

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 09/01/2024 and ending 08/31/2025

- A This return/report is for: a multiemployer plan, a multiple-employer plan (checked), a single-employer plan, a DFE (specify), B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report (less than 12 months), C If the plan is a collectively-bargained plan, check here, D Check box if filing under: Form 5558, automatic extension, the DFVC program, special extension (enter description), E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here

Part II Basic Plan Information—enter all requested information

1a Name of plan: ELECTRIC COALITION OF WISCONSIN HEALTH BENEFIT TRUST AND PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 09/01/1996
2a Plan sponsor's name (employer, if for a single-employer plan): ELECTRIC COALITION OF WISCONSIN
2b Employer Identification Number (EIN): 39-1879477
2c Plan Sponsor's telephone number: 608-372-4131
2d Business code (see instructions): 221100

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	207
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	207
	6a(2)	219
	6b	10
	6c	0
	6d	229
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	

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

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

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" 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>1</u>
(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____	(4) <input checked="" type="checkbox"/> C (Service Provider Information)
(5) <input checked="" type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	(5) <input type="checkbox"/> D (DFE/Participating Plan Information)
	(6) <input type="checkbox"/> G (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning **09/01/2024** and ending **08/31/2025**

A Name of plan ELECTRIC COALITION OF WISCONSIN HEALTH BENEFIT TRUST AND PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 ELECTRIC COALITION OF WISCONSIN		D Employer Identification Number (EIN) 39-1879477

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

1 Coverage Information:

(a) Name of insurance carrier

HCC LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-1817054	92711	E944	200	09/01/2024	08/31/2025

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

(a) Total amount of commissions paid 82954	(b) Total amount of fees paid 4261
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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

THE BENEFIT WORKS

**6200 MINERAL POINT RD
MADISON, WI 53705**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
58067	4261	BROKER FEE	4

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

JON D PLAMANN & ASSOCIATES

**2650 W LAWRENCE ST
APPLETON, WI 54914**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
24887			3

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Schedule A (Form 5500) 2024
v. 240311

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

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

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

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

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

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

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

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

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

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

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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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)	
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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	759031
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 **09/01/2024** and ending **08/31/2025**

A Name of plan ELECTRIC COALITION OF WISCONSIN HEALTH BENEFIT TRUST AND PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 ELECTRIC COALITION OF WISCONSIN	D Employer Identification Number (EIN) 39-1879477	

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

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

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

BAUMAN ASSOCIATES, LTD

39-1277627

(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	37300	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)

PRAIRIE STATES ENTERPRISES, INC

36-3730559

(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	56418	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 09/01/2024 and ending 08/31/2025	
A Name of plan ELECTRIC COALITION OF WISCONSIN HEALTH BENEFIT TRUST AND PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 ELECTRIC COALITION OF WISCONSIN	D Employer Identification Number (EIN) 39-1879477

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
Assets			
a Total noninterest-bearing cash	1a	47	54
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	99749	41029
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	297421	350500
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	5855273	5618975
(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)	2700000	2700000
(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)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d	Employer-related investments:		
(1)	Employer securities.....	1d(1)	
(2)	Employer real property.....	1d(2)	
e	Buildings and other property used in plan operation.....	1e	
f	Total assets (add all amounts in lines 1a through 1e).....	1f	8952490 8710558
Liabilities			
g	Benefit claims payable.....	1g	342006 639831
h	Operating payables.....	1h	19920 39905
i	Acquisition indebtedness.....	1i	
j	Other liabilities.....	1j	
k	Total liabilities (add all amounts in lines 1g through 1j).....	1k	361926 679736
Net Assets			
l	Net assets (subtract line 1k from line 1f).....	1l	8590564 8030822

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.

		(a) Amount	(b) Total
Income			
a	Contributions:		
(1)	Received or receivable in cash from: (A) Employers.....	2a(1)(A)	5541603
	(B) Participants.....	2a(1)(B)	
	(C) Others (including rollovers).....	2a(1)(C)	
(2)	Noncash contributions.....	2a(2)	
(3)	Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)	5541603
b	Earnings on investments:		
(1)	Interest:		
	(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	241418
	(B) U.S. Government securities.....	2b(1)(B)	
	(C) Corporate debt instruments.....	2b(1)(C)	112965
	(D) Loans (other than to participants).....	2b(1)(D)	
	(E) Participant loans.....	2b(1)(E)	
	(F) Other.....	2b(1)(F)	
	(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)	354383
(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)	
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)	
(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)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		5895986

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	5360932	
(2) To insurance carriers for the provision of benefits	2e(2)	759031	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		6119963
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)	128891	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	41763	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	42772	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	122339	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		335765
j Total expenses. Add all expense amounts in column (b) and enter total	2j		6455728

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-559742
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **BAUMAN ASSOCIATES, LTD.**

(2) EIN: **39-1277657**

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	
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.			

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 _____.

ECW Health Benefit Trust and Plan

Financial Statements

Years ended August 31, 2025 and 2024

ECW HEALTH BENEFIT TRUST AND PLAN

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Report of Independent Certified Public Accountants

Board of Directors
Electric Coalition of Wisconsin, Inc.
Richland Center, Wisconsin

Opinion

We have audited the accompanying financial statements of ECW Health Benefit Trust and 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 August 31, 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 ECW Health Benefit Trust and Plan as of August 31, 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 conformity with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of ECW Health Benefit Trust and Plan and to meet our 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 these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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 ECW Health Benefit Trust and Plan's ability to continue as a going concern for one year after the date the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

- Exercise professional judgement 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 ECW Health Benefit Trust and Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgement, there are conditions or events, considered in the aggregate, that raise substantial doubt about ECW Health Benefit Trust and 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 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 listed in the table of contents, together referred to as "supplemental information," are presented for the purpose of additional analysis and are not a required part of the financial statements but is supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare

the financial statements. The information has been subjected to the auditing procedures applied in the audit 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 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 Disclosures 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 their form and content are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

Bauman Associates, Ltd.

CERTIFIED PUBLIC ACCOUNTANTS

Eau Claire, Wisconsin
February 02, 2026

ECW HEALTH BENEFIT TRUST AND PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
August 31, 2025 and 2024

ASSETS	<u>2025</u>	<u>2024</u>
Cash	\$ 54	\$ 47
Stop-loss insurance receivable	271,354	204,444
Interest receivable	79,146	79,146
Prepaid insurance	-	13,831
Contributions receivable	41,029	99,749
Investments	<u>8,318,975</u>	<u>8,555,273</u>
 TOTAL ASSETS	 <u>8,710,558</u>	 <u>8,952,490</u>
LIABILITIES		
Accounts payable	\$ <u>39,905</u>	\$ <u>19,920</u>
 TOTAL LIABILITIES	 <u>39,905</u>	 <u>19,920</u>
 NET ASSETS AVAILABLE FOR BENEFITS	 <u>\$ 8,670,653</u>	 <u>\$ 8,932,570</u>

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

ECW HEALTH BENEFIT TRUST AND PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years Ended August 31, 2025 and 2024

	2025	2024
ADDITIONS TO NET ASSETS ATTRIBUTED TO -		
Contributions:		
Participating employers	\$ 5,541,603	\$ 5,424,589
Investment income:		
Interest	354,383	458,945
TOTAL ADDITIONS	5,895,986	5,883,534
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO -		
Health care benefits	5,063,107	4,236,092
Other costs:		
Reinsurance premiums	759,031	693,024
Administration fees	128,891	205,314
PPO fees	9,497	9,068
HRA fees	11,796	11,608
Agent fees	87,215	83,063
Professional fees	41,763	47,482
Insurance	13,831	13,581
Bank service charges	42,772	22,253
TOTAL DEDUCTIONS	6,157,903	5,321,485
NET INCREASE (DECREASE) DURING THE YEAR	(261,917)	562,049
NET ASSETS AVAILABLE FOR BENEFITS:		
BEGINNING OF YEAR	8,932,570	8,370,521
END OF YEAR	\$ 8,670,653	\$ 8,932,570

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

ECW HEALTH BENEFIT TRUST AND PLAN
STATEMENTS OF BENEFIT OBLIGATIONS AND CHANGES IN BENEFIT OBLIGATIONS
Years Ended August 31, 2025 and 2024

	2025	2024
BENEFIT OBLIGATIONS		
Amounts currently payable for participants:		
Health claims payable	\$ <u>639,831</u>	\$ <u>342,006</u>
Total benefit obligations	\$ <u><u>639,831</u></u>	\$ <u><u>342,006</u></u>
CHANGES IN BENEFIT OBLIGATIONS		
Amounts currently payable for participants:		
Balance, beginning of year	\$ 342,006	\$ 399,836
Claims reported/approved for payment	5,360,932	4,178,262
Claims paid	<u>(5,063,107)</u>	<u>(4,236,092)</u>
Balance, end of year	<u>639,831</u>	<u>342,006</u>
Benefit obligations - end of year	\$ <u><u>639,831</u></u>	\$ <u><u>342,006</u></u>

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

ECW HEALTH BENEFIT TRUST AND PLAN
NOTES TO FINANCIAL STATEMENTS
August 31, 2025 and 2024

Note 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Description of Plan

The following description of the ECW Health Benefit Trust and Plan (the Plan) provides only general information. Participants should refer to the Plan agreement for a complete description of the Plan's provisions.

General

The Plan provides health and other benefits covering all participants associated with the Electric Coalition of Wisconsin, Inc. The Plan and related trust were established on September 1, 1996 and are subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Investments

Union Bank & Trust is the investment custodian for the plan. Investment income is recorded by the Plan as earned or declared. Investments are stated at fair value.

Fair Value Measurements

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

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

Level 2 Inputs to the valuation methodology include:

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

ECW HEALTH BENEFIT TRUST AND PLAN
NOTES TO FINANCIAL STATEMENTS
August 31, 2025 and 2024

Note 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Fair Value Measurements (Continued)

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.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at August 31, 2025 and 2024.

Corporate bonds: Valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

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

Benefits

The Plan provides health benefits (medical, hospital, surgical, major medical, and dental) to full-time participants and to their beneficiaries and covered dependents.

Contributions

The Plan agreement provides that the Plan Administrator will recommend levels of employer funding in conjunction with covered employee benefits. The contribution amounts are determined based on insurance premium rates and related deductibles, levels of claims incurred, and related administrative expenses.

The Plan agreement also states that each participating employer will share proportionately in any deficiencies, including run-out for the plan year(s) in which they are a member. Participating employers must give 90 days' written notice of intent to terminate.

ECW HEALTH BENEFIT TRUST AND PLAN
NOTES TO FINANCIAL STATEMENTS
August 31, 2025 and 2024

Note 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Plan Termination

The continuance of the Plan is contingent upon the participation of the Cooperatives remaining in the plan as of August 31, 2025. In the event the Plan terminates, the assets remaining after providing for all obligations of the Plan will be used for the benefit of the Plan's participants.

Concentration of Credit Risk

Financial instruments that potentially subject the Plan to concentration of credit risk consist principally of cash. The Plan maintains cash balances at financial institutions, which, at times, may exceed federally insured limits. The Plan has not experienced any losses from these accounts. The Plan believes it is not exposed to any significant risk on such balances.

Income Tax Status

The Plan is qualified as a tax-exempt organization pursuant to Section 501(c) (9) of the Internal Revenue Code. The Plan will recognize any accrued interest and penalties related to unrecognized benefits in income tax, if incurred.

Basis of Accounting

The financial statements of the Plan are prepared using the accrual method of accounting.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the Plan Administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from those estimates. Significant estimates used in preparing these financial statements include those assumed in reporting claims payable. As a result of possible delays in submitting and processing claims incurred at year-end, it is reasonably possible that the amount of the claims payable might change in the future.

Management Review

In preparing these financial statements, the Plan has evaluated events and transactions for potential recognition or disclosure through February 02, 2026, the date the financial statements were available for issue.

ECW HEALTH BENEFIT TRUST AND PLAN
NOTES TO FINANCIAL STATEMENTS
August 31, 2025 and 2024

Note 2 INVESTMENTS

A summary of investments by class is presented below. The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of August 31, 2025 and 2024.

August 31, 2025	Level 1	Level 2	Level 3	Fair Value
Money market fund	\$ 5,618,975	-	-	\$ 5,618,975
Corporate bonds	-	2,700,000	-	2,700,000
	<u>\$ 5,618,975</u>	<u>2,700,000</u>	<u>-</u>	<u>\$ 8,318,975</u>

August 31, 2024	Level 1	Level 2	Level 3	Fair Value
Money market fund	\$ 5,855,273	-	-	\$ 5,855,273
Corporate bonds	-	2,700,000	-	2,700,000
	<u>\$ 5,855,273</u>	<u>2,700,000</u>	<u>-</u>	<u>\$ 8,555,273</u>

Note 3 HEALTH CLAIMS PAYABLE

The benefit obligation for health claims payable represents claims covering medical costs incurred by plan participants through Plan year-ends, but paid by the Plan subsequent to the year ends.

Note 4 CONTRACTED SERVICES

Administrative Services

The Plan contracts with Prairie States Enterprises, Inc. for the administration, claims review, claims settlement and other related administrative services for the Plan. Administrative fees totaled \$61,194 and \$66,351 for the years ended August 31, 2025 and 2024, respectively.

Stop-Loss Insurance Coverage

The Plan contracted with HCC Life Insurance Company as of August 31, 2025 and 2024 for stop-loss coverage. The specific stop-loss amount for the years ended August 31, 2025 and 2024 was \$125,000, per participant, with unlimited maximum annual specific stop-loss coverage for 2025 and 2024, per participant. The Plan also has a split funded liability. This is an amount that must be paid before the insurance company is responsible to pay any specific loss benefits under the policy. The split funded liability amount for the years ended August 31, 2025 and 2024 was \$60,000. Premiums paid totaled \$759,031 and \$693,024 for the years ended August 31, 2025 and 2024, respectively.

ECW HEALTH BENEFIT TRUST AND PLAN
NOTES TO FINANCIAL STATEMENTS
August 31, 2025 and 2024

Note 4 CONTRACTED SERVICES (Continued)

Stop-Loss Insurance Coverage (Continued)

Stop loss insurance reimbursements totaled \$576,175 and \$182,038 for the years ended August 31, 2025 and 2024, respectively. The stop loss insurance reimbursements are netted with health care benefits on the statements of changes in net assets available for benefits.

Note 5 RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of benefits incurred to providers per the financial statements to the Form 5500 for the years ended August 31, 2025 and 2024:

	2025	2024
Health care benefits	\$ 5,063,107	\$ 4,236,092
Changes in benefit obligations	297,825	(57,830)
 Health care benefits to providers per Form 5500	 \$ 5,360,932	 \$ 4,178,262

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 for the years ended August 31, 2025 and 2024:

	2025	2024
Net assets available for benefits per the financial statements	\$ 8,670,653	\$ 8,932,570
Benefits obligations currently payable	(639,831)	(342,006)
 Net assets available for benefits per the Form 5500	 \$ 8,030,822	 \$ 8,590,564

ECW HEALTH BENEFIT TRUST AND PLAN
SCHEDULE H, LINE 4(i) - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Plan 501
EIN 39-1879477
August 31, 2025

(a)	Identity of Issue, borrower, lessor, or similar party (b)	Description of Investment (c)	Par value/ Number of Shares	Cost (d)	Current Value (e)
	CFC Select Note 4.11% 11/26/2025	Corporate Bonds	900,000	900,000	900,000
	CFC Select Note 4.11% 12/31/2025	Corporate Bonds	500,000	500,000	500,000
	CFC Select Note 4.23% 09/30/2025	Corporate Bonds	600,000	600,000	600,000
	CFC Select Note 4.18% 10/31/2025	Corporate Bonds	700,000	700,000	700,000
	Goldman Sachs Finl Square Treasury Fund	Money Market Fund	5,618,975	5,618,975	5,618,975
				<u>\$ 8,318,975</u>	<u>\$ 8,318,975</u>

* Identifies a Party in Interest

ECW HEALTH BENEFIT TRUST AND PLAN
SCHEDULE H, LINE 4(j) - SCHEDULE OF REPORTABLE TRANSACTIONS
Plan 501
EIN 39-1879477
Year Ended August 31, 2025

Party - in - interest (a)	Description of Asset (b)	Purchase Price (c)	Selling Price (d)	Cost of Asset (g)	Current Value of Asset on Transaction Date (h)	Net Gain (Loss) (f)
Sales						
	Goldman Sachs Finl Square Treasury Fund	n/a	\$ 6,242,504	\$ 6,242,504	n/a	\$ -
	CFC Select Note 5.45% 9/30/2024	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 5.44% 10/31/2024	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
	CFC Select Note 5.29% 11/27/2024	n/a	\$ 900,000	\$ 900,000	n/a	\$ -
	CFC Select Note 5.15% 12/31/2024	n/a	\$ 500,000	\$ 500,000	n/a	\$ -
	CFC Select Note 4.66% 1/31/2025	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 4.6% 2/28/2025	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
	CFC Select Note 4.47% 03/30/2025	n/a	\$ 900,000	\$ 900,000	n/a	\$ -
	CFC Select Note 4.23% 4/30/2025	n/a	\$ 500,000	\$ 500,000	n/a	\$ -
	CFC Select Note 4.2% 5/30/2025	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 4.25% 06/30/2025	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
Purchases						
	Goldman Sachs Finl Square Treasury Fund	\$ 6,005,848	n/a	n/a	\$ 6,005,848	n/a
	CFC Select Note 4.66% 1/31/2024	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.6% 2/28/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a
	CFC Select Note 4.47% 3/31/2025	\$ 900,000	n/a	n/a	\$ 900,000	n/a
	CFC Select Note 4.23% 4/30/2025	\$ 500,000	n/a	n/a	\$ 500,000	n/a
	CFC Select Note 4.2% 5/30/2025	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.25% 6/30/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a
	CFC Select Note 4.24% 7/31/2025	\$ 900,000	n/a	n/a	\$ 900,000	n/a
	CFC Select Note 4.25% 8/29/2025	\$ 500,000	n/a	n/a	\$ 500,000	n/a
	CFC Select Note 4.23% 9/30/2025	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.18% 10/31/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a

* Identifies a Party in Interest

ECW HEALTH BENEFIT TRUST AND PLAN
SCHEDULE H, LINE 4(i) - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

Plan 501
EIN 39-1879477
August 31, 2025

(a)	Identity of Issue, borrower, lessor, or similar party (b)	Description of Investment (c)	Par value/ Number of Shares	Cost (d)	Current Value (e)
	CFC Select Note 4.11% 11/26/2025	Corporate Bonds	900,000	900,000	900,000
	CFC Select Note 4.11% 12/31/2025	Corporate Bonds	500,000	500,000	500,000
	CFC Select Note 4.23% 09/30/2025	Corporate Bonds	600,000	600,000	600,000
	CFC Select Note 4.18% 10/31/2025	Corporate Bonds	700,000	700,000	700,000
	Goldman Sachs Finl Square Treasury Fund	Money Market Fund	5,618,975	5,618,975	5,618,975
				<u>\$ 8,318,975</u>	<u>\$ 8,318,975</u>

* Identifies a Party in Interest

ECW HEALTH BENEFIT TRUST AND PLAN
SCHEDULE H, LINE 4(j) - SCHEDULE OF REPORTABLE TRANSACTIONS
Plan 501
EIN 39-1879477
Year Ended August 31, 2025

Party - in - interest (a)	Description of Asset (b)	Purchase Price (c)	Selling Price (d)	Cost of Asset (g)	Current Value of Asset on Transaction Date (h)	Net Gain (Loss) (f)
Sales						
	Goldman Sachs Finl Square Treasury Fund	n/a	\$ 6,242,504	\$ 6,242,504	n/a	\$ -
	CFC Select Note 5.45% 9/30/2024	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 5.44% 10/31/2024	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
	CFC Select Note 5.29% 11/27/2024	n/a	\$ 900,000	\$ 900,000	n/a	\$ -
	CFC Select Note 5.15% 12/31/2024	n/a	\$ 500,000	\$ 500,000	n/a	\$ -
	CFC Select Note 4.66% 1/31/2025	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 4.6% 2/28/2025	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
	CFC Select Note 4.47% 03/30/2025	n/a	\$ 900,000	\$ 900,000	n/a	\$ -
	CFC Select Note 4.23% 4/30/2025	n/a	\$ 500,000	\$ 500,000	n/a	\$ -
	CFC Select Note 4.2% 5/30/2025	n/a	\$ 600,000	\$ 600,000	n/a	\$ -
	CFC Select Note 4.25% 06/30/2025	n/a	\$ 700,000	\$ 700,000	n/a	\$ -
Purchases						
	Goldman Sachs Finl Square Treasury Fund	\$ 6,005,848	n/a	n/a	\$ 6,005,848	n/a
	CFC Select Note 4.66% 1/31/2024	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.6% 2/28/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a
	CFC Select Note 4.47% 3/31/2025	\$ 900,000	n/a	n/a	\$ 900,000	n/a
	CFC Select Note 4.23% 4/30/2025	\$ 500,000	n/a	n/a	\$ 500,000	n/a
	CFC Select Note 4.2% 5/30/2025	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.25% 6/30/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a
	CFC Select Note 4.24% 7/31/2025	\$ 900,000	n/a	n/a	\$ 900,000	n/a
	CFC Select Note 4.25% 8/29/2025	\$ 500,000	n/a	n/a	\$ 500,000	n/a
	CFC Select Note 4.23% 9/30/2025	\$ 600,000	n/a	n/a	\$ 600,000	n/a
	CFC Select Note 4.18% 10/31/2025	\$ 700,000	n/a	n/a	\$ 700,000	n/a

* Identifies a Party in Interest

**ELECTRIC COALITION OF WISCONSIN
MULTIPLE-EMPLOYER PLAN PARTICIPATING EMPLOYER INFORMATION
PLAN NO. 501
EIN: 39-1879477**

<u>Employer</u>	<u>EIN</u>	<u>Percent of total contributions</u>
Adams-Columbia Electric	39-0121840	31%
Central Wisconsin Electric	39-0783977	10%
Chippewa Valley Electric	39-0207312	15%
Clark Electric	39-0212464	11%
Oakdale Electric	39-0512153	14%
Oconto Electric	39-0513423	4%
Richland Electric	39-0568995	6%
Scenic Rivers Electric	39-0314085	<u>10%</u>
		100%

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 **09/01/2024** and ending **08/31/2025**

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

Part II Basic Plan Information—enter all requested information

1a Name of plan ELECTRIC COALITION OF WISCONSIN HEALTH BENEFIT TRUST AND PLAN	1b Three-digit plan number (PN) ▶ 501
	1c Effective date of plan 09/01/1996
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) ELECTRIC COALITION OF WISCONSIN PO BOX 40 OAKDALE WI 54649	2b Employer Identification Number (EIN) 39-1879477
	2c Plan Sponsor's telephone number 608-372-4131
	2d Business code (see instructions) 221100

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	<i>AMY MARTIN</i>	<i>2/9/26</i>	AMY MARTIN	SIGN HERE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator	
SIGN HERE				
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor	
SIGN HERE				
	Signature of DFE	Date	Enter name of individual signing as DFE	

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

Form 5500 (2024)