

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

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.

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

- 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 IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 09/01/1975
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) IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN AMERICAN BENEFIT CORPORATION 9200 US ROUTE 60 ONA, WV 25545
2b Employer Identification Number (EIN) 51-0168650
2c Plan Sponsor's telephone number 304-399-9010
2d Business code (see instructions) 237990

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, and Name. Rows include: 1. Filed with authorized/valid electronic signature, 01/13/2026, JESSICA MORRISON (plan administrator); 2. Filed with authorized/valid electronic signature, 01/13/2026, JESSICA MORRISON (employer/plan sponsor); 3. Signature of DFE, Date, Enter name of individual signing as 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	885
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)	567
	6a(2)	542
	6b	315
	6c	
	6d	857
	6e	
	6f	857
	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	112

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 4D

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>4</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 _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN	D Employer Identification Number (EIN) 51-0168650

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

1 Coverage Information:

(a) Name of insurance carrier

DELTA DENTAL OF WEST VIRGINIA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
55-0523124	12329	01044/01038	1570	04/01/2024	03/31/2025

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 1538	(b) Total amount of fees paid 18004
------------------------------------------------------------	------------------------------------------------------

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

DELAWARE VALLEY HEALTH CARE COALITI
2980 SOUTHAMPTON ROAD
PHILADELPHIA, PA 19154

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1538			3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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)	285389
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))	9b(3)	285389
	(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	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

<p>A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN</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 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN</p>	<p>D Employer Identification Number (EIN) 51-0168650</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	G3357/G4619	740	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	(b) Total amount of fees paid
---------------------------------------------	--------------------------------------

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier.....		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(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) ▶ **ACCIDENTAL DEATH AND DISMEMBERMENT**

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	74515
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 style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: small;">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 style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

<p>A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN</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 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN</p>	<p>D Employer Identification Number (EIN) 51-0168650</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
BERKLEY ACCIDENT AND HEALTH

(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
91-6034263	64890	ERLL23101596004		01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

c Additions: (1) Contributions deposited during the year **7c(1)**
 (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)	583148	
	(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)		583148
b	Benefit charges (1) Claims paid	9b(1)		
	(2) Increase (decrease) in claim reserves	9b(2)		
	(3) Incurred claims (add (1) and (2))	9b(3)		0
	(4) Claims charged	9b(4)		
c	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions	9c(1)(A)	29977	
	(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)		29977
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)		
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)		
	(2) Claim reserves	9d(2)		
	(3) Other reserves	9d(3)		
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e		

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

<p>A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN</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 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN</p>	<p>D Employer Identification Number (EIN) 51-0168650</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
SIERRA HEALTH AND LIFE INSURANCE COMPANY. INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-0734860	71420	H2001	297	04/01/2024	03/31/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶		
b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	
e Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		

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

a Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
(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)	470084
	(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)	470084
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	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN	D Employer Identification Number (EIN) 51-0168650	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ANTHEM BLUE CROSS BLUE SHIELD

3075 VANDEREAR WAY
CINCINNATI, OH 45209

31-1440175

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15	MEDICAL CLAIMS ADMIN	416622	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)

AMERICAN BENEFIT CORPORATION

9200 US ROUTE 60
ONA, WV 25545

55-0672859

(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 49 50	PLAN ADMINISTRATOR	303540	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)

CAPITAL RX

228 PARK AVENUE S, SUITE 87234
NEW YORK CITY, NY 10003

35-2612946

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	PRESCRIPTION CLAIMS ADMIN	67608	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)

FOSTER AND FOSTER

184 SHUMAN BOULEVARD SUITE 305
NAPERVILLE, IL 60563

59-1921114

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	PLAN ACTUARY	57538	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)

GRAY, GRIFFITH & MAYS PLLC

400 PIERPONT DRIVE, SUITE 202
MORGANTOWN, WV 26508

82-5354495

(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	AUDITOR	36867	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)

MACALA & PIATT

601 SOUTH MAIN STREET
NORTH CANTON, OH 44720

34-1933033

(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	ATTORNEY	35286	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)

WEX HEALTH INC.

PO BOX 843529
BOSTON, MA 02284

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	HRA CLAIMS PROCESSING	28687	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)

JOHNSON PRINTING

4136 GREEN VALLEY ROAD
HUNTINGTON, WV 25701

99-0662908

(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?
36 50	PRINTING SERVICES	15593	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)

ALERA GROUP

22901 MILLCREEK BLVD SUITE 160
HIGHLAND HILLS, OH 44122

81-4473358

(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?
22 50	INSURANCE AGENT	12217	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)

ALAN D BILLER ASSOCIATES, INC

535 MIDDLEFIELD ROAD, SUITE 230
MENLO PARK, CA 94025

94-2854958

(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	INVESTMENT ADVISOR	12000	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)

INTERNATIONAL FOUNDATION OF EMPLOYE

18700 W. BLUEMOUND ROAD
BROOKFIELD, WI 53045

39-1034021

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	8497	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)

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------

For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLAN	D Employer Identification Number (EIN) 51-0168650

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
a Total noninterest-bearing cash	1a	49356	96115
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1096562	1309739
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	85990	144397
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	7061519	7950916
(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)	7241618	7702528
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	15535045	17203695
Liabilities			
g Benefit claims payable.....	1g	1695000	1697000
h Operating payables.....	1h	26801	22305
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	19047	40285
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	1740848	1759590
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	13794197	15444105

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)	10534705	
(B) Participants.....	2a(1)(B)	908640	
(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)		11443345
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	280200	
(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)		280200
(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)	288712	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		288712
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	7519337	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	6841623	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		677714
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-454791
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		12235180

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	8257017	
(2) To insurance carriers for the provision of benefits	2e(2)	1349886	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		9606903
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)	286200	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	36867	
(5) Investment advisory and investment management fees	2i(5)	13410	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	57538	
(8) Legal fees	2i(8)	35286	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	9769	
(11) Other expenses.....	2i(11)	539299	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		978369
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		10585272

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		1649908
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: GRAY, GRIFFITH, & MAYS PLLC

(2) EIN: 82-5354495

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

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

Part IV Compliance Questions

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

During the plan year:

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

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 _____.

**Iron Workers Locals 549 and 550
Medical and Benefit Plan**

FINANCIAL STATEMENTS

March 31, 2025 and 2024

Iron Workers Local 549 and 550 Medical and Benefit Plan

FINANCIAL STATEMENTS AND INDEPENDENT AUDITOR'S REPORT

March 31, 2025 and 2024

TABLE OF CONTENTS

	<u>Page</u>
Independent Auditor's Report	1 – 3
FINANCIAL STATEMENTS:	
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	5
Statements of Plan Benefit Obligations	6
Statements of Changes in Plan Benefit Obligations	7
Notes to the Financial Statements	8 – 18
SUPPLEMENTAL SCHEDULE:	
Schedule H, Line 4(i) – Schedule of Assets Held at End of Year	19
Schedule H, Line 4(j) – Schedule of Reportable Transactions	20



400 Fort Pierpont Drive • Suite 202 • Morgantown, WV 26508
Phone: 304.241.1267 • Fax: 304.241.1265

INDEPENDENT AUDITOR'S REPORT

Board of Trustees and Plan Participants of
Iron Workers Local 549 and 550 Medical and Benefit Plan
Ona, West Virginia

Opinion on the Financial Statements

We have audited the financial statements of the Iron Workers Local 549 and 550 Medical and Benefit Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and the statements of plan benefit obligations as of March 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in plan 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, information regarding the Plan's net assets available for benefits as of March 31, 2025 and 2024, and the changes in its net assets available for benefits for the years then ended, and the plan benefit obligations as of March 31, 2025 and 2024 and the changes in its plan benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion on the Financial Statements

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

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 reportable transactions, referred to as "supplemental information," are presented for the 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 GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including the 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.

Gray, Griffith & Mays, a.c.

January 12, 2026
Morgantown, West Virginia

Iron Workers Local 549 and 550 Medical and Benefit Plan

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

March 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
<u>ASSETS</u>		
Investments, at fair value	\$ 7,720,296	\$ 7,807,529
Receivables:		
Employer contribution	992,909	788,131
Reciprocal contribution	316,830	308,431
Other receivables	<u>138,434</u>	<u>80,027</u>
Total receivables	1,448,173	1,176,589
Prepaid expenses	<u>5,963</u>	<u>5,963</u>
Cash in operating and claims checking	2,739,566	2,346,163
Cash in HRA checking	<u>5,289,697</u>	<u>4,198,801</u>
Total cash in checking	<u>8,029,263</u>	<u>6,544,964</u>
Total assets	<u>\$ 17,203,695</u>	<u>\$ 15,535,045</u>
<u>LIABILITIES</u>		
Accounts payable and accrued expenses	\$ 22,305	\$ 26,801
Reciprocity payable	<u>40,285</u>	<u>19,047</u>
Total liabilities	<u>62,590</u>	<u>45,848</u>
Net assets available for benefits	<u>\$ 17,141,105</u>	<u>\$ 15,489,197</u>

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

Iron Workers Local 549 and 550 Medical and Benefit Plan

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

March 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
ADDITIONS TO NET ASSETS ATTRIBUTED TO:		
Investment income:		
Net realized and unrealized (losses) on investments	\$ 222,923	\$ 372,108
Interest and dividends	568,912	378,626
Total investment gain/(loss)	<u>791,835</u>	<u>750,734</u>
Less: Investment expenses	<u>(13,410)</u>	<u>(12,833)</u>
Net investment gain/(loss)	778,425	737,901
Contributions:		
Employer - to the overall plan	8,212,666	8,655,724
Employer - to the HRA	1,011,066	959,103
Reciprocal	1,725,056	1,873,481
Retiree and member self-pay	908,640	749,707
Contribution income	<u>11,857,428</u>	<u>12,238,015</u>
Less: Reciprocity paid	<u>(414,083)</u>	<u>(346,234)</u>
Net contributions	<u>11,443,345</u>	<u>11,891,781</u>
Total additions	12,221,770	12,629,682
DEDUCTIONS FROM PLAN ASSETS:		
Benefits paid:		
Medical claims, net of stop loss reimbursement	5,962,497	6,158,768
Disability claims	17,764	37,877
HRA claims	717,229	715,736
Prescription claims	1,247,170	1,209,853
Dental claims	291,682	290,282
Vision claims	12,675	16,391
Death benefit claims	6,000	2,000
Premiums paid	1,349,886	1,357,748
Total benefits and premiums paid	<u>9,604,903</u>	<u>9,788,655</u>
Provider and administrator fees	764,931	779,217
Operational fees	<u>200,028</u>	<u>155,521</u>
Total deductions	<u>10,569,862</u>	<u>10,723,393</u>
Net increase	1,651,908	1,906,289
NET ASSETS AVAILABLE FOR BENEFITS:		
Beginning of year	<u>15,489,197</u>	<u>13,582,908</u>
End of year	<u>\$ 17,141,105</u>	<u>\$ 15,489,197</u>

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

Iron Workers Local 549 and 550 Medical and Benefit Plan

STATEMENTS OF PLAN BENEFIT OBLIGATIONS

March 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS AND DEPENDENTS:		
Claims payable and incurred but not reported	\$ 1,697,000	\$ 1,695,000
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS:		
Accumulated eligibility credits	2,494,000	2,544,000
Death benefit obligations	60,071	66,022
Health reimbursement account balances	<u>3,872,678</u>	<u>3,668,201</u>
Total other obligations	6,426,749	6,278,223
POSTRETIREMENT BENEFIT OBLIGATIONS, NET OF AMOUNTS CURRENTLY PAYABLE:		
Current retirees, beneficiaries and dependents	14,444,149	19,539,739
Other participants fully eligible for benefits	6,809,238	5,295,392
Participants not fully eligible for benefits	<u>7,465,702</u>	<u>7,279,854</u>
Total postretirement benefit obligations	<u>28,719,089</u>	<u>32,114,985</u>
Plan's total benefit obligations	<u><u>\$ 36,842,838</u></u>	<u><u>\$ 40,088,208</u></u>

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

Iron Workers Local 549 and 550 Medical and Benefit Plan

STATEMENTS OF CHANGES IN PLAN BENEFIT OBLIGATIONS

March 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS AND DEPENDENTS:		
Balance at beginning of year	\$ 1,695,000	\$ 935,000
Claims reported and approved for payment	(9,602,903)	(9,028,655)
Claims and premiums paid, including disability	<u>9,604,903</u>	<u>9,788,655</u>
Balance at end of year	1,697,000	1,695,000
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE, AT PRESENT VALUE OF ESTIMATED AMOUNTS:		
Balance at beginning of year	6,278,223	6,188,285
Increase (decrease) during the year attributable to:		
Accumulated eligibility credits	(106,000)	(56,000)
Death benefit obligation	(13,539)	(7,588)
Health reimbursement accounts - contributions	1,011,066	959,103
Health reimbursement accounts - claims paid	(717,229)	(715,736)
Health reimbursement accounts - other	<u>(179,298)</u>	<u>(89,841)</u>
Balance at end of year	6,273,223	6,278,223
POSTRETIREMENT BENEFIT OBLIGATIONS NET OF AMOUNTS CURRENTLY PAYABLE:		
Balance at beginning of year	32,114,985	33,385,883
Increase (decrease) during the year attributable to:		
Benefits earned net of benefits paid	(871,200)	(862,017)
Actuarial experience (gain)	(113,877)	5,026,390
Change in actuarial assumptions	<u>(2,410,819)</u>	<u>(5,435,271)</u>
Balance at end of year	<u>28,719,089</u>	<u>32,114,985</u>
Plan's total benefit obligations	<u>\$ 36,689,312</u>	<u>\$ 40,088,208</u>

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

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

1 – DESCRIPTION OF THE PLAN

The following description of the Iron Workers Local 549 & 550 Medical and Benefit Plan (the Plan) provides only general information. Users of these financial statements should refer to the Plan agreement for a complete description of the Plan's provisions.

General

The Trust for the Plan was originally effective October 1, 1975, and was most recently amended and restated July 1, 2024. The Plan is a defined benefit health and welfare plan, covering eligible members of Iron Workers Locals 549 and 550 (Members), and their spouses and dependents, who have completed the required service hours or dollars for an employer who is subject to the terms of the Collective Bargaining Agreements (Agreements) between the International Association of Bridge, Structural and Ornamental Iron Workers Local Unions 549 and 550 (Unions) and the Ohio Valley Construction Employers Council, Inc., Wheeling, West Virginia, and the Structural Contractors Independent Employers Association of Canton, Ohio (Employers). The Plan is subject to provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Eligibility

To become initially eligible a member must work a consecutive six-month period during which a total of at least 390 hours have been contributed on the member's behalf. The Plan does permit entry into the Plan for apprentices and newly organized employees even if the dollar bank threshold has not been attained in order to attract entrants into the Apprenticeship Program.

Benefits

The Plan provides health benefits (medical, prescription and dental), disability and death benefits covering eligible members and their spouses and dependents. The Plan also subsidizes the cost of the post-Medicare retiree benefit.

Self-insured Benefits

The health and disability benefits of the Plan are self-insured. The claims for these self-insured benefits are processed by a third-party claims processors under administrative service arrangements. The claims processors pay claims directly on behalf of participants and are then reimbursed by the Plan. Despite the Plan's utilization of the third-party claim's processors, the ultimate responsibility for payments to providers is retained by the Plan.

Death Benefits

The Plan provides a death benefit to eligible members and retirees of the Plan, which is fully insured. The Plan purchased an annual insurance contract to insure the death

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

benefits. The insured coverage provides a benefit of \$10,000 per active participant and \$5,000 per retired participant who meet certain eligibility requirements.

In addition, the Plan also provides a self-insured death benefit to retired participants of the Iron Workers Local 549 & 550 Medical and Benefit Plan who meet certain eligibility requirements.

Stop-Loss Premiums

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits. Generally, the specific stop-loss deductible per covered participant is \$250,000.

	2025	2024
Stop loss premiums paid	\$ 583,148	\$ 555,932
Stop loss reimbursements	\$ 1,431,291	\$ 1,707

At March 31, 2025 and 2024, the stop loss reimbursements included receivables of \$131,730 and \$0, respectively.

Health Reimbursement Arrangement (HRA)

The Plan has health reimbursement arrangements for each Local that are funded solely through contributions. The HRA amounts for eligible participants can be used for reimbursement of submitted eligible medical, prescription, and dental costs not covered by the Plan (co-pays, deductibles, etc.). Amounts remaining at the end of year can generally be carried over to the next year. The Plan is not permitted to refund any part of the balance to participants for anything other than reimbursements for qualified medical expenses.

Contributions

The Agreements provide, among other things, for employers to contribute to the Plan, on behalf of the members according to the following rate schedule in effect for the periods covered by these financial statements and through the date these financial statements were issued:

	Main Plan	HRA	Total
Local 549			
May 1, 2021 - November 30, 2021	\$8.05/hour	\$1.40/hour	\$9.45/hour
December 1, 2021 - November 30, 2022*	\$8.05/hour	\$1.70/hour	\$9.75/hour
<i>Rate allocation shift effective August 1, 2022*</i>	\$8.45/hour	\$1.30/hour	\$9.75/hour
December 1, 2022 - November 30, 2023	\$8.45/hour	\$2.04/hour	\$10.49/hour
		<i>\$1.93 + \$.11 Vision</i>	
<i>Effective Feb 2023: Local 549 carved out a Vision Benefit</i>	\$8.45 hour	= \$2.04/hour	\$10.49/hour
December 1, 2023 - November 30, 2024	\$8.95/hour	\$2.19/hour	\$11.14/hour
December 1, 2024 - November 30, 2025	\$9.55/hour	\$2.29/hour	\$11.84/hour

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

	<u>Main Plan</u>	<u>HRA</u>	<u>Total</u>
Local 550			
May 1, 2021 - April 30, 2022	\$8.05/hour	\$.53/hour	\$8.58/hour
May 1, 2022 - April 30, 2023**	\$8.05/hour	\$.93/hour	\$8.98/hour
<i>Rate allocation shift effective August 1, 2022**</i>	<i>\$8.45/hour</i>	<i>\$.53/hour</i>	<i>\$8.98/hour</i>
May 1, 2023 - April 30, 2024	\$8.95/hour	\$.53/hour	\$9.48/hour
May 1, 2024 - April 30, 2025	\$9.55/hour	\$.53/hour	\$10.08/hour

Self-Payment Program

The Plan also has a self-payment program whereby members may, for a limited period of time, supplement contributions by employers to maintain their eligibility for plan benefits. Disabled members, retirees and widows may also self-pay for varying periods.

Funding Policy

Participating employers contribute such amounts as are specified in their collective bargaining agreement no later than the 15th day of the month following when the wages are paid to the member.

Reciprocals

Members of the Unions may work from time to time in the jurisdictions of other locals. In these cases, the other local(s) will forward the contribution due on behalf of these members of the Unions for submission to the Plan. Likewise, members of other locals may work from time to time for employers in the Plan's jurisdictions. Contributions for these members are forwarded to their local union.

Participant Banks

All contributions made on behalf of a participant are credited to the participant's dollar bank. Contributions are credited in the form of hours paid for Local 549 members and hours worked for Loan 550 members. The credits are accumulated in each participant's bank and are utilized for the payment of monthly premiums.

The maximum dollar bank is the amount able to cover 6 months of eligibility. The maximum dollar bank is determined by multiplying the current monthly premium times 780 months (130 hours a month for 6 months).

However, members with a balance of \$7,000 in their bank prior to 2019 are permitted to maintain that balance provided they do not go below it. Once they do, the 6-month threshold goes into effect.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting

The accompanying financial statements are prepared on the accrual basis of accounting. The Plan has established the policy of recording employer contributions when hours are worked. Self-pay contributions are recorded when amounts are received from participants.

Payments of Benefits

Benefits are recorded when paid.

Estimates

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

Investment Valuation

Investments are reported at fair value (Note 4). Purchases and sales of securities are reflected on a trade date basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's realized and unrealized gains and losses.

3 – INVESTMENTS

Investment Composition

As of March 31, 2025, the Plan's investments consisted of:

	Level 1	Level 2	Level 3	Investments measured at net asset value	Total
Money markets	\$ 17,768	\$ -	\$ -	\$ -	\$ 17,768
Mutual funds	7,702,528	-	-	-	7,702,528
Total investments, at fair value	<u>\$ 7,720,296</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 7,720,296</u>

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

As of March 31, 2024, the Plan's investments consisted of:

	Level 1	Level 2	Level 3	Investments measured at net asset value	Total
Money markets	\$ 565,911	\$ -	\$ -	\$ -	\$ 565,911
Mutual funds	7,241,618	-	-	-	7,241,618
Total investments, at fair value	<u>\$ 7,807,529</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 7,807,529</u>

4 – FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a fair value hierarchy which 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 (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy under FASB ASC 820 are described below:

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; or
- 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 measurements.

The asset'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.

Methodologies

Money market funds: Valued at \$1 per share.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value and to transact at that price. The mutual funds held by the Plan are actively traded.

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

5 – CLAIMS PAYABLE AND INCURRED BUT NOT REPORTED

The obligations for claims payable and incurred but not reported, included in the Statements of Benefit Obligations, have been estimated based on historical lag data and certain other factors. Because these obligations are estimates, it is at least reasonably possible that a change in these estimates will occur in the near term.

6 – ACCUMULATED ELIGIBILITY CREDITS

Under current eligibility policies, the Plan provides for benefit coverage during periods of low or no employment for those members who have accumulated, in the current or prior years, credit amounts in excess of hours required for current benefit coverage. A maximum of six months benefit coverage may be carried forward (See Note 1). The trustees, at their discretion, determine the policies for continuation of eligibility.

The liability for Accumulated Eligibility Credits included in the Statements of Benefit Obligations as of March 31, 2025 and 2024, represents an accumulate of contributions which are used by participants to pay the monthly premiums for continued coverage.

7 – DEATH BENEFIT OBLIGATION

The liability for the present value of the active death benefits is calculated using actuarial assumptions consistent with those described in Note 8, including the 5.31% and 4.97%, respective discount rate.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

8 – POSTRETIREMENT BENEFITS

The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed to employee service rendered March 31, 2025 and 2024. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service.

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

The significant assumptions are summarized as follows. Users of these financial statements should refer to the "Actuarial Valuation and Review of Post-Retirement Welfare Benefits" in accordance with FASB ASC 965:

	2025	2024
Assumption:		
Discount rate	5.31%	4.97%
Postretirement mortality rates	Headcount weighted PRI-2012	Headcount weighted PRI-2012
Administrative expense increase rate	3.00%	3.00%
Retiree contribution increase rate	5.00%	5.00%

The weighted average discount rate (5.31% and 4.97% in 2025 and 2024, respectively) has a significant effect on the postretirement benefit obligation described above. If the assumed health trend rates increased by one percentage point in each year, it would increase the obligation as of March 31, 2025 and 2024 by \$4,312,043 and \$3,943,031, respectively.

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

The postretirement benefit obligation is net of amounts to be funded by disabled participants, retirees, and widows in the self-pay program. Projected contributions from retirees and others is expected to reduce the Plan's postretirement obligations by 46% and 37% in 2025 and 2024, respectively.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

The Plan's deficiency of net assets available for benefits over the Plan's total benefit obligations at March 31, 2025 and 2024, relates primarily to the postretirement benefit obligation, the funding of which is not covered by the current contribution rate. It is expected that the deficiency will be funded through future increases in contribution rates, increases in self-payment rates, and/or adjustments to benefits.

9 – TRANSACTIONS WITH PARTIES-IN-INTEREST

General – Parties-in-interest are defined by IRC Section 4785(e)(2) and ERISA Section 3(14)(c) to include, among others, any entity that provides services to the Plan. Therefore, the following general parties-in-interest relationships exist:

- All disbursements for professional, administrative, insurance, investment management and other expenses included in the accompanying financial statements.
- All contributions received by the Plan.

The Plan utilizes Gray, Griffith & Mays – Morgantown, PLLC for payroll and financial auditing, Foster & Foster for actuarial services, American Benefit Corporation for third-party administrator services and Macala & Piatt for legal services. The Plan purchases life and accidental death and dismemberment insurance from the Union Labor Life Insurance Company and stoploss insurance from Berkley Accident and Health. The Plan utilizes Wex, Anthem, Delta Dental, and CapitalRX for the processing of claims related to the health reimbursement account, general healthcare, dental, and pharmacy features respectively.

10 – FEDERAL INCOME TAX

The Iron Workers Local 549 & 550 Medical and Benefit Plan is a tax exempt 501(c)(9) VEBA trust. The purpose of the VEBA trust is to provide health benefits to union members and their families. The Plan's tax-exempt determination letter is dated November 10, 2011.

In addition, the Plan and the trust are required to operate in conformity with the Internal Revenue Code (IRC) to maintain the tax-exempt status of the trust. The plan administrator believes that the Plan is being operated in compliance with the applicable requirements of the IRC, and therefore, believe that the related trust is tax-exempt.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

11 – FEES PAID FROM PLAN ASSETS

Fees incurred by the Plan are summarized as follows:

	2025	2024
Premiums paid:		
Death benefit premiums	\$ 73,075	\$ 72,335
Stop loss premiums	583,148	555,932
Retiree insurance premiums	693,663	729,481
Total premiums	<u>\$ 1,349,886</u>	<u>\$ 1,357,748</u>
Provider and administrator fees:		
Medical provider (Anthem)	\$ 362,571	\$ 378,699
Prescription provider (Capital Rx)	67,608	57,965
Dental provider (Delta Dental)	19,865	20,754
Third party administrator	286,200	291,705
BennyCard	28,687	29,044
Paid Health	-	1,050
Total provider and administrator fees	<u>\$ 764,931</u>	<u>\$ 779,217</u>
Operational fees:		
Affordable Care Act	\$ 6,471	\$ 6,232
Actuary consultant	57,538	62,350
Attorney	35,286	39,731
Audit	36,867	5,140
Insurance	12,217	12,398
Meeting	9,769	2,370
Conference	-	4,733
Lost Wages	2,183	-
Other: printing, postage, supplies, and bank charges	39,697	22,567
Total operational fees	<u>\$ 200,028</u>	<u>\$ 155,521</u>

12 – CONCENTRATIONS OF CREDIT RISK

As of March 31, 2025 and 2024, the Plan had accounts with a total of \$0 and \$0, respectively, in excess of the \$250,000 FDIC insured limit.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

13 – INVESTMENT RISK

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 changes could materially affect the amounts reported in the statements of net assets available for benefits.

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

14 – PLAN TERMINATION

In the event the Plan, in the opinion of the Trustees, is inadequate to carry out the intent and purpose under the Agreement and Declaration of Trust, or to meet the payments due or to become due under this Agreement to participants already drawing benefits, the Plan may be terminated by the Trustees.

Upon termination of the Plan, provided there are funds remaining, the Trustees may (1) make provisions for the payment of expenses incurred up to the date of termination of the Plan and the expenses incident to such termination and (2) apply funds remaining after the payment of any and all obligations and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purpose of the Plan.

15 – CLASSIFICATIONS DIFFERENCES

Form 5500 has certain assets and liabilities that differ from amounts shown on the accompanying financial statements. These differences relate to classifications only and have no effect upon net assets available for benefits.

Iron Workers Local 549 and 550 Medical and Benefit Plan

NOTES TO FINANCIAL STATEMENTS

March 31, 2025 and 2024

16 – RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	March 31, 2025	March 31, 2024
Net assets available for benefits per the financial statements	\$ 17,141,105	\$ 15,489,197
Benefit obligations currently payable	<u>(1,697,000)</u>	<u>(1,695,000)</u>
Net assets available for benefits per Form 5500	<u>\$ 15,444,105</u>	<u>\$ 13,794,197</u>

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

	March 31, 2025	March 31, 2024
Benefits paid per the financial statements	\$ 9,604,903	\$ 9,788,655
Add: amounts currently payable at March 31, 2025 and 2024	1,697,000	1,695,000
Less: amounts currently payable at March 31, 2024 and 2023	<u>(1,695,000)</u>	<u>(935,000)</u>
Benefits paid per Form 5500	<u>\$ 9,606,903</u>	<u>\$ 10,548,655</u>

17 – SUBSEQUENT EVENTS

Management has evaluated subsequent events through the date that the financial statements were issued, January 12, 2026.

SUPPLEMENTARY INFORMATION

Iron Workers Local 549 and 550 Medical and Benefit Plan

SCHEDULE H, LINE 4(i) – SCHEDULE OF ASSETS HELD AT END OF YEAR

EIN: 51-0168650

PN: 001

As of March 31, 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 date	(d) Cost	(e) Current Value
Short Term Investment				
	Goldman Sachs Final Square Government	Short Term Investment	\$ 17,768	\$ 17,768
Mutual Funds				
*	Vanguard Total Stock Market Index	Domestic Equity Mutual Fund	1,499,186	1,526,009
*	PIMCO Income Instl	Domestic Equity Mutual Fund	3,078,555	3,103,533
*	Baird Core Plus Bond Inst	Corporate Bonds Fund	<u>3,053,492</u>	<u>3,072,986</u>
			<u>\$ 7,649,001</u>	<u>\$ 7,720,296</u>
*	Denotes party-in-interest as defined by ERISA.			

See accompanying independent auditor's report.

Iron Workers Local 549 and 550 Medical and Benefit Plan

SCHEDULE H, LINE 4(j) – SCHEDULE OF REPORTABLE TRANSACTIONS

EIN: 51-0168650

PN: 001

As of March 31, 2025

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Identity of party involved	Description of asset	Purchase Price	Selling Price	Cost of asset	Current value of asset on transaction date	Net Gain/(loss)
<u>SINGLE TRANSACTIONS EXCEEDING 5%</u>						
Union Bank & Trust	Baird Core Plus Bond Institutional	\$ 2,840,000	\$ -	\$ 2,840,000	\$ -	\$ -
Union Bank & Trust	Vanguard Total Stock Market Index Fund	1,420,000	-	1,420,000	-	-
Union Bank & Trust	Pimco Income Institutional	2,840,000	-	-	-	-
Vanguard	Vanguard Total Stock Market Index Fund	-	1,546,042	538,396	-	1,007,646
Baird	Baird Intermediate Bond Institutional	-	5,873,295	6,266,408	-	(393,113)
	Purchase	<u>\$ 7,100,000</u>				
	Sale		<u>\$ 7,419,337</u>			
	Issue Aggregate Total				<u>\$ -</u>	<u>\$ 614,533</u>

See accompanying independent auditor's report.

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 **04/01/2024** and ending **03/31/2025**

- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- B** This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here ▶
- D** Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here ▶

Part II Basic Plan Information - enter all requested information

1a Name of plan IRONWORKERS LOCAL 549-550 MEDICAL & BENEFIT PLAN	1b Three-digit plan number (PN) ▶	501
	1c Effective date of plan	09/01/1975
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) IRON WORKERS LOCALS 549 & 550 MEDICAL & BENEFIT PLA 9200 US ROUTE 60 ONA WV 25545-9507	2b Employer Identification Number (EIN)	51-0168650
	2c Plan Sponsor's telephone number	304-399-9010
	2d Business code (see instructions)	237990

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			JESSICA MORRISON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			JESSICA MORRISON
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311