 12/15/27	290,727	279,595
285,000	CHARTER COMM OPT LLC CAP 4.908% 07/23/25	284,826	287,453
835,000	CITIGROUP INC SR VAR 02/24/2028	806,051	826,254
200,000	CLEARWAY ENERGY OP LLC 4.75% 3/15/28	193,494	193,794
30,000	CLEVELAND-CLIFFS INC 6.875% 11/01/2029	30,093	30,000
710,000	CONOCOPHILLIPS SR NT 4.7% 01/15/2030	704,079	706,374
280,000	CROWN AMERS LLC / CROWN 4.75% 02/01/2026	279,266	274,485
70,000	DEERE JOHN CAPITAL 3.45% 03/07/2029	66,765	75,939
635,000	DUKE ENERGY CAROLINAS 2.95% 12/01/2026	617,919	609,263
160,000	DUKE ENERGY CAROLINAS 3.95% 11/15/2028	155,970	178,085
285,000	ESAB CORPORATION 6.25% 04/15/2029	288,836	286,733
305,000	FORTRESS TRANSN & INFRA 5.5% 05/01/2028	298,122	290,357
105,000	GENTING NEW YORK LLC 7.25% 10/01/2029	107,939	105,456
195,000	GFL ENVIRONMENTAL INC 3.75% 08/01/2025	193,760	200,853
105,000	GGAM FIN LTD SR 144A 8.00% 02/15/2027	108,427	106,184
180,000	GGAM FIN LTD SR GLBL 7.75% 05/15/2026	182,821	180,000
85,000	GLP CAPITAL LP / FIN II 5.25% 6/1/2025	84,890	88,360
195,000	GLP CAPITAL LP-FIN II 5.375% 04/15/2026	195,320	190,925
35,000	HAT HLDGS I LLC / HAT 8.00% 06/15/2027	36,385	35,644
270,000	HAT HLDGS I LLC 3.375% 06/15/2026	261,595	253,530
190,000	HERC HLDGS INC SR 6.625% 06/15/2029	194,186	191,594
90,000	HERC HOLDINGS INC 5.5% 07/15/2027	89,655	89,542
140,000	HILTON DOMESTIC OPER 5.375% 05/01/2025	139,481	141,196
	<u>Forward</u>	<u>\$ 9,118,296</u>	<u>\$ 9,194,074</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

Face Value	Corporate Debt Securities (Continued)	Fair Value	Cost
	<u>Forwarded</u>	\$ 9,118,296	\$ 9,194,074
\$ 60,000	HILTON WORLDWIDE FIN LLC 4.875% 04/01/2	59,567	58,350
60,000	HOME DEPOT INC 2.95% 6/15/2029	55,922	52,759
115,000	HOME DEPOT INC SR 4.85% 06/25/2031	115,084	114,359
185,000	ICHAN ENTERPRISES FIN 525% 05/15/2027	179,309	171,631
72,000	ICHAN ENTERPRISES- FIN 6.25% 05/15/26	71,900	69,660
285,000	INTERNATIONAL GAME TECH 6.25% 01/15/2027	288,959	288,975
320,000	JAZZ SECURITIES 4.375% 01/15/2029	304,819	296,536
115,000	JOHN DEERE CAPITAL 4.4% 09/08/2031	111,754	115,159
575,000	JOHN DEERE CAPITAL 4.75% 06/08/2026	577,599	574,273
295,000	JPMORGAN CHASE & CO FLTG 04/23/2029	287,554	315,986
655,000	JPMORGAN CHASE & CO VAR 01/29/2027	650,598	700,495
285,000	KINETIK HLDGS LP SR 6.625% 12/15/2028	291,427	287,400
35,000	MACQUARIE AIRFINANCE 6.4% 03/26/2029	36,066	35,700
180,000	MACQUARIE AIRFINANCE 8.375% 05/01/2028	188,660	184,642
85,000	MARSH & MCLENNAN COS 5.15% 03/15/2034	84,388	84,934
75,000	MIDAMERICAN ENERGY CO 3.65% 4/15/2029	71,677	81,779
125,000	ONEMAIN FINANCIAL 3.5% 01/15/2027	120,264	116,897
100,000	ONEMAIN FINANCIAL 3.875% 09/15/2028	93,412	92,497
130,000	PARK INTER HLDGS LLC 4.875% 05/15/2029	124,194	122,144
170,000	PARK INTERMED HOLDINGS 5.875% 10/01/28	168,054	167,400
210,000	PHINIA INC SR SEC 6.75% 04/15/2029	215,733	212,523
280,000	PRIME SEC SVCS 5.75% 04/15/2026	280,678	275,414
125,000	REPUBLIC SVCS 2.375% 03/15/2033	101,709	100,958
290,000	SBA COMMUNICATIONS 3.875% 02/15/2027	280,604	292,354
295,000	SIRIUS XM RADIO INC 3.125% 09/01/2026	285,224	294,283
170,000	SLM CORP 4.2% 10/29/25	169,653	178,326
25,000	SLM CORP SR 6.5% 01/31/2030	25,235	24,944
120,000	SLM CORP SR GBL 3.125% 11/02/2026	115,367	107,960
70,000	SPRINGLEAF FINANCE CORP 7.125% 03/15/26	71,399	71,225
130,000	SS&C TECHNOLOGIES INC 5.5% 09/30/2027	129,661	129,650
315,000	STARWOOD PPTY TR INC 3.625% 07/15/2026	306,067	311,176
535,000	STATE STR CORP SR NT VAR 11/21/2029	551,253	536,109
45,000	SUNOCO LP -FINANCE CORP 6% 04/15/2027	44,942	44,480
235,000	SUNOCO LP-FINANCE CORP 5.875% 03/15/28	235,226	232,650
110,000	TALLGRASS ENERGY 5.5% 01/15/2028	107,602	105,294
130,000	TALLGRASS ENERGY 7.375% 02/15/2029	132,323	130,000
60,000	TALLGRASS NRG PRTNR -FIN 6% 03/01/2027	59,720	58,825
30,000	TEGNA INC 4.625% 03/15/28	28,734	27,906
255,000	TEGNA INC 4.75% 03/15/26	253,498	263,836
170,000	TENET HEALTHCARE CORP 4.25% 06/01/2029	160,618	156,938
125,000	TENET HEALTHCARE CORP 5.125% 11/01/2027	123,644	122,870
90,000	TEVA PHARMACEUTICAL 4.75% 05/09/2027	88,558	86,713
15,000	TEVA PHARMACEUTICAL 6.75% 03/01/2028	15,435	15,113
185,000	TEVA PHARMACEUTICALS NE 3.15% 10/01/2026	179,261	165,516
70,000	TEXAS CHILDRENS HOSPITAL 3.368% 10/01/29	67,740	69,734
65,000	TOYOTA MTR CR CORP FR 0.8% 10/16/2025	63,370	64,257
490,000	TOYOTA MTR CR CORP FR 5.05% 05/16/2029	494,792	489,068
125,000	TRANSDIGM INC SR SEC 6.375% 03/01/2029	126,253	125,039
	<u>Forward</u>	\$ 17,713,802	\$ 17,818,811

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

<u>Face Value</u>	<u>Corporate Debt Securities (Continued)</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>	\$ 17,713,802	\$ 17,818,811
\$ 170,000	TRANSDIGM INC SR SEC 6.75% 08/15/2028	173,012	172,350
215,000	TRAVEL PLUS LEISURE CO VAR 10/01/2025	215,561	230,585
165,000	TRUIST BANK 2.25% 03/11/2030	142,987	139,104
490,000	TRUIST FINL CORP FR VAR 07/28/2026	488,657	488,416
580,000	VERIZON COMMUNICATIONS 4.125% 03/16/2027	574,333	578,451
230,000	VERIZON COMMUNICATIONS 4.329% 9/21/2028	226,884	259,064
665,000	VIRGINIA PWR FUEL 4.877% 05/01/2033	665,160	683,717
280,000	VISTRA OPERATIONS CO 5.5% 09/01/2026	279,885	272,902
345,000	WASTE MGMT INC DEL SR 0.75% 11/15/2025	335,281	317,583
170,000	WASTE MGMT INC DEL SR 1.15% 03/15/2028	153,286	162,102
155,000	WESCO DISTR INC SR 6.375% 03/15/2029	157,903	155,769
280,000	WESTERN DIGITAL CORP 4.75% 02/15/2026	278,351	302,478
70,000	WYNDHAM WORLDWIDE 6.625% 7/31/2026	71,124	69,756
280,000	XPO INC SR SEC 6.25% 06/01/2028	283,702	280,936
	<u>TOTALS - CORPORATE DEBT SECURITIES</u>	<u>\$ 21,759,928</u>	<u>\$ 21,932,024</u>
	<u>Government Debt Securities</u>		
\$ 115,000	CHICAGO ILL SALES TAX 0.00% 01/01/2032	\$ 80,127	\$ 87,206
70,000	CHICAGO ILL SALES TAX 0.00% 01/01/2033	46,003	51,987
1,834,924	FANNIE MAE 2019-M11 2.65% 06/25/2029	1,706,441	1,700,243
82,017	FHLMC MULTIFAM STRU CMO 2.896% 04/25/26	81,088	80,895
452,073	FHLMC MULTIFAMILY CMO 3.284% 06/25/2025F	449,677	465,641
669,870	FANNIE MAE REMIC TRUST 2.937% 06/25/2029	627,363	629,678
62,447	FHLMC GOLD POOL #WN0007 3.42% 10/01/2033	56,388	69,268
251,460	FHLMC GLD PL #WA2801 3.49% 10/01/2033	242,816	263,512
638,530	FHLMC POOL # SA-0088 1.5% 01/01/2032	573,811	587,149
487,565	FHLMC POOL #SB-0308 2.5% 01/01/2035	448,788	471,732
196,870	FHLMC POOL #SD-4154 3.5% 08/01/2045	179,183	179,280
265,102	FHLMC POOL #SI-2036 5.00% 12/01/2047	263,652	268,721
158,595	FHLMC POOL #WA-1625 3.4499999% 08/01/32	145,511	146,653
229,585	FHLMC POOL #ZA5113 4.00% 12/01/2047	217,317	245,208
21,291	FHLMC POOL #ZS-9446 3.5% 08/01/2045	19,401	19,700
41,287	FHLMC REMIC SERIES 0.681% 06/25/2026	40,899	38,618
25,000	FHLMC REMIC SERIES 1.47% 09/25/2027	23,125	22,772
1,605,000	FHLMC REMIC SERIES 2.77% 05/25/2025	1,593,259	1,595,161
440,000	FHLMC REMIC SERIES 2.995% 12/25/2025	434,476	431,610
25,000	FHLMC REMIC SERIES 3.465% 02/25/2031	23,427	23,296
432,904	FHLMC REMIC SERIES 3.902% 07/25/2029	423,425	432,346
190,000	FHLMC REMIC SERIES VAR 01/25/2029	194,832	197,363
450,000	FHLMC REMIC SERIES VAR 03/25/2029	409,865	395,204
155,000	FHLMC REMIC SERIES VAR 11/25/2032	141,427	137,770
33,103	FNMA PL #FM2993 3.5% 07/01/44	30,299	36,227
341,027	FNMA POOL #AL2893 3.5% 12/01/2042	310,867	341,897
246,823	FNMA POOL #AL3495 3.2% 04/01/2028	238,030	266,038
5,000	FNMA POOL #AN9316 3.46% 05/01/2028	4,826	4,661
159,704	FNMA POOL #BM4567 VAR 07/01/2044	164,695	162,779
87,071	FNMA POOL #BM4870 3.5% 03/01/2033	84,500	93,318
478,074	FNMA POOL #BM7277 VAR 08/01/2051	424,813	413,750
	<u>Forward</u>	<u>\$ 9,680,331</u>	<u>\$ 9,859,683</u>

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

<u>Face Value</u>	<u>Government Debt Securities (Continued)</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>	\$ 9,680,331	\$ 9,859,683
\$ 505,000	FNMA POOL #BS9744 5.27% 10/01/2028	515,179	521,178
340,000	FNMA POOL #BZ1048 5.13% 06/01/2029	346,109	347,650
255,156	FNMA POOL #FM3066 4.5% 11/01/2038	253,761	276,749
410,291	FNMA POOL #FM3228 3.5% 09/01/2047	373,878	413,267
229,046	FNMA POOL #FM3244 5.00% 07/01/2045	227,794	257,167
168,314	FNMA POOL #FM8873 3.5% 07/01/2034	164,527	179,903
294,036	FNMA POOL #FS1116 5.00% 12/01/2047	291,739	316,975
228,165	FNMA POOL #FS1485 3.00% 11/01/2046	201,320	219,222
596,422	FNMA POOL #FS7952 6.00% 02/01/2049	618,136	615,926
273,408	FNMA POOL #FS7981 2.5% 04/01/2036	259,567	260,464
1,216,051	FNMA POOL #FS8559 5.5% 11/01/2052	1,233,342	1,243,982
207,064	FNMA POOL #FS9640 5.5% 11/01/2052	209,070	211,658
182,677	FNMA POOL #FS9946 6.00% 02/01/2049	189,327	191,475
1,513,878	FNMA REMIC TRUST 0.96% 01/25/2031	1,317,576	1,331,739
301,832	FNMA REMIC TRUST 2.00% 02/25/2033	278,538	282,345
98,538	FNMA REMIC TRUST 2.5% 09/25/2045	88,080	97,848
330,000	FNMA REMIC TRUST VAR 04/25/2032	275,099	257,136
682,980	FNMA REMIC TRUST VAR 07/25/2028	671,099	664,179
360,925	FNMA REMIC TRUST VAR 10/25/2027	347,109	361,822
577,912	FNMA SUPER POOL #FS9260 2.5% 08/01/2035	547,571	547,571
716,396	FNMA UMBS POOL #MA4389 1.5% 07/01/2031	661,435	659,980
260,812	GNMA I POOL #BX7719X 1.97% 09/15/2041	208,772	242,465
459,965	GNMA PL #AC1428 2.690% 06/15/2033	420,077	448,100
22,941	GNMA PL #AC3667 1.660% 08/15/2026	22,389	23,120
519,645	GNMA PL #AI8404 3.310% 05/15/2030	505,111	538,898
591,647	GNMA PL #AU4920 3.020% 09/15/2041	504,933	595,829
105,161	GNMA PL #BB2949 3.63% 9/15/2037	98,391	114,385
320,188	GNMA POOL #786470X 5.00% 11/15/2040	319,338	327,270
282,711	GNMA POOL #787712X 5.5% 11/15/2045	288,056	289,959
359,181	GNMA POOL #BB5549X 3.59% 12/15/2034	342,906	374,783
470,000	HUNTSVILLE ALA WTR SYS 1.337% 11/01/2028	420,298	388,831
145,000	MASSACHUSETTS ST SCH 1.753% 08/15/2030	127,825	122,164
110,000	METRO WSTWTR RECLAMATION 2.413% 04/01/28	103,727	115,987
330,000	NEW YORK ST 1.538% 03/15/2027	310,834	291,629
405,000	NEW YORK ST DORM AUTH 2.738% 03/15/2026	397,670	404,218
325,000	NEW YORK ST URBAN DEV 1.00% 03/15/2026	313,138	295,338
445,000	NEW YORK ST URBAN DEV 1.31% 03/15/2026	430,101	406,746
235,000	NEW YORK ST URBAN DEV 3.25% 03/15/2025	234,640	228,434
90,000	NORFOLK VA TAXABLE GO 1.704% 10/01/2030	76,678	73,523
200,000	OKLAHOMA DEV FIN AUTH 4.38% 11/01/2045	183,036	190,355
270,000	OREGON ED DISTS FULL 0.874% 06/30/2025	266,217	261,586
10,000	OREGON ST CMNTY CLG DISTS 5.68% 06/30/26	10,179	12,218
255,000	RFCSP STRIP PRINCIPAL ZERO CPN 04/15/2030	201,057	205,752
90,000	ST JOHNS CNTY FL 5% 08/15/47	90,839	105,267
815,677	TEXAS NAT GAS 5.102% 04/01/2035	820,367	821,332
1,610,000	U.S. TREASURY NOTE 1.25% 03/31/2028	1,468,562	1,422,269
2,175,000	U.S. TREASURY NOTE 2.25% 02/15/2027	2,092,589	2,047,463
25,000	U.S. TREASURY NOTE 2.25% 11/15/2025	24,611	23,652
	<u>Forward</u>	\$ 29,032,928	\$ 29,489,492

**IBEW LOCAL 595 HEALTH & WELFARE TRUST**  
**FORM 5500**  
**SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)**  
**E.I.N. 94-6085740; PLAN NO. 501**  
**JANUARY 31, 2025**

<u>Face Value</u>	<u>Government Debt Securities (Continued)</u>	<u>Fair Value</u>	<u>Cost</u>
	<u>Forwarded</u>	\$ 29,032,928	\$ 29,489,492
\$ 1,305,000	U.S. TREASURY NOTE 2.375% 03/31/2029	1,209,109	1,200,068
610,000	U.S. TREASURY NOTES 1.375% 08/31/2026	583,959	582,328
1,470,000	U.S. TREASURY NOTES 1.625% 11/30/2026	1,404,026	1,394,198
1,525,000	U.S. TREASURY NOTES 2.25% 08/15/2027	1,453,569	1,413,618
325,000	U.S. TREASURY NTS 0.625% 08/15/30	265,522	265,352
375,000	U.S. TREASURY NTS 1.375% 11/15/2031	308,029	304,563
165,000	US TREASURY NOTE 3.875% 08/15/2033	157,608	161,453
	<u>TOTALS - GOVERNMENT DEBT SECURITIES</u>	<u>\$ 34,414,750</u>	<u>\$ 34,811,072</u>
<u>Par Value</u>	<u>INTEREST BEARING CASH</u>		
\$ 5,126,846	COMERICA MONEY MARKET 1.00%	<u>\$ 5,126,846</u>	<u>\$ 5,126,846</u>