

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

- A This return/report is for: [X] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension... 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.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND
1b Three-digit plan number (PN): 501
1c Effective date of plan: 04/01/1960
2a Plan sponsor's name (employer, if for a single-employer plan): TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND
2b Employer Identification Number (EIN): 62-0637976
2c Plan Sponsor's telephone number: 615-859-0131
2d Business code (see instructions): 238220

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

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

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include BEN SNYDER (plan administrator) and DAVID W. SINK JR. (employer/plan sponsor).

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	724
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)	668
	6a(2)	668
	6b	119
	6c	0
	6d	787
	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	56

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

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

<p>A Name of plan U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 62-0637976</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
5STAR 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
54-1829709	77879	D0136	1320	04/01/2024	03/31/2025

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

<p>(a) Total amount of commissions paid 4825</p>	<p>(b) Total amount of fees paid 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
THE HILB GROUP OF NEW ENGLAND **C/O ROBERT F. CALISE**
2000 CHAPEL VIEW BLVD, SUITE 2
CRANSTON, RI 02920

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4825			3

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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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. **6d**
 Specify nature of costs ▶

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	35865
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

<p>A Name of plan U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 62-0637976</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
HUMANA 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
39-1263473	73288	306682	181	04/01/2024	03/31/2025

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

<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
	(c) Amount	(d) Purpose	

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

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	578781
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: 24pt;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025

<p>A Name of plan U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 62-0637976</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
HCC LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
35-1817054	92711	HCL34164	8	04/01/2024	03/31/2025

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

<p>(a) Total amount of commissions paid</p> <p style="color: blue;">7483</p>	<p>(b) Total amount of fees paid</p> <p style="color: blue;">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

HILB GROUP OF NEW ENGLAND, LLC
30 BRAINTREE HILL OFFICE PARK
SUITE 203
BRAintree, MA 02184

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
7483			3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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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)	
(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)	
	(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	299328
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **04/01/2024** and ending **03/31/2025**

A Name of plan U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 62-0637976	

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

OPTUMRX, INC

33-0441200

(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)

CIGNA

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	NONE	372978	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)

SOUTHERN BENEFIT ADMIN

62-1116095

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14 16 17 50	NONE	217469	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)

NOVARA TESIJA & CATENACCI, PLLC

888 W BIG BEAVER RD
STE 600
TROY, MI 48084

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	112234	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)

LABOR FIRST

39-1263473

(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?
15	NONE	62980	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NEEDLES & ASSOCIATES LLC

51-0435869

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	53204	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)

NEW SOUTH CAPITAL MANAGEMENT

62-1237220

(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?
28 50	NONE	25830	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)

UNITED ACTUARIAL SERVICES, INC

11590 NORTH MERIDAN STREET
SUITE 610
CARMEL, IN 46032

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	6025	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"/>

(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
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation CASTLIGHT HEALTH 26-1989091	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. TO DEFRAY THE COSTS OF INFRASTRUCTURE CIGNA RECEIVED 3.24 PER PARTICIPANT.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation OMADA HEALTH, INC. 45-2355015	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. SUPPORT AT-RISK INDIVIDUALS APPROXIMATELY \$1.23 PER PARTICIPANTS.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation VISION SERVICE PLAN 06-1227840	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. VISION SERVICES APPROXIMATELY \$0.67	

Part I Service Provider Information (continued)

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

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

Part I Service Provider Information (continued)

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation JPMORGAN CHASE 59-1031071	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. EARNING CREDITS ON DAILY FUND FOR YEAR 2024 \$4.38 PER PARTICIPANTS RATE OF EARNINGS CREDIT AT 3.54%	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation CIGNA HELATHY REWARDS VENDOR 85-0437037	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. REWARD PROGRAM THAT OFFER DISCOUNT SERVICES FOR YEAR 2024 \$0.00 PMPY	
(a) Enter service provider name as it appears on line 2 CIGNA	(b) Service Codes (see instructions) 12 13 31 38 49 50 56 62	(c) Enter amount of indirect compensation 0
(d) Enter name and EIN (address) of source of indirect compensation OMADA COMPLETE 45-2355015	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. SERVICES FOR ENROLLMENT AND SCREENING PARTICIPANTS APPROXIMATELY \$0.17 PER PARTICIPANTS	

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 04/01/2024 and ending 03/31/2025	
A Name of plan U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES - U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 62-0637976

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	1689816	1851146
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1651995	881713
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	318533	659005
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	51293	1239271
(2) U.S. Government securities	1c(2)	7599572	8741157
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	796326	795552
(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)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	12107535	14167844
Liabilities			
g Benefit claims payable.....	1g	347334	433379
h Operating payables.....	1h	45394	81303
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	5877862	6260187
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	6270590	6774869
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	5836945	7392975

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)	9015553	
(B) Participants.....	2a(1)(B)	484190	
(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)		9499743
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	97975	
(B) U.S. Government securities.....	2b(1)(B)	161674	
(C) Corporate debt instruments.....	2b(1)(C)	41581	
(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)		301230
(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)		0
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	199760	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	201140	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		-1380
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	268066	
(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	219
d Total income. Add all income amounts in column (b) and enter total	2d	10067878

Expenses

e Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	6700878
(2) To insurance carriers for the provision of benefits	2e(2)	949809
(3) Other	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)	7650687
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)	589463
(3) Recordkeeping fees	2i(3)	
(4) IQPA audit fees	2i(4)	53204
(5) Investment advisory and investment management fees	2i(5)	34438
(6) Bank or trust company trustee/custodial fees	2i(6)	
(7) Actuarial fees	2i(7)	6025
(8) Legal fees	2i(8)	112234
(9) Valuation/appraisal fees	2i(9)	
(10) Other trustee fees and expenses	2i(10)	4477
(11) Other expenses	2i(11)	61320
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)	861161
j Total expenses. Add all expense amounts in column (b) and enter total	2j	8511848

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k	1556030
l Transfers of assets:		
(1) To this plan	2l(1)	
(2) From this plan	2l(2)	

Part III Accountant's Opinion

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

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

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

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

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

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

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

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

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		1000000
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 _____.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

FINANCIAL STATEMENTS
March 31, 2025 and 2024

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

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March 31, 2025 and 2024

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INDEPENDENT AUDITOR'S REPORT

Plan Participants and Board of Trustees
U.A. Local Union No. 614 Health and Welfare Fund
Goodlettsville, Tennessee

Opinion

We have audited the accompanying financial statements of the U.A. Local Union No. 614 Health and Welfare Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of March 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of the U.A. Local Union No. 614 Health and Welfare Fund as of March 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the U.A. Local Union No. 614 Health and Welfare Fund and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. 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 U.A. Local Union No. 614 Health and Welfare Fund's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Responsibilities of Management for the Financial Statements (continued)

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 auditors' 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 generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of U.A. Local Union No. 614 Health and Welfare Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about U.A. Local Union No. 614 Health and Welfare Fund's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and of reportable transactions, together referred to as "supplemental information," are presented for purposes of additional

analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

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

Needle & Associates, LLC

Broomfield, CO
December 11, 2025

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Statements of Net Assets Available for Benefits
March 31, 2025 and 2024**

	<u>2025</u>	<u>2024</u>
Assets		
Cash	\$ 1,851,146	\$ 1,689,816
Investments, at fair value		
Interest bearing cash	17,380	13,291
Money market	1,221,891	38,002
Government bonds	8,741,157	7,599,572
Corporate bonds	<u>795,552</u>	<u>796,326</u>
Total investments, at fair value	<u>10,775,980</u>	<u>8,447,191</u>
Receivables		
Employers' contributions	881,713	1,651,995
Accrued interest	53,411	46,457
Other receivables	<u>541,176</u>	<u>225,751</u>
Total receivables	<u>1,476,300</u>	<u>1,924,203</u>
Other assets		
Prepaid expenses	<u>64,418</u>	<u>46,325</u>
Total assets	<u>\$ 14,167,844</u>	<u>\$ 12,107,535</u>
Liabilities		
Accounts payable		
Operating	\$ 47,823	\$ 42,633
Due to other funds	<u>33,480</u>	<u>2,761</u>
Total liabilities	<u>\$ 81,303</u>	<u>\$ 45,394</u>
Net assets available for benefits	<u><u>\$ 14,086,541</u></u>	<u><u>\$ 12,062,141</u></u>

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

Statements of Changes in Net Assets Available for Benefits

Years Ended March 31, 2025 and 2024

	<u>2025</u>	<u>2024</u>
Additions		
Contributions		
Employers'	\$ 8,793,414	\$ 10,300,588
Participants'	484,190	502,472
Reciprocity in	222,139	237,741
Total contributions	<u>9,499,743</u>	<u>11,040,801</u>
Investment earnings		
Interest	301,230	202,820
Net appreciation (depreciation) fair value	266,686	97,255
Total investment earnings	<u>567,916</u>	<u>300,075</u>
Other income	219	-
Total additions	<u>\$ 10,067,878</u>	<u>\$ 11,340,876</u>
Deductions		
Benefit payments		
Self-funded claims paid, net	\$ 6,232,508	\$ 5,954,135
Insurance premiums paid	949,809	833,667
Total benefit payments	<u>7,182,317</u>	<u>6,787,802</u>
Operating expenses (Note H)	861,161	767,707
Total deductions	<u>\$ 8,043,478</u>	<u>\$ 7,555,509</u>
 Net increase (decrease)	 2,024,400	 3,785,367
Net assets available for benefits		
Beginning of year	<u>\$ 12,062,141</u>	<u>\$ 8,276,774</u>
 End of year	 <u>\$ 14,086,541</u>	 <u>\$ 12,062,141</u>

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Statements of Benefit Obligations
March 31, 2025 and 2024**

	<u>2025</u>	<u>2024</u>
<i>Other obligations for current benefit coverage, at present value of estimated amounts</i>		
Claims incurred but not reported	204,670	146,586
RX claims payable	228,709	200,748
Estimated future benefits based on participants accumulated eligibility	<u>6,260,187</u>	<u>5,877,862</u>
Total obligations other than postretirement benefit obligations	<u>\$ 6,693,566</u>	<u>\$ 6,225,196</u>
 <i>Postretirement benefit obligations(net of retiree self payments)</i>		
Current retirees	\$ 5,429,946	\$ 4,518,545
Other participants fully eligible for benefits	6,383,190	5,417,350
Other participants not yet fully eligible for benefits	<u>10,149,008</u>	<u>7,762,872</u>
Total accumulated postretirement benefit obligations	<u>\$ 21,962,144</u>	<u>\$ 17,698,767</u>
 Total benefit obligations	<u>\$ 28,655,710</u>	<u>\$ 23,923,963</u>

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Statements of Changes in Benefit Obligations
Years Ended March 31, 2025 and 2024**

	<u>2025</u>	<u>2024</u>
<i>Other obligations for current benefits</i>		
<i>at present value of estimated amounts</i>		
Balance at beginning of year	\$ 6,225,196	\$ 5,306,453
Net change during year:		
Claims incurred, but not reported	58,084	(118,414)
RX claims payable	27,961	126,090
Estimated future benefits based on participants accumulated eligibility	<u>382,325</u>	<u>911,067</u>
Balance at end of year	<u>\$ 6,693,566</u>	<u>\$ 6,225,196</u>
<i>Postretirement benefit obligations</i>		
Balance at beginning of year	\$ 17,698,767	\$ 16,606,288
Increase (decrease) during the year attributable to:		
Benefits earned and other changes	4,297,874	1,154,979
Interest	929,185	830,314
Plan amendments	-	(201,316)
Assumption changes	(119,751)	(691,498)
Estimated net benefits paid	<u>(843,931)</u>	<u>-</u>
Balance at end of year	<u>\$ 21,962,144</u>	<u>\$ 17,698,767</u>
Total benefit obligations	<u>\$ 28,655,710</u>	<u>\$ 23,923,963</u>

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

***Notes to Financial Statements
March 31, 2025 and 2024***

NOTE A - DESCRIPTION OF PLAN

The following description of the U.A. Local Union No. 614 Health and Welfare Fund (Plan) provides only general information. Participants should refer to the Trust Documents and Plan Documents for a complete description of the Plan's provisions.

- **General**

The Plan is a multiemployer defined benefit health plan formed in 1960 under an agreement between Local 614 of the United Association of Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada and Memphis Mechanical Contractors Association, Inc. and other Memphis mechanical, piping, and refrigeration contractors. The Plan provides health and other benefits to eligible participants and covered dependents. The Plan is administered by a Board of Trustees with equal representation between union and management.

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

The Plan has contracted with Southern Benefit Administrators, Inc. to manage daily operations and Raymond James as custodian of Plan assets.

- **Tax status**

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

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the Internal Revenue Service. Plan management has evaluated the Plan's tax positions and concluded that the Plan has taken no uncertain tax positions that would require financial statement recognition or disclosure for the years ended March 31, 2025 and 2024.

The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. With few exceptions, the Plan is no longer subject to tax examinations by tax authorities for years preceding March 31, 2021.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

***Notes to Financial Statements
March 31, 2025 and 2024***

NOTE A - DESCRIPTION OF PLAN (continued)

- **Funding**

The Plan is funded by employers' contributions in accordance with formulas set forth in the applicable Collective Bargaining Agreement(s). Additionally, the Plan has entered into reciprocity agreements with other health and welfare plans, whereby, eligibility may be continued for a participant working out of jurisdiction.

Under a Federal Law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), participants may elect to contribute a specified fixed amount, determined periodically by the Board of Trustees, to temporarily continue health coverage when there is a "qualifying event" that would result in loss of health coverage. The costs of postretirement benefits are shared by the Plan's participating employers and retirees.

- **Benefits**

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

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

The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. During the years ended March 31, 2025 and 2024, prescription drug rebates totaling \$736,208 and \$357,700 respectively, have been netted against benefit payments.

- **Stop-loss insurance**

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits of individual participant claims in excess of \$250,000, plus an aggregating deductible of \$219,990. During the year ended March 31, 2025 and 2024 the Plan received \$60,040 and \$0 in stop loss reimbursements.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

***Notes to Financial Statements
March 31, 2025 and 2024***

NOTE A - DESCRIPTION OF PLAN (continued)

- **Termination of the Plan**

Although it has not expressed any intention to do so, the Plan's Board of Trustees, as Sponsor, has the right under the Plan to modify the benefits provided to, and contributions required of, participants or to terminate the Plan subject to the provisions of ERISA. In the event of termination of the Plan, remaining assets, after payment of liabilities, will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants, including the transfer of said assets to another Plan established for the same general purpose. No assets of the Plan may revert to a contributing employer or be used for purposes other than for the exclusive benefit of the Plan's participants.

NOTE B - SUMMARY OF ACCOUNTING POLICIES

- **Basis of accounting**

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

- **Use of estimates**

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

- **Investment valuation and income recognition**

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's Board of Trustees determines the Plan's valuation policies utilizing information provided by its investment custodian and investment advisor.

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

- **Employers' contributions receivable**

Employers' contributions are recorded as income in the month the hours are worked. Employers' contributions receivable represents contributions applicable to work months prior to March 31, 2025 and 2024, but collected subsequent to those dates. Plan management believes these receivables to be fully collectible. The Board of Trustees has a policy of performing procedures on the payroll records of contributing employers on a regular basis. Delinquencies may arise from these procedures, but due to the uncertainty of collections, no estimates of amounts due will be accrued until settlements are reached. Consequently, no allowance for uncollectible receivables is recorded.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Notes to Financial Statements
March 31, 2025 and 2024**

NOTE B - SUMMARY OF ACCOUNTING POLICIES (continued)

- **Plan of continuing eligibility (hour bank liability)**

The Plan has established a plan of continuing eligibility under an "hour bank reserve" method. The Plan provides that participants accumulate rights to future benefits, after initial eligibility, when they work more than the one hundred forty (145) hours. One hundred thirty (130) hours are required to maintain current eligibility. The hour bank is drawn upon only when actual hours worked are insufficient to otherwise maintain eligibility. The maximum "hour bank reserve" is twelve months (1,560 hours) after deduction for the current month's coverage.

The liability for participants' future benefits is calculated by multiplying the additional months of eligibility in the "hour bank reserve" times the projected cost per eligible. This cost includes estimated insurance premiums, self-funded benefits, and cost of administration as projected by the Plan's consultant.

- **Claims incurred but not reported**

Plan obligations at March 31, 2025 and 2024 for claims incurred but not reported are estimated based on claims data provided by the Plan's benefit consultant. These amounts are paid by the Plan only if claims are submitted and approved for payment.

- **Payment of benefits**

Claim payments are recorded when paid by the third-party claim's processor.

- **Subsequent events**

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

NOTE C - POST RETIREMENT BENEFIT OBLIGATION

A postretirement benefit obligation has been recognized for retiree medical benefits for eligible participants and their dependents upon retirement. These benefit obligations represent the actuarial present value of the cost of those estimated future benefits that are attributed by the terms of the Plan to participant service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current retirees of the Plan. The obligations represent the amounts that are expected to be funded by contributions from participating employers and from existing assets of the Plan. Postretirement benefits include future benefits expected to be paid to or for (a) currently retired or terminated participants and their beneficiaries and dependents, and (b) active participants and their beneficiaries and dependents after retirement from service with participating employers.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

***Notes to Financial Statements
March 31, 2025 and 2024***

NOTE C - POST RETIREMENT BENEFIT OBLIGATION (continued)

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

The following change in Plan provisions were made for the Plan year.

- The discount rate was changed from 5.25% used last year to 5.50% used this year.
- Medical, drug, dental and self-payment trend rates were changed to reflect our best projection for future medical inflation.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported as postretirement benefit obligations. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of March 31, 2025 and 2024, by \$1,110,561 and \$922,936 respectively.

The following were other significant assumptions used to determine the postretirement benefit obligation as of March 31, 2025 and 2024:

- Administrative expenses are 5% addition to claim costs.
- The discount rate is 5.50%.
- For measurement purposes, a weighted-average annual rate of increase in the average per capita cost of covered health care benefits is assumed (medical 7.20%, drug 8.20%, dental 5.40%); the rates are assumed to decrease gradually to 4.0% and to remain at that level thereafter.

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

The Plan's deficiency of net assets over benefit obligations at March 31, 2025 and 2024, relates primarily to the postretirement benefit obligation, the funding of which is not covered by the contribution rate provided by the current collective bargaining agreements. It is expected that the deficiency will be funded through future increases in either the collective bargaining agreement or the self-payment rate.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

***Notes to Financial Statements
March 31, 2025 and 2024***

NOTE D - FAIR VALUE MEASUREMENTS

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

- Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
- Level 2 Inputs to the valuation methodology include:
- quoted prices for similar assets or liabilities in active markets;
 - quoted prices for identical or similar assets or liabilities in inactive markets;
 - inputs other than quoted prices that are observable for the asset or liability;
 - inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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

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

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

Interest bearing cash: Value of cash held in interest bearing accounts with FDIC insured banking institutions.

Government bonds: Valued using pricing models maximizing the use of observable inputs for similar securities.

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Notes to Financial Statements
March 31, 2025 and 2024**

NOTE D - FAIR VALUE MEASUREMENTS (continued)

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. When quoted prices are not available for identical or similar bonds, the bond is valued under a discounted cash flows approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks or a broker quote if available.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date. The Plan's investments have no unfunded commitment and can be redeemed at will by the Plan.

The following table sets forth by level, within the fair value hierarchy, the Plan's assets at fair value as of March 31, 2025 and 2024:

Assets at fair value as of March 31, 2025

Description	Level 1	Level 2	Level 3	Total
Interest bearing cash	17,380	-	-	17,380
Money market	1,221,891	-	-	1,221,891
Government bonds	-	8,741,157	-	8,741,157
Corporate bonds	-	795,552	-	795,552
Total investments at fair value	\$ 1,239,271	\$ 9,536,709	\$ -	\$ 10,775,980

Assets at fair value as of March 31, 2024

Description	Level 1	Level 2	Level 3	Total
Interest bearing cash	13,291	-	-	13,291
Money market	\$ 38,002	\$ -	\$ -	\$ 38,002
Government bonds	-	7,599,572	-	7,599,572
Total investments at fair value	\$ 51,293	\$ 8,395,898	\$ -	\$ 8,447,191

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Notes to Financial Statements
March 31, 2025 and 2024**

NOTE E - RISKS AND UNCERTAINTIES

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

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

NOTE F - PARTY-IN-INTEREST TRANSACTIONS

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

The Plan's third-party administrator and consultant, Southern Benefit Administrators, Inc., subcontracts United Actuarial Services, Inc. to provide the Plan's FASB ASC 965 Post-Employment Welfare Benefit Valuation.

NOTE G - RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2025</u>	<u>2024</u>
Per financial statements	\$ 14,086,541	\$ 12,062,141
Less: Claims incurred but not reported	(204,670)	(146,586)
Less: RX claims payable	(228,709)	(200,748)
Less: Hour bank liability	<u>(6,260,187)</u>	<u>(5,877,862)</u>
Per Form 5500	<u>\$ 7,392,975</u>	<u>\$ 5,836,945</u>

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

**Notes to Financial Statements
March 31, 2025 and 2024**

NOTE H - OPERATING EXPENSES

The following is a detailed summary of the Plan's operating expenses for the years ended March 31, 2025 and 2024:

	<u>2025</u>	<u>2024</u>
Third party administrator fees	\$ 216,489	\$ 216,186
PPACA fees	4,725	4,269
Network fees	372,974	317,380
Custodial fees	8,608	6,677
Investment management fees	25,830	19,172
Consulting fees	48,000	48,000
Actuary fees	6,025	6,975
Legal fees	112,234	96,059
Audit fees	53,204	38,191
Insurance - bonding premiums	8,047	11,590
Meeting - conference expenses	4,477	2,940
Fringe benefits	548	268
Total operating expenses	<u>\$ 861,161</u>	<u>\$ 767,707</u>

NOTE I - MEDICARE PART D SUBSIDY

The Medicare Prescription Drug Improvement and Modernization Act of 2003 has provisions for employers that sponsor postretirement health care plans that provide prescription drug benefits. The Plan has determined during the year ended March 31, 2025 and 2024 that the prescription drug coverage offered through the Plan, is on average for all participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Therefore, no subsidy will be applied for or received by the Plan.

NOTE J - AMENDMENTS

There were no amendments adopted during the Plan year.

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

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

EIN: 62-0637976, Plan Number 501

Form 5500, Schedule H, line 4i

Schedule of Assets (Held at End of Year)

March 31, 2025

(c) Description of investment including maturity date, rate of interest, collateral, par, or maturity value

(a)	(b) Identity of issue, borrower, lessor, or similar party	Maturity Date	Rate of Interest	Maturity Value	(d) Cost	(e) Current value
Money Market Fund						
	Interest bearing cash					
*	Invesco Short term Government & Agency F	N/A	0.050%	N/A	\$ 17,380	\$ 17,380
	Total interest bearing cash	N/A	0.050%	N/A	<u>\$ 1,221,891</u>	<u>1,221,891</u>
					<u>\$ 1,239,271</u>	<u>\$ 1,239,271</u>
Government and agency obligations						
	Federal Home Loan Bank	4/14/2025	0.500%	1,000,000	\$ 999,399	\$ 998,659
	Federal Home Loan Bank	6/30/2028	4.000%	1,000,000	988,199	1,001,635
	Federal Home Loan Bank	11/16/2028	3.250%	1,000,000	1,361,907	1,367,796
	Federal Home Loan Mtge Corp	9/23/2025	0.375%	1,000,000	1,354,271	1,349,408
	Federal Natl Mtge Assoc	4/24/2026	2.125%	1,000,000	1,377,185	1,371,986
	Federal Natl Mtge Assoc	9/24/2026	1.875%	1,000,000	1,353,532	1,357,463
	Federal Natl Mtge Assoc	10/8/2027	0.750%	1,000,000	<u>1,290,800</u>	<u>1,294,210</u>
	Total government and agency obligations				\$ 8,725,293	\$ 8,741,157
Corporate Bonds						
	Ares Capital Corp	3/1/2029	5.875%	200,000	\$ 198,599	\$ 202,878
	Fiserv Inc.	8/21/2028	5.375%	200,000	199,162	204,418
	Warnermedia Holdings	3/15/2029	4.054%	200,000	188,287	188,239
	Willis North America	6/15/2027	4.650%	200,000	<u>199,782</u>	<u>200,017</u>
	Total corporate bonds				\$ 785,830	\$ 795,552
					<u>\$ 10,750,394</u>	<u>\$ 10,775,980</u>

* Denotes party-in-interest

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

EIN: 62-0637976, Plan Number 501

Form 5500, Schedule H, line 4j

Schedule of Reportable Transactions

Year Ended March 31, 2025

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Raymond James Bank, N.A.	Invesco Short term Gov't Money	\$ 2,812,000	\$ -	-	-	\$ 2,812,000	\$ 2,812,000	-
Raymond James Bank, N.A.	Invesco Short term Gov't Money	-	1,666,100	-	-	1,666,100	1,666,100	-
Raymond James Bank, N.A.	Discovery Communication, 4.9%, 3/11/26	-	199,760	-	-	200,000	199,760	(240)
Raymond James Bank, N.A.	Federal Natl Mtge Assoc, 2.625%, 9/6/24	-	1,000,000	-	-	1,000,000	1,000,000	-

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

EIN: 62-0637976, Plan Number 501

Form 5500, Schedule H, line 4i

Schedule of Assets (Held at End of Year)

March 31, 2025

(a)	(b) Identity of issue, borrower, lessor, or similar party	Maturity Date	Rate of Interest	Maturity Value	(d) Cost	(e) Current value
Money Market Fund						
	Interest bearing cash					
*	Invesco Short term Government & Agency F	N/A	0.050%	N/A	\$ 17,380	\$ 17,380
	Total interest bearing cash				<u>\$ 1,239,271</u>	<u>\$ 1,239,271</u>
Government and agency obligations						
	Federal Home Loan Bank	4/14/2025	0.500%	1,000,000	\$ 999,399	\$ 998,659
	Federal Home Loan Bank	6/30/2028	4.000%	1,000,000	988,199	1,001,635
	Federal Home Loan Bank	11/16/2028	3.250%	1,000,000	1,361,907	1,367,796
	Federal Home Loan Mtge Corp	9/23/2025	0.375%	1,000,000	1,354,271	1,349,408
	Federal Natl Mtge Assoc	4/24/2026	2.125%	1,000,000	1,377,185	1,371,986
	Federal Natl Mtge Assoc	9/24/2026	1.875%	1,000,000	1,353,532	1,357,463
	Federal Natl Mtge Assoc	10/8/2027	0.750%	1,000,000	<u>1,290,800</u>	<u>1,294,210</u>
	Total government and agency obligations				\$ 8,725,293	\$ 8,741,157
Corporate Bonds						
	Ares Capital Corp	3/1/2029	5.875%	200,000	\$ 198,599	\$ 202,878
	Fiserv Inc.	8/21/2028	5.375%	200,000	199,162	204,418
	Warnermedia Holdings	3/15/2029	4.054%	200,000	188,287	188,239
	Willis North America	6/15/2027	4.650%	200,000	<u>199,782</u>	<u>200,017</u>
	Total corporate bonds				\$ 785,830	\$ 795,552
	Total assets (held at end of year)				<u>\$ 10,750,394</u>	<u>\$ 10,775,980</u>

* Denotes party-in-interest

U.A. LOCAL UNION NO. 614 HEALTH AND WELFARE FUND

EIN: 62-0637976, Plan Number 501

Form 5500, Schedule H, line 4j

Schedule of Reportable Transactions

Year Ended March 31, 2025

(a) Identity of party involved	(b) Description of asset (include interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expense incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Raymond James Bank, N.A.	Invesco Short term Gov't Money	\$ 2,812,000	\$ -	-	-	\$ 2,812,000	\$ 2,812,000	-
Raymond James Bank, N.A.	Invesco Short term Gov't Money	-	1,666,100	-	-	1,666,100	1,666,100	-
Raymond James Bank, N.A.	Discovery Communication, 4.9%, 3/11/26	-	199,760	-	-	200,000	199,760	(240)
Raymond James Bank, N.A.	Federal Natl Mtge Assoc, 2.625%, 9/6/24	-	1,000,000	-	-	1,000,000	1,000,000	-

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

- A This return/report is for: [x] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [x] D Check box if filing under: [x] Form 5558 [] automatic extension... 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.A. Local Union No. 614 Health and Welfare Fund
1b Three-digit plan number (PN): 501
1c Effective date of plan: 04/01/1960
2a Plan sponsor's name: Trustees - U.A. Local Union No. 614 Health and Welfare Fund
2b Employer Identification Number (EIN): 62-0637976
2c Plan Sponsor's telephone number: (615) 859-0131
2d Business code: 238220

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 signatures of Ben Snyder and David W. Sink Jr.

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

Form 5500 (2024) v. 240311