

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: [X] 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. [X]
D Check box if filing under: [X] Form 5558 [] automatic extension [] the DFVC program [] special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. []

Part II Basic Plan Information—enter all requested information

1a Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 05/01/1967
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) OHIO BRICKLAYERS HEALTH AND WELFARE PLAN 700 TOWER DRIVE, SUITE 300 TROY, MI 48098
2b Employer Identification Number (EIN) 31-6064918
2c Plan Sponsor's telephone number 248-813-9800
2d Business code (see instructions) 238100

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes entries for JOSHUA HUGHES and DANIEL MUSACCHIO.

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1546
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1239
	6a(2)	1234
	6b	232
	6c	0
	6d	1466
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	187

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	D Employer Identification Number (EIN) 31-6064918

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
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	G8019/C8019	1466	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
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	259395
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

<p style="text-align: center;">SCHEDULE A (Form 5500)</p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: x-small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p style="font-size: large;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2024 or fiscal plan year beginning **05/01/2024** and ending **04/30/2025**

<p>A Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 OHIO BRICKLAYERS HEALTH AND WELFARE PLAN</p>	<p>D Employer Identification Number (EIN) 31-6064918</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
GERBER LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-2611847	70939	GL-0228-VU	1266	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
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a	Premiums: (1) Amount received	9a(1)	1161571
	(2) Increase (decrease) in amount due but unpaid	9a(2)	
	(3) Increase (decrease) in unearned premium reserve	9a(3)	
	(4) Earned ((1) + (2) - (3))	9a(4)	1161571
b	Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves	9b(2)	
	(3) Incurred claims (add (1) and (2))	9b(3)	
	(4) Claims charged	9b(4)	
c	Remainder of premium: (1) Retention charges (on an accrual basis) --		
	(A) Commissions	9c(1)(A)	
	(B) Administrative service or other fees	9c(1)(B)	
	(C) Other specific acquisition costs	9c(1)(C)	
	(D) Other expenses	9c(1)(D)	
	(E) Taxes	9c(1)(E)	
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention	9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	9d(1)	
	(2) Claim reserves	9d(2)	
	(3) Other reserves	9d(3)	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)	9e	

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

A Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	D Employer Identification Number (EIN) 31-6064918	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

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

ANTHEM INC

P.O.BOX 951254
CLEVELAND, OH 44193

(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?
99 50 16 15 13 12	NONE	611158	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)

BENESYS

700 TOWER DRIVE, SUITE 300
TROY, MI 48098

(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?
50 49 13 10	NONE	446633	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)

CONIFER VALUE BASED CARE LLC

52-1964905

(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?
50 16	NONE	119465	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)

THE JAMES B OSWALD COMPANY

P.O. BOX 853
WEST CENTER, OH 44251

(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	97848	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)

LEDBETTER, PARISI, LLC

03-0599899

(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?
50 29	NONE	55473	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 INVESTMENT SERVICES

777 E WISCONSIN AVE, 235
MILWAUKEE, WI 53202

(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?
50 28	NONE	46235	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)

BENDA, GRACE, STULZ & COMPANY P.C.

38-2284921

(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?
50 10	NONE	33500	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)

AMERICAN GRAPHICS PRINTING CO

24895 GROESBECK
CLINTON TOWNSHIP, MI 48035

(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?
50 36	NONE	24859	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)

HINGE HEALTH LLC

81-1884841

(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?
50 16	NONE	15835	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)

CUNI, RUST & STRENK

31-1227755

(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?
50 11	NONE	11000	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)

MERRILL LYNCH

45000 RIVER RIDGE DR120
CLINTON TOWNSHIP, MI 48038

(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?
50 27	NONE	10836	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)

US BANK

PO BOX 70870
ST. PAUL, MN 55170

(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?
50 19	NONE	8256	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)

TUCKER ARENSBERG ATTORNEYS

ONE PPG PLACE, SUITE 1500
PITTSBURGH, PA 15222

(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?
50 29	NONE	5915	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

A Name of plan <u>OHIO BRICKLAYERS HEALTH AND WELFARE PLAN</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>OHIO BRICKLAYERS HEALTH AND WELFARE PLAN</u>	D Employer Identification Number (EIN) <u>31-6064918</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE: NIS TOTAL ABSOLUTE RETURN FUND, LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES

c EIN-PN <u>45-4783986-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>1046710</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: NIS INTERMEDIATE FIXED INCOME FUND,

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES

c EIN-PN <u>20-0065449-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>10044136</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: NIS HIGH YIELD FUND,LLC

b Name of sponsor of entity listed in (a): NATIONAL INVESTMENT SERVICES

c EIN-PN <u>39-2021943-001</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>758309</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
-----------------	----------------------	-----------------------------------------------------------------------------------------------------

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

b Name of sponsor of entity listed in (a):

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 05/01/2024 and ending 04/30/2025			
A Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">B Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> </table>	B Three-digit plan number (PN) ▶	501
B Three-digit plan number (PN) ▶	501		
C Plan sponsor's name as shown on line 2a of Form 5500 OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;">D Employer Identification Number (EIN) 31-6064918</td> </tr> </table>	D Employer Identification Number (EIN) 31-6064918	
D Employer Identification Number (EIN) 31-6064918			

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

		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	3802102	2266797
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	2001643	1988664
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	2537797	786466
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	6528359	6599036
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	10923238	11849155
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	18459326	20475859
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	220637	7501
f Total assets (add all amounts in lines 1a through 1e).....	1f	44473102	43973478
Liabilities			
g Benefit claims payable.....	1g	2107658	2937701
h Operating payables.....	1h	167398	269390
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	24462600	24807021
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	26737656	28014112
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	17735446	15959366

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	16434347	
(B) Participants.....	2a(1)(B)	1279879	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		17714226
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	265750	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		265750
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	559698	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		559698
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		925917
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1256851
c Other income	2c		90624
d Total income. Add all income amounts in column (b) and enter total	2d		20813066

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	64131	
(2) To insurance carriers for the provision of benefits	2e(2)	1420966	
(3) Other	2e(3)	19686498	
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		21171595
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	1004096	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	33500	
(5) Investment advisory and investment management fees	2i(5)	65191	
(6) Bank or trust company trustee/custodial fees	2i(6)	44091	
(7) Actuarial fees	2i(7)	11000	
(8) Legal fees	2i(8)	53308	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	1661	
(11) Other expenses	2i(11)	204704	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1417551
j Total expenses. Add all expense amounts in column (b) and enter total	2j		22589146

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-1776080
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **BENDA, GRACE, STULZ & COMPANY, P.C.**

(2) EIN: **38-2284921**

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

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

Part IV Compliance Questions

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

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

**OHIO BRICKLAYERS'
HEALTH AND WELFARE FUND**

Troy, Michigan

FINANCIAL STATEMENTS

April 30, 2025

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John M. Grace, CPA
Bryan D. Stulz, CPA
George Benda, CPA
(1941-2007)



INDEPENDENT AUDITOR'S REPORT

Board of Trustees
Ohio Bricklayers'
Health and Welfare Fund
700 Tower Drive, Suite 300
Troy, MI 48098

Trustees:

Opinion

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of Ohio Bricklayers' Health and Welfare Fund as of April 30, 2025 and 2024, and changes in its net assets available for benefits and 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 Ohio Bricklayers' Health and Welfare Fund 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 these 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 Ohio Bricklayers' Health and Welfare Fund'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 aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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

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

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

Bender, Gura, Stul & Company, P.C.

Sterling Heights, Michigan
February 10, 2026

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND
STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS
AND BENEFIT OBLIGATIONS

	April 30,	
	2025	2024
<u>ASSETS</u>		
Investments at fair value (Notes B, E and F):		
Mutual funds	\$ 20,475,859	\$ 18,459,326
Common collective trusts	11,849,155	10,923,238
Money market funds	6,599,036	6,528,359
Total investments	38,924,050	35,910,923
Receivables:		
Employer contributions (Notes A and B)	1,622,889	1,720,156
Stop loss refunds	588,623	2,091,171
Reciprocity	365,775	281,487
Other	174,979	418,851
Accrued income	22,864	27,775
Total receivables	2,775,130	4,539,440
Other assets:		
Cash	2,266,797	3,802,102
Combined funds deposit	-	215,064
Prepaid expense	2,620	-
Unexpired insurance premiums	4,881	5,573
Total other assets	2,274,298	4,022,739
Total assets	43,973,478	44,473,102
<u>LIABILITIES</u>		
Accounts payable	269,390	167,398
Payable to other plans	69,597	1,460,354
Reciprocity payable	463,522	617,650
Total liabilities	802,509	2,245,402
<u>NET ASSETS AVAILABLE FOR BENEFITS</u>	43,170,969	42,227,700
<u>BENEFIT OBLIGATIONS</u> (Note C)		
Claims incurred but not reported	2,937,701	2,107,658
Accumulated eligibility credits	24,273,902	22,384,596
Total benefit obligations	27,211,603	24,492,254
<u>EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS</u>		
<u>OVER BENEFIT OBLIGATIONS</u>	\$ 15,959,366	\$ 17,735,446

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

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
AND BENEFIT OBLIGATIONS**

	Years ended April 30,	
	2025	2024
<u>ADDITIONS</u>		
Investment income:		
Interest and dividends	\$ 825,448	\$ 763,520
Net appreciation in fair value of investments (Note F)	2,182,768	1,828,323
	3,008,216	2,591,843
Less - investment expenses	65,191	38,309
Net investment income	2,943,025	2,553,534
Employer contributions	16,434,347	14,887,265
Self-payments from participants	1,279,879	1,363,023
Other income	90,624	122,018
Total additions	20,747,875	18,925,840
<u>DEDUCTIONS</u>		
Benefit expenses (Note G)	19,063,403	13,429,426
Administrative expenses (Note H)	741,202	793,828
Total deductions	19,804,605	14,223,254
<u>INCREASE IN NETS ASSETS AVAILABLE FOR BENEFITS</u>	943,270	4,702,586
<u>INCREASE IN BENEFIT OBLIGATIONS</u> (Note C)		
Change in claims incurred but not reported	830,043	29,431
Change in accumulated eligibility credits	1,889,307	606,142
Total increase in benefit obligations	2,719,350	635,573
<u>INCREASE (DECREASE) IN NETS ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS</u>	(1,776,080)	4,067,013
<u>EXCESS OF NET ASSETS AVAILABLE FOR BENEFITS OVER BENEFIT OBLIGATIONS</u>		
Beginning of year	17,735,446	13,668,433
End of year	\$ 15,959,366	\$ 17,735,446

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

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

Note A: Description of the Plan

The following brief description of the Ohio Bricklayers' Health and Welfare Fund, as in effect on April 30, 2025, is provided for general purposes only. For more complete information refer to the amended plan document.

1. General – The Plan (and related trust) was established on May 1, 1967. The Plan is a multiemployer defined benefit health and welfare plan established pursuant to collective bargaining agreements ("CBAs") by and between participating employers and various local unions affiliated with the International Union of Bricklayers and Allied Craftsmen (AFL-CIO). The Plan provides benefits for eligible covered participants and their enrolled dependents. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Administration of the Plan is the responsibility of a joint board of trustees ("Board of Trustees"), which consists of representation from the participating employers and the local unions.
2. Eligibility – The Plan provides benefits for eligible participants and covered dependents. The Plan uses a "Dollar Bank" program to determine eligibility for benefits. A participant becomes initially eligible the first day of the month that follows a period of twelve or less consecutive months during which the employer contributes to the Plan, on the participant's behalf, less any assessment set by the Board of Trustees, equal, in total, the monthly premium rate for active family coverage for the standard plan. The current assessment set by the Trustees is \$0.25 per reported hour. Participant eligibility is maintained by having contributions for covered employment made to the Plan on a participant's behalf, in an amount sufficient to meet the monthly premium rate. The Plan also extends benefits to participants during periods of unemployment (less than full time), provided they have enough hours accumulated in their Dollar Bank or they self-pay their monthly assessed premium. The Dollar Bank usage is expressly conditioned upon participants maintaining status as active employees as being available for work under the CBAs. When an employee is no longer available for work, the eligibility for coverage will terminate at the end of the month when the change of status occurred, and any balance in the participant's Dollar Bank will be forfeited to the Plan.

Participants who have retired under an affiliated pension plan are also eligible for benefits, provided they remain in good standing with the local union and use their available Dollar Bank balances to extend coverage or self-pay their monthly premiums.

3. Benefits – The Plan provides participants, beneficiaries, and covered dependents with regarding medical, prescription, dental, vision and certain insurance benefits. For more complete information regarding eligibility and benefits provided, refer to the Plan's summary plan description.
4. Contributions – Under the terms of the CBAs, participating employers contribute various amounts to the Plan for each reported hour for covered employees. The hourly contribution rates and hours base (hours worked or hours paid) are determined by each participating local, subject to the CBAs.

Participant contributions are permitted under the Plan, in certain circumstances, including contributions by active participants to extend coverage during periods of unemployment, for retiree coverage, or for COBRA coverage. Self-payment rates are established by the trustees on an annual basis. The trustees determine the self-payment rates for retiree coverage with a target of a 25% subsidy for retiree healthcare. The self-payment amount for retiree coverage is based on the retiree's age at the time of retirement and the retirement date.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS (Continued)

Note A: Description of the Plan (Continued)

5. Reciprocity – Participants of the Plan and participants of the benefit plans of other affiliated local unions may have temporary employment assignments outside the jurisdiction of their local union. Therefore, the Plan has entered into reciprocity agreements with other affiliated locals to ensure that employer contributions are forwarded to the benefit plans of the participant's local union. Reciprocal contributions received and reciprocal contributions paid have been recorded in the statements of changes in net assets available for benefits.

Note B: Summary of Significant Accounting Policies

1. General – The accounting records of the Plan are maintained on the accrual basis. Contributions received subsequent to April 30, 2025, attributed to hours worked prior to May 1, 2025, have been reflected as contributions due from employers as of April 30, 2025, in accordance with the consistent policy of the Fund.
2. Estimates – The preparation of financial statements in conformity with generally accepted accounting principles requires the Plan Administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein, IBNR, eligibility credits, claims payable and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.
3. Investment Valuation and Income Recognition – Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note E for a discussion of fair value investments.

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 (depreciation) includes the Plan's gains and losses on investments bought and sold as well as those held during the year.

4. Depository Account – The Plan's Third Party Administrator and recordkeeper (BeneSys, Inc.) maintains a bank account that is used to receive employer contributions. This depository account is held in the Plan's name and received contributions for other plans, which were subsequently transferred to those plans.

Accordingly, the balance of the depository account, which is \$907,580 and \$1,954,290 as of April 30, 2025, and 2024, respectively, is recorded within non-interest-bearing cash on the statements of net assets available for benefits and is offset by \$65,597 and \$1,460,354 liability for amounts owed to other plans as of such date. As disclosed in Note O, BeneSys is considered a party-in-interest.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS (Continued)

Note C: Benefit Obligations

1. Claims Incurred but Not Reported – Claims incurred but not reported includes the estimated ultimate cost of settling claims and has been projected based on claims paid subsequent to April 30, 2025, representing claims incurred prior to and including that date.
2. Accumulated Eligibility Credits (Dollar Bank) – Participants of the Plan may accumulate excess contributions within their Dollar Bank to provide for extended eligibility when unemployed. The Dollar Bank usage is expressly conditioned upon participants maintaining status as active employees as being available for work under the CBAs. When an employee is no longer available for work, the eligibility for coverage will terminate at the end of the month in which the change of status occurred and any balance in the participant's Dollar Bank will be forfeited to the Plan. Retired participants may use any accumulated excess in their Dollar Bank to maintain coverage.

Within a participant's Dollar Bank account, any amount in excess of the equivalent of 2 months of current cost of coverage are available for use by the participant as a Health Reimbursement Account ("HRA") for qualified medical expenses. Participants make submissions for Dollar Bank reimbursements, and benefits are recorded when paid. This arrangement allows eligible participants to be reimbursed tax free for qualified medical expenses up to the unused amount in the participants' accounts. Amounts remaining at the end of the year can generally be carried over to the next year. The Plan is not permitted to refund any part of the balance to the participant, and the account cannot be used for anything other than reimbursements for qualified medical expenses or future coverage. If a participant terminates and is not considered an eligible retiree, then the former participant may submit claims for qualified medical expenses incurred prior to the date of termination. Such claims must be made no later than 24 months following the date such claims were incurred. In the case of death of the participant, the balance is available for the surviving spouse or eligible dependents to maintain coverage in the Plan. Participant accounts will be subject to forfeiture at the end of the month in which employment terminates.

Total amounts available within the Dollar Bank, including accumulated excess contributions available for the Health Reimbursement Arrangement, total \$24,273,902 and \$22,384,596 as of April 30, 2025, and 2024, respectively. The obligation associated with these Dollar Bank balances is estimated by the Plan's management. Such estimated amounts are reported in the accompanying statement of Net Assets Available for Benefits and Benefit Obligations.

3. Postretirement Benefit Obligations – The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed, by the terms of the Plan, to employees' service rendered to the date of the financial statements. Postretirement benefits include future benefits expected to be paid to or for (a) currently retired employees and their beneficiaries and dependents and (b) active employees and their beneficiaries and dependents after retirement from service for the participating employers. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS (Continued)

Note C: Benefit Obligations (Continued)

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

For measurement purposes, a 9.00% and 7.50% annual rate of increase in the per capita cost of covered health care benefits was assumed for April 30, 2025, and 2024, respectively, reducing by .50% per year to an ultimate rate of 4.50% per year. These assumptions are consistent with those used to measure the benefit obligations at April 30, 2024. The health care cost-trend rate assumption has a significant effect on the amounts reported. If the assumed rates increased by one percentage point in each year, it would increase the accumulated postretirement benefit obligation as of April 30, 2025, and 2024, by \$3,256,900 and \$3,132,548, respectively. The Fund's estimated cost of providing postretirement benefits funded by retiree contributions is \$823,915 and \$991,588 for the years ended April 30, 2025, and 2024, respectively. The self-payment rates for retirees vary depending upon the type of benefit options selected and range from \$243 to \$1,754 per month.

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

Weighted-average discount rate	5.5% for April 30, 2025, and 2024.
Average retirement age	Various rates from age 55 through 70 for 2025 and 2024.
Mortality table	Blue Collar adjusted Pre-2012 Mortality Table was used for April 30, 2025, and 2024 (non-disabled). Pre-2012 Disabled retiree Mortality Table was used for April 30, 2025, and 2024 (disabled). Projected generationally using scale MP-2021 was used for April 30, 2025, and 2024 (future mortality).

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.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note C: Benefit Obligations (Continued)

The following is a summary of postretirement benefit obligations at April 30, 2025, and 2024 and changes for the years then ended.

	April 30,	
	2025	2024
Current retirees	\$ 9,463,426	\$ 7,837,145
Other participants fully eligible for benefits	6,043,680	6,046,023
Participants not yet fully eligible for benefits	8,166,480	5,977,296
	\$ 23,673,586	\$ 19,860,464
	Years ended April 30,	
	2025	2024
Changes due to:		
Benefits earned and other changes	\$ 522,632	\$ 853,023
Change in actuarial assumptions	813,388	(9,174,453)
Retiree premiums different than expected	2,695,203	2,122,259
Passage of time	1,098,413	1,238,718
Net claims paid	(823,915)	(991,588)
Actuarial experience	(492,599)	91,456
	\$ 3,813,122	\$ (5,860,585)

There is no provision for funding the postretirement obligation in the current collective bargaining agreements. The calculation of the obligation does not imply that there is any legal liability to provide the benefits valued nor do the participants have any vested rights in the postretirement benefit obligations.

Note D: Administrative Service Contract

The Fund has contracted Anthem Blue Cross and Blue Shield of Michigan to administer health care benefits. Under the current arrangement, the Fund pays an amount weekly which is comprised of actual claims and administration fees.

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). The Plan's benefit claim exposure is limited to \$350,000 and \$325,000 per year per participant or dependent for the Plan years ended April 30, 2025, and 2024.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS (Continued)

Note E: Fair Value Measurements

FASB Accounting Standards Codification (ASC) 820 Fair Value Measurements and Disclosures provide a framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (level 1 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB ASC 820 are described as follows:

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

Level 2 Inputs to the valuation methodology include:

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

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

Level 3 Inputs to the valuation methodology are unobservable and significant to the fair value measurement. These level 3 fair value measurements are based primarily on management's own estimates, using pricing models, discounted cash flow methodologies, or similar techniques considering the characteristics of the assets. Significant level 3 inputs include information provided by fund managers, third-party appraisals, year-end audited financial statements, projected discounted cash flows, and net asset value with adjustments related to certain restrictions. Management assesses the valuation of these investments through the engagement of a third-party investment advisor and periodic meetings to review these investments.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Fund's assessment of the significance of particular inputs to these fair value measurements requires judgement and considers factors specific to each asset.

The following valuation methodologies have been used to value the Fund's investments:

Mutual funds – Mutual funds are valued at closing quoted prices reported in active markets.

Money market funds – These investments are valued at their outstanding balance, which is the best estimate of fair value.

Common collective trusts – Common collective trust funds are valued at net asset value per shares (or its equivalent) of the funds, which is based on the fair value of the Fund's underlying net assets.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note E: Fair Value Measurements (Continued)

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

The following tables set forth by level within the fair value hierarchy, the Plan's assets at fair value as of:

Fair Value Measurement at April 30, 2025

	<u>Fair Value</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Mutual funds	\$ 20,475,859	\$ 20,475,859	\$ -	\$ -
Money market funds	6,599,036	-	6,599,036	-
	<u>27,074,895</u>	<u>\$ 20,475,859</u>	<u>\$ 6,599,036</u>	<u>\$ -</u>
Investment measured at NAV:				
Common collective trusts	11,849,155			
	<u>\$ 38,924,050</u>			

Fair Value Measurement at April 30, 2024

	<u>Fair Value</u>	<u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u>	<u>Significant Other Observable Inputs (Level 2)</u>	<u>Significant Unobservable Inputs (Level 3)</u>
Mutual funds	\$ 18,459,326	\$ 18,459,326	\$ -	\$ -
Money market funds	6,528,359	-	6,528,359	-
	<u>24,987,685</u>	<u>\$ 18,459,326</u>	<u>\$ 6,528,359</u>	<u>\$ -</u>
Investment measured at NAV:				
Common collective trusts	10,923,238			
	<u>\$ 35,910,923</u>			

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note E: Fair Value Measurements (Continued)

At year end, the fair value, unfunded commitments, and redemption limitations of investments measured at NAV are as follows:

	Fair Value as of April 30,		Unfunded Commitments	Redemption Frequency, if Eligible	Redemption Notice period
	2025	2024			
Common collective trusts:					
NIS Intermediate Fixed Income Fund, LLC	\$ 10,044,136	\$ 9,129,028	\$ -	Monthly	15 Days
NIS Total Absolute Return Fund, LLC	1,046,710	1,123,795	-	Quarterly	15 Days
NIS High Yield Fund, LLC	758,309	670,415	-	Monthly	15 Days
	<u>\$ 11,849,155</u>	<u>\$ 10,923,238</u>			

Note F: Investments

The following is a comparison of cost to market value of investments, other than cash, held at April 30, 2025.

	Market Value	Cost	Market Value Over (Under)
Mutual funds	\$ 20,475,859	\$ 15,026,230	\$ 5,449,629
Common collective trusts	11,849,155	9,844,698	2,004,457
Money market funds	6,599,036	6,599,036	-
	<u>\$ 38,924,050</u>	<u>\$ 31,469,964</u>	<u>\$ 7,454,086</u>

During the years ended April 30, 2025, and 2024 the Plan's investments (including investments bought, sold, and held during the year) appreciated in value by \$2,182,768 and \$1,828,323, respectively, as follows:

	2025	2024
Mutual funds	\$ 1,256,851	\$ 1,495,220
Common collective trusts	925,917	333,103
	<u>\$ 2,182,768</u>	<u>\$ 1,828,323</u>

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note G: Benefit Expenses

Following is a list of benefit expenses incurred for the years ended April 30,

	<u>2025</u>	<u>2024</u>
Medical benefits	\$ 13,852,795	\$ 11,079,642
Prescription benefits	1,894,545	1,684,809
MRA reimbursements	1,521,134	1,360,205
Stop loss premiums	1,161,571	937,232
Administrative service contract fees	611,158	564,889
Insurance premiums	259,395	245,907
Disability benefits	64,131	91,579
Stop loss credits	<u>(301,326)</u>	<u>(2,534,837)</u>
	19,063,403	13,429,426
Changes in:		
Claims incurred but not reported	830,043	29,431
Accumulated eligibility credits	<u>1,889,307</u>	<u>606,142</u>
	<u>\$ 21,782,753</u>	<u>\$ 14,064,999</u>

Note H: Administrative Expenses

Following is a list of administrative expenses incurred for the years ended April 30,

	<u>2025</u>	<u>2024</u>
Administrative manager fees	\$ 392,938	\$ 384,715
Actuarial and consulting fees	108,873	117,967
Printing and miscellaneous	75,079	77,382
Legal fees	53,308	88,265
Bank service charges	44,091	50,653
Audit fees	33,500	37,655
Trustee and fiduciary liability insurance and bonding	27,466	30,981
Other	4,286	2,268
Trustee meeting and conference expense	<u>1,661</u>	<u>3,942</u>
	<u>\$ 741,202</u>	<u>\$ 793,828</u>

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS (Continued)

Note I: Tax Status

The Trust established under the Plan to hold the Plan's assets is qualified and exempt from income tax pursuant to Section 501(c)(9) of the Internal Revenue Code as a tax-exempt organization. The Plan has obtained a favorable tax determination letter from the Internal Revenue Service, and the Plan Sponsor believes the Plan, as amended, continues to qualify and to operate as designed.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the taxing authorities. The Plan is subject to routine audits by jurisdiction; however, there are currently no audits for any tax periods in progress.

Note J: Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such 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 inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimates 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.

In addition to investments and cash equivalents, financial instruments which potentially subject the Plan to concentrations of credit risk consist principally of cash. The Plan places its cash with tier I financial institutions. At times, the amount of cash on deposit in banks may be in excess of the respective financial institution's FDIC insurance limit.

The Plan's contributing employers are primarily located throughout the Midwest Region. Due to the Plan's dependence on the construction industry and its geographical concentration of contributing employers, the Plan is affected by the economic conditions of the aforementioned region. Consequently, contributions may be affected, either positively or negatively, by changes in economic conditions in this geographic area.

Note K: Priorities Upon Termination

In the event of termination, the Trustees shall make provision from the Trust fund to pay any and all obligations of the trust to the extent possible and distribute any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Trust.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note L: 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.

	April 30,	
	2025	2024
Net assets available for benefits per the financial statements	\$ 43,170,969	\$ 42,227,700
Less:		
Claims incurred but not reported	(2,937,701)	(2,107,658)
Accumulated eligibility credits	(24,273,902)	(22,384,596)
Net assets available for benefits per Form 5500	\$ 15,959,366	\$ 17,735,446

The following is a reconciliation of benefit expenses per the financial statements to Form 5500.

	Years ended April 30,	
	2025	2024
Benefit expenses per the financial statements	19,063,403	13,429,426
Less – administrative services only contract fees	(611,158)	(564,889)
Changes in reserves for:		
Claims incurred but not reported	830,043	29,431
Accumulated eligibility credits	1,889,307	606,142
Benefit expenses per Form 5500	\$ 21,171,595	\$ 13,500,110

Note M: Reportable Transactions

The United States Department of Labor requires all transactions in excess of 5% of the current value of the Plan's net assets for non-participant-directed investments to be disclosed separately in the financial statements as a reportable transaction.

Note N: Party-in-Interest Transactions

Plan investments are held at U.S Bank and National Investment Services (the Custodian). The transactions of the custodian qualify as party-in-interest transactions.

Fees paid during the year for third party administrative services (BeneSys, Inc), legal, auditing, investment management, investment advisory, and other professional services rendered by parties-in-interest were based on customary and reasonable rates for such services.

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND

**NOTES TO FINANCIAL STATEMENTS
(Continued)**

Note O: Subsequent Events

The date to which events occurring after April 30, 2025, the date of the most recent Statement of Net Assets Available for Benefits and Benefit Obligations, has been evaluated for possible adjustment to the financial statements or disclosures is February 10, 2026, which is the date on which the financial statements were available to be issued.

**OHIO BRICKLAYERS'
HEALTH AND WELFARE FUND**

SUPPLEMENTAL SCHEDULES



John M. Grace, CPA
Bryan D. Stulz, CPA
George Benda, CPA
(1941-2007)



INDEPENDENT AUDITOR'S
REPORT ON SUPPLEMENTAL INFORMATION

Board of Trustees
Ohio Bricklayers'
Health and Welfare Fund
700 Tower Drive, Suite 300
Troy, MI 48098

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets held for investment as of April 30, 2025, and reportable transactions for the year ended April 30, 2025, are presented for the purpose of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

Benda, Grace, Stulz & Company, P.C.

Sterling Heights, Michigan
February 10, 2026

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND
SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS HELD AT END OF YEAR
Employer I.D. No. 31-6064918 Plan No. 501
April 30, 2025

Party-In-Interest	Identity of Issue, Borrower, Lessor, Or Similar Party	Description of Investments Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	Cost	Current Value
	<u>INTEREST BEARING CASH</u>			
*	Cash		\$ 6,599,036	\$ 6,599,036
	<u>MUTUAL FUNDS</u>			
	Vanguard Ttl	Vanguard Ttl Stk Mkt Idx	4,410,328	10,269,088
	Baird Inter	Baird Inter Bond Fd Instle CL	<u>10,615,902</u>	<u>10,206,771</u>
	TOTAL MUTUAL FUNDS		<u>15,026,230</u>	<u>20,475,859</u>
	<u>COMMON COLLECTIVE TRUSTS</u>			
	National Investment Services	Total Absolute Return Fund, LLC	694,293	1,046,710
	National Investment Services	Intermediate Fixed Income Fund, LLC	8,604,582	10,044,136
	National Investment Services	High Yield Fund, LLC	<u>545,823</u>	<u>758,309</u>
	TOTAL COMMON COLLECTIVE TRUSTS		<u>9,844,698</u>	<u>11,849,155</u>
	TOTAL ASSETS HELD FOR INVESTMENT		<u>\$ 31,469,964</u>	<u>\$ 38,924,050</u>

OHIO BRICKLAYERS' HEALTH AND WELFARE FUND
SCHEDULE H, LINE 4j - SCHEDULE OF REPORTABLE TRANSACTIONS
Employer I.D. No. 31-6064918 Plan No. 501
Year Ended April 30, 2025

Identity of Party Involved	Description of Assets (Include Rate of Return and Maturity in Case of Loan)	Purchase Price	Selling Price	Lease Rental	Expense Incurred with Transaction	Cost of Asset	Current Value of Asset on Transaction Date	Net Gain or (Loss)
iii) SERIES OF TRANSACTIONS IN EXCESS OF 5% OF THE CURRENT VALUE OF PLAN ASSETS								
U.S. Bank N.A.	First Amer Govt Oblig Fund CI Z 15 purchases 2 sales	\$ 3,820,677				\$ 324,616 3,750,000	\$ 324,616 3,750,017	17
Vanguard	Vanguard Total Stock MKt Idx 4 purchases 1 sale	142437.35				139,400 307,434	139,400 750,000	442,566
Baird	Baird Inter Bond Fd Instle CL 14 purchases 1 sale	4,167,261				295,456 2,958,753	295,456 2,800,000	(158,753)

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)	OMB Nos 1210-0110 1210-0069
	Complete all entries in accordance with the instructions to the Form 5500.	2024 This Form is Open to Public Inspection

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

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

B This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)

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



D Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan OHIO BRICKLAYERS HEALTH AND WELFARE PLAN	1b Three-digit plan number (PN) ▶ 501
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt, suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) OHIO BRICKLAYERS HEALTH AND WELFARE PLAN 700 TOWER DRIVE, SUITE 300 Troy MI 48098	1c Effective date of plan 05/01/1967 2b Employer Identification Number (EIN) **-***4918 2c Plan Sponsor's telephone number 248-813-9800 2d Business code (see instructions) 238100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
 Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE		2/10/26	Joshua Hughes
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		2/10/26	Daniel Mosacchio
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor		3b Administrator's EIN	
		3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:		4b EIN	
a Sponsor's name		4d PN	
c Plan Name			
5 Total number of participants at the beginning of the plan year	5		1546
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).			
a(1) Total number of active participants at the beginning of the plan year	6a(1)		1239
a(2) Total number of active participants at the end of the plan year	6a(2)		1234
b Retired or separated participants receiving benefits	6b		232
c Other retired or separated participants entitled to future benefits	6c		0
d Subtotal. Add lines 6a(2), 6b, and 6c.	6d		1466
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e		
f Total. Add lines 6d and 6e.	6f		
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)		
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)		
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7		187

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

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

4A 4B

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

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

a Pension Schedules

- (1) R (Retirement Plan Information)
- (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) DCG (Individual Plan Information) - Number Attached _____
- (5) MEP (Multiple-Employer Retirement Plan Information)

b General Schedules

- (1) H (Financial Information)
- (2) I (Financial Information - Small Plan)
- (3) A (Insurance Information) - Number Attached 2
- (4) C (Service Provider Information)
- (5) D (DFE/Participating Plan Information)
- (6) G (Financial Transaction Schedules)

1511 OHIO BRICKLAYERS HEALTH AND
31-6064918

Federal Statements

FYE: 4/30/2025 **OHIO BRICKLAYERS HEALTH AND WELFARE PLAN**
Plan: 501

Assets Held for Investment

<u>Party in Interest</u>	<u>Identity</u>	<u>Description</u>	<u>Cost</u>	<u>Current Value</u>
		SEE ATTACHED FINANCIAL STATEMENT	\$	\$