

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

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

**Part II Basic Plan Information—enter all requested information**

<b>1a</b> Name of plan <u>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</u>	<b>1b</b> Three-digit plan number (PN) ▶ <u>501</u>
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</u>  <u>1301 S COLUMBUS BLVD. 1ST FLOOR</u> <u>PHILADELPHIA, PA 19147</u>	<b>1c</b> Effective date of plan <u>06/28/1949</u>  <b>2b</b> Employer Identification Number (EIN) <u>23-1324693</u>  <b>2c</b> Plan Sponsor's telephone number <u>215-952-1990</u>  <b>2d</b> Business code (see instructions) <u>561110</u>

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

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

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	02/09/2026	THOMAS J. KLINGENBERG
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	3308
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	2037
	<b>6a(2)</b>	2046
	<b>6b</b>	1251
	<b>6c</b>	
	<b>6d</b>	3297
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	152

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

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

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> 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)

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

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

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**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.

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**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 \_\_\_\_\_

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<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

<p><b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-1324693</b></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  
**DELTA DENTAL OF PENNSYLVANIA**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1667011	54798	04187	848	05/01/2024	04/30/2025

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

<p><b>(a)</b> Total amount of commissions paid <b>809</b></p>	<p><b>(b)</b> Total amount of fees paid <b>0</b></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  
**DELAWARE VALLEY HEALTH CARE COLAITI 2980 SOUTHAMPTON RD PHILADELPHIA, PA 19154**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
809			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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	(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.

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

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	383689
<b>b</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.	<b>10b</b>	

**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><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

<p><b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶ <b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-1324693</b></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  
**STANDARD 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
93-0242990	69019	156753	2055	05/01/2024	04/30/2025

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

<p><b>(a)</b> Total amount of commissions paid <b>49130</b></p>	<p><b>(b)</b> Total amount of fees paid <b>0</b></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  
**WADE FINANCIAL INC. 1225 SCARLETT OAK DRIVE CHALFONT, PA 18914**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
49130			3

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

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

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

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

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(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	

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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.

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

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

**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:

<b>a</b> Premiums: (1) Amount received .....		<b>9a(1)</b>	416347
(2) Increase (decrease) in amount due but unpaid .....		<b>9a(2)</b>	-32416
(3) Increase (decrease) in unearned premium reserve .....		<b>9a(3)</b>	
(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	383931
<b>b</b> Benefit charges (1) Claims paid .....		<b>9b(1)</b>	265000
(2) Increase (decrease) in claim reserves .....		<b>9b(2)</b>	30405
(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	295405
(4) Claims charged .....		<b>9b(4)</b>	295405
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....		<b>9c(1)(A)</b>	49130
(B) Administrative service or other fees .....		<b>9c(1)(B)</b>	
(C) Other specific acquisition costs .....		<b>9c(1)(C)</b>	
(D) Other expenses .....		<b>9c(1)(D)</b>	44335
(E) Taxes .....		<b>9c(1)(E)</b>	7679
(F) Charges for risks or other contingencies .....		<b>9c(1)(F)</b>	27296
(G) Other retention charges .....		<b>9c(1)(G)</b>	
(H) Total retention .....		<b>9c(1)(H)</b>	128440
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
(2) Claim reserves .....		<b>9d(2)</b>	78660
(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>
<b>b</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. ....	<b>10b</b>

Specify nature of costs.

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b>	<b>D</b> Employer Identification Number (EIN) <b>23-1324693</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**DELTA DENTAL OF PENNSYLVANIA**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>23-1667011</b>	<b>54798</b>	<b>75381</b>	<b>224</b>	<b>05/01/2024</b>	<b>04/30/2025</b>

**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.

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
---	--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	54316
<b>b</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. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

<p><b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>23-1324693</b></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  
**BERKSHIRE HATHAWAY SPECIALTY 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
63-0202590	22276	47-MSL-000950-0	3297	05/01/2024	04/30/2025

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1787132
<b>b</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.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b>	<b>D</b> Employer Identification Number (EIN) <b>23-1324693</b>

**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  
**HEALTH CARE SERVICE CORPORATION**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>36-1236610</b>	<b>70670</b>	<b>NGL40611</b>	<b>1549</b>	<b>05/01/2024</b>	<b>04/30/2025</b>

**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.

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
---	--

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

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

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

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

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

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

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

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

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

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

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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
----------------	--

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

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	4094845
<b>b</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.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b>	<b>D</b> Employer Identification Number (EIN) <b>23-1324693</b>

**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  
**BLUE MEDI CARE ADVANTAGE**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>30-0326654</b>	<b>12812</b>	<b>PA003GRS</b>	<b>1540</b>	<b>05/01/2024</b>	<b>04/30/2025</b>

**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.

<b>(a)</b> Total amount of commissions paid <b>0</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
---	--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1724077
<b>b</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.	<b>10b</b>	

**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. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

<b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b>	<b>D</b> Employer Identification Number (EIN) <b>23-1324693</b>	

**Part I Service Provider Information (see instructions)**

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

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

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

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

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

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**(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

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

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

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

INDEPENDENCE BLUE CROSS

23-0370270

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	1206313	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)

SHEET METAL WORKERS LOC,#19 PENSION

23-1494364

(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 50	RELATED PARTY	1178083	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GUARDIAN NURSES

57-1187937

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	661816	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 LLC

06-1750191

(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?
53 50	NONE	634657	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)

BENECARD SERVICES INC

22-2998772

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	250873	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)

DELTA DENTAL OF PENNSYLVANIA

23-1667011

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	120851	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)

CONNER STRONG & BUCKELEW COMPANIES

21-0718159

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	114000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ALLIED TRADES ASSISTANCE PROGRAM

23-2591093

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50		72225	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)

BRIDGEWAY BENEFIT TECHNOLOGIES LLC

52-1796473

(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 50	NONE	13865	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	52658	Yes <input type="checkbox"/> No <input checked="" 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)

CHARTWELL INVESTMENT PARTNERS

23-2891243

(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 51	NONE	58717	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)

BOYD WATTERSON ASSET MGMT LLC

34-1922005

(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 52	NONE	52235	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)

SPEAR WILDERMAN,PC

23-2749511

(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	36359	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	8612	Yes <input type="checkbox"/> No <input checked="" 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)

NOVAK FRANCELLA, LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	39000	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	2658	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

SUSANIN, WIDMAN & BRENNAN, PC

23-2265950

(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	33780	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)

INVESTMENT PERFORMANCE SERVICES

58-2432392

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 51	NONE	32500	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)

DELAWARE VALLEY HEALTHCARE COALITIO

23-2813763

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53	NONE	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	23588	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

TD BANK, N.A.

01-0137770

(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 50	NONE	19909	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)

NATIONAL VISION ADMINISTRATORS

74-3033381

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	17853	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)

PRINCIPAL FINANCIAL GROUP, INC.

42-1520346

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 49 50	NONE	8015	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

KENNEDY PRINTING COMPANY INC

23-1699861

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	7424	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

**Part I Service Provider Information (continued)**

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
NOVAK FRANCELLA, LLC	10 50	2658
(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.	
SHEET METAL WORKERS LOCAL UN  23-1494364	ACCOUNTING FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
SPEAR WILDERMAN,PC	29 50	8612
(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.	
SHEET METAL WORKERS LOCAL UN  23-1494364	LEGAL FEES	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
DELAWARE VALLEY HEALTHCARE COALITIO	22 53	10498
(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.	
DELTA DENTAL OF PENNSYLVANIA  23-1667011	INSURANCE BROKERAGE COMMISSIONS	

**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
DELAWARE VALLEY HEALTHCARE COALITIO	49 73	13090

(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.	
BENECARD SERVICES INC  22-2998772	SERVICE FEE	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
BRIDGEWAY BENEFIT TECHNOLOGIES LLC	15 50	52658

(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.	
SHEET METAL WORKERS LOCAL UN  23-1494364	PROGRAMMING	

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation

(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE D</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>	<b>DFE/Participating Plan Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <hr/> <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning 05/01/2024 and ending 04/30/2025

<b>A</b> Name of plan <u>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</u>	<b>B</b> Three-digit plan number (PN)	<u>501</u>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</u>	<b>D</b> Employer Identification Number (EIN) <u>23-1324693</u>	

<b>Part I</b>	<b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b> (Complete as many entries as needed to report all interests in DFEs)
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<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>BNYM MELLON AFL-CIO SL STOCK INDEX</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>THE BANK OF NEW YORK MELLON</u>		
<b>c</b> EIN-PN <u>84-7064589-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>2798171</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)





<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>► File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>05/01/2024</b> and ending <b>04/30/2025</b>	
<b>A</b> Name of plan <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19</b>	<b>B</b> Three-digit plan number (PN) <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19</b>	<b>D</b> Employer Identification Number (EIN) <b>23-1324693</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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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
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	2248353	1868069
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	4128397	4947562
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	3023657	5207837
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	703750	496445
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>	5218715	4439401
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>	13844220	12865877
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	3414087	4039914
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>	2842316	2798171
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	35423495	36663276
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>	14489772	20062299
<b>h</b> Operating payables.....	<b>1h</b>	373525	509328
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>	237792	412586
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	15101089	20984213
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	20322406	15679063

**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.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	54146056	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	7073458	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		61219514
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	56217	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>	124009	
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>	477786	
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>	227578	
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		885590
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		
(3) Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	17231584	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	16068557	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>	399807	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		353864
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<b>c</b> Other income .....	<b>2c</b>		47514
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		64069316

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	57965423	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	8992415	
(3) Other .....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		66957838
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions) .....	<b>2g</b>		
<b>h</b> Interest expense .....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>		
(2) Contract administrator fees .....	<b>2i(2)</b>		
(3) Recordkeeping fees .....	<b>2i(3)</b>	2658	
(4) IQPA audit fees .....	<b>2i(4)</b>	39000	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	143452	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	8015	
(7) Actuarial fees .....	<b>2i(7)</b>	114000	
(8) Legal fees .....	<b>2i(8)</b>	78751	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>		
(11) Other expenses .....	<b>2i(11)</b>	1368945	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		1754821
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		68712659

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		-4643343
<b>l</b> Transfers of assets:			
(1) To this plan .....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**Part III Accountant's Opinion**

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

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

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

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

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

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

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

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

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> 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>b</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	
<b>c</b> 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	
<b>d</b> 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	
<b>e</b> Was this plan covered by a fidelity bond?	X		3000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> 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		4039914
<b>h</b> 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	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> 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		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

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

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> 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 \_\_\_\_\_.

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION NO. 19**

FINANCIAL STATEMENTS

APRIL 30, 2025

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION NO. 19**

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

APRIL 30, 2025 AND 2024

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the  
Sheet Metal Workers' Health Fund  
of Local Union No. 19

### Opinion

We have audited the financial statements of the Sheet Metal Workers' Health Fund of Local Union No. 19 (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of April 30, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

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

### Basis for Opinion

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

### Responsibilities of Management for the Financial Statements

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

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

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

### **Auditor's Responsibilities for the Audit of the Financial Statements**

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

In performing an audit in accordance with GAAS, we:

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

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

### **Report on Supplemental Information**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule of Assets Held at End of Year, Schedule of Reportable Transactions, and Schedules of Administrative Expenses, together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represent supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Supplemental information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

*Novak Francella LLC*

Bala Cynwyd, Pennsylvania  
February 10, 2026

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**

APRIL 30, 2025 AND 2024

ASSETS	<u>2025</u>	<u>2024</u>
INVESTMENTS - at fair value		
Corporate obligations	\$ 11,589,611	\$ 13,048,312
United States Government and Government		
Agency obligations	4,439,401	5,218,715
Mortgage - backed securities	1,276,266	795,908
Limited partnerships	4,039,914	3,414,087
Common collective trust	2,798,171	2,842,316
Money market mutual fund	496,445	558,684
Total investments	<u>24,639,808</u>	<u>25,878,022</u>
RECEIVABLES		
Employer contributions	4,947,562	4,128,397
Prescription rebate	1,890,170	1,436,425
Stop loss reimbursements	2,059,850	289,214
Accrued investment income	170,918	190,451
Total receivables	<u>9,068,500</u>	<u>6,044,487</u>
PREPAID EXPENSES	<u>-</u>	<u>24,567</u>
DEPOSIT WITH INSURANCE COMPANY	<u>1,086,899</u>	<u>1,083,000</u>
CASH	<u>1,868,069</u>	<u>2,393,419</u>
Total assets	<u>36,663,276</u>	<u>35,423,495</u>
LIABILITIES AND NET ASSETS		
LIABILITIES		
Due to related organizations	368,542	236,430
Accrued administrative expenses	509,328	373,525
Due to broker	44,044	1,362
Total liabilities	<u>921,914</u>	<u>611,317</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>\$ 35,741,362</u>	<u>\$ 34,812,178</u>

See accompanying notes to financial statements.

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**

YEARS ENDED APRIL 30, 2025 AND 2024

	2025	2024
<b>ADDITIONS</b>		
Investment income		
Net appreciation (depreciation) in fair value of investments	\$ 1,877,139	\$ (991,368)
Interest and dividends	925,149	1,362,372
	2,802,288	371,004
Less investment expenses	(151,467)	(176,126)
Investment income - net	2,650,821	194,878
 Contributions		
Employer contributions	54,146,056	48,863,694
Participant and COBRA contributions	7,073,458	7,032,195
Total contributions	61,219,514	55,895,889
 Miscellaneous income	47,514	34,863
 Total additions	63,917,849	56,125,630
 <b>DEDUCTIONS</b>		
Cost of benefits		
Self-insured benefits		
Medical	35,900,551	35,740,488
Prescription, net of rebates	11,998,000	11,101,384
Dental	2,002,647	1,810,221
Vision	561,909	601,341
Other	2,819,059	2,713,253
	53,282,166	51,966,687
Insured benefits		
Life insurance	383,731	383,917
Dental	353,408	319,451
Medicare plan	6,468,144	5,766,459
	7,205,283	6,469,827

See accompanying notes to financial statements.

	<u>2025</u>	<u>2024</u>
DEDUCTIONS (continued)		
Benefit provider administrative fees	\$ 1,595,890	\$ 1,895,011
Stop loss premiums	1,787,132	1,534,261
Less: Medicare Part D subsidy	-	(85,020)
Less: Stop loss reimbursements	<u>(2,485,160)</u>	<u>(1,496,841)</u>
Total cost of benefits	61,385,311	60,283,925
Regulatory fees and taxes	19,620	18,579
Administrative expenses	<u>1,583,734</u>	<u>1,528,068</u>
Total deductions	<u>62,988,665</u>	<u>61,830,572</u>
NET INCREASE (DECREASE)	929,184	(5,704,942)
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	<u>34,812,178</u>	<u>40,517,120</u>
End of year	<u>\$ 35,741,362</u>	<u>\$ 34,812,178</u>

See accompanying notes to financial statements.

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**STATEMENTS OF BENEFIT OBLIGATIONS**

APRIL 30, 2025 AND 2024

	2025	2024
<b>AMOUNTS CURRENTLY PAYABLE TO OR FOR</b>		
<b>PARTICIPANTS, BENEFICIARIES AND DEPENDENTS</b>		
Vision claims payable	\$ 61,435	\$ 53,844
Prescription claims payable	1,535,568	1,162,615
Dental claims payable	232,599	227,248
Health claims payable	10,618,323	5,316,143
Medical claims payable	103,454	109,617
Stop loss insurance payable	561,158	663,249
Claims incurred but not reported	6,949,762	6,957,056
Total amounts currently payable	20,062,299	14,489,772
 <b>POSTEMPLOYMENT BENEFIT OBLIGATIONS, NET OF</b>		
<b>AMOUNTS CURRENTLY PAYABLE</b>		
Accumulated eligibility credits	31,323,085	30,362,363
 Total obligations other than postretirement benefit obligations		
	51,385,384	44,852,135
 <b>POSTRETIREMENT BENEFIT OBLIGATIONS -</b>		
<b>net of amounts currently payable</b>		
Current retirees, beneficiaries and dependents	119,046,100	98,482,717
Other participants fully eligible for benefits	60,157,877	46,749,024
Other participants not fully eligible for benefits	25,931,135	21,059,689
Total postretirement benefit obligations	205,135,112	166,291,430
 <b>TOTAL BENEFIT OBLIGATIONS</b>	 <b>\$ 256,520,496</b>	 <b>\$ 211,143,565</b>

See accompanying notes to financial statements.

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

YEARS ENDED APRIL 30, 2025 AND 2024

	2025	2024
<b>AMOUNTS CURRENTLY PAYABLE TO OR FOR</b>		
<b>PARTICIPANTS, BENEFICIARIES AND DEPENDENTS</b>		
Balance at beginning of year	\$ 14,489,772	\$ 10,997,186
Increase (decrease) during the year attributable to changes in claims payable and claims incurred but not reported	5,572,527	3,492,586
Balance at end of year	20,062,299	14,489,772
<b>POSTEMPLOYMENT BENEFIT OBLIGATIONS,</b>		
<b>NET OF AMOUNTS CURRENTLY PAYABLE</b>		
Balance at beginning of year	30,362,363	29,605,177
Increase (decrease) during the year attributable to changes in accumulated eligibility credits	960,722	757,186
Balance at end of year	31,323,085	30,362,363
Total benefit obligations other than post-retirement benefit obligations	51,385,384	44,852,135
<b>POSTRETIREMENT BENEFIT OBLIGATIONS -</b>		
<b>net of amounts currently payable</b>		
Balance at beginning of year	166,291,430	185,549,979
Increase (decrease) during the year attributable to		
Changes in actuarial assumptions and (gain) loss	36,478,543	(21,028,547)
Benefits earned	2,339,447	1,979,437
Passage of time	11,543,872	9,367,181
Benefits paid	(11,518,180)	(9,576,620)
Balance at end of year	205,135,112	166,291,430
<b>TOTAL BENEFIT OBLIGATIONS</b>	<b>\$ 256,520,496</b>	<b>\$ 211,143,565</b>

See accompanying notes to financial statements.

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION NO. 19**

**NOTES TO FINANCIAL STATEMENTS**

APRIL 30, 2025 AND 2024

**NOTE 1. DESCRIPTION OF PLAN**

The following description of the Plan provides only general information. Participants should refer to the Summary Plan Description for a more complete description of the Plan's provisions; copies of this book are available from the Plan administrators. In addition, a copy of any collective bargaining agreement may be obtained upon written request to the Plan administrator.

The Plan provides health and death benefits covering substantially all members of Local Union No. 19 and their dependents. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan provides health and death benefits (hospital, surgical, major medical, dental and long-term disability) covering, initially, employees of contributing employers on the first day of the month following a period of six consecutive calendar months in which they have worked 680 hours (480 hours for Sign Industry workers), and on a continuing basis provided a covered employee works 180 hours (96 hours for Sign Industry workers) or more for a contributing employer in any three month period. The Plan also provides health benefits to certain active and retired members if they have accumulated, in the current year or prior years, credit amounts in excess of hours required for current coverage.

The Plan Agreement between Local Union No. 19 and the Sheet Metal Workers' International Association, the Roofing and Sheet Metal Contractors' Association of Philadelphia and Vicinity and the Sheet Metal Contractors' Association of Central Pennsylvania and Delaware Contractors' Association provides that contribution made to the Plan of a specified amount for each hour worked to provide benefits for employees. A member may contribute specified amounts as determined by the Plan's management to continue coverage in the event of termination or retirement if the member meets certain conditions as stated in the Plan Agreement.

**NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

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

**Investments and Income Recognition** - Investments in common stock, corporate obligations, United States Government and Government Agency obligations, mortgage - backed securities - corporate, and money market mutual funds are carried at fair value as provided by the investment custodian, which generally represents quoted market price as of the last business day of the year or valued using pricing models maximizing the use of observable inputs for similar securities. The limited partnerships and common collective trust are carried at net asset value (NAV) as provided by the Partnership and Trust.

## **NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)**

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

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

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

The CBA empowers the President/Business Manager of Local Union No. 19, in recognition of the serious nonunion competition and infringement upon the Local's jurisdiction by other crafts, to take steps necessary, including additional flexible conditions on particular jobs sometimes known as "Pinpointing", to enter into specialty agreements and addendums to the CBA to ensure that such work is captured for the Local's membership. During the year ended April 30, 2025, 755,157 hours were reported to the Plan for which a portion of contributions were waived under this provision of the CBA. The waived contributions totaled \$5,503,002.

**Payment of Benefits** - Claims payments and insurance premiums are recorded in the accompanying statement of changes in net assets available for benefits when paid by the Plan. Amounts for insurance premiums and claims due that have yet to be paid by the Plan are recorded as premiums and claims payable in the accompanying statement of benefit obligations.

**Refunds** - Refunds due from the Plan's pharmacy benefit manager (PBM) are recorded when earned. Refunds due as of the financial statement date have been reported as receivable to the extent this information is available with the offset being netted against prescription claims. Pharmacy rebates totaling \$3,228,049 and \$2,586,487, respectively, have been netted with prescription claims in the accompanying statements of changes in net assets available for benefits for the years ended April 30, 2025 and 2024.

**Benefit Obligations** - Claims incurred but not reported and accumulated eligibility liabilities are determined by the Plan's consultant based on claims experience. These amounts are paid by the Plan only if claims are submitted and approved for payment.

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

**Stop Loss Coverage** - The Plan has entered into a stop loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims). Stop loss refunds have been netted with claims paid in the accompanying statements of changes in net assets.

**NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)**

**Reclassifications** - Certain reclassifications have been made to prior year amounts to conform to current year presentation.

**NOTE 3. PRIORITIES UPON TERMINATION**

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

**NOTE 4. TAX STATUS**

The Plan obtained its latest determination letter, dated March 22, 1978, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements under Section 501(c)(9) of the Internal Revenue Code and was, therefore, not subject to tax under present Federal income tax laws. The Plan has been amended since receiving the determination letter. The Plan's Trustees and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

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

**NOTE 5. DEPOSIT WITH HEALTH INSURANCE COMPANY**

Independence Blue Cross holds a Plan deposit totaling \$1,086,899 and \$1,083,000 at April 30, 2025 and 2024, respectively.

## NOTE 6. FAIR VALUE MEASUREMENTS

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

### Basis of Fair Value Measurement:

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

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

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

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

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

	Fair Value Measurements at April 30, 2025			
	Total	Level 1	Level 2	Level 3
United States Government and Government Agency obligations	\$ 4,439,401	\$ 3,127,213	\$ 1,312,188	\$ -
Corporate obligations	11,589,611	-	11,589,611	-
Mortgage-backed securities - corporate	1,276,266	-	1,276,266	-
Money market mutual fund	496,445	496,445	-	-
Total assets in the fair value hierarchy	17,801,723	<u>\$ 3,623,658</u>	<u>\$ 14,178,065</u>	<u>\$ -</u>
Investments measured of NAV	<u>6,838,085</u>			
Total investments	<u>\$ 24,639,808</u>			

**NOTE 6. FAIR VALUE MEASUREMENTS (continued)**

	Fair Value Measurements at April 30, 2024			
	Total	Level 1	Level 2	Level 3
United States Government and Government Agency obligations	\$ 5,218,715	\$ 4,048,152	\$ 1,170,563	\$ -
Corporate obligations	13,048,312	-	13,048,312	-
Mortgage-backed securities - corporate	795,908	-	795,908	-
Money market mutual fund	558,684	558,684	-	-
Interest-bearing cash	-	-	-	-
Total assets in the fair value hierarchy	19,621,619	<u>\$ 4,606,836</u>	<u>\$ 15,014,783</u>	<u>\$ -</u>
Investments measured of NAV	<u>6,256,403</u>			
Total investments	<u>\$ 25,878,022</u>			

In accordance with Subtopic 820 -10 certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statement of net assets available for benefits.

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

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

The unfunded commitments, redemption, and redemption notice period information are as follows at April 30, 2025 and 2024:

	2025 Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
Common collective trust				
BNY Mellon AFL-CIO	\$ 2,798,171	\$ -	Daily	1 day
Limited partnership - real estate:				
Boyd Watterson State Government L.P.	1,241,448	-	Quarterly	60 days
Boyd Watterson GSA Fund L.P.	<u>2,798,466</u>	<u>-</u>	(a)	(a)
	<u>\$ 6,838,085</u>	<u>\$ -</u>		

**NOTE 6. FAIR VALUE MEASUREMENTS (continued)**

	<u>2024 Fair Value</u>	<u>Unfunded Commitments</u>	<u>Redemption Frequency</u>	<u>Redemption Notice Period</u>
Common collective trust				
BNY Mellon AFL-CIO	\$ 2,842,316	\$ -	Daily	1 day
Limited partnership - real estate:				
Boyd Watterson State Government L.P.	1,343,931	-	Quarterly	60 days
Boyd Watterson GSA Fund L.P.	<u>2,070,156</u>	<u>-</u>	(a)	(a)
	<u>\$ 6,256,403</u>	<u>\$ -</u>		

- (a) Each Limited Partner may request that the Partnership redeem some or all of its Units it desires to redeem at least sixty days prior to a calendar quarter end. Unless waived by the General Partner, partial redemptions of Units shall only be permitted in increments of \$250,000 and shall not be permitted for amounts less than \$250,000. Unless the notice period is waived by the General Partner, each redemption notice will become effective upon the 60<sup>th</sup> day following delivery of the redemption notice to the General Partner.

The Boyd Watterson GSA Fund L.P., a Delaware limited partnership, was formed on August 16, 2013 to acquire, develop, own and operate a diversified portfolio of real estate investments in commercial property. The Fund's objective is to generate a stable stream of investment grade current income while also preserving wealth using risk parameters and portfolio management strategies established by the General Partner. The Fund intends to meet this objective through the purchase of real estate assets that are primarily leased to the Federal Agencies for remaining terms of at least seven years on a weighted average basis in length.

**NOTE 7. MULTIEMPLOYER DEFINED BENEFIT PENSION PLANS**

The Sheet Metal Workers' Pension Fund of Local Union No. 19 (the Pension Fund) and the Sheet Metal Workers' Health Fund of Local Union No. 19 (the Health Fund), under the terms of a collective bargaining agreement that covers its collectively bargained employees, participate in three multiemployer defined benefit pension plans. The Pension Fund remits the contributions to the multiemployer defined benefit pension plans on behalf of the Sheet Metal Workers Benefit Funds for the shared employees. The Health Fund, Annuity Fund, and the Supplemental Unemployment Benefit (S.U.B.) Fund reimburse the Pension Fund for their share of the contributions based on a cost allocation study. The risks of participating in a multiemployer defined benefit pension plan are different from a single-employer plan in the following aspects:

- a. Assets contributed to the multiemployer defined benefit pension plan by one employer may be used to provide benefits to employees of other participating employers.
- b. If a participating employer stops contributing to the multiemployer defined benefit pension plan, the unfunded obligations of the multiemployer defined benefit pension plan may be borne by the remaining participating employers.

**NOTE 7. MULTIEMPLOYER DEFINED BENEFIT PENSION PLANS (continued)**

- c. If the Benefit Funds choose to stop participating in any of its multiemployer defined benefit pension plans, the Benefit Funds may be required to pay those multiemployer defined benefit pension plans an allocated amount based on the underfunded status of those multiemployer defined benefit pension plans, referred to as a withdrawal liability.

The Benefit Funds participation in these multiemployer defined benefit pension plans for the annual periods ended April 30, 2025 and 2024 is outlined in the table below. The zone status is based on information that the Benefit Funds received from the multiemployer defined benefit pension plan and is certified by the multiemployer defined benefit pension plan's actuary. Among other factors, pension plans in the red zone are generally less than 65 percent funded, pension plans in the yellow zone are less than 80 percent funded, and pension plans in the green zone are at least 80 percent funded.

Legal Name of Pension Plans	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Pension Protection Act Zone Status				Expiration Date of Collective Bargaining Agreement
			Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	
Sheet Metal Workers' Pension Fund of Local Union No. 19	23-1494364	001	Green as of 05/01/25	No	Green as of 05/01/24	No	04/30/25
SMART Local Unions and Councils Pension Fund	87-4825609	333	Green as of 12/01/24	No	Green as of 12/01/23	No	*

\* Employees of the Sheet Metal Workers Local 19 Benefit Funds participate in the SMART Local Unions and Councils Pension Fund through a participation agreement that does not have an expiration date.

Legal Name of Pension Plans	Contribution paid by the Health Fund directly to the Pension Plans		Contributions to the Pension Plans greater than 5% of total Pension Plan contributions (Plan year ending)		Employer Contribution Rates of the Pension Plans		Number of Employees Covered by the Pension Plans for which the Health Fund contributes directly to Pension Fund.	
	4/30/2025	4/30/2024	4/30/2025	4/30/2024	4/30/2025	4/30/2024	4/30/2025	4/30/2024
Sheet Metal Workers' Pension Fund of Local Union No. 19	\$ -	\$ -	No, Plan year ending 04/30/24.	No, Plan year ending 04/30/24.	\$8.33 - \$16.65 per hour	\$8.33 - \$16.65 per hour	0	0
SMART Local Unions and Councils Pension Fund	-	-	No, Plan year ending 04/30/24.	No, Plan year ending 04/30/24.	17% of gross wages	17% of gross wages	0	0
Total contributions to Pension Plans	\$ -	\$ -						

The Plan reimbursed the Pension Fund \$111,416 and \$118,476 during the years ended April 30, 2025 and 2024, respectively, for the Plan's allocated share of the pension contributions for shared employees participating in the Sheet Metal Workers' Pension Fund of Local Union No. 19.

**NOTE 7. MULTIEMPLOYER DEFINED BENEFIT PENSION PLANS (continued)**

The Plan reimbursed the Pension Fund \$28,477 and \$30,406 during the years ended April 30, 2025 and 2024, respectively, for the Plan’s allocated share of the pension contributions for shared employees participating in the SMART Local Unions and Councils Pension Fund.

Legal Name of Pension Plans	Funding Improvement Plan or Rehabilitation Plan Implemented or Pending?	Surcharge paid to Pension Plan by the Benefit Funds?	Minimum contributions required in future by CBA, statutory requirements, or other contractual requirements.	
			No?	If yes, description
Sheet Metal Workers' Pension Fund of Local Union No. 19	Yes	No	No	N/A
SMART Local Unions and Councils Pension Fund	No	No	No	N/A

**NOTE 8. MULTIEMPLOYER PLAN THAT PROVIDES POSTRETIREMENT BENEFITS OTHER THAN PENSIONS**

The Benefit Funds contribute to a multiemployer defined benefit health and welfare plan that provides postretirement benefits for its collectively bargained employees during the years ended April 30, 2025 and 2024. The Pension Fund remits the contributions to the multiemployer health and welfare plan that provides postretirement benefits for the shared employees on behalf of the Benefit Funds. The Health Fund, Annuity Fund, and the S.U.B. Fund reimburse the Pension Fund for their share of the contributions based on a cost allocation study. Information about the health and welfare plan is below:

Legal Name of Plan providing postretirement benefits other than pension	Contribution paid by the Health Fund directly to the Plans		Employer contribution rates of the Plan		Number of employees covered by the Plan for which the Health Fund contributes directly to the Plan	
	4/30/2025	4/30/2024	4/30/2025	4/30/2024	4/30/2025	4/30/2024
Sheet Metal Workers' Health Fund of Local Union No. 19*	\$ -	\$ -	\$15.85 per hour	\$14.85 per hour	0	0

The Plan reimbursed the Pension Fund \$180,007 and \$177,459 during the years ended April 30, 2025 and 2024, respectively, for the Plan’s allocated share of the health and welfare contributions for shared employees participating in the Sheet Metal Workers’ Health Fund of Local Union No.19.

\* The Plan provides postretirement health benefits (medical, hospital, surgical, major medical, organ transplant, vision, and prescription drug), disability, death benefits, and accidental death and dismemberment benefits for eligible participants and their spouses, beneficiaries, and covered dependents.

## **NOTE 9. RELATED PARTY TRANSACTIONS**

The Plan has common Trustees and shares office facilities and staff with the Sheet Metal Workers' International Association Local Union No. 19 Benefit Funds. The operating expenses of the common facilities and staff are paid by the Pension Fund. During the years ended April 30, 2025 and 2024, the Plan reimbursed the Pension Fund \$1,310,195 and \$1,291,508, respectively, for these expenses. At April 30, 2025 and 2024, the Plan owed \$368,542 and \$237,216, respectively, to the Pension Fund for shared operating expenses. At April 30, 2024, the Plan was owed \$786 from the Pension Fund for non-allocated administrative expenses.

The Plan did not owe the Master Fund any money at April 30, 2025 and 2024.

Certain plan investments are shares of mutual funds managed by Wells Fargo. Wells Fargo is the investment custodian, and therefore these transactions qualify as party-in-interest transactions. These transactions have been denoted as such on the supplemental schedules of assets held for investment purposes at end of year and reportable transactions.

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

## **NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS**

The postretirement benefit obligations represent the actuarial present value of those estimated future benefits that are attributed to participants' service rendered to April 30, 2025 and 2024. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired participants and their beneficiaries and dependents, and (2) active participants and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service rendered to the valuation date.

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

The benefit obligations were calculated using the Projected Unit Credit Cost Method.

The following were significant assumptions used in the valuations as of April 30, 2025 and 2024:

Discount rate:	5.79% and 5.80% at April 30, 2025 and 2024, respectively
Mortality:	RP-2014 Combined Healthy with Blue Collar Adjustment

**NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)**

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

<u>Age</u>	<u>Probability of Retirement</u>
55-61	20%
62	50%
63-65	40%
66-69	20%
70 and older	100%

Disability Incidence Rates Varying by Age as Illustrated for 2025 and 2024:

<u>Age</u>	<u>Unisex Rates</u>
20	0.060 %
25	0.085 %
30	0.110 %
35	0.147 %
40	0.220 %
45	0.360 %
50	0.606 %
55	1.009 %
60	1.627 %
65	- %

Family Composition Costs for retired participants with family coverage were based on the assumption that the family unit consists of the retiree and spouse only.

Participation Rate 80% of all participants (pre-Medicare and Medicare) are assumed to elect post-retirement coverage.

The effects of the following changes are included in the postretirement benefit obligation calculation as of April 30, 2025:

- 1) The discount rate decreased from 5.80% to 5.79%.
- 2) The increase is primarily driven by the increase in post-65 retiree costs.

**Claim Cost and Trend Rate**

The claim cost assumptions were based on the actual claims in the 2024-2025 plan years. The trend rate was based on 7% in year 1 trending down to an ultimate rate of 4.5% at 0.25% per year.

## NOTE 10. POSTRETIREMENT BENEFIT OBLIGATIONS (continued)

### Retiree Contributions

The retiree contribution amount for current retirees is based on the actual premium paid in the 2024-2025 plan year. The pre-65 retiree contribution amount for future retirees was based on the rates of \$556 per month as of April 30, 2025 and 2024 for employees who have not obtained both the age of fifty-five and thirty-five years of service. The contribution rate for post-65 retirees was \$346 at April 30, 2025 and 2024. Contributions are assumed to increase 5% per year.

The healthcare cost-trend rate has a significant effect on the amounts reported. If the assumed rate increased by one percentage point, that would increase the postretirement obligations as of April 30, 2025 and 2024, by \$31,952,093 and \$24,881,911, respectively.

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

## NOTE 11. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2025</u>	<u>2024</u>
Net assets available for benefits as reported on the financial statements	\$ 35,741,362	\$ 34,812,178
Benefit obligations currently payable and claims incurred but not reported	<u>(20,062,299)</u>	<u>(14,489,772)</u>
Net assets available for benefits as reported on Form 5500	<u>\$ 15,679,063</u>	<u>\$ 20,322,406</u>

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

Benefits paid to or for participants per the financial statements	\$ 61,385,311
Add: Amounts currently payable and claims incurred but not reported - 2025	20,062,299
Less: Amounts currently payable and claims incurred but not reported - 2024	<u>(14,489,772)</u>
Total benefits as reported on Form 5500	<u>\$ 66,957,838</u>

Claims payable and claims incurred but not reported are included in the Statements of Benefit Obligations in the financial statements but are included as liabilities on Form 5500.

#### **NOTE 12. RISKS AND UNCERTAINTIES**

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and sector risks. Due to the level of risk associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the 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 initiation rates, and participant demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

#### **NOTE 13. CASH CONCENTRATIONS**

The Plan maintains its cash with one financial institution deemed to be credit worthy. The balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. As of April 30, 2025, cash on deposit with TD Bank totaling \$2,393,419 exceeded the FDIC insured limit of \$250,000 in a single bank by \$1,618,069.

#### **NOTE 14. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

The Plan is subject to certain fees mandated by the Patient Protection and Affordable Care Act. Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are equal to \$2 per covered life for the 2013 calendar year and thereafter, the fee will be indexed based on increases in the projected per capita amount of national health expenditures. For the years ended April 30, 2025 and 2024, the Plan paid \$19,620 and \$18,579, respectively, in PCORI fees.

#### **NOTE 15. SUBSEQUENT EVENTS**

The Plan has evaluated subsequent events through February 10, 2026, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

## **SUPPLEMENTAL INFORMATION**

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**SCHEDULES OF ADMINISTRATIVE EXPENSES**

YEARS ENDED APRIL 30, 2025 AND 2024

	2025	2024
Professional fees		
Accounting, auditing, and government filings	\$ 39,000	\$ 39,025
Benefit consultant	114,000	111,000
Legal	70,139	68,903
Office and data processing		
Printing expense	7,424	7,101
Bank fees	19,909	21,189
Programming	15,348	12,067
Insurance	5,567	5,567
Phone	2,152	-
Other		
Expense reimbursements to related organizations	1,310,195	1,263,216
Total administrative expenses	\$ 1,583,734	\$ 1,528,068

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION NO. 19**

**SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES**

APRIL 30, 2025

Form 5500, Schedule H, Line 4i

EIN: 23-1324693

Plan No. 501

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
<u>United States Government and Government Agency obligations:</u>						
Federal Home Loan Bank	Note	117,000	1.000 %	03/23/26	\$ 117,000	\$ 113,837
Federal Home Loan Bank	Note	110,000	1.150	10/26/26	110,000	105,707
Federal Home Loan Bank	Note	130,000	1.500	11/23/26	130,000	125,435
FFCB	Note	150,000	5.100	09/12/31	150,000	150,075
FFCB	Note	75,000	4.300	05/17/32	75,000	73,340
FFCB	Note	85,000	4.980	07/20/32	85,000	84,721
FHLB	Note	105,000	4.540	04/17/30	105,000	105,048
FHLB	Note	165,000	5.000	04/21/30	165,000	165,182
FNMA	Note	80,000	4.125	08/28/25	80,000	79,903
United States Treasury	Note	215,000	0.625	05/15/30	171,683	184,498
United States Treasury	Note	295,000	1.125	02/15/31	280,835	254,485
United States Treasury	Note	315,000	1.375	11/15/31	271,421	269,190
United States Treasury	Note	315,000	2.750	08/15/32	286,273	290,896
United States Treasury	Note	270,000	4.500	11/15/33	280,018	278,289
United States Treasury	Note	300,000	1.625	09/30/26	291,840	291,375
United States Treasury	Tips	141,243	0.125	04/15/27	125,706	139,242
United States Treasury	Note	95,000	2.375	05/15/27	90,476	92,710
United States Treasury	Inde	152,287	1.750	01/15/28	143,827	155,398
United States Treasury	Note	430,000	1.125	08/31/28	378,819	396,641
United States Treasury	Note	460,000	3.250	06/30/29	443,540	452,563
United States Treasury	Tips	278,468	1.125	01/15/33	250,962	265,346
United States Treasury	Tips	55,601	2.125	01/15/35	56,269	56,580
VR Fed Home Ln Bk	Note	175,000	1.250	03/17/31	175,000	162,608
VR Fed Home Ln Bk	Note	165,000	2.000	01/27/32	165,000	146,332
Total United States Government and Government Agency obligations					4,428,669	4,439,401
<u>Corporate obligations:</u>						
Accenture Capital	Bond	40,000	3.900	10/04/27	39,948	39,960
Albertons	Bond	180,000	3.250	03/15/26	178,531	176,650
Albertons	Bond	15,000	4.625	01/15/27	14,704	14,830
American Airlines	Bond	110,000	5.500	04/20/26	108,212	109,267
American Airlines	Bond	70,000	5.750	04/20/29	69,091	67,893
Amgen Inc	Bond	80,000	5.250	03/02/33	80,008	80,843
Anheuser-Busch Inbev	Bond	40,000	3.500	06/01/30	39,850	38,408
Anthem Inc	Bond	75,000	3.650	12/01/27	72,900	73,793
Aph/Aph2/Aph3/Aq	Bond	75,000	7.875	11/01/29	73,444	73,199
Ares Capital Corp	Bond	155,000	3.250	07/15/25	152,223	154,499
Ares Capital Corp	Bond	110,000	3.875	01/15/26	107,891	109,137

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	<u>Corporate obligations (continued):</u>					
Bank Of America Mtn V-d	Bond	65,000	6.204 %	11/10/28	\$ 68,657	\$ 67,661
Bank Of America V	Bond	75,000	5.321	09/15/26	70,713	74,920
Blackrock Funding	Bond	20,000	4.600	07/26/27	19,999	20,266
Blackrock Funding	Bond	65,000	4.700	03/14/29	64,987	66,421
Boyd Gaming Corp	Bond	210,000	4.750	12/01/27	198,176	205,689
Brinks Co	Bond	75,000	4.625	10/15/27	73,519	73,825
Brinks Co	Bond	105,000	6.500	06/15/29	106,791	106,972
Brixmor Operating	Bond	90,000	5.200	04/01/32	89,784	89,946
Caesars Entmt Inc	Bond	50,000	7.000	02/15/30	50,213	51,182
Centene Corp	Bond	160,000	4.250	12/15/27	147,904	156,354
Clearway Energy	Bond	125,000	4.750	03/15/28	121,650	122,162
Cleveland Cliffs Inc	Bond	20,000	6.875	11/01/29	20,000	19,371
Comcast Corp	Bond	105,000	4.250	10/15/30	113,754	103,755
Comcast Corp	Bond	150,000	4.150	10/15/28	151,174	149,617
Crown Amer/Cap Corp	Bond	210,000	4.750	02/01/26	206,258	208,780
CVS Health Corp	Bond	115,000	3.250	08/15/29	112,806	108,356
Darling Ingredients	Bond	40,000	6.000	06/15/30	39,419	39,887
Duke Energy Car	Bond	145,000	4.850	01/15/34	142,119	143,341
Energy Transfer Lp	Bond	35,000	5.200	04/01/30	34,932	35,341
ESAB Corporation	Bond	190,000	6.250	04/15/29	191,140	192,780
Extra Space Storage	Bond	85,000	2.200	10/15/30	77,291	74,283
Fortress Trans	Bond	215,000	5.500	05/01/28	203,824	211,143
General Motors Finl	Bond	50,000	5.650	01/17/29	50,721	50,647
Genting New York LLC	Bond	80,000	7.250	10/01/29	80,362	79,946
Georgia Power Co	Bond	60,000	5.004	02/23/27	59,860	60,925
GGAM Finance Ltd	Bond	130,000	7.750	05/15/26	130,000	131,462
GLP Capital LF / Fin	Bond	205,000	5.375	04/15/26	200,824	204,449
Hat Holdings I	Bond	195,000	3.375	06/15/26	183,405	189,169
Hat Holdings I LLC	Bond	20,000	8.000	06/15/27	20,000	20,542
Healthpeak Propertie	Bond	15,000	2.875	01/15/31	14,247	13,475
Herc Holdings	Bond	130,000	6.625	06/15/29	131,169	128,430
Herc Holdings In	Bond	80,000	5.500	07/15/27	79,621	79,103
Hess Midstream	Bond	90,000	5.125	06/15/28	88,712	88,109
Hess Midstream Operation	Bond	70,000	5.875	03/01/28	70,238	70,147
Hewlett Packard Ente	Bond	70,000	5.000	10/15/34	69,351	67,583
Hilton Domestic	Bond	15,000	5.750	05/01/28	14,944	15,010
Hilton Worldwide Fin	Bond	180,000	4.875	04/01/27	178,851	179,336
Icahn Enterprises/Fi	Bond	66,000	6.250	05/15/26	63,780	65,754
Icahn Enterprises/Fi	Bond	120,000	5.250	05/15/27	111,331	113,790
Intercontin Exchange	Bond	45,000	4.600	03/15/33	44,321	44,249
International Ga	Bond	210,000	6.250	01/15/27	212,895	210,979
Jazz Securities	Bond	220,000	4.375	01/15/29	204,361	208,784
Jefferies Fin Group	Bond	55,000	6.200	04/14/34	54,939	55,732
Jefferies Fin Group	Bond	45,000	5.875	07/21/28	44,773	46,182
Jefferies Group Mtn	Bond	65,000	5.000	02/10/26	65,000	65,091
Jp Morgan Chase V-q	Bond	20,000	5.103	04/22/31	20,000	20,362
Kinetik Holdings LP	Bond	205,000	6.625	12/15/28	206,885	206,499
Lincoln National Cor	Bond	45,000	3.400	01/15/31	42,208	41,450
Morgan Stan Mtn	Bond	70,000	5.656	04/18/30	73,077	72,404
Morgan Stanley	Bond	75,000	4.210	04/20/28	73,086	74,594
Onemain Finance Corp	Bond	150,000	3.500	01/15/27	139,606	143,607

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	<u>Corporate obligations (continued):</u>					
Onemain Finance Corp	Bond	10,000	3.875	% 09/15/28	\$ 9,237	\$ 9,254
Oracle Corp	Bond	65,000	6.250	11/09/32	65,974	69,317
Owl Rock Capital Cor	Bond	115,000	3.400	07/15/26	111,051	111,777
Park Intermed	Bond	100,000	5.875	10/01/28	98,574	97,586
Park Intermed	Bond	115,000	4.875	05/15/29	108,869	107,660
Phillip Morris In	Bond	65,000	5.625	09/07/33	63,576	67,432
Phillip Morris Intl	Bond	110,000	5.250	02/13/34	107,592	111,114
Phinia Inc	Bond	155,000	6.750	04/15/29	157,250	156,654
PNC Fin Serv V-D	Bond	80,000	5.300	01/21/28	80,047	81,160
Precision Castparts	Bond	50,000	3.250	06/15/25	52,846	49,904
Prime Sercsrv	Bond	129,000	5.750	04/15/26	126,402	128,871
Prime Sercsrv	Bond	55,000	3.375	08/31/27	52,105	52,458
Rockwell Automation	Bond	90,000	3.500	03/01/29	94,189	87,407
Safehold Operating	Bond	115,000	2.800	06/15/31	104,484	101,708
Safehold Operating	Bond	95,000	2.850	01/15/32	86,346	80,850
Sba Communications	Bond	200,000	3.875	02/15/27	205,565	195,660
Simon Property Group	Bond	50,000	3.500	09/01/25	52,362	49,800
Simon Property Group	Bond	155,000	2.450	09/13/29	144,187	142,744
Sirius Xm Radio	Bond	200,000	3.125	09/01/26	199,528	194,618
SLM Corp	Bond	125,000	3.125	11/02/26	118,180	121,084
SLM Corp Sr Nt	Bond	70,000	6.500	01/31/30	71,279	72,260
Springleaf Finance	Bond	55,000	7.125	03/15/26	55,962	55,481
SS&C & Technologie	Bond	195,000	5.500	09/30/27	194,584	194,039
Starwood Property	Bond	200,000	3.625	07/15/26	200,277	195,230
Starwood Property	Bond	10,000	4.375	01/15/27	9,737	9,810
Sunoco Lp	Bond	175,000	5.875	03/15/28	173,250	174,158
Sunoco Lp/ Finance Co	Bond	35,000	6.000	04/15/27	34,652	34,885
Tallgrass NRG	Bond	95,000	7.375	02/15/29	95,000	94,654
Tallgrass NRG PR	Bond	30,000	6.000	03/01/27	29,412	29,613
Tallgrass NRG PR	Bond	85,000	5.500	01/15/28	81,481	82,640
Tenet Healthcare	Bond	85,000	5.125	11/01/27	83,571	84,300
Tenet Healthcare	Bond	115,000	4.250	06/01/29	106,280	109,523
Tenga Inc	Bond	195,000	4.750	03/15/26	199,293	192,592
Teva Pharmaceutical	Bond	25,000	4.750	05/09/27	24,025	24,526
Teva Pharmaceuticals	Bond	165,000	3.150	10/01/26	147,543	159,430
Teva Pharmaceuticals	Bond	10,000	6.750	03/01/28	10,075	10,242
Tractor Supply Co	Bond	50,000	5.250	05/15/33	49,719	50,210
Transdigm Inc	Bond	105,000	6.750	08/15/28	106,395	107,109
Transdigm Inc	Bond	85,000	6.375	03/01/29	85,027	86,590
Truist Bank	Bond	170,000	2.250	03/11/30	153,238	149,738
Verizon Communications	Bond	100,000	2.550	03/21/31	93,658	89,039
Virginia Elec & Powe	Bond	25,000	5.050	08/15/34	24,939	24,739
Virginia Elec & Powe	Bond	70,000	3.500	03/15/27	69,138	69,236
Vistra Operation	Bond	205,000	5.500	09/01/26	199,571	204,434
VR Goldman Sachs Gro	Bond	165,000	3.691	06/05/28	158,844	162,340
VR Jpmorgan Chase	Bond	105,000	4.452	12/05/29	110,419	104,869
Walt Disney Company	Bond	80,000	3.375	11/15/26	83,191	79,207
Warnermedia Hldg Inc	Bond	120,000	3.755	03/15/27	117,722	116,778
Wesco Distr Inc	Bond	120,000	6.375	03/15/29	120,725	121,585
Western Digital Corp	Bond	45,000	4.750	02/15/26	48,851	44,703
Wyndham Destination	Bond	15,000	6.625	07/31/26	15,131	15,105

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	<u>Corporate obligations (continued):</u>					
Wyndham Worldwide Co	Bond	195,000	5.100 %	10/01/25	\$ 201,290	\$ 194,764
XPO Inc	Bond	185,000	6.250	06/01/28	185,669	186,833
	Total corporate obligations				<u>11,348,791</u>	<u>11,356,061</u>
	<u>Foreign obligations:</u>					
Ggam Finance Ltd	Bond	75,000	8.000	02/15/27	75,487	77,001
Jbs Usa Lux Sa	Bond	105,000	5.125	02/01/28	102,635	106,114
Nutrien Ltd	Bond	50,000	5.250	03/12/32	49,823	50,435
	Total foreign bonds				<u>227,945</u>	<u>233,550</u>
	<u>Mortgage-backed securities - corporate:</u>					
FHLMC PL	Bond	80,635	6.000	09/01/53	79,904	81,982
FHLMC PL	Bond	106,929	5.500	08/01/54	105,642	106,913
FHLMC PL	Bond	101,409	5.000	11/01/54	98,430	99,475
FHLMC PL	Bond	160,752	4.500	11/01/44	154,850	156,510
FHLMC Ser 5388 CMO	Bond	21,235	6.000	07/25/48	21,235	21,642
FNMA PL	Bond	96,688	4.000	07/01/38	92,533	94,471
FNMA PL	Bond	134,525	4.500	12/01/52	128,377	128,908
FYBR ABS	Bond	90,000	6.600	08/20/53	86,532	91,418
GNMA Ser 151	Bond	88,258	5.000	05/20/52	86,797	88,289
GS Mortgage CMO V-M	Bond	99,899	5.000	10/27/53	95,872	97,050
GS Mortgage CMO V-M	Bond	83,082	6.500	01/25/54	82,895	84,414
JP Morgan CMO V-M	Bond	27,764	6.000	04/25/54	27,144	27,990
Onslow Bay CMO V-M	Bond	80,346	6.000	11/25/53	79,019	80,706
SBA SER 20L ABS	Bond	39,352	2.810	12/01/36	39,057	36,745
Small Business Admin	Bond	14,975	2.090	11/01/32	14,687	14,044
Small Business Admin	Bond	33,068	2.130	01/01/33	32,234	30,895
Small Business Admin	Bond	11,746	2.220	03/01/33	11,540	10,987
Small Business Admin	Bond	25,695	2.570	11/01/36	25,627	23,827
	Total mortgage - backed securities - corporate				<u>1,262,375</u>	<u>1,276,266</u>
	<u>Limited Partnerships:</u>					
Boyd Watterson GSA Fund LP		1,926			2,128,031	2,798,466
Boyd Watterson State Govt Fund LP		1,254			1,361,125	1,241,448
	Total limited partnerships				<u>3,489,155</u>	<u>4,039,914</u>
	<u>Common collective trust:</u>					
BNY Mellon AFL-CIO		197,794			2,847,837	2,798,171
	<u>Money market mutual fund:</u>					
* Allspring Government MM Fund Instl		496,445			496,445	496,445
	Total investments				<u>\$ 24,101,217</u>	<u>\$ 24,639,808</u>

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

**SHEET METAL WORKERS' HEALTH FUND  
OF LOCAL UNION No. 19**

**SCHEDULE OF REPORTABLE TRANSACTIONS**

YEAR ENDED APRIL 30, 2025

Form 5500, Schedule H, Line 4j

EIN: 23-1324693  
Plan No. 501

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Description of Assets		Purchase Price	Selling Price	Cost of Asset	Value of Asset on the Transaction Date	Net Gain/ or (Loss)
* All Spring Government MM Fund Instl		\$ 8,793,120 N/A	N/A \$ 8,855,357	\$ 8,793,120 8,855,357	\$ 8,793,120 8,855,357	N/A \$ -

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

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE  
OF ASSETS HELD

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110  
1210-0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

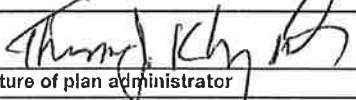
- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 the first return/report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

**Part II Basic Plan Information** - enter all requested information

<b>1a</b> Name of plan SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO. 19	<b>1b</b> Three-digit plan number (PN) ▶ 501
	<b>1c</b> Effective date of plan 06/28/1949
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION NO19  1301 S COLUMBUS BLVD. 1ST FLOOR  PHILADELPHIA PA 19147	<b>2b</b> Employer Identification Number (EIN) 23-1324693
	<b>2c</b> Plan Sponsor's telephone number 215-952-1990
	<b>2d</b> Business code (see instructions) 561110

**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.

<b>SIGN HERE</b>		2-9-26	THOMAS J. KLINGENBERG
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
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<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
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<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	3,308
<b>6</b> 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).		
<b>a(1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	2,037
<b>a(2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	2,046
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	1,251
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c	<b>6d</b>	3,297
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e	<b>6f</b>	
<b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	152

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

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

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

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

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

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

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

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

Receipt Confirmation Code \_\_\_\_\_

SEE ACCOUNTANT'S OPINION FOR SCHEDULE  
OF FIVE PERCENT TRANSACTIONS