

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

Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 05/01/2024 and ending 04/30/2025

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

| | |
|---|--|
| <p>1a Name of plan <u>BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND</u></p> | <p>1b Three-digit plan number (PN) ▶ <u>501</u></p> |
| <p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FD</u></p> <p><u>2704 BLACK LAKE PLACE</u> <u>PHILADELPHIA, PA 19154</u></p> | <p>1c Effective date of plan <u>05/01/1997</u></p> <p>2b Employer Identification Number (EIN) <u>23-2892285</u></p> <p>2c Plan Sponsor's telephone number <u>215-856-9663</u></p> <p>2d Business code (see instructions) <u>238100</u></p> |

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

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

| | | | |
|------------------|---|------------|--|
| SIGN HERE | Filed with authorized/valid electronic signature. | 01/20/2026 | JUSTIN SCARINCI |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | Signature of DFE | Date | Enter name of individual signing as DFE |

| | | |
|---|--|------|
| 3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor | 3b Administrator's EIN | |
| | 3c Administrator's telephone number | |
| 4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name | 4b EIN | |
| | 4d PN | |
| 5 Total number of participants at the beginning of the plan year | 5 | 1213 |
| 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) | 1205 |
| | 6a(2) | 1278 |
| | 6b | 5 |
| | 6c | |
| | 6d | 1283 |
| | 6e | |
| | 6f | |
| | 6g(1) | |
| 6g(2) | | |
| 6h | | |
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 | 161 |

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

**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 **05/01/2024** and ending **04/30/2025**

| | | |
|---|--|--|
| A Name of plan BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND | | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FD | | D Employer Identification Number (EIN) 23-2892285 |

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

AMALGAMATED LIFE

| (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 |
| 13-5501223 | 60216 | 26AP14 | 1253 | 05/01/2024 | 04/30/2025 |

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

| | |
|---|--|
| (a) Total amount of commissions paid 0 | (b) Total amount of fees paid 0 |
|---|--|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

| | | | | |
|--|---------------------------|--------------|-----------|--|
| b Balance at the end of the previous year | | | 7b | |
| c Additions: (1) Contributions deposited during the year | 7c(1) | | | |
| | 7c(2) | | | |
| | 7c(3) | | | |
| | 7c(4) | | | |
| | 7c(5) | | | |
| | (6) Total additions | | | |
| d Total of balance and additions (add lines 7b and 7c(6)) | | | 7d | |
| e Deductions: | | | | |
| | 7e(1) | | | |
| | 7e(2) | | | |
| | 7e(3) | | | |
| | 7e(4) | | | |
| (5) Total deductions | | 7e(5) | 0 | |
| f Balance at the end of the current year (subtract line 7e(5) from line 7d)..... | | | 7f | |

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

| | | | |
|----------|--|------------|-------|
| a | Total premiums or subscription charges paid to carrier | 10a | 40172 |
| b | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. | 10b | |

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

| | |
|---|--|
| A Name of plan BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FD | D Employer Identification Number (EIN) 23-2892285 |

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
GERBER LIFE INSURANCE CO.

| (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 |
| 57-0523959 | 77828 | GL-0033-VU | 1259 | 03/01/2024 | 02/28/2025 |

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

| | |
|---|--|
| (a) Total amount of commissions paid 0 | (b) Total amount of fees paid 0 |
|---|--|

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

| | | |
|---|------------|---------|
| a Total premiums or subscription charges paid to carrier | 10a | 1044788 |
| b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs. | 10b | |

Part IV Provision of Information

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

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

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

For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

| | | |
|---|--|------------|
| A Name of plan BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND | B Three-digit plan number (PN) ▶ | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FD | D Employer Identification Number (EIN) 23-2892285 | |

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

THE VANGUARD GROUP

23-1945930

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

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

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

INDEPENDENCE BLUE CROSS

23-0370270

| (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 | NONE | 760548 | 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)

BRICKLAYERS BENEFIT PLANS, INC.

23-1739024

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 14 50 | NONE | 270834 | 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)

GUARDIAN NURSES HEALTHCARE ADVOCATE

57-1187937

| (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 | NONE | 227893 | 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)

DELTA DENTAL OF PENNSYLVANIA

23-1667011

| (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 | NONE | 50887 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

THE MCKEOGH COMPANY

23-3003375

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 11 50 | NONE | 38167 | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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

NOVAK FRANCELLA LLC

61-1436956

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 50 | NONE | 36000 | 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)

SAV-RX

224 NORTH PARK AVE
FREMONT, NE 68025

| (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 | NONE | 27949 | 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)

ALLIED TRADES ASSISTANCE PROGRAM

23-2591093

| (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 | NONE | 23975 | 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)

THOMAS J. MCGOLDRICK, ESQ.

10 E. 6TH AVENUE - SUITE 100
CONSHOHOCKEN, PA 19428

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29 50 | NONE | 23230 | 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)

YOUR PART-TIME CONTROLLER, LLC

22-3631980

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 50 | NONE | 7409 | 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)

O'DONOGHUE & O'DONOGHUE, LLP

53-0120528

| (b) Service Code(s) | (c) Relationship to employer, employee organization, or person known to be a party-in-interest | (d) Enter direct compensation paid by the plan. If none, enter -0-. | (e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-. | (h) Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29 50 | NONE | 7383 | 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. | OMB No. 1210-0110 2024 This Form is Open to Public Inspection |
|--|--|---|

| | |
|---|--|
| For calendar plan year 2024 or fiscal plan year beginning 05/01/2024 and ending 04/30/2025 | |
| A Name of plan BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND | B Three-digit plan number (PN) ▶ 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500 BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEALTH & WELFARE FD | D Employer Identification Number (EIN) 23-2892285 |

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

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

| | | (a) Beginning of Year | (b) End of Year |
|---|-----------------|-----------------------|-----------------|
| Assets | | | |
| a Total noninterest-bearing cash | 1a | | |
| b Receivables (less allowance for doubtful accounts): | | | |
| (1) Employer contributions | 1b(1) | 3696523 | 4271884 |
| (2) Participant contributions | 1b(2) | | |
| (3) Other | 1b(3) | 1287539 | 1409640 |
| c General investments: | | | |
| (1) Interest-bearing cash (include money market accounts & certificates of deposit) | 1c(1) | 2150464 | 1840296 |
| (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) | 51756988 | 60264980 |
| (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 | 58891514 | 67786800 |
| Liabilities | | | |
| g Benefit claims payable..... | 1g | 3058342 | 3334275 |
| h Operating payables..... | 1h | 87648 | 293527 |
| i Acquisition indebtedness..... | 1i | | |
| j Other liabilities..... | 1j | 176973 | 141960 |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k | 3322963 | 3769762 |
| Net Assets | | | |
| l Net assets (subtract line 1k from line 1f)..... | 1l | 55568551 | 64017038 |

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) | 26704697 | |
| (B) Participants..... | 2a(1)(B) | 1316889 | |
| (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) | | 28021586 |
| b Earnings on investments: | | | |
| (1) Interest: | | | |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) | 266 | |
| (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) | 1906 | |
| (G) Total interest. Add lines 2b(1)(A) through (F) | 2b(1)(G) | | 2172 |
| (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) | 1367630 | |
| (D) Total dividends. Add lines 2b(2)(A) , (B) , and (C) | 2b(2)(D) | | 1367630 |
| (3) Rents..... | 2b(3) | | |
| (4) Net gain (loss) on sale of assets: | | | |
| (A) Aggregate proceeds..... | 2b(4)(A) | | |
| (B) Aggregate carrying amount (see instructions)..... | 2b(4)(B) | | |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result..... | 2b(4)(C) | | |
| (5) Unrealized appreciation (depreciation) of assets: | | | |
| (A) Real estate..... | 2b(5)(A) | | |
| (B) Other..... | 2b(5)(B) | | |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B) | 2b(5)(C) | | |

| | | (a) Amount | (b) Total |
|---|---------------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts | 2b(6) | | |
| (7) Net investment gain (loss) from pooled separate accounts | 2b(7) | | |
| (8) Net investment gain (loss) from master trust investment accounts | 2b(8) | | |
| (9) Net investment gain (loss) from 103-12 investment entities | 2b(9) | | |
| (10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) | 2b(10) | | 5140361 |
| c Other income | 2c | | 94678 |
| d Total income. Add all income amounts in column (b) and enter total | 2d | | 34626427 |

Expenses

| | | | |
|---|---------------|----------|----------|
| e Benefit payment and payments to provide benefits: | | | |
| (1) Directly to participants or beneficiaries, including direct rollovers | 2e(1) | 24682545 | |
| (2) To insurance carriers for the provision of benefits | 2e(2) | 1084593 | |
| (3) Other | 2e(3) | 7731 | |
| (4) Total benefit payments. Add lines 2e(1) through (3) | 2e(4) | | 25774869 |
| 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) | 270834 | |
| (3) Recordkeeping fees | 2i(3) | 7409 | |
| (4) IQPA audit fees | 2i(4) | 36000 | |
| (5) Investment advisory and investment management fees | 2i(5) | | |
| (6) Bank or trust company trustee/custodial fees | 2i(6) | | |
| (7) Actuarial fees | 2i(7) | 38167 | |
| (8) Legal fees | 2i(8) | 30613 | |
| (9) Valuation/appraisal fees | 2i(9) | | |
| (10) Other trustee fees and expenses | 2i(10) | | |
| (11) Other expenses | 2i(11) | 20048 | |
| (12) Total administrative expenses. Add lines 2i(1) through (11) | 2i(12) | | 403071 |
| j Total expenses. Add all expense amounts in column (b) and enter total | 2j | | 26177940 |

Net Income and Reconciliation

| | | | |
|---|--------------|--|---------|
| k Net income (loss). Subtract line 2j from line 2d | 2k | | 8448487 |
| l Transfers of assets: | | | |
| (1) To this plan | 2l(1) | | |
| (2) From this plan | 2l(2) | | |

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **NOVAK FRANCELLA, LLC**

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

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined
 If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

FINANCIAL STATEMENTS

APRIL 30, 2025

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

APRIL 30, 2025 AND 2024

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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Bricklayers and Allied Craftworkers
Local 1 of PA/DE Health and Welfare Fund

Opinion

We have audited the financial statements of the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health and Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of April 30, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of April 30, 2025 and 2024, and the changes in its net assets available for benefits and changes in its benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule of Assets Held at End of Year, Schedules of Administrative Expenses and Schedule of Reportable Transactions together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represents supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Supplemental information is the responsibility of the Plan's 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 information, we evaluated whether the supplemental information, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

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

Novak Francella LLC

Bala Cynwyd, Pennsylvania
January 29, 2026

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

APRIL 30, 2025 AND 2024

| | 2025 | 2024 |
|-----------------------------------|---------------|---------------|
| ASSETS | | |
| INVESTMENTS - at fair value | | |
| Equity mutual funds | \$ 27,381,247 | \$ 33,411,323 |
| Fixed income mutual funds | 32,883,733 | 18,345,665 |
| Total investments | 60,264,980 | 51,756,988 |
| RECEIVABLES | | |
| Employer contributions | 4,271,884 | 3,696,523 |
| Prescriptions rebates | 614,563 | 488,818 |
| Due from related benefit funds | 23,966 | 7,428 |
| Stop loss reimbursement | 29,941 | 51,760 |
| Total receivables | 4,940,354 | 4,244,529 |
| ADVANCE DEPOSITS | | |
| Independence Blue Cross | 578,000 | 578,000 |
| Allied Trades Assistance Program | 150,000 | 150,000 |
| Total cash advance deposits | 728,000 | 728,000 |
| PREPAID EXPENSES | 13,170 | 11,533 |
| CASH | 1,840,296 | 2,150,464 |
| Total assets | 67,786,800 | 58,891,514 |
| LIABILITIES AND NET ASSETS | | |
| LIABILITIES | | |
| Accrued administrative expenses | 293,527 | 87,648 |
| Reciprocal contributions payable | 141,960 | 176,973 |
| Total liabilities | 435,487 | 264,621 |
| NET ASSETS AVAILABLE FOR BENEFITS | \$ 67,351,313 | \$ 58,626,893 |

See accompanying notes to financial statements.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED APRIL 30, 2025 AND 2024

| | 2025 | 2024 |
|--|--------------|--------------|
| ADDITIONS | | |
| Investment income | | |
| Net appreciation in fair value of investments | \$ 5,140,361 | \$ 4,573,866 |
| Interest and dividends | 1,369,802 | 1,075,015 |
| Net investment income | 6,510,163 | 5,648,881 |
| Contributions | | |
| Employer and reciprocal contributions, net | 26,704,697 | 25,318,316 |
| Participants' COBRA contributions | 357,626 | 396,864 |
| Vacation contributions | 959,263 | 816,181 |
| Total contributions | 28,021,586 | 26,531,361 |
| Liquidated damages | 75,952 | 119,794 |
| Other income | 18,726 | 36,298 |
| Total additions | 34,626,427 | 32,336,334 |
| DEDUCTIONS | | |
| Cost of benefits | | |
| Self-insured medical benefits: | | |
| Medical, surgical, x-ray, lab work and hospitalization | | |
| Independence Blue Cross | 16,923,973 | 15,494,677 |
| Prescription, net of rebates | 3,910,157 | 3,599,979 |
| Mental health and substance abuse | 826,612 | 862,300 |
| Life insurance and disability | 39,805 | 35,282 |
| Disease management and case management | 227,893 | 219,128 |
| Dental | 821,939 | 833,556 |
| Vacation | 931,942 | 698,613 |
| Benefit provider administrative fees | 863,359 | 766,110 |
| Fees mandated by the ACA | 7,731 | 7,263 |
| Stop loss insurance | 1,044,788 | 1,061,043 |
| Less: Stop loss reimbursements | (99,263) | (502,856) |
| Total cost of benefits | 25,498,936 | 23,075,095 |
| Administrative expenses | 403,071 | 180,184 |
| Total deductions | 25,902,007 | 23,255,279 |

See accompanying notes to financial statements.

| | <u>2025</u> | <u>2024</u> |
|-----------------------------------|-----------------------------|-----------------------------|
| NET INCREASE | \$ 8,724,420 | \$ 9,081,055 |
| NET ASSETS AVAILABLE FOR BENEFITS | | |
| Beginning of year | <u>58,626,893</u> | <u>49,545,838</u> |
| End of year | <u><u>\$ 67,351,313</u></u> | <u><u>\$ 58,626,893</u></u> |

See accompanying notes to financial statements.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

STATEMENTS OF BENEFIT OBLIGATIONS

APRIL 30, 2025 AND 2024

| | <u>2025</u> | <u>2024</u> |
|--|-----------------------------|-----------------------------|
| AMOUNTS CURRENTLY PAYABLE TO OR FOR | | |
| PARTICIPANTS, BENEFICIARIES AND DEPENDENTS | | |
| Self-insured claims, insurance premiums payable and claims incurred but not reported | <u>\$ 3,334,275</u> | <u>\$ 3,058,342</u> |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE - | | |
| at present value of estimated amounts, net of amounts currently payable | | |
| Accumulated eligibility credits | <u>18,259,772</u> | <u>17,364,566</u> |
| Total benefit obligations other than postretirement benefit obligations | <u>21,594,047</u> | <u>20,422,908</u> |
| POSTRETIREMENT BENEFIT OBLIGATIONS - net of amounts currently payable | | |
| Current retirees, beneficiaries and dependents | 113,683 | N/A |
| Other participants fully eligible for benefits | 3,112,414 | N/A |
| Other participants not fully eligible for benefits | <u>9,683,859</u> | <u>N/A</u> |
| Total postretirement benefit obligations | <u>12,909,956</u> | <u>N/A</u> |
| Total benefit obligations | <u><u>\$ 34,504,003</u></u> | <u><u>\$ 20,422,908</u></u> |

See accompanying notes to financial statements.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED APRIL 30, 2025 AND 2024

| | 2025 | 2024 |
|--|---------------|---------------|
| AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES, AND DEPENDENTS | | |
| Balance at beginning of year | \$ 3,058,342 | \$ 3,211,671 |
| Increase (decrease) during the year attributable to changes in self-insured claims, insurance premiums payable, and claims incurred but not reported | 275,933 | (153,329) |
| Balance at end of year | 3,334,275 | 3,058,342 |
| OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE - at present value of estimated amounts, net of amounts currently payable | | |
| Balance at beginning of year | 17,364,566 | 16,890,440 |
| Increase (decrease) during the year attributable to changes in accumulated eligibility credits | 895,206 | 474,126 |
| Balance at end of year | 18,259,772 | 17,364,566 |
| Total benefit obligations other than postretirement benefit obligations | 21,594,047 | 20,422,908 |
| POSTRETIREMENT BENEFIT OBLIGATIONS - net of amounts currently payable | | |
| Balance at beginning of year | - | N/A |
| Increase (decrease) during the year attributable to | | |
| Change in nature of plan | 12,572,986 | N/A |
| Benefit accumulation | 206,680 | N/A |
| Passage of time | 209,186 | N/A |
| Benefits paid | (43,159) | N/A |
| Actuarial gain (loss) | (35,737) | N/A |
| Balance at end of year | 12,909,956 | N/A |
| Total benefit obligations | \$ 34,504,003 | \$ 20,422,908 |

See accompanying notes to financial statements.

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

NOTES TO FINANCIAL STATEMENTS

APRIL 30, 2025 AND 2024

NOTE 1. DESCRIPTION OF PLAN

The following brief description of the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health and Welfare Fund (the Plan) is provided for general information purposes only. Participants should refer to the summary plan description for more complete information.

The Bricklayers and Allied Craftworkers Local 1 of PA/DE Health and Welfare Fund (the Plan) provides health and welfare benefits for eligible members (and dependents) of the Bricklayers and Allied Craftworkers Local 1 of PA/DE (the Union).

The Plan is a multiemployer welfare benefit plan and is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan was established on May 1, 1997, by an Agreement and Declaration of Trust.

Benefits - The Plan provides hospital, surgical, major medical, dental, vision, prescription, mental health, accidental death and dismemberment, life insurance, and vacation benefits. The type and level of benefits vary and are determined by the criteria outlined in the collective bargaining agreements.

Stop Loss Coverage - The Plan has entered into a stop-loss insurance arrangement with Vista Underwriting Partners, LLC in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims).

Initial Eligibility - Participants become eligible upon attaining the required number of hours within 12 months of employment (750). Once the participant has attained the required number of hours in a work period, they will be eligible on the first day of the corresponding benefit period.

Continuing Eligibility - Continuing eligibility is determined on a month to month basis. In order to maintain eligible status, participants are required to work 100 hours per month or utilize banked hours of up to 100 per month. Initial eligibility earns a participant 200 hours in the Hour Bank. After this, monthly hours in excess of 100 will be credited to the bank up to 1,200. Participants may combine worked hours and banked hours in order to maintain status. Hour bank usage may be suspended for participants of employers who are chronically delinquent. Upon termination of employment, participant will lose any accumulated hours banked.

Participants should refer to the summary plan description for more complete information.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Method of Accounting - The accompanying financial statements are prepared using the accrual basis of accounting.

Investment Valuation and Income Recognition - Investments in equity and fixed income mutual funds are carried at fair value as provided by the investment manager, which generally represents quoted market prices or net asset value of the fund as of the last business day of the year. Purchases and sales are recorded on a trade-date basis. Interest income is recorded on an accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Contributions Receivable - Contributions due and not paid prior to the year end are recorded as contributions receivable. The Plan believes that the receivables are fully collectible; therefore, no allowance for credit losses is recorded.

Funding Policy and Revenue Recognition - The Plan is funded by contributions from participating employers under the terms of the collective bargaining agreements. Employer contributions are accounted for as exchange transactions. The contributions are due on a monthly basis. It is the policy of the Trustees to pursue monies due.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized, while replacements, maintenance, and repairs which do not improve or extend the useful lives of the related assets are expensed currently. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets. The estimated useful lives are generally three years for computer equipment and five to seven years for office furniture and equipment. There was no depreciation expense for the years ended April 30, 2025 and 2024.

Benefit Obligations - Claims incurred but not reported, accumulated eligibility credits, and postretirement benefits were estimated by the Plan's consultant.

Rebates - Rebates due from the Plan's Pharmacy Benefit Manager are recorded when earned. Pharmacy rebates totaling \$1,136,934 and \$1,300,869 have been netted with prescription claims paid in the accompanying Statements of Changes in Net Assets Available for Benefits for the years ended April 30, 2025 and 2024, respectively. Amounts due from the Plan's Pharmacy Benefit Manager as of April 30, 2025 and 2024 totaled \$614,563 and \$488,818, respectively.

Stop Loss - Premiums for stop loss insurance and stop loss insurance reimbursements are included in the cost of benefits in the accompanying Statements of Changes in Net Assets Available for Benefits for the years ended April 30, 2025 and 2024. Amounts due from the Plan's Stop Loss insurance provider as of April 30, 2025 and 2024 totaled \$29,941 and \$51,760, respectively.

Payments of Benefits - Self-funded claims paid for medical, prescription, mental health, dental, vacation, preventative health and disease management benefits are recorded in the accompanying Statement of Changes in Net Assets Available for Benefits when paid by the Plan. Amounts due at year end for claims payable or incurred but not reported are reported on the Statements of Benefit Obligations.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Advance Deposits - The Plan is required to maintain cash advance deposits with Independence Blue Cross and Allied Trades Assistance Program, which can be drawn against to reduce future claim payments, when claims paid to Independence Blue Cross and Allied Trades Assistance Program exceed the total of claims paid and other charges. The deposits have been included as assets of the Plan until such amounts are used to pay claims. The deposits will be returned to the Plan, less any outstanding claims, should the insurance contract terminate. Refer to Note 10 for additional information.

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

NOTE 3. PRIORITIES UPON TERMINATION

It is the intent of the Trustees to continue the Plan in full force and effect; however, to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining Plan assets will be distributed in such a manner as will, in the opinion of the Trustees, bring about the purpose of the Plan. Termination shall not permit any part of the Plan to be used for or diverted to purposes other than the exclusive benefit of the participants.

NOTE 4. TAX STATUS

The Plan obtained its latest determination letter on December 2, 1999, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements under Section 501(c)(9) of the Internal Revenue Code and was, therefore, not subject to tax under present Federal income tax laws. The Plan has been amended since receiving the determination letter. The Plan Trustees and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that, more likely than not, would not be sustained upon examination by the U.S. Federal, state, or local taxing authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Typically, Plan tax years will remain open for three years; however, this may differ depending upon the circumstances of the Plan.

NOTE 5. FUNDING POLICY

The Plan is funded by employer contributions as specified in the collective bargaining agreements. The contribution rate for each of the years ended April 30, 2025 and 2024 was \$13.30 per hour. Unemployed and ineligible participants along with their dependents are allowed to continue coverage by purchasing benefits through Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA rates are determined by the Plan administrator.

NOTE 6. PROPERTY AND EQUIPMENT

At April 30, 2025 and 2024, property and equipment consisted of the following:

| Category | 2025 | 2024 |
|-----------------------------------|-----------------|-----------------|
| Furniture, fixtures and equipment | \$ 32,965 | \$ 32,965 |
| Less: accumulated depreciation | <u>(32,965)</u> | <u>(32,965)</u> |
| Net property and equipment | <u>\$ -</u> | <u>\$ -</u> |

NOTE 7. FAIR VALUE MEASUREMENTS

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

Basis of Fair Value Measurement:

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

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

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

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

NOTE 7. FAIR VALUE MEASUREMENTS (continued)

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

| | Fair Value Measurements at April 30, 2025 | | | |
|----------------|---|----------------------|-------------|-------------|
| | Total | Level 1 | Level 2 | Level 3 |
| Mutual funds * | | | | |
| Equity | \$ 27,381,247 | \$ 27,381,247 | \$ - | \$ - |
| Fixed income | 32,883,733 | 32,883,733 | - | - |
| | <u>\$ 60,264,980</u> | <u>\$ 60,264,980</u> | <u>\$ -</u> | <u>\$ -</u> |

* - The two mutual funds account for 89% of net assets at April 30, 2025.

| | Fair Value Measurements at April 30, 2024 | | | |
|--------------|---|----------------------|-------------|-------------|
| | Total | Level 1 | Level 2 | Level 3 |
| Mutual funds | | | | |
| Equity | \$ 33,411,323 | \$ 33,411,323 | \$ - | \$ - |
| Fixed income | 18,345,665 | 18,345,665 | - | - |
| | <u>\$ 51,756,988</u> | <u>\$ 51,756,988</u> | <u>\$ -</u> | <u>\$ -</u> |

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the period.

For the years ended April 30, 2025 and 2024, there were no transfers in or out of levels 1, 2, or 3.

NOTE 8. RELATED PARTY TRANSACTIONS

The Plan shares Trustees and staff with a related entity, which include the Bricklayers Benefit Plans (BBP). The staff are employees of BBP. Certain administrative expenses, such as payroll, benefits, taxes, rent and administrative expenses are paid by BBP. The Plan reimburses BBP for these expenses monthly through an administrative services agreement. The Plan paid the BBP \$270,834 and \$53,352 for its portion of this administrator fee for the years ended April 30, 2025 and 2024, respectively.

BBP collects delinquency contributions and interest for all the related entities and other funds during the year and then reconciles and makes payments to these funds. At April 30, 2025 and 2024, BBP had collected and processed, but not yet paid out \$23,966 and \$7,428, respectively, to the Plan.

NOTE 8. RELATED PARTY TRANSACTIONS (continued)

The above transactions qualify as party-in-interest transactions which are exempt from the prohibited transaction rules of ERISA.

NOTE 9. ACTIVE PARTICIPANTS' ACCUMULATED ELIGIBILITY

Active participants become eligible upon attaining the required number of hours (750). Once the participant has attained the required number of hours in a work period, they will be eligible on the first day of the corresponding benefit period. They are required to work 100 hours per month or utilize banked hours of up to 100 per month to maintain eligible status. Newly eligible participants receive 200 banked hours automatically. Additional hours are acquired by working over 100 hours in a one month period. Banked hours can be accumulated up to 1,200 hours.

At April 30, 2025 and 2024, the active participants had earned an accumulated eligibility for benefits in the amounts of \$18,259,772 and \$17,364,566, respectively.

NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS

The April 30, 2025 plan year end valuation results reflect the liabilities associated with the retiree coverage provisions which became effective on January 1, 2025. The Plan now provides certain retired participants between the ages of 62 and 65 with medical, hospital, dental, prescription, vision, and death benefits. Those retirees eligible for benefits must meet defined requirements such as being eligible for benefits immediately prior to their retirement and having a minimum number of worked hours (1,000) in five of the preceding seven calendar years prior to retiring, or a total of at least 30,000 hours contributed to the Fund over the course of their career.

The postretirement benefit obligations represent the actuarial present value of those estimated future benefits that are attributed to participants' service rendered to April 30, 2025, reduced by the actuarial present value of contributions expected to be received in the future from current retirees of the Plan. Postretirement benefits include future benefits expected to be paid to or for currently retired participants and their beneficiaries and dependents, active participants and their beneficiaries, and dependents after retirement from service and COBRA benefits. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by the Plan's actuary and is the amount that results from applying actuarial assumptions to historical claims cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment. The amounts reported on the Statements of Benefit Obligations and Changes in Benefit Obligations are net of retiree contributions for the plan year ended April 30, 2025. Retiree contributions for the year ended April 30, 2025 were \$8,886.

NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

The healthcare trend rates used in the valuation are as follows:

| | First Year | | Ultimate | | Years to Reach Ultimate | |
|--------------------|------------|--------|----------|------|----------------------------|-------|
| | 2025 | 2024 | 2025 | 2024 | 2025 | 2024 |
| | Medical | 10.00% | N/A | 5.0% | N/A | -1.0% |
| Prescription | 15.00% | N/A | 5.0% | N/A | -2.0% | N/A |
| Other benefits | 5.00% | N/A | 5.0% | N/A | N/A | N/A |
| Admin expense cost | 3.00% | N/A | 3.0% | N/A | N/A | N/A |

The following were other significant assumptions used in the valuation as of April 30, 2025:

Discount rate: 5% per annum

Mortality:

Healthy RPH-2014 Blue Collar mortality table with no projected mortality improvement

Disabled RPH-2014 Disability Retiree mortality table with no projected mortality improvement

Retirement Age: Eligible participants are assumed to retire in accordance with the rates shown:

| Age | Probability of Retirement |
|--------------|---------------------------|
| 59-61 | 15% |
| 62 and older | 100% |

Claims Cost: The claim cost assumptions were based on the actual claims in the 2024-2025 and 2025-2026 plan years.

| | 2025 | 2024 |
|-------------------------------|----------|------|
| <i>Medical Benefits</i> | \$ 9,085 | N/A |
| <i>Prescription Benefits</i> | \$ 3,144 | N/A |
| <i>Dental Benefits</i> | \$ 475 | N/A |
| <i>Administrative Expense</i> | \$ 548 | N/A |

NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

Sensitivity: A one percentage point increase in the Assumed HealthCare Cost Trend Rate would result in a decrease in the total Benefit Obligations by \$953,910 in 2025 and N/A in 2024.

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

NOTE 11. DEPOSITS WITH SERVICE PROVIDERS

The Plan is required to maintain a cash advance reserve with Independence Blue Cross and a cash advance with the Allied Trades Assistance Program, which can be drawn against to reduce future claim payments, when claims paid to Independence Blue Cross or the Allied Trades Assistance Program exceed the total of claims paid and other charges. These cash advances have been included as assets of the Plan until such amounts are used to pay claims. The cash advances will be returned to the Plan, less any outstanding claims, should the insurance contract terminate.

At April 30, 2025 and 2024, Independence Blue Cross held a deposit from the Plan totaling \$578,000 for each Plan year. This deposit was required by Independence Blue Cross as part of the Personal Choice arrangement between Independence Blue Cross and the Plan, effective March 1, 2014. The deposit is reviewed annually by Blue Cross during the renewal period January 1st of each year to determine whether the amount on deposit is adequate. Under the terms of this arrangement, the deposit is used to fund claims that are paid by Independence Blue Cross on behalf of the Plan that have not yet been invoiced.

At April 30, 2025 and 2024, Allied Trades Assistance Program held a deposit from the Plan totaling \$150,000 for each year. This deposit was required by Allied Trades Assistance Program as part of an agreement between Allied Trades Assistance Program and the Plan, effective January 1, 2017. Under the terms of this agreement, the deposit is used to fund claims that are paid by Allied Trades Assistance Program on behalf of the Plan that have not yet been invoiced.

NOTE 12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits as reported on the financial statements as of April 30, 2025 and 2024, to the balances as reported on Form 5500:

| | <u>2025</u> | <u>2024</u> |
|--|----------------------|----------------------|
| Net assets available for benefits as reported on the financial statements | \$ 67,351,313 | \$ 58,626,893 |
| Benefit obligations currently payable and claims incurred but not reported | <u>(3,334,275)</u> | <u>(3,058,342)</u> |
| Net assets available for benefits as reported on Form 5500 | <u>\$ 64,017,038</u> | <u>\$ 55,568,551</u> |

The following is a reconciliation of total benefits as reported on the financial statements for the year ended April 30, 2025, to the balance reported on Form 5500:

| | |
|---|----------------------|
| Total benefits as reported on the financial statements | \$ 25,498,936 |
| Add: Amounts currently payable and claims incurred but not reported - 2025 | 3,334,275 |
| Less: Amounts currently payable and claims incurred but not reported - 2024 | <u>(3,058,342)</u> |
| Total benefits as reported on Form 5500 | <u>\$ 25,774,869</u> |

Benefit obligations currently payable and claims incurred but not reported at April 30, 2025 and 2024, are included in the Statements of Benefit Obligations in the financial statements but are included in the Statements of Benefit Obligations in the financial statements but are included as liabilities on Form 5500.

NOTE 13. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Plan is subject to certain fees mandated by the Patient Protection and Affordable Care Act (ACA). The fee will be indexed based on increases in the projected per capita amount of national health expenditures. For the year ended April 30, 2025 and 2024, the Plan paid \$7,731 and \$7,263, respectively, in PCORI fees.

NOTE 14. CASH CONCENTRATIONS

Cash at April 30, 2025 and 2024, consisted of the following:

| | <u>2025</u> | <u>2024</u> |
|-------------------------------|---------------------|---------------------|
| Citizens Bank | | |
| Checking account | \$ 1,492,957 | \$ 1,803,422 |
| Stone Masons Vacation account | 63,623 | 57,630 |
| Bricklayers Vacation account | <u>283,716</u> | <u>289,412</u> |
| Total | <u>\$ 1,840,296</u> | <u>\$ 2,150,464</u> |

The Plan places its cash with a financial institution deemed to be creditworthy. Cash balances may at times exceed the insured deposit limit of \$250,000 in a single bank. At April 30, 2025, the Plan's cash in excess of FDIC coverage totaled \$1,590,296.

NOTE 15. RISKS AND UNCERTAINTIES

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

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

NOTE 16. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through January 29, 2026, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED APRIL 30, 2025 AND 2024

| | <u>2025</u> | <u>2024</u> |
|--|-----------------------|-----------------------|
| Administrator fees | \$ 270,834 | \$ 53,352 |
| Office supplies and expense | 11,484 | 6,979 |
| Professional fees | | |
| Accounting, auditing, and government filings | 43,409 | 41,621 |
| Actuary | 38,167 | 34,667 |
| Legal | 30,613 | 33,657 |
| Insurance | <u>8,564</u> | <u>9,908</u> |
| Total administrative expenses | <u>\$ 403,071</u> | <u>\$ 180,184</u> |

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

SCHEDULE OF ASSETS HELD AT END OF YEAR

APRIL 30, 2025

Form 5500, Schedule H, Line 4i

EIN No: 23-2892285
Plan No: 501

| (a) | (b) | (c) | | | (d) | (e) |
|--|---|----------------------|------------------|------------------|----------------------|----------------------|
| Issuer, Borrower | Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value | | | Cost | Current Value | |
| | Type | Shares/ Principal | Interest Rate | Maturity Date | | |
| | <u>Equity mutual fund:</u> | | | | | |
| * Vanguard Total Stock Market Index Fund | | 206,060 | | | <u>\$ 12,593,187</u> | <u>\$ 27,381,247</u> |
| | <u>Fixed income mutual fund:</u> | | | | | |
| * Vanguard Intermediate Term Bond Index Fund | | 3,158,860 | | | <u>34,261,431</u> | <u>32,883,733</u> |
| | Total investments | | | | <u>\$ 46,854,618</u> | <u>\$ 60,264,980</u> |

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

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND**

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED APRIL 30, 2025

Form 5500, Schedule H, Line 4j

EIN No: 23-2892285

Plan No: 501

| (a) | (b) | (c) | (d) | (e) | (f) | (g) |
|--|-------------------|----------------------|---------------------|--------------------------|--------------------------------|-----|
| Description of Asset | Purchase Price | Selling Price | Cost of Asset | Current Value of Asset | Net Gain (Loss) on Transaction | |
| * Vanguard Total Stock Market Index Fund | \$ 478,711 N/A | N/A \$ 10,421,736 | N/A \$ 4,492,216 | \$ 478,711 10,421,736 | N/A \$ 5,929,520 | |
| * Vanguard Intermediate Term Bond Index Fund | 13,310,655 | N/A | N/A | 13,310,655 | N/A | |

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

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

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 **05/01/2024** and ending **04/30/2025**


- 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 BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1 OF PA/DE HEALTH AND WELFARE FUND | 1b Three-digit plan number (PN) ▶ 501 |
| 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) BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 1 PA/DE HEA 2704 BLACK LAKE PLACE PHILADELPHIA PA 19154 | 1c Effective date of plan 05/01/1997 2b Employer Identification Number (EIN) 23-2892285 2c Plan Sponsor's telephone number 215-856-9663 2d Business code (see instructions) 238100 |

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 | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/> 1-20-26 | JUSTIN SCARINCI |
| | Signature of plan administrator | Date | Enter name of individual signing as plan administrator |
| SIGN HERE | | | |
| | Signature of employer/plan sponsor | Date | Enter name of individual signing as employer or plan sponsor |
| SIGN HERE | | | |
| | 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: | 4b EIN |
| a Sponsor's name | 4d PN |
| c Plan Name | |

| | |
|---|----------------|
| 5 Total number of participants at the beginning of the plan year | 5 1,213 |
|---|----------------|

| | |
|--|--------------------|
| 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). | |
| a(1) Total number of active participants at the beginning of the plan year | 6a(1) 1,205 |
| a(2) Total number of active participants at the end of the plan year | 6a(2) 1,278 |
| b Retired or separated participants receiving benefits | 6b 5 |
| c Other retired or separated participants entitled to future benefits | 6c |
| d Subtotal. Add lines 6a(2) , 6b , and 6c | 6d 1,283 |
| e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | 6e |
| f Total. Add lines 6d and 6e | 6f |
| g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) | 6g(1) |
| (2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | 6g(2) |
| h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested | 6h |

| | |
|--|--------------|
| 7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) | 7 162 |
|--|--------------|

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

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

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

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

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

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 _____