

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 07/01/2024 and ending 06/30/2025

- 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
 - special extension (enter description)
 - the DFVC program
- 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 <u>IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
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>IRON WORKERS REGIONAL HEALTH & WELFARE TRUST</u> <u>625 ENTERPRISE DR</u> <u>OAK BROOK, IL 60523-8813</u>	1c Effective date of plan <u>03/15/1956</u> 2b Employer Identification Number (EIN) <u>36-2234288</u> 2c Plan Sponsor's telephone number <u>630-472-0626</u> 2d Business code (see instructions) <u>332300</u>

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.	02/06/2026	JAMES GARDINER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/06/2026	STEPHEN LAMB
	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: a Sponsor's name IRON WORKERS MIDWEST REGION HEALTH WELFARE TRUST c Plan Name IRON WORKERS MIDWEST REGION HEALTH AND WELFAREPLAN		4b EIN 36-2234288	
		4d PN 501	
5 Total number of participants at the beginning of the plan year		5	568
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)	568
a(2) Total number of active participants at the end of the plan year		6a(2)	942
b Retired or separated participants receiving benefits.....		6b	
c Other retired or separated participants entitled to future benefits		6c	
d Subtotal. Add lines 6a(2) , 6b , and 6c		6d	942
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.		6e	
f Total. Add lines 6d and 6e		6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)		6g(1)	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)		7	44

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 4F

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<p>A Name of plan IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS REGIONAL HEALTH & WELFARE TRUST</p>	<p>D Employer Identification Number (EIN) 36-2234288</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
AMALGAMATED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5501223	60216	26IL13	501	07/01/2024	06/30/2025

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.

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	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	22210
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<p>A Name of plan IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS REGIONAL HEALTH & WELFARE TRUST</p>	<p>D Employer Identification Number (EIN) 36-2234288</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
AMALGAMATED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5501223	60216	SL1035	907	07/01/2024	06/30/2025

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.

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">0</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	1076931
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 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 **07/01/2024** and ending **06/30/2025**

A Name of plan IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS REGIONAL HEALTH & WELFARE TRUST	D Employer Identification Number (EIN) 36-2234288

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

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL OF PENNSYLVANIA

(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
23-1667011	54798	20529	215	07/01/2024	06/30/2025

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	

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 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	51076
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

A Name of plan IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS REGIONAL HEALTH & WELFARE TRUST	D Employer Identification Number (EIN) 36-2234288	

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

CAPITAL RESEARCH AND MANAGEMENT COM

95-1411037

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

HARBOR CAPITAL ADVISORS, INC.

34-1953397

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

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

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

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)

HEALTH CARE SERVICE CORP (BCBS)

36-1236610

(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 73	NONE	426307	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

BENEFITS MANAGEMENT GROUP, INC

20-0188125

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	224010	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)

IRONWORKERS EMPLOYEES' BENEFIT CORP

95-3084599

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13	NONE	60000	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)

MARCO, MCGUIRE & ARREOLA, LLC

88-4115449

(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	NONE	39661	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)

ASB CAPITAL MANAGEMENT

80-0618452

(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?
	NONE	37227	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)

SAV-RX

86-1323040

(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	NONE	36406	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)

CALIBRE CPA GROUP, PLLC

47-0900880

(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	NONE	21700	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)

JAMES V GALLERY & ASSOCIATES

20-0188135

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	NONE	8000	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)

FIDUCIENT ADVISORS

36-4001764

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27	NONE	8000	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)

AMALGAMATED BANK OF CHICAGO

36-0721895

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 62	NONE	6539	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

(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"/>

(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

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(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
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For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025			
A Name of plan IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">B Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> </table>	B Three-digit plan number (PN) ▶	501
B Three-digit plan number (PN) ▶	501		
C Plan sponsor's name as shown on line 2a of Form 5500 IRON WORKERS REGIONAL HEALTH & WELFARE TRUST	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">D Employer Identification Number (EIN) 36-2234288</td> </tr> </table>	D Employer Identification Number (EIN) 36-2234288	
D Employer Identification Number (EIN) 36-2234288			

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	793741	827236
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	354869	498860
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	612541	300045
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	691041	2431545
(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)	7439327	13941641
(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	158357	158357
f Total assets (add all amounts in lines 1a through 1e).....	1f	10049876	18157684
Liabilities			
g Benefit claims payable.....	1g	243144	519793
h Operating payables.....	1h	38263	71119
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	561827	991019
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	843234	1581931
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	9206642	16575753

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)	9861779	
(B) Participants.....	2a(1)(B)	13672	
(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)		9875451
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	51114	
(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)	1973	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		53087
(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)	389975	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		389975
(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)		427055
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		10745568

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	8318312	
(2) To insurance carriers for the provision of benefits	2e(2)	1150217	
(3) Other.....	2e(3)	426307	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		9894836
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)	284010	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	21700	
(5) Investment advisory and investment management fees	2i(5)	45227	
(6) Bank or trust company trustee/custodial fees	2i(6)	11187	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)	38649	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	3425	
(11) Other expenses.....	2i(11)	23111	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		427309
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		10322145

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		423423
l Transfers of assets:			
(1) To this plan.....	2l(1)		6945688
(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: CALIBRE CPA GROUP, PLLC

(2) EIN: 47-0900880

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

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



**IRON WORKERS REGIONAL
HEALTH AND WELFARE PLAN**

FINANCIAL STATEMENTS

JUNE 30, 2025





IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

FINANCIAL STATEMENTS AND SUPPLEMENTAL INFORMATION

YEARS ENDED JUNE 30, 2025 AND 2024

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INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Iron Workers Regional Health and Welfare Plan
Oak Brook, Illinois

Opinion

We have audited the accompanying financial statements of Iron Workers Regional Health and Welfare Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of June 30, 2025 and 2024, and the related statements of changes in net assets available for benefits and changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the Plan as of June 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 that 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, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

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

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



Supplemental Schedules Required by ERISA

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

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

Other Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of general and administrative expenses are presented for purposes of additional analysis and are not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

Calibre CPA Group, PLLC

Chicago, IL
January 29, 2026



IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

JUNE 30, 2025 AND 2024

	2025	2024
Assets		
Investments, at fair value	<u>\$ 16,373,186</u>	<u>\$ 8,130,368</u>
Receivables		
Employer contributions	498,860	354,869
Accrued interest and dividends	8,345	2,948
Stop-loss recoveries	128,855	462,093
Prescription drug rebates	162,845	143,000
Other	<u>-</u>	<u>4,500</u>
Total receivables	<u>798,905</u>	<u>967,410</u>
Prepaid expenses	<u>2,957</u>	<u>2,957</u>
Reserve deposit - Blue Cross	<u>155,400</u>	<u>155,400</u>
Cash - non-interest bearing	<u>827,236</u>	<u>793,741</u>
Total assets	<u>18,157,684</u>	<u>10,049,876</u>
Liabilities and Net Assets		
Accounts payable and accrued expenses	<u>71,119</u>	<u>38,263</u>
Total liabilities	<u>71,119</u>	<u>38,263</u>
Net assets available for benefits	<u>\$ 18,086,565</u>	<u>\$ 10,011,613</u>

See accompanying notes to financial statements.



IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED JUNE 30, 2025 AND 2024

	2025	2024
Additions		
Investment income		
Net appreciation in fair value of investments	\$ 427,055	\$ 249,956
Interest and dividends	443,062	277,043
Investment expenses	<u>(48,355)</u>	<u>(43,125)</u>
Net investment income	821,762	483,874
Employer contributions	9,861,779	9,162,340
Employee contributions	<u>13,672</u>	<u>21,491</u>
Total additions	<u>10,697,213</u>	<u>9,667,705</u>
 Deductions		
Cost of benefits		
Benefits paid		
Claim payments - net of claims reimbursements and rebates	7,650,494	6,645,881
Disability benefits and related payroll taxes	158,843	71,439
Stop-loss insurance premiums	1,076,931	1,138,811
Stop-loss insurance reimbursements	(145,790)	(488,406)
Life and AD&D insurance premiums	<u>22,210</u>	<u>22,407</u>
Total benefits paid	8,762,688	7,390,132
Claims access and review fees	<u>426,307</u>	<u>408,817</u>
Total cost of benefits	9,188,995	7,798,949
Affordable Care Act fees	2,326	1,225
General and administrative expenses	<u>376,628</u>	<u>297,830</u>
Total deductions	<u>9,567,949</u>	<u>8,098,004</u>
Net change	1,129,264	1,569,701
 Net assets available for benefits		
Beginning of year	10,011,613	6,485,219
Merger proceeds from Shopmen's Local 527 Benefit Fund	-	1,956,693
Merger proceeds from Local 855 Welfare Fund	<u>6,945,688</u>	<u>-</u>
End of year	<u>\$ 18,086,565</u>	<u>\$ 10,011,613</u>

See accompanying notes to financial statements.



**IRON WORKERS REGIONAL
HEALTH AND WELFARE PLAN**

STATEMENTS OF BENEFIT OBLIGATIONS

JUNE 30, 2025 AND 2024

	<u>2025</u>	<u>2024</u>
Obligations for current benefit coverage, at present value of estimated amounts		
Claims payable	\$ 519,793	\$ 243,144
Claims incurred but not reported	900,000	454,000
Accumulated balance in participant Medical Savings Accounts	<u>91,019</u>	<u>107,827</u>
Total benefit obligations	<u>\$ 1,510,812</u>	<u>\$ 804,971</u>

See accompanying notes to financial statements.



**IRON WORKERS REGIONAL
HEALTH AND WELFARE PLAN**

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED JUNE 30, 2025 AND 2024

	2025	2024
Obligations for current benefit coverage, at present value of estimated amounts		
Balance at beginning of year	\$ 804,971	\$ 367,932
Claims and premiums incurred	9,485,337	7,719,344
Claims and premiums paid	(8,762,688)	(7,390,132)
Increase (decrease) in participant Medical Savings Accounts	(16,808)	107,827
Total benefit obligations at end of year	<u>\$ 1,510,812</u>	<u>\$ 804,971</u>

See accompanying notes to financial statements.



IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2025 AND 2024

NOTE 1. DESCRIPTION OF THE PLAN

The following brief description of the Iron Workers Regional Health and Welfare Plan (the Plan) provides general information only. Participants should refer to the trust agreement for a more complete description of the Plan's provisions.

General - The Plan was created and is maintained and administered according to the provisions of a joint agreement between the Iron League of Chicago, Inc. on behalf of its member companies and other eligible employers which adopted the Plan and Shopmen's Local Union No. 473 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers (AFL-CIO) to establish the Health and Welfare Trust Estate for Shopmen's Local Union No. 473 of the International Association of Bridge, Structural and Ornamental Iron Workers. Effective May 1, 2018, Local Union No. 473 was consolidated into the Ironworkers Regional Shop Local No. 853 of the International Association of Bridge, Structural and Ornamental Iron Workers (AFL-CIO). Effective January 1, 2019, the Plan was amended to change its name from the "Shopmen's Union No. 473 Health and Welfare Plan" to the "Iron Workers Midwest Region Health and Welfare Plan." Effective March 1, 2023, the Plan was amended to change its name from the "Iron Workers Midwest Region Health and Welfare Plan" to "Iron Workers Regional Health and Welfare Plan". The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan is administered by the Board of Trustees (Trustees) consisting of a union group and an employer group of representatives, each having equal voting power.

Benefits - The Plan provides accident, health, prescription drug and loss of time under self-funded programs. In addition, life benefits are provided through a premium arrangement. These benefits are provided for eligible employees of participating employers.

There is no provision in the Plan for postretirement benefits.

Eligibility - An employee becomes eligible for benefit coverage on the first day of the calendar month succeeding or coinciding with the date such employee completes two consecutive calendar months of employment and has worked at least 300 hours. For eligibility purposes, employees paid on a salary rather than an hourly basis shall be deemed to have worked 40 hours in any week for which they receive a salary payment. A participant will continue to be eligible for benefits under the Plan for each calendar month in which the employer submits contributions on or before the last day of the month.



NOTE 1. DESCRIPTION OF THE PLAN (CONTINUED)

Contributions - The Trustees established a funding policy and method in order to promote the purpose of the Plan and to insure compliance with ERISA. Each employer contributes to the Plan such amounts and at such times as are required by the applicable provisions of the collective bargaining agreement or such other agreements as are approved by the Trustees to provide benefits for employees.

The revenue of the Plan is dependent on the continued activity of the employers of the Plan. Contributions are based on employee coverage type and are made on a monthly basis throughout the year. Self-contributions may be made by previously qualified individuals under certain conditions described in the Plan.

Other - The Plan's Trustees, as Sponsor, has the right under the Plan to modify the benefits provided.

Stop-Loss Coverage - The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims in excess of \$175,00 and \$150,000 for the years ended June 30, 2025 and 2024, respectively, as well as its aggregate exposure for all claims).

Termination of the Plan - Although there is no intention to terminate the Plan at this time, the Plan's Trustees have the right under the Plan to modify the benefits provided to active employees. The Plan may be terminated only by joint agreement between management and union, subject to the provisions set forth in ERISA.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting - The accompanying financial statements have been prepared using the accrual basis of accounting. Under this basis, revenue is recognized when earned and expenses are recognized when incurred.

Employer Contributions Receivable - Contributions receivable represents subsequent contributions received for work performed through year end. Employer records are subject to audit and additional revenue, if any, that may arise as a result of these audits is recognized when received. Based on review of historical losses, current economic conditions and supportable and reasonable forecast assumptions, management has concluded that any expected credit losses on balances outstanding at year end will be immaterial.

Stop-Loss Recoveries Receivable - Claims that were already paid from the Plan that exceeded the stop-loss coverage and are due to the Plan at year-end are recorded as a receivable.

Investment Valuation and Income Recognition - Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Cash and equivalents held by the custodian represents assets held for investment purposes and are reported as investments.



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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

Payment of Benefits - Premium payments by the Plan are recorded as premium expense under cost of benefits in the accompanying statements of changes in net assets available for benefits.

Claim payments are recorded when paid by the Plan in the accompanying statements of changes in net assets available for benefits.

Administrative Expenses - The Plan's general and administrative expenses are paid by the Plan as provided by the Plan document. Expenses incurred with the general administration of the Plan are reported as deductions in the accompanying statements of changes in net assets available for benefits.

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 the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

NOTE 3. ESTIMATED LIABILITY FOR FUTURE CLAIMS

The estimated liability for claims payable and claims incurred but not yet reported was prepared by the consultant of the Plan. The estimate is based on claims incurred prior to July 1, 2025 and 2024 but paid after the fiscal year end.

NOTE 4. TAX STATUS

The Plan is qualified pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC) as a tax-exempt organization. The Plan Sponsor believes that the Plan, as amended, continues to qualify and to operate in accordance with applicable provisions of the IRC.

Accounting principles generally accepted in the United States of America require plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the taxing authorities.

As of June 30, 2025, there were no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.



NOTE 5. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2025</u>	<u>2024</u>
Net assets available for benefits per the financial statements	\$18,086,565	\$10,011,613
Benefit obligations currently payable	<u>(1,510,812)</u>	<u>(804,971)</u>
Net assets available for benefits per the Form 5500	<u>\$16,575,753</u>	<u>\$ 9,206,642</u>

The following is a reconciliation of benefits paid to participants from the financial statements to the Form 5500 for the year ended June 30, 2025:

Cost of benefits per the financial statements	\$ 9,188,995
Add: benefit obligations at June 30, 2025	1,510,812
Less: benefit obligations at June 30, 2024	<u>(804,971)</u>
Cost of benefits per the Form 5500	<u>\$ 9,894,836</u>

Claims and premiums that have been processed and approved for payment at year-end, but not paid and claims incurred but not reported are not considered liabilities under GAAP and, therefore, are not presented as liabilities or claims and premiums paid in the accompanying financial statements but are recorded on the Form 5500 as a liability.

The following is a reconciliation of additions and deductions per the statement of changes in net assets available for benefits to income and expenses per the Form 5500 for the year ended June 30, 2025:

Total additions per audited financial statements	\$ 10,697,213
Add: investment management expenses	<u>48,355</u>
Total additions per the Form 5500	<u>\$ 10,745,568</u>
Total deductions per audited financial statements	\$ 9,567,949
Add: effects of changes in benefit obligations	705,841
Add: investment management expenses	<u>48,355</u>
Total deductions per the Form 5500	<u>\$ 10,322,145</u>



NOTE 6. INVESTMENTS

The following is the Plan's investments held at June 30, 2025 and 2024.

<u>Investments at quoted market price</u>	<u>2025</u>	<u>2024</u>
Money market fund	\$ 2,431,545	\$ 691,041
Registered investment companies	<u>13,941,641</u>	<u>7,439,327</u>
	<u>\$ 16,373,186</u>	<u>\$ 8,130,368</u>

NOTE 7. FAIR VALUE MEASUREMENTS

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

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

Level 2 – Inputs to the valuation methodology include other significant observable inputs including:

- 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.

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



NOTE 7. FAIR VALUE MEASUREMENTS (CONTINUED)

Following are descriptions of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at June 30, 2025 and 2024.

Cash equivalents: Valued at cost plus accrued interest, which approximates fair value.

Registered investment companies: Mutual and exchange traded funds are valued based on the closing price reported in the active market in which the funds are traded.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of June 30, 2025 and 2024.

Description	Assets at Fair Value as of June 30, 2025			
	Total	Level 1	Level 2	Level 3
Money market fund	\$ 2,431,545	\$ 2,431,545	\$ -	\$ -
Registered investment companies	13,941,641	13,941,641	-	-
Total	<u>\$ 16,373,186</u>	<u>\$ 16,373,186</u>	<u>\$ -</u>	<u>\$ -</u>

Description	Assets at Fair Value as of June 30, 2024			
	Total	Level 1	Level 2	Level 3
Money market fund	\$ 691,041	\$ 691,041	\$ -	\$ -
Registered investment companies	7,439,327	7,439,327	-	-
Total	<u>\$ 8,130,368</u>	<u>\$ 8,130,368</u>	<u>\$ -</u>	<u>\$ -</u>

NOTE 8. PARTY-IN-INTEREST TRANSACTIONS

The Plan also pays certain investment and administrative fees directly to service providers. These transactions qualify as party-in-interest transactions, which are exempt from the prohibited transaction rules of ERISA.

NOTE 9. CREDIT RISK

The Plan maintains cash in bank accounts which, at times, exceed federally insured limits. At June 30, 2025 and 2024, the balance of funds held in excess of federally insured limits was approximately \$591,000 and \$487,000, respectively. The Plan has not experienced any losses, nor does it believe it is exposed to any significant risk of loss at this time.



NOTE 10. RISKS AND UNCERTAINTIES

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

NOTE 11. MERGERS

The Board of Trustees of the Iron Workers Regional Health and Welfare Plan and the Board of Trustees of the Iron Workers Regional Shop Local 855 Welfare Plan approved the merger of the Iron Workers Regional Shop Local 855 Welfare Plan into the Iron Workers Regional Health and Welfare Plan on May 1, 2025. The assets and liabilities received as merger proceeds from the Iron Workers Welfare Fund during the year ended June 30, 2025 were as follows:

Cash	\$ 10,534
Investments	<u>6,935,154</u>
	<u>\$ 6,945,688</u>

The Board of Trustees of the Iron Workers Regional Health and Welfare Plan and the Board of Trustees of the Shopmen's Local 527 Benefit Fund approved the merger of the Shopmen's Local 527 Benefit Fund into the Iron Workers Regional Health and Welfare Plan on July 1, 2023. The assets and liabilities received as merger proceeds from the Iron Workers Welfare Fund during the year ended June 30, 2024 were as follows:

Cash	\$ 51,440
Investments	1,607,215
Employer contributions receivable	144,242
Participant contributions receivable	22,376
Other receivables	424
Blue Cross reserve deposit	155,400
Payroll taxes payable	(10,117)
Accounts payable	<u>(14,287)</u>
	<u>\$ 1,956,693</u>

NOTE 12. SUBSEQUENT EVENTS

Subsequent events have been evaluated through January 29, 2026, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require adjustment to or disclosure in the accompanying financial statements.



SUPPLEMENTAL INFORMATION





**IRON WORKERS REGIONAL
HEALTH AND WELFARE PLAN**

SCHEDULES OF GENERAL AND ADMINISTRATIVE EXPENSES

YEARS ENDED JUNE 30, 2025 AND 2024

	<u>2025</u>	<u>2024</u>
Administrative fees	\$ 284,010	\$ 174,668
Audit and accounting fees	21,700	76,018
Bank charges	8,059	5,203
Consulting fees	8,000	8,000
Dues and subscriptions	638	598
Insurance	4,157	3,616
Legal fees	38,649	12,046
Meeting and conference expense	3,425	8,454
Office expense	<u>7,990</u>	<u>9,227</u>
 Total general and administrative expenses	 <u>\$ 376,628</u>	 <u>\$ 297,830</u>

IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

JUNE 30, 2025

Schedule H, Page 4, Line 4i

EIN No.: 36-2234288
Plan No.: 501

(c) Description of Investment Including Maturity Date, Rate of Interest, Shares or Par/Maturity Value							
(a)	(b) Identity of Issuer, Borrower, Lessor, or Similar Party	Description	Maturity Date	Rate of Interest	Number of Shares or Par/Maturity Value	(d) Cost	(e) Current Value
	<u>Cash equivalents</u>						
	Goldman Financial Square Prime Obligations Fund	Money market fund	N/A	N/A	2,431,545	<u>\$ 2,431,545</u>	<u>\$ 2,431,545</u>
	<u>Registered investment companies</u>						
	American Europacific Growth	Mutual fund	N/A	N/A	18,948	1,055,621	1,151,869
	Blackrock Corporate High Yield Fund, Inc.	Exchange traded fund	N/A	N/A	20,500	195,258	199,875
	Cohen & Steers Institutional Realty Shares	Mutual fund	N/A	N/A	6,228	280,507	306,861
	Conestoga Small Cap	Mutual fund	N/A	N/A	4,268	290,456	313,203
	Dodge & Cox Stock	Mutual fund	N/A	N/A	3,289	796,845	891,065
	DWS Rreef Real Assets	Mutual fund	N/A	N/A	38,047	433,202	464,171
	GQG Partners Emerging Institutional	Mutual fund	N/A	N/A	27,361	475,802	475,529
	Harbor Capital Appreciation	Mutual fund	N/A	N/A	7,824	766,729	956,422
	Hotchkis & Wiley Diversified Value	Mutual fund	N/A	N/A	28,205	317,571	327,740
	iShares Core U.S. Aggregate Bond	Exchange traded fund	N/A	N/A	7,995	767,292	793,104
	iShares TIPS Bond	Exchange traded fund	N/A	N/A	1,465	157,194	161,209
	Vanguard Intermediate-Term Bond	Exchange traded fund	N/A	N/A	35,955	2,788,465	2,780,760
	Vanguard Short-Term Bond	Exchange traded fund	N/A	N/A	65,025	5,052,971	5,117,468
	Vanguard Total Bond Market	Mutual fund	N/A	N/A	244	<u>2,210</u>	<u>2,365</u>
	Total registered investment companies					<u>13,380,123</u>	<u>13,941,641</u>
	Total assets (held at end of year)					<u>\$ 15,811,668</u>	<u>\$ 16,373,186</u>

Form 5500 Department of the Treasury Internal Revenue Service <hr/> Department of Labor Employee Benefits Security Administration <hr/> 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 <hr/> <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> <hr/> This Form is Open to Public Inspection
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Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

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 IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN	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) IRON WORKERS REGIONAL HEALTH & WELFARE TRUST 625 ENTERPRISE DR OAK BROOK IL 60523-8813	1c Effective date of plan 03/15/1956	2b Employer Identification Number (EIN) 36-2234288
	2c Plan Sponsor's telephone number 630-472-0626	2d Business code (see instructions) 332300

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			JAMES GARDINER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		<u>2/6/26</u>	STEPHEN LAMB
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE		<u>2-6-26</u>	
	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 <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
--	--

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name IRON WORKERS MIDWEST REGION HEALTH c Plan Name IRON WORKERS MIDWEST REGION HEALTH AND WELFARE PLAN	4b EIN 36-2234288 4d PN 501
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5 Total number of participants at the beginning of the plan year	5	568
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)	568
a (2) Total number of active participants at the end of the plan year	6a(2)	942
b Retired or separated participants receiving benefits	6b	
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	942
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	44

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 4F

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

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

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

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

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

Receipt Confirmation Code _____



IRON WORKERS REGIONAL HEALTH AND WELFARE PLAN

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED JUNE 30, 2025

Schedule H, Page 4, Line 4j

EIN No.: 36-2234288
Plan No. 501

Description of Asset	Purchase Price	Selling Price	Cost of Asset	Fair Value of Asset at Transaction Date	Net Gain or (Loss)
Purchases					
<u>Cash equivalents</u>					
Goldman Financial Square Prime Obligations Fund #462	\$ 36,098	\$ -	\$ 36,098	\$ 36,098	\$ -
Goldman Financial Square #465	10,747,253	-	10,747,253	10,747,253	-
<u>Registered investment companies</u>					
American Europacific Growth	577,730	-	577,730	577,730	-
Vanguard Intermediate-Term Bond	1,209,264	-	1,209,264	1,209,264	-
Vanguard Short-Term Bond	2,164,860	-	2,164,860	2,164,860	-
Sales					
<u>Cash equivalents</u>					
Goldman Financial Square Gov't Fund #465	-	9,125,708	9,125,708	9,125,708	-
Goldman Financial Square Gov't Fund #462	-	727,139	727,074	727,139	65