

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

- A This return/report is for: [X] 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. [X]
D Check box if filing under: [X] Form 5558 [] automatic extension [] the DFVC program [] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. []

Part II Basic Plan Information—enter all requested information

1a Name of plan: TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND
1b Three-digit plan number (PN): 501
1c Effective date of plan: 07/01/1958
2a Plan sponsor's name (employer, if for a single-employer plan): TRUSTEES-TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND
2b Employer Identification Number (EIN): 84-6030963
2c Plan Sponsor's telephone number: 303-430-1118
2d Business code (see instructions): 484120
5511 W 56TH AVE
SUITE 250
ARVADA, CO 80002

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

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

Table with 4 columns: SIGN HERE, Signature, Date, Name. Rows include: 1. Filed with authorized/valid electronic signature, 12/15/2025, HERB WHITAKER; 2. Signature of plan administrator; 3. Filed with authorized/valid electronic signature, 12/15/2025, DANA RUTZ; 4. Signature of employer/plan sponsor; 5. Signature of DFE.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	317
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	317
	6a(2)	279
	6b	
	6c	
	6d	279
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	5

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

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

9a Plan funding arrangement (check all that apply)	9b 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)

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

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

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

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

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

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

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**

<p>A Name of plan TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶ 501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES-TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 84-6030963</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
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	G3319/C4584	281	08/01/2024	07/31/2025

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 0	(b) Total amount of fees paid 0
--------------------------------------------------	-------------------------------------------

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

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

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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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.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

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

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

e Deductions:

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	7507
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**

<p>A Name of plan TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES-TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 84-6030963</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	HCL30003	334	03/01/2024	02/28/2025

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
0	0

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

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

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

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

e Deductions:

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	438691
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **03/01/2024** and ending **02/28/2025**

A Name of plan TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES-TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 84-6030963	

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

SEGAL SELECT INSURANCE SERVICES INC

46-0619194

(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

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

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

ZENITH AMERICAN SOLUTIONS, INC.

52-1590516

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 50 99	NONE	178181	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	24132	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

CIGNA

59-1031071

(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 31 38 49 50 56 62	NONE	133437	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

WELLS FARGO ADVISORS

34-1542819

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	71085	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)

THE SEGAL COMPANY

46-0619194

(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	55620	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	1859	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

SPENCER FANE LLP

44-0561981

(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	55289	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NEEDLES & ASSOCIATES, LLC

51-0435869

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	25646	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CASTLIGHT HEALTH 26-1989091	APPROXIMATELY \$3.24 PER PARTICIPANT TO HELP DEFRAY	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
OMADA HEALTH, INC. 45-2355015	APPROXIMATELY \$1.23 PER PARTICIPANT TO HELP AT-RISK INDIVIDUALS TO USE PREVENTIVE CARE SERVICES AND ENROLLMENT	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
VISION SERVICE PLAN 06-1227840	APPROXIMATELY \$0.67 PER PARTICIPANT FOR CIGNA'S EXPENSES THAT ARE ADMINISTERING PLANS WITH VISION BENEFITS	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation SAGAMORE NETWORK HOSPITALS 35-1720796	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. APPROXIMATELY \$0.06 PER PARTICIPANT.	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation BANK OF AMERICA (LOCKBOX) 59-1031071	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. FOR 2024, \$0.37 PER PARTICIPANT AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 4.00%	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation CITIBANK NA 59-1031071	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. FOR 2024, \$1.97 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66%	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA (OMNIBUS) 59-1031071	FOR 2024, \$0.01 PER PARTICIPANT AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 3.66%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA (CHLIC CORE DEPOSITS) 59-1031071	FOR 2024, \$1.02 PER PARTICIPANT WITH AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 3.25%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
DEUTSCHE BANK 59-1031071	FOR 2024, \$0.00 PER PARTICIPANT WITH ANNUAL AVERAGE RATE OF EARNINGS CREDIT AT 0.50%	

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation JPMORGAN CHASE 59-1031071	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. FOR 2024, \$4.38 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF EARNINGS CREDIT AT 3.54%	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation CIGNA HEALTH REWARDS VENDOR 38-3983812	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. FOR 2024, \$0.00 PMPY	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation OMADA COMPLETE 45-2355015	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. FOR 2024, \$0.17 PER PARTICIPANT	

Part II Service Providers Who Fail or Refuse to Provide Information

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

(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide
US BANK PO BOX 1800 SAINT PAUL, MN 55101	18 50	NO REPLIES TO THE EMAIL SENT FOR REQUEST ON SCHEDULE C

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025	
A Name of plan TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES-TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 84-6030963

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	-63892	-100836
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	15237	15694
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	152184	875369
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	2810972	1660239
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	8100007	8705357
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)	8050	5394

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	11022558	11161217
Liabilities			
g Benefit claims payable.....	1g	47752	56820
h Operating payables.....	1h	5132	3553
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	921248	1803180
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	974132	1863553
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	10048426	9297664

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	5325441	
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		5325441
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	27519	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		27519
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	628565	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		628565
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		270878
c Other income	2c		450826
d Total income. Add all income amounts in column (b) and enter total.....	2d		6703229

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	6396086	
(2) To insurance carriers for the provision of benefits	2e(2)	446366	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		6842452
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions).....	2g		
h Interest expense.....	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	311618	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	25646	
(5) Investment advisory and investment management fees	2i(5)	71085	
(6) Bank or trust company trustee/custodial fees	2i(6)	38819	
(7) Actuarial fees	2i(7)	55620	
(8) Legal fees	2i(8)	55289	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	998	
(11) Other expenses.....	2i(11)	52464	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		611539
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		7453991

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-750762
l Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

3 Complete lines 3a through 3c if the opinion of an independent qualified public accountant is attached to this Form 5500. Complete line 3d if an opinion is not attached.

a The attached opinion of an independent qualified public accountant for this plan is (see instructions):

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

b Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1) DOL Regulation 2520.103-8 (2) DOL Regulation 2520.103-12(d) (3) neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

c Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **NEEDLES & ASSOCIATES, LLC**

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

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

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

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

***TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND***

***FINANCIAL STATEMENTS
February 28, 2025 and February 29, 2024***

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

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February 28, 2025 and February 29, 2024***

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INDEPENDENT AUDITOR'S REPORT

Plan Participants and Board of Trustees
Teamsters Local No. 455 Health and Welfare Fund
Arvada, Colorado

Opinion

We have audited the accompanying financial statements of Teamsters Local No. 455 Health and Welfare Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of February 28, 2025 and February 29, 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 financial status of Teamsters Local No. 455 Health and Welfare Fund as of February 28, 2025 and February 29, 2024, and the changes in its financial status 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 Teamsters Local No. 455 Health and Welfare Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Teamsters Local No. 455 Health and Welfare Fund's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Teamsters Local No. 455 Health and Welfare Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Teamsters Local No. 455 Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

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) and of reportable transactions, together referred to as "supplemental information," 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.

Needle & Associates, LLC

Broomfield, CO
December 11, 2025

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND

**Statements of Net Assets Available for Benefits
February 28, 2025 and February 29, 2024**

	<u>2025</u>	<u>2024</u>
Assets		
Cash	\$ (100,836)	\$ (63,892)
Investments, at fair value		
Interest bearing cash	67,105	11,433
Money market funds	1,593,134	2,799,539
Mutual funds	<u>8,705,357</u>	<u>8,100,007</u>
Total investments, at fair value	<u>10,365,596</u>	<u>10,910,979</u>
Receivables		
Employers' contributions	15,694	15,237
Other receivables	<u>875,369</u>	<u>152,184</u>
Total receivables	<u>891,063</u>	<u>167,421</u>
Other assets		
Prepaid expenses	<u>5,394</u>	<u>8,050</u>
Total assets	<u>\$ 11,161,217</u>	<u>\$ 11,022,558</u>
Liabilities		
Accounts payable		
Operating	<u>\$ 3,553</u>	<u>\$ 5,132</u>
Total liabilities	<u>\$ 3,553</u>	<u>\$ 5,132</u>
Net assets available for benefits	<u><u>\$ 11,157,664</u></u>	<u><u>\$ 11,017,426</u></u>

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

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND

***Statements of Changes in Net Assets Available for Benefits
Years Ended February 28, 2025 and February 29, 2024***

	<u>2025</u>	<u>2024</u>
<i>Additions</i>		
Contributions		
Employers'	\$ 5,325,441	\$ 5,406,418
Participants'	-	1,437
Total contributions	<u>5,325,441</u>	<u>5,407,855</u>
Investment earnings		
Interest	27,519	-
Dividends	628,565	401,497
Net appreciation (depreciation) fair value	<u>270,878</u>	<u>424,745</u>
Total investment earnings	<u>926,962</u>	<u>826,242</u>
Other income	<u>450,826</u>	<u>321,067</u>
Total additions	<u>\$ 6,703,229</u>	<u>\$ 6,555,164</u>
<i>Deductions</i>		
Benefit payments		
Self-funded claims paid, net	\$ 5,505,085	\$ 3,586,146
Insurance premiums paid	<u>446,366</u>	<u>402,634</u>
Total benefit payments	<u>5,951,451</u>	<u>3,988,780</u>
Operating expenses (Note G)	<u>611,540</u>	<u>598,532</u>
Total deductions	<u>\$ 6,562,991</u>	<u>\$ 4,587,312</u>
Net increase (decrease)	140,238	1,967,852
<i>Net assets available for benefits</i>		
Beginning of year	<u>\$ 11,017,426</u>	<u>\$ 9,049,574</u>
End of year	<u>\$ 11,157,664</u>	<u>\$ 11,017,426</u>

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

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND

**Statements of Benefit Obligations
February 28, 2025 and February 29, 2024**

	<u>2025</u>	<u>2024</u>
<i>Other obligations for current benefit coverage, at present value of estimated amounts</i>		
Claims incurred but not reported	\$ 1,803,180	\$ 921,248
Claims payable	<u>56,820</u>	<u>47,752</u>
Total obligations other than postretirement benefit obligations	<u>\$ 1,860,000</u>	<u>\$ 969,000</u>

**Statements of Changes in Benefit Obligations
Years Ended February 28, 2025 and February 29, 2024**

	<u>2025</u>	<u>2024</u>
<i>Other obligations for current benefits at present value of estimated amounts</i>		
Balance at beginning of year	\$ 969,000	\$ 617,000
Net change during year:		
Claims reported and approved for payment, including benefits reclassified from benefit obligations	6,396,085	3,938,146
Claims paid	<u>(5,505,085)</u>	<u>(3,586,146)</u>
Balance at end of year	<u>\$ 1,860,000</u>	<u>\$ 969,000</u>

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

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

***Notes to Financial Statements
February 28, 2025 and February 29, 2024***

NOTE A - DESCRIPTION OF PLAN

The following description of the Teamsters Local No. 455 Health and Welfare Fund (Plan) provides only general information. Participants should refer to the Trust Documents and Plan Documents for a complete description of the Plan's provisions.

- **General**

The Trust agreement was revised effective March 1, 2024 to rename the Plan to be Teamsters Local No. 455 Health and Welfare Fund. The Plan is a multiemployer defined benefit health plan formed in July 1956 and has been amended to its current status of June 1, 2009. The Fund covers all eligible persons working in covered employment under the respective collective bargaining agreements with the International Brotherhood of Teamsters. The Plan provides health and other benefits to eligible participants and covered dependents. The Plan is administered by a Board of Trustees with equal representation between union and management.

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

The Plan has contracted with Zenith American Solutions Inc., a third-party administrator, to manage the daily operations of the Fund. US Bank maintains the operating and benefits checking accounts and the investments are held by Wells Fargo Advisors, who acts as the investment advisor. The investments are managed by other money managers.

- **Tax status**

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

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Plan management has evaluated the Plan's tax positions and concluded that the Plan has taken no uncertain tax positions. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. With few exceptions, the Plan is no longer subject to tax examinations by tax authorities.

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE A - DESCRIPTION OF PLAN (continued)

- **Funding**

The Plan is funded by employers' contributions in accordance with formulas set forth in the applicable Collective Bargaining Agreement(s). Additionally, the Plan has entered into reciprocity agreements with other health and welfare plans, whereby, eligibility may be continued for a participant working out of jurisdiction. Under a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), participants may elect to contribute a specified fixed amount, determined periodically by the Board of Trustees, to temporarily continue health coverage when there is a "qualifying event" that would result in loss of health coverage.

- **Benefits**

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

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

The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. During the years ended February 28, 2025 and February 29, 2024 prescription drug rebates totaling \$441,996 and \$321,067, respectively, have been netted against benefit payments.

- **Stop-loss insurance**

The Plan has entered into a stop-loss insurance arrangement with HCC Company in an effort to limit its exposure for self-insured benefits of individual participant claims in excess of \$180,000. During the years ended February 28, 2025 and February 29, 2024, amount of stop loss reimbursements netted against benefit payments were \$835,190 and \$34,002 respectively.

- **Termination of the Plan**

Although it has not expressed any intention to do so, the Plan's Board of Trustees, as Sponsor, has the right under the Plan to modify the benefits provided to, and contributions required of, participants or to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, remaining assets, after payment of liabilities, will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants, including the transfer of said assets to another Plan established

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE A - DESCRIPTION OF PLAN (continued)

for the same general purpose. No assets of the Plan may revert to a contributing employer or be used for purposes other than for the exclusive benefit of the Plan's participants.

NOTE B - SUMMARY OF ACCOUNTING POLICIES

- **Basis of accounting**

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

- **Use of estimates**

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

- **Investment valuation and income recognition**

Investments are reported 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. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by its investment custodian(s) and investment advisor(s).

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

- **Employers' contributions receivable**

Employers' contributions are recorded as income in the month the hours are worked. Employers' contributions receivable represents contributions applicable to work months prior to February 28, 2025, but collected subsequent to those dates. Plan management believes these receivables to be fully collectible. The Board of Trustees has a policy of performing agreed-upon procedures on the payroll records of contributing employers on a regular basis. Delinquencies may arise from these procedures, but due to the uncertainty of collections, no estimates of amounts due will be accrued until settlements are reached. Consequently, no allowance for uncollectible receivables is recorded.

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE B - SUMMARY OF ACCOUNTING POLICIES (continued)

- **Claims incurred but not reported**

Plan obligations at February 28, 2025 and February 29, 2024 for claims incurred but not reported are estimated based on claims data provided by the Plan's third-party claims administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment.

- **Payment of benefits**

Claim payments are recorded when paid by the CIGNA network service.

- **Subsequent events**

Plan management has evaluated subsequent events through December 11, 2025, the date the financial statements were available to be issued. No subsequent events have occurred requiring accrual or disclosure.

NOTE C - FAIR VALUE MEASUREMENTS

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

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

Level 2 Inputs to the valuation methodology include:

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

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

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

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE C - FAIR VALUE MEASUREMENTS (continued)

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

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 February 28, 2025 and February 29, 2024.

Money market funds and mutual funds: Valued at the closing price reported on the active market on which the individual securities are traded.

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 Plan's investments have no unfunded commitment and can be redeemed at will by the Plan.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of February 28, 2025 and February 29, 2024:

Assets at fair value as of February 28, 2025

Description	Level 1	Level 2	Level 3	Total
Interest bearing cash	\$ 67,105	\$ -	\$ -	\$ 67,105
Money market funds	1,593,134	-	-	1,593,134
Mutual funds	8,705,357	-	-	8,705,357
Total assets at fair value	<u>\$10,365,596</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$10,365,596</u>

Assets at fair value as of February 29, 2024

Description	Level 1	Level 2	Level 3	Total
Interest bearing cash	\$ 11,433	\$ -	\$ -	\$ 11,433
Money market funds	\$ 2,799,539	\$ -	\$ -	\$ 2,799,539
Mutual funds	8,100,007	-	-	8,100,007
Total assets at fair value	<u>\$10,910,979</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$10,910,979</u>

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE D - RISKS AND UNCERTAINTIES

The plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the statement of net assets available for benefits.

Due to uncertainties inherent in the estimations and assumptions process of benefit obligations, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Cash consists of non-interest-bearing transaction accounts. The Plan puts its cash with financial institutions deemed to be creditworthy. Balances are insured by FDIC up to \$250,000. As of February 28, 2025 the Plan's cash did not exceed the federally insured limit.

NOTE E - PARTY-IN-INTEREST TRANSACTIONS

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

NOTE F - RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2025</u>	<u>2024</u>
Per financial statements	\$11,157,664	\$11,017,426
Less: Claims incurred but not reported	(1,803,180)	(921,248)
Less: Claims payable	<u>(56,820)</u>	<u>(47,752)</u>
Per Form 5500	<u>\$ 9,297,664</u>	<u>\$10,048,426</u>

Claims incurred but not reported are not considered liabilities under accounting principles generally accepted in the United States of America and, therefore, are not presented as liabilities in the accompanying financial statements but are recorded on the Form 5500 as a liability.

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

**Notes to Financial Statements
February 28, 2025 and February 29, 2024**

NOTE G - OPERATING EXPENSES

The following is a detailed summary of the Plan's operating expenses for the years ended February 28, 2025 and February 29, 2024:

	<u>2025</u>	<u>2024</u>
Third party administrator fees	\$ 178,181	\$ 183,992
Network fees	133,437	116,511
Custodial fees	38,819	34,329
Investment management - advisor fees	71,085	54,413
Actuary fees	55,620	52,654
Legal fees	55,289	93,108
Audit fees	25,646	24,331
Insurance - bonding premiums	13,682	14,865
Office expenses	35,622	19,860
Meeting - conference expenses	998	963
Other expenses	<u>3,161</u>	<u>3,506</u>
Total operating expenses	<u>\$ 611,540</u>	<u>\$ 598,532</u>

NOTE H - CONCENTRATION OF RISK

As of the Plan year end there were 6 signatory companies remitting contributions to the Plan. One employer makes up 60% of the monthly contributions. If this employer left the plan, there would be substantial concerns about the continuing viability of the plan.

NOTE I - AMENDMENTS

The Board of Trustees approved amendments to the Restated and Amended Plan Document which incorporated the following changes:

The Plan Document was updated and restated effective March 1, 2024, to incorporate all prior amendments.

- Plan Amendment No. 1: The Plan was amended effective October 1, 2024, to redefine initial employee eligibility for part-time and full-time employees.

The Plan Document was updated and restated effective March 1, 2021, to incorporate all prior amendments.

- Plan Amendment No. 1: The Plan was amended effective January 15, 2022, to add coverage of over-the-counter COVID-19 tests as required by law. The Plan was amended effective March 1, 2022, to comply with the No Surprises Act.

**TEAMSTERS LOCAL NO. 455
HEALTH AND WELFARE FUND**

***Notes to Financial Statements
February 28, 2025 and February 29, 2024***

NOTE I – AMENDMENTS (continued)

- Plan Amendment No. 3: Effective January 1, 2023, the Plan provides services for the treatment of autism spectrum disorder, including Applied Behavioral Therapy. In addition, effective March 1, 2023, the Plan’s preventative care provisions are amended to comply with the current US Preventive Service Task Force A and B recommendations. Coverage of certain preventative over-the-counter drugs is also amended.
- Plan Amendment No. 4: Effective March-August 2023, the following items were revised:
- plan’s precertification review procedures, COVID-19 testing and vaccine coverage, certification of total disability, removal of telemedicine exclusion and the enrolment and waiver of newly eligible participants.
- Plan Amendment No. 5: Effective August 1, 2023, the Plan revised the exclusion for injuries suffered by a covered individual while operating or riding a motor vehicle.

Participants should refer to the Plan Documents and / or Summary Plan Description for a complete description of the Plan’s provisions.

NOTE J - CHANGES IN CLASSIFICATION AND RECLASSIFICATION

The presentation of certain financial statement amounts of the previous year has been changed to reflect the presentation adopted for the current year.

NOTE K – RELATED PARTY TRANSACTIONS

Effective May 1, 2016, the Plan amended its administrative agreement with Zenith American Solutions Inc (Zenith). The agreement allowed Zenith to enter into a preferred vendor agreement that provides certain cost saving functions by retaining a sub-contractor agreement. Consequently, there is an agreement between the Plan, Zenith and Zelis Healthcare (formerly known as Preferred Healthcare Exchange-PHX) to provide cost containment services, discount arrangements, claims payment services and other administrative processing services.

As a function of the claims processing transactions, Zenith and Zelis shall apply gross savings on applicable savings which will be shared between the Plan, Zenith and Zenith. Based on the cost containment functions, there is fund savings retained at 76%; the total fee will be 24% of the savings (paid by Plan) of which Zenith and Zelis will split this 24% fee in proportionate terms based on certain services performed.

In addition, through Change Healthcare, Zenith will arrange for Virtual Payment Card Services on behalf of the Fund for those health claims administered by Zenith. For compensation, Change HealthCare shares the fee with Zenith at 45% to 55% respectively.

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND

*EIN: 84-6030963, Plan Number 501
Form 5500, Schedule H, line 4i
Schedule of Assets (Held at End of Year)
February 28, 2025*

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	<i>Money market funds</i>			
*	Wells Fargo bank deposit sweep account		\$ 1,591,667	\$ 1,591,667
	Wells Fargo standard bank deposit		67,105	67,105
	Fidelity Govt Portfolio Instl Class Shares		<u>1,467</u>	<u>1,467</u>
	<i>Total money market funds</i>		<u>\$ 1,660,239</u>	<u>\$ 1,660,239</u>
	<i>Mutual funds</i>			
	American Balanced Fund Income Class F2		\$ 3,234,352	\$ 3,887,021
	Macquarie Limited-Term Diversified Income fund		943,304	911,056
	Eaton Vance Global Return Fund		1,036,746	1,028,356
	Blackrock Strategic Inc Opportunities CL		1,203,255	1,190,442
	Lord Abbett Floating Rate Fund Class I		833,641	795,520
	Pimco Real Return Bond Fund Institutional Class		<u>945,262</u>	<u>892,962</u>
	<i>Total mutual funds</i>		<u>\$ 8,196,560</u>	<u>\$ 8,705,357</u>
	<i>Total assets (held at end of year)</i>		<u>\$ 9,856,799</u>	<u>\$ 10,365,596</u>

* Denotes party in interest

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND
EIN: 84-6030963, Plan Number 501
Form 5500, Schedule H, line 4j
Schedule of Reportable Transactions
Year Ended February 28, 2025

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Wells Fargo Advisors	Wells Fargo bank deposit sweep account	6,197,649	-	N/A	N/A	6,197,649	6,197,649	-
Wells Fargo Advisors	Wells Fargo bank deposit sweep account		6,560,722	N/A	N/A	6,560,722	6,560,722	-
Wells Fargo Advisors	Fidelity Govt Portfolio Instl Class Shares	-	1,300,000	N/A	N/A	1,300,000	1,300,000	-
Wells Fargo Advisors	Templeton Income Tr Global Bond Fund Advisors CL		701,954	N/A	N/A	910,818	701,954	(208,864)

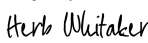
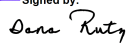
<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I	Annual Report Identification Information
For calendar plan year 2024 or fiscal plan year beginning <u>03/01/2024</u> and ending <u>02/28/2025</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <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 single-employer plan <input type="checkbox"/> a DFE (specify) ____
B This return/report is:	<input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.	<input type="checkbox"/>

Part II	Basic Plan Information—enter all requested information				
1a Name of plan Teamsters Local No. 455 Health and Welfare Fund	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">1b Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">07/01/1958</td> </tr> </table>	1b Three-digit plan number (PN) ▶	501	1c Effective date of plan	07/01/1958
1b Three-digit plan number (PN) ▶	501				
1c Effective date of plan	07/01/1958				
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) Trustees-Teamsters Local No. 455 Health and Welfare Fund 5511 W 56th Ave Suite 250 Arvada CO 80002	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">2b Employer Identification Number (EIN) 84-6030963</td> </tr> <tr> <td>2c Plan Sponsor's telephone number (303) 430-1118</td> </tr> <tr> <td>2d Business code (see instructions) 484120</td> </tr> </table>	2b Employer Identification Number (EIN) 84-6030963	2c Plan Sponsor's telephone number (303) 430-1118	2d Business code (see instructions) 484120	
2b Employer Identification Number (EIN) 84-6030963					
2c Plan Sponsor's telephone number (303) 430-1118					
2d Business code (see instructions) 484120					

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	Signed by:  <small>301C4224B9EC404...</small> Signature of plan administrator	12/11/2025	Herb Whitaker
SIGN HERE	Signed by:  <small>2C6ARD0ATC2684B7...</small> Signature of employer/plan sponsor	12/12/2025	Dana Rutz
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND

*EIN: 84-6030963, Plan Number 501
Form 5500, Schedule H, line 4i
Schedule of Assets (Held at End of Year)
February 28, 2025*

(a)	(b) Identity of issue, borrower, lessor, or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value	(d) Cost	(e) Current value
	<i>Money market funds</i>			
*	Wells Fargo bank deposit sweep account		\$ 1,591,667	\$ 1,591,667
	Wells Fargo standard bank deposit		67,105	67,105
	Fidelity Govt Portfolio Instl Class Shares		<u>1,467</u>	<u>1,467</u>
	<i>Total money market funds</i>		<u>\$ 1,660,239</u>	<u>\$ 1,660,239</u>
	<i>Mutual funds</i>			
	American Balanced Fund Income Class F2		\$ 3,234,352	\$ 3,887,021
	Macquarie Limited-Term Diversified Income fund		943,304	911,056
	Eaton Vance Global Return Fund		1,036,746	1,028,356
	Blackrock Strategic Inc Opportunities CL		1,203,255	1,190,442
	Lord Abbett Floating Rate Fund Class I		833,641	795,520
	Pimco Real Return Bond Fund Institutional Class		<u>945,262</u>	<u>892,962</u>
	<i>Total mutual funds</i>		<u>\$ 8,196,560</u>	<u>\$ 8,705,357</u>
	<i>Total assets (held at end of year)</i>		<u>\$ 9,856,799</u>	<u>\$ 10,365,596</u>

* Denotes party in interest

TEAMSTERS LOCAL NO. 455 HEALTH AND WELFARE FUND
EIN: 84-6030963, Plan Number 501
Form 5500, Schedule H, line 4j
Schedule of Reportable Transactions
Year Ended February 28, 2025

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Wells Fargo Advisors	Wells Fargo bank deposit sweep account	6,197,649	-	N/A	N/A	6,197,649	6,197,649	-
Wells Fargo Advisors	Wells Fargo bank deposit sweep account		6,560,722	N/A	N/A	6,560,722	6,560,722	-
Wells Fargo Advisors	Fidelity Govt Portfolio Instl Class Shares	-	1,300,000	N/A	N/A	1,300,000	1,300,000	-
Wells Fargo Advisors	Templeton Income Tr Global Bond Fund Advisors CL		701,954	N/A	N/A	910,818	701,954	(208,864)