

<p>Form 5500</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information
 For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

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

a single-employer plan a DFE (specify) _____

B This return/report is: the first return/report the final return/report

an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: Form 5558 automatic extension the DFVC program

special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

<p>1a Name of plan <u>PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN</u></p>	<p>1b Three-digit plan number (PN) ▶ <u>503</u></p>
<p>2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>THE PROCTER & GAMBLE COMPANY</u></p> <p><u>PROCTER AND GAMBLE TAX DIVISION</u> <u>P.O BOX 599</u> <u>CINCINNATI, OH 45201</u></p>	<p>1c Effective date of plan <u>07/01/1940</u></p> <p>2b Employer Identification Number (EIN) <u>31-0411980</u></p> <p>2c Plan Sponsor's telephone number <u>513-983-7777</u></p> <p>2d Business code (see instructions) <u>325600</u></p>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	02/22/2026	KYLE SCHEIDLER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	02/22/2026	KYLE SCHEIDLER
	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 type="checkbox"/> Same as Plan Sponsor THE PROCTER & GAMBLE U.S. BUSINESS SERVICES COMPANY GO, TE-3 ATTN - KELLEY MCCABE TWO PROCTER AND GAMBLE PLAZA CINCINNATI, OH 45202	3b Administrator's EIN 26-0048600 3c Administrator's telephone number 513-983-7777																														
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 26178																														
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.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:10%;">6a(1)</td><td style="width:10%;"></td><td style="width:80%; text-align: right;">26042</td></tr> <tr><td>6a(2)</td><td></td><td style="text-align: right;">27006</td></tr> <tr><td>6b</td><td></td><td style="text-align: right;">104</td></tr> <tr><td>6c</td><td></td><td style="text-align: right;">0</td></tr> <tr><td>6d</td><td></td><td style="text-align: right;">27110</td></tr> <tr><td>6e</td><td></td><td></td></tr> <tr><td>6f</td><td></td><td></td></tr> <tr><td>6g(1)</td><td></td><td></td></tr> <tr><td>6g(2)</td><td></td><td></td></tr> <tr><td>6h</td><td></td><td></td></tr> </table>	6a(1)		26042	6a(2)		27006	6b		104	6c		0	6d		27110	6e			6f			6g(1)			6g(2)			6h		
6a(1)		26042																													
6a(2)		27006																													
6b		104																													
6c		0																													
6d		27110																													
6e																															
6f																															
6g(1)																															
6g(2)																															
6h																															
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7																														

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

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

<p>A Name of plan PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN</p>	<p>B Three-digit plan number (PN) ▶ 503</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 THE PROCTER & GAMBLE COMPANY</p>	<p>D Employer Identification Number (EIN) 31-0411980</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
HAWAII MEDICAL SERVICE ASSN. OF HAWAII, BCBS OF HAWAII

(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
99-0040115	49948	72446	9	07/01/2024	06/30/2025

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

(a) Total amount of commissions paid 0	(b) Total amount of fees paid 0
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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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(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)	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier.....		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	77990
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

<p>A Name of plan PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN</p>	<p>B Three-digit plan number (PN) ▶ 503</p>	
<p>C Plan sponsor's name as shown on line 2a of Form 5500 THE PROCTER & GAMBLE COMPANY</p>	<p>D Employer Identification Number (EIN) 31-0411980</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
TRIPLE-S SALUD, INC.

(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
66-0555677	55816	SP0003998	136	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 59640</p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
IKON BENEFITS GROUP INC **270 AVE MUNOZ RIVERA PH1**
SAN JUAN 00918 PR

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
59640			3

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

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)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	1192798
(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)	1192798
b Benefit charges (1) Claims paid	9b(1)	782824
(2) Increase (decrease) in claim reserves	9b(2)	
(3) Incurred claims (add (1) and (2))	9b(3)	782824
(4) Claims charged	9b(4)	782824
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 **07/01/2024** and ending **06/30/2025**

A Name of plan PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN	B Three-digit plan number (PN) ▶	503
C Plan sponsor's name as shown on line 2a of Form 5500 THE PROCTER & GAMBLE COMPANY	D Employer Identification Number (EIN) 31-0411980	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

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

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

UNITED HEALTHCARE INSURANCE COMPANY

41-1289245

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 49 50	NONE	22159476	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)

CIGNA HEALTH & LIFE INSURANCE

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 62	NONE	2716503	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

BEST DOCTORS

04-2908444

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	642360	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)

METROPOLITAN LIFE INSURANCE COMPANY

13-5581829

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	319710	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)

SSDC SERVICES CORP.

38-3357459

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 28 49 50 99	NONE	100550	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)

NORTHERN TRUST

36-1561860

(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?
25 50	NONE	20101	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)

CITIBANK

13-3124140

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50 65	NONE	8870	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation		(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
BANK OF AMERICA (LOCKBOX) 540 WEST MADISON STREET CHICAGO, IL 60661		\$0.37 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 4.00%.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation		(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
DEUTSCHE BANK 60 WALL ST. NEW YORK, NY 10005-2836		\$0.00 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT .50%.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation		(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CIGNA HEALTHY REWARDS VENDORS 85-0437037		\$0.00 PMPY (THIS FORMULA IS BASED UPON TOTAL COMPENSATION RECEIVED FROM HEALTHY REWARD VENDORS ACROSS CIGNA COMPANIES ENTIRE INSURED AND SELF-INSURED BOOK OF BUSINESS.)

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CITIBANK NA ONE PENNS WAY NEW CASTLE, DE 19720	\$1.97 AND \$0.01 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66%.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
JPMORGAN CHASE 59-1031071	\$4.38 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.54%	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
CIGNA HEALTH & LIFE INSURANCE CO.	12 13 31 38 49 50 56 62	0
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
CHLIC - COR DEPOSITS, PNC BANK 1600 MARKET ST., 19TH FL PHILADELPHIA, PA 19102	\$1.02 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.25%.	

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

A Name of plan <u>PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN</u>	B Three-digit plan number (PN) ▶	<u>503</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>THE PROCTER & GAMBLE COMPANY</u>	D Employer Identification Number (EIN) <u>31-0411980</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: NT COMMON 1-5 YR CR BOND INDEX F NL

b Name of sponsor of entity listed in (a): NORTHERN TRUST INVESTMENTS, INC.

c EIN-PN <u>46-7353066-001</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>15732219</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: NT COMMON ST GOVT BOND INDEX FUND

b Name of sponsor of entity listed in (a): NORTHERN TRUST INVESTMENTS, INC.

c EIN-PN <u>36-7385651-001</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>7843221</u>
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a Name of MTIA, CCT, PSA, or 103-12 IE: NT COMMON GOVERNMENT BOND INDEX FUN

b Name of sponsor of entity listed in (a): NORTHERN TRUST INVESTMENTS, INC.

c EIN-PN <u>36-7145602-001</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>15790277</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)
-----------------	----------------------	---

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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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 07/01/2024 and ending 06/30/2025	
A Name of plan PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN	B Three-digit plan number (PN) ▶ 503
C Plan sponsor's name as shown on line 2a of Form 5500 THE PROCTER & GAMBLE COMPANY	D Employer Identification Number (EIN) 31-0411980

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.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	208067	211269
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)	14166470	6226854
(3) Other	1b(3)	255851	121964
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	24290018	35968361
(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)	39998093	39365717
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	150000	150000

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	79068499	82044165
Liabilities			
g Benefit claims payable.....	1g	33750182	43315096
h Operating payables.....	1h	16973812	22231099
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	50723994	65546195
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	28344505	16497970

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)	403191838	
(B) Participants.....	2a(1)(B)	113121121	
(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)		516312959
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	3638859	
(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)		
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		710480
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		520662298

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	504765186	
(2) To insurance carriers for the provision of benefits	2e(2)	367927	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		505133113
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)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	28971	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	27346749	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		27375720
j Total expenses. Add all expense amounts in column (b) and enter total	2j		532508833

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-11846535
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: **DELOITTE & TOUCHE LLP**

(2) EIN: **13-3891517**

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		10000000
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.)			
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 _____.

Procter & Gamble Health and Long-Term Disability Plan

EIN: 31-0411980
Plan Number: 503

Financial Statements as of and for the Years Ended June 30, 2025 and
2024, Supplemental Schedules as of and for the Year Ended June 30,
2025 and Independent Auditor's Report

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

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NOTE: All other schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.



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INDEPENDENT AUDITOR'S REPORT

To the Procter & Gamble U.S. Business Services Company:

Opinion

We have audited the financial statements of Procter & Gamble Health and Long-Term Disability Plan (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and statements of plan's benefit obligations as of June 30, 2025 and 2024, and the related statements of changes in net assets available for benefits and statements of changes in plan's benefit obligations for the years then ended, and the related notes to the financial statements.

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

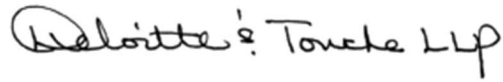
We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

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

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

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

Deloitte & Touche LLP

December 11, 2025

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
AS OF JUNE 30, 2025 AND 2024**

	2025	2024
ASSETS —		
Investments —		
Common collective trust funds	\$ 39,365,717	\$ 39,998,093
Cash	211,269	208,067
Money market funds	35,968,361	24,290,018
	<hr/>	<hr/>
Total investments	75,545,347	64,496,178
Participant contributions receivable	6,226,854	14,166,470
Advances to insurance companies	150,000	150,000
Investment income receivable	121,964	255,851
	<hr/>	<hr/>
Total assets	82,044,165	79,068,499
	<hr/>	<hr/>
LIABILITIES —		
Administrative expenses payable	9,918	25,367
Contributions received in advance	42,276	46,078
Reimbursement payable (see Note 5)	22,188,823	16,927,734
	<hr/>	<hr/>
Total liabilities	22,241,017	16,999,179
	<hr/>	<hr/>
NET ASSETS AVAILABLE FOR BENEFITS	\$ 59,803,148	\$ 62,069,320
	<hr/> <hr/>	<hr/> <hr/>

See notes to financial statements.

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
FOR THE YEARS ENDED JUNE 30, 2025 AND 2024**

	2025	2024
ADDITIONS —		
Investment income —		
Net appreciation in Fair Value of Investments	\$ 710,480	\$ 396,957
Interest	3,638,859	3,614,715
Net investment income	<u>4,349,339</u>	<u>4,011,672</u>
Contributions —		
The Procter & Gamble Company	403,191,838	358,141,932
Participants	113,121,121	115,899,980
Total contributions	<u>516,312,959</u>	<u>474,041,912</u>
Total additions	<u>520,662,298</u>	<u>478,053,584</u>
DEDUCTIONS —		
Net claims paid for participants	495,200,272	450,306,958
Administrative expenses	27,360,271	22,814,002
Medical premium expense	367,927	364,777
Total deductions	<u>522,928,470</u>	<u>473,485,737</u>
NET (DECREASE) INCREASE IN NET ASSETS	(2,266,172)	4,567,847
NET ASSETS AVAILABLE FOR BENEFITS —		
Beginning of year	<u>62,069,320</u>	<u>57,501,473</u>
End of year	<u>\$ 59,803,148</u>	<u>\$ 62,069,320</u>

See notes to financial statements.

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

**STATEMENTS OF PLAN'S BENEFIT OBLIGATIONS
AS OF JUNE 30, 2025 AND 2024**

	2025	2024
AMOUNTS CURRENTLY PAYABLE —		
Claims payable	\$ 1,361,263	\$ 1,242,850
Estimated claims incurred but not reported	<u>41,953,833</u>	<u>32,507,332</u>
Total amounts currently payable	<u>43,315,096</u>	<u>33,750,182</u>
POSTEMPLOYMENT BENEFIT OBLIGATIONS —		
Net of amounts currently payable:		
Future long-term disability benefits	58,621,000	61,567,000
Health benefits for inactive participants	<u>4,417,000</u>	<u>1,474,000</u>
Total postemployment benefit obligations	<u>63,038,000</u>	<u>63,041,000</u>
PLAN'S BENEFIT OBLIGATIONS	<u>\$ 106,353,096</u>	<u>\$ 96,791,182</u>

See notes to financial statements.

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

**STATEMENTS OF CHANGES IN PLAN'S BENEFIT OBLIGATIONS
FOR THE YEARS ENDED JUNE 30, 2025 AND 2024**

	2025	2024
AMOUNTS CURRENTLY PAYABLE:		
Balance — beginning of year	\$ 33,750,182	\$ 34,571,705
Claims reported and approved for payment	504,765,186	449,485,435
Claims paid	<u>(495,200,272)</u>	<u>(450,306,958)</u>
Balance — end of year	<u>43,315,096</u>	<u>33,750,182</u>
POSTEMPLOYMENT BENEFIT OBLIGATIONS — Net of amounts currently payable:		
Balance — beginning of year	63,041,000	61,989,000
Increase/(decrease) in postemployment benefits attributable to:		
Benefits earned	10,629,000	10,852,000
Benefits reclassified to currently payable	(15,118,257)	(14,881,287)
Interest cost	2,556,000	2,301,000
Change in actuarial assumptions	877,000	(1,171,000)
Other actuarial losses	<u>1,053,257</u>	<u>3,951,287</u>
Balance — end of year	<u>63,038,000</u>	<u>63,041,000</u>
PLAN'S BENEFIT OBLIGATIONS — End of year	<u>\$ 106,353,096</u>	<u>\$ 96,791,182</u>

See notes to financial statements.

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

NOTES TO FINANCIAL STATEMENTS AS OF AND FOR THE YEARS ENDED JUNE 30, 2025 AND 2024

1. DESCRIPTION OF THE PLAN

General — The following description of the Procter & Gamble Health and Long-Term Disability Plan (the “Plan”) is provided only for general information purposes. Participants should refer to the Plan document, including any applicable incorporated documents, for a complete description of the Plan’s terms and conditions.

The Plan is an employee welfare benefit plan that The Procter & Gamble Company (“P&G”) established to provide health and welfare benefits to the eligible employees of P&G and its subsidiaries (collectively, the “Company”). The Plan is subject the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), including where applicable the terms of the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) that are incorporated into ERISA.

The Procter & Gamble U.S. Business Services Company is the Plan administrator for the Plan. Claims administration for the Plan is handled by a combination of Company employees, third-party administrators and insurance companies (for fully-insured benefits).

The assets of the Plan are held in the Procter & Gamble Benefit Plan Trust (the “BPT”), an employee benefit plan trust that was established on September 8, 1981. The Northern Trust Company (“Northern”) serves as the directed trustee for the BPT and the Procter & Gamble Investment Committee (the “Investment Committee”) is authorized to direct the trustee. The Investment Committee is also a fiduciary for the Plan and the BPT.

Benefits — The Plan provides the following health benefits to employees of the Company and their spouses and dependents: medical, dental, prescription drugs, employee assistance program, continuation of medical coverage, short-term disability, long-term disability, and optional disability benefits. Coverage begins at the date of hire after the employee enrolls in a health care plan as long as they enroll in the calendar year of hire.

For disability, the Plan offers long-term disability, optional disability and short-term disability coverage. For long-term disability, the Plan pays a benefit equal to 50% of the employee’s average pre-disability pay. For optional disability, the Plan pays a benefit equal to 20% of the employee’s base pay. When the two coverages are combined, total disability benefits equal 70% of pre-disability pay. Benefits will continue for as long as the employee is disabled to a maximum age of 65, or if employee is disabled after reaching age 60, benefits continue for up to five years. For short-term disability, participants are eligible for benefits on the first day of the month after their first day of employment. Benefits equal to two-thirds of the participant’s average pay, as defined by the Plan, up to a maximum benefit of \$5,555.56 (effective January 1, 2019), less other disability income benefits, are paid by the Plan for each separate qualifying disability for a maximum of 52 weeks.

Contributions — For health care benefits, the Company contributes an amount to the Plan based upon the actual current year’s claim expense less the investment return earned by the Plan and participant contributions. The contributions and estimated liability for health claims incurred but not reported are determined by management based upon anticipated claims and lag factor data provided by the various insurance carriers. Contributions by participants include premiums paid by former employees of the Company to continue their enrollment in the Plan, including COBRA continuation coverage. Active employees of the Company also make contributions to participate in and extend coverage to eligible dependents for certain of the health care plans provided through the Plan.

For long-term disability benefits, the Company contributes an amount to the Plan based upon the estimated current year claim liability of the Plan. Participant contributions are made in certain locations in an amount determined by Company management in accordance with the specific Plan document for that location. For optional disability, contributions to the Plan are made by participants in an amount determined by Company management based upon anticipated claims and an actuarial determination of costs.

For short-term disability benefits, the Plan is funded by participating employees of the Company through employee payroll deductions which are contributed on an after-tax basis. The Plan provides that the Company has the discretion to make payments to the BPT from time to time as it deems advisable. Effective January 1, 2017, participants contribute 1.04% of gross pay up to the maximum covered salary of \$85,000.

Advances to Insurance Companies — Represents funds deposited with various carriers for cash flow requirements related to claim payments.

Health Flexible Spending Arrangement — The Plan also sponsors a Flexible Spending Account (“FSA”) for active employees. The FSA is 100% employee funded and employees can direct up to \$2,500 of their pre-tax compensation into the FSA plan for health care expenses.

During the fiscal years ended June 30, 2025 and 2024, employees contributed \$9,682,277 and \$10,140,359 to the FSA, respectively. Employees were reimbursed \$9,226,569 and \$9,834,360 by the FSA, and \$455,708 and \$305,999 remained available to reimburse participants for qualifying medical expenses as of June 30, 2025 and 2024, respectively.

The portion, if any, of a participant’s healthcare contributions to the FSA in which the participant does not claim reimbursement by April 15 of the following year will be forfeited. Such forfeitures will become the property of the Plan. For the calendar year ended December 31, 2023, \$592,649 was forfeited. For the calendar year ended December 31, 2024, \$613,219 was forfeited.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting — The accompanying financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP).

Use of Estimates — The preparation of financial statements in conformity with GAAP requires the Plan administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein, claims incurred but not reported, claims payable, and disclosure of contingent assets and liabilities. Actual amounts could differ from those estimates.

Risk and Uncertainties — The Plan utilizes various investment instruments. Investment securities, in general, are exposed to various risks, such as interest rate, credit, and overall market volatility, including global events which could impact the value of investment securities, such as a pandemic or international conflict. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the financial statements.

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

Unrelated Business Income Taxes — The Plan accounts for income taxes under the liability method as prescribed by Accounting Standards Codification (ASC) 740, *Income Taxes*. Under the liability method,

deferred income taxes are derived on the differences between the book and tax basis of assets and liabilities.

Estimated Future Long-Term Disability Benefits – Represents an actuarial determination of claims and future liabilities calculated using a discount rate of 4.2% and 4.51% as of the measurement date of June 30, 2025 and 2024, respectively.

Health Benefits for Inactive Participants – Represents an actuarial determination of benefits continuation liabilities for inactive participants based on a discount rate of 4.2% and 4.51% as of the measurement date of June 30, 2025 and 2024, respectively.

Estimated Health Claims Incurred but Not Reported — The Plan’s liability for incurred but unreported claims is estimated using claims expense lag factor data. It includes a liability for administrative expenses related to the estimated claims.

Investment Valuation and Income Recognition — The Plan’s investments are stated at fair value. Fair value of a financial instrument is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan’s investments in common collective trust funds are valued by the investment managers based upon the fair value of the funds’ underlying investments. Shares of money market funds are valued at quoted market prices that represent the net asset value of shares held by the Plan at year-end.

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

Benefits Payments — Benefit payments are recorded when paid by the third-party claims processor. Amounts due to claims processors that have yet to be reimbursed by the Plan are recorded as payable to claims administrators. Refunds from the Plan’s claims processor are recorded when received. Pharmacy rebates of \$36,828,877 and \$38,992,213 have been netted with claims paid for the years ended June 30, 2025 and 2024, respectively.

Administrative Expenses — Plan administrative expenses related primarily to claims processing fees and investment management fees are paid by the Plan. Certain administrative expenses related to Plan operations are paid by the Company.

Subsequent Events — For the year ended June 30, 2025, subsequent events were evaluated through December 11, 2025, the date the financial statements were available to be issued.

3. BENEFIT OBLIGATIONS FUNDING

The Plan’s total benefit obligations in excess of net assets available for benefits at June 30, 2025 and 2024 relate to postemployment benefits. The postemployment benefit obligation has been recognized for health and welfare benefits for individuals currently on long-term disability or COBRA. It is expected that the deficiency will be funded by Company and participant contributions.

4. FEDERAL INCOME TAX STATUS

The BPT established under the Plan to hold the Plan’s assets is intended to qualify pursuant to Section 501(c)(9) of the Internal Revenue Code (IRC), and accordingly, the BPT net investment income is exempt from income taxes. The BPT has obtained an exemption letter from the Internal Revenue Service. The Plan is subject to routine audits by taxing jurisdictions at any time. The Company believes

that the BPT, as amended, continues to operate in accordance with the applicable requirements of the IRC and qualify as tax-exempt. However, the BPT is subject to unrelated business taxable income tax. Income taxes of \$1,392,699 and \$1,317,517 were recorded for unrelated business taxable income for the years ended June 30, 2025 and 2024, respectively.

5. RELATED AND EXEMPT PARTY-IN-INTEREST TRANSACTIONS

Northern is the appointed custodian of the BPT. Northern manages the Plan's investments in money market funds and common collective trust funds. Therefore, these transactions qualified as party-in-interest transactions. Fees paid to Northern for investment management and custodial services were \$20,101 and \$24,110 for the years ended June 30, 2025 and 2024, respectively.

The Company's general funds are used to pay for expenses, claims and premiums of the Plan, then reimbursement is made from Plan assets to the Company in a subsequent period. Any payments made by the Company that are considered to be an expense of the Plan but due to timing have not been reimbursed by the Plan are included as reimbursement payable on the statements of net assets available for benefits.

6. PLAN TERMINATION

Although it has not expressed any intention to do so, the Company has the right under the Plan to amend or terminate the Plan subject to the provisions set forth in ERISA. In the event of termination, the Company will contribute the necessary amounts to fund all claims incurred prior to the date of termination.

7. FAIR VALUE MEASUREMENTS

ASC 820, *Fair Value Measurements and Disclosures*, provides 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, as follows: Level 1, which refers to securities valued using unadjusted quoted prices from active markets for identical assets; Level 2, which refers to securities not traded on an active market but for which observable market inputs are readily available; and Level 3, which refers to securities valued based on significant unobservable inputs. There are no Level 2 or Level 3 investments in this Plan. Assets are valued in their entirety based on the lowest level of input that is significant to the fair value measurement.

Asset Valuation Methodologies – Valuation methodologies maximize the use of relevant observable inputs and minimize the use of unobservable inputs. The following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at June 30, 2025 and 2024.

Cash — Highly liquid investments, including interest-bearing cash with maturities of three months or less when purchased are considered cash equivalents and recorded at fair value.

Money Market Funds — Valued at the daily closing price as reported by the funds. The mutual funds held by the Plan are open-ended mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value and to transact at that price. The mutual funds held by the Plan are actively traded.

Common Collective Trust Funds — Valued at the net asset value of units of the bank collective trusts as currently held by the Plan. The net asset value as provided by the trustee is used as a practical expedient to estimate fair value. The net asset value is based on the fair value of the underlying investments held by the fund less its liabilities. This practical expedient is not used when it is determined to be probable that the fund will sell the investment for an amount different from the reported net asset value. Participant transactions (purchases and sales) may occur daily. Redemption for common collective trusts is permitted daily with no other restrictions or notice periods and there are no unfunded commitments. In accordance

with GAAP, the common collective trust funds measured at net asset value have not been classified in the fair value hierarchy. The fair value amounts presented in the table below are intended to permit reconciliation to the amounts presented in the Statements of Net Assets Available for benefits.

The following tables set forth by level within the fair value hierarchy a summary of the Plan's investments measured at fair value on a recurring basis at June 30, 2025 and 2024.

	<u>Fair Value Measurements</u>	
	2025	2024
Investments Measured at Fair Value:		
Cash - Level 1	\$ 211,269	\$ 208,067
Money market funds - Level 1	35,968,361	24,290,018
Total Investments Measured at Fair Value	<u>36,179,630</u>	<u>24,498,085</u>
Investments measured at NAV:		
Common collective trust funds	<u>39,365,717</u>	<u>39,998,093</u>
Total Investments	<u>\$ 75,545,347</u>	<u>\$ 64,496,178</u>

All investment options are held with parties-in-interest

8. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits per the financial statements to the Form 5500 for the years ended June 30, 2025 and 2024:

	2025	2024
Net assets available for benefits per the financial statements	\$ 59,803,148	\$ 62,069,320
Claims payable and IBNR	(43,315,096)	(33,750,182)
Certain administrative expenses payable	9,918	25,367
	<u>16,497,970</u>	<u>28,344,505</u>
Net assets per Form 5500	\$ 16,497,970	\$ 28,344,505

The following is a reconciliation of claims paid and administrative expenses per the financial statements to the Form 5500 for the year ended June 30, 2025:

	2025
Claims paid per the financial statements	\$ 495,200,272
Less amounts payable at June 30, 2024	(33,750,182)
Add amounts payable at June 30, 2025	43,315,096
	<u>504,765,186</u>
Claims paid per Form 5500	\$ 504,765,186

	2025
Administrative expenses per the financial statements	\$ 27,360,271
Less amounts payable at June 30, 2025	(9,918)
Add amounts payable at June 30, 2024	25,367
	<u>27,375,720</u>
Administrative expenses per Form 5500	\$ 27,375,720

* * * * *

SUPPLEMENTAL SCHEDULES

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

FORM 5500, SCHEDULE H, PART IV, LINE 4i — SCHEDULE OF ASSETS (HELD AT END OF YEAR)

AS OF JUNE 30, 2025

EIN: 31-0411980

Plan No: 503

Identity of Issue	June 30, 2025	
	Cost	Fair Value
CASH	\$ 211,269	\$ 211,269
COMMON COLLECTIVE TRUST FUNDS		
Northern Trust Short Term Gov't Bond Index Fund	14,881,635	15,790,277
Northern Trust 1-5 Year Credit Bond Index Non-Lendable Fund	14,847,574	15,732,219
Northern Trust Daily Short Term Gov't Bond Index Fund	7,497,753	7,843,221
MUTUAL FUND		
Northern Trust Money Market Funds	35,968,361	35,968,361
TOTAL	<u>\$ 73,406,592</u>	<u>\$ 75,545,347</u>

All investment options are held with parties-in-interest

PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN

FORM 5500, SCHEDULE H, PART IV, LINE 4j— REPORTABLE TRANSACTIONS
 FOR THE YEAR ENDED JUNE 30, 2025
 EIN: 31-0411980
 Plan No: 503

<u>Identity of Party Involved and Description of Assets</u>	<u>Purchases</u>	<u>(A)</u>	<u>Sales</u>	<u>(A)</u>	<u>Cost of Sales</u>	<u>Gain/(Loss)</u>
Single Transactions						
Northern Trust Money Market	\$ 8,030,631		\$ -		\$ -	\$ -
Northern Trust Money Market	6,084,584		-		-	-
Northern Trust Money Market	5,981,411		-		-	-
Northern Trust Money Market	5,827,555		-		-	-
Northern Trust Money Market	6,186,094		-		-	-
Northern Trust Money Market	6,183,433		-		-	-
Northern Trust Money Market	6,331,872		-		-	-
Northern Trust Money Market	5,957,591		-		-	-
Northern Trust Money Market	5,956,990		-		-	-
Northern Trust Money Market	6,207,321		-		-	-
Northern Trust Money Market	7,633,417		-		-	-
Northern Trust Money Market	5,827,555		-		-	-
Northern Trust Money Market	6,003,354		-		-	-
Northern Trust Money Market	7,633,417		-		-	-
Northern Trust Money Market	6,002,904		-		-	-
Northern Trust Money Market	6,221,094		-		-	-
Northern Trust Money Market	12,372,187		-		-	-
Northern Trust Money Market	8,030,631		-		-	-
Northern Trust Money Market	6,293,454		-		-	-
Northern Trust Money Market	5,957,591		-		-	-
Northern Trust Money Market	5,956,990		-		-	-
Northern Trust Money Market	-		20,319,428		20,319,428	-
Northern Trust Money Market	-		4,878,729		4,878,729	-
Northern Trust Money Market	-		8,030,631		8,030,631	-
Northern Trust Money Market	-		5,956,990		5,956,990	-
Northern Trust Money Market	-		6,207,321		6,207,321	-
Northern Trust Money Market	-		5,479,623		5,479,623	-
Northern Trust Money Market	-		5,827,105		5,827,105	-
Northern Trust Money Market	-		18,009,496		18,009,496	-
Northern Trust Money Market	-		19,641,753		19,641,753	-
Northern Trust Money Market	-		5,822,020		5,822,020	-
Northern Trust Money Market	-		18,404,253		18,404,253	-
Northern Trust Money Market	-		12,372,187		12,372,187	-
Northern Trust Money Market	-		7,633,417		7,633,417	-
Northern Trust Money Market	-		5,740,805		5,740,805	-
Northern Trust Money Market	-		6,002,904		6,002,904	-
Northern Trust Money Market	-		4,723,542		4,723,542	-
Series of Transactions						
Northern Trust Money Market Fund	182,716,204	(133)	171,037,861	(53)	171,037,861	-
Northern Trust 1-5 Year Credit Bond Index Non-Lendable Fund	711,562	(12)	1,334,000	(6)	1,350,154	(16,154)
Northern Trust Short Term Gov't Bond Index Fund	620,655	(12)	1,088,000	(12)	1,152,152	(64,152)
Northern Trust Daily Short Term Gov't Bond Index Fund	336,927	(12)	590,000	(5)	584,286	5,714

All investment options are held with parties-in-interest.
 (A) Represents the number of transactions in a series.

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

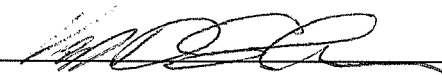
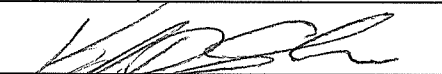
- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
 a single-employer plan a DFE (specify) _____
- B** This return/report is: the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ▶
- D** Check box if filing under: Form 5558 automatic extension 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 PROCTER & GAMBLE HEALTH AND LONG-TERM DISABILITY PLAN		1b Three-digit plan number (PN) ▶ 503
		1c Effective date of plan 07/01/1940
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) THE PROCTER & GAMBLE COMPANY		2b Employer Identification Number (EIN) 31-0411980
PROCTER AND GAMBLE TAX DIVISION P.O BOX 599 CINCINNATI, OH 45201		2c Plan Sponsor's telephone number (513) 983-7777
		2d Business code (see instructions) 325600

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		2/23/26	KYLE SCHEIDLER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		2/23/26	KYLE SCHEIDLER
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor THE PROCTER & GAMBLE U.S. BUSINESS SERVICES COMPANY GO, TE-3 ATTN - KELLEY MCCABE TWO PROCTER AND GAMBLE PLAZA CINCINNATI, OH 45202	3b Administrator's EIN 26-0048600 <hr/> 3c Administrator's telephone number (513) 983-7777
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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 <hr/> 4d PN
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5 Total number of participants at the beginning of the plan year	5	26178
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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) 26042
a(2) Total number of active participants at the end of the plan year	6a(2) 27006
b Retired or separated participants receiving benefits.....	6b 104
c Other retired or separated participants entitled to future benefits	6c 0
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d 27110
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
--	----------

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

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

4A 4D 4E 4H

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

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

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

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

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

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

Receipt Confirmation Code _____

Plan Name	Procter & Gamble Health and Long-Term Disability Plan
Plan Sponsor EIN	31-0411980
ERISA Plan #	503
Plan Year Ending	June 30, 2025

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	

Plan Name	Procter & Gamble Health and Long-Term Disability Plan
Plan Sponsor EIN	31-0411980
ERISA Plan #	503
Plan Year Ending	June 30, 2025

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	