SUMMARY ANNUAL REPORT FOR HAYNES MECHANICAL SYSTEMS, INC. HEALTH & WELFARE BENEFITS PLAN

This is a summary of the annual report of the Haynes Mechanical Systems, Inc. Health & Welfare Benefits Plan (Employer Identification Number 84-1318272, Plan Number 505) for the plan year 06/01/2023 through 05/31/2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Haynes Mechanical Systems, Inc. has committed itself to pay certain Medical and Employee Assistance Program claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with Cigna Health and Life Insurance Company and Affiliates, UnitedHealthcare Insurance Company, Vision Service Plan and Cigna Health and Life Insurance Company to pay certain Dental, Indemnity Contract, Vision, Life Insurance, Accidental Death & Dismemberment, Temporary Disability, Long-Term Disability, Hospital Care, Accidental Injury and Critical Illness claims incurred under the terms of the plan. The total premiums paid for the plan year ending 05/31/2024 were \$382,370.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 5700 S Quebec St Ste 210, Greenwood Village, CO 80111-2310 and phone number, 303-779-2012.

You also have the legally protected right to examine the annual report at the main office of the plan: 5700 S Quebec St Ste 210, Greenwood Village, CO 80111-2310, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

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

2023

This Form is Open to Public Inspection

Part I	Annual Report Id	entification information						
For cale	ndar plan year 2023 or fisca	al plan year beginning 06/01/2023		and ending 05/31/2024				
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.)					
		·····	ou doubo.,					
R This	return/report is:	a single-employer plan the first return/report	a DFE (specify the final return	· 				
D IIIIS	return/report is.	an amended return/report	별	ear return/report (less than 12 m	onths)		
C If the	plan is a collectively-barga	ined plan, check here		. ,	П.	,		
		Form 5558	automatic exte		□ ೄ	e DFVC program		
D Chec	k box if filing under:	special extension (enter description	Ш	:1151011	☐ uı	e Dr vC plogram		
E If this	in a retracetively adented	plan permitted by SECURE Act section	•					
		•		······································	Ш			
Part II	ne of plan	nation—enter all requested information	on		1h	Three-digit plan		
		S, INC. HEALTH & WELFARE BENEF	ITS PLAN			number (PN) ▶	505	
					1c	Effective date of pla 06/01/2022	an	
Mail	ing address (include room,	r, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code 3, INC.	e (if foreign, see instr	uctions)	2b	Employer Identifica Number (EIN) 84-1318272	tion	
		s, inc.			2c	number	Plan Sponsor's telephone number 303-779-2012	
	QUEBEC ST STE 210 WOOD VILLAGE, CO 8011	1-2310			2d	2d Business code (see instructions) 238220		
Caution	: A penalty for the late or	incomplete filing of this return/repo	rt will be assessed	unless reasonable cause is e	stablis	shed.		
		r penalties set forth in the instructions, Il as the electronic version of this return						
SIGN HERE	Filed with authorized/valid	electronic signature.	12/17/2024	DEBBIE FINN				
HEKE	Signature of plan admin	istrator	Date	Enter name of individual sign	ing as	plan administrator		
SIGN HERE								
TIERE	Signature of employer/p	olan sponsor	Date	Enter name of individual sign	ing as	employer or plan sp	onsor	
SIGN HERE								
				1				

Date

Signature of DFE

Enter name of individual signing as DFE

Page 2 Form 5500 (2023) **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: 4d PN а Sponsor's name Plan Name Total number of participants at the beginning of the plan year 220 5 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 220 6a(1) a(2) Total number of active participants at the end of the plan year 226 6a(2)Retired or separated participants receiving benefits..... 2 b 6b Other retired or separated participants entitled to future benefits...... 0 C 6c d Subtotal. Add lines 6a(2), 6b, and 6c. 228 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the beginning of the plan year (only defined contribution plans 6g(1)complete this item) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 6g(2)Number of participants who terminated employment during the plan year with accrued benefits that were 6h less than 100% vested..... Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)...... 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: 4B 4D 4E 4F 4H 4L 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) Trust (3) (4) General assets of the sponsor (4) General assets of the sponsor Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) a Pension Schedules **b** General Schedules R (Retirement Plan Information) (1) (1) **H** (Financial Information) I (Financial Information – Small Plan) (2) (2) MB (Multiemployer Defined Benefit Plan and Certain Money A (Insurance Information) – Number Attached _ (3) Purchase Plan Actuarial Information) - signed by the plan actuary C (Service Provider Information) (4) SB (Single-Employer Defined Benefit Plan Actuarial (3) D (DFE/Participating Plan Information) (5) Information) - signed by the plan actuary

(6)

G (Financial Transaction Schedules)

DCG (Individual Plan Information) - Number Attached

MEP (Multiple-Employer Retirement Plan Information)

(4) (5)

Part III Form W-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.)	
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.)	
11c Enter the Receipt Confirmation Code for the 2023 Form M-1 annual report. If the plan was not required to file the 2023 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.)	he
Receipt Confirmation Code	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

						Inspection	
For calendar plan year 202	23 or fiscal pla	n year beginning 06/01/2023		and en	ding 05/3	31/2024	•
A Name of plan HAYNES MECHANICAL	SYSTEMS, IN	C. HEALTH & WELFARE BENE	FITS PLAN		e-digit number (Pl	N) •	505
C Plan sponsor's name a HAYNES MECHANICAL				-	oyer Identific 1318272	cation Number (I	EIN)
		rning Insurance Contract. Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car CIGNA HEALTH AND LIFE		E COMPANY AND AFFILIATES					
/h) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
59-1031071	67369	0650229	17	3	06/01/202	23	05/31/2024
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total a	amount of com	missions paid		(b) To	otal amount	of fees paid	
		5278					0
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid	
CHERRY CREEK INSURA	NCE AGENC		IVERNESS DR W EWOOD, CO 80112				
(b) Amount of sales an	nd base	<u>F</u> e	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	5278						3
	(a) Name a	and address of the agent, broker	or other person to who	m commiss	ions or fees	were paid	
		•	,				
(b) Amount of sales an	nd base	Fe	es and other commissio	ns paid			
commissions pai		(c) Amount		(d) Purpos	е		(e) Organization code

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
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(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
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(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
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(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
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(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated a	s a unit for purposes of
4		this report.		1 4	
		ent value of plan's interest under this contract in the general account at year		5	
_		ent value of plan's interest under this contract in separate accounts at year er tracts With Allocated Funds:	10	่อ	
U	a	State the basis of premium rates •			
	u	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 con			
	-	retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(6) [] Silici (Specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin-	ating plan shock here		
_		· · · · · · · · · · · · · · · · · · ·	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts mai			
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	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)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
		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)		
		>			
		(C) Total deductions		7o(5)	0
	f	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

8 Benefit and contract type (check all applicable boxes) a	Pa	art I	II	Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individuals.	group of employees of th ing purposes if such cont	racts are expe	erience-rated as a un	it. Where co	ontracts cover indi	
e Temporary disability (accident and sickness) i Stop lose (large deductible) j HMO contract k PPO contract l I Indemnity contract m Other (specify) Experience-rated contracts: a Premiums: (1) Amount received (2) Increase (decrease) in unwarred premium asserve 9 aga(1) (3) Increase (decrease) in unwarred premium asserve 9 aga(3) (4) Earned ((1) + (2) - (3)) 9 Benefit charges (1) Claims paid (2) Increase (decrease) in claim reserves 9 aga(3) (3) Increase (decrease) in claim reserves 9 aga(4) (4) Claims charged (1) Claims paid (2) Increase (decrease) in claim reserves 9 bb(1) (3) Increase (decrease) in claim reserves 9 bb(2) (3) Increase (decrease) in claim reserves 9 bb(3) (4) Claims charged (6) Claims charged (7) Claims charged (8) Administrative service or other fees (9) Cloim reserves 9 c(1)(A) (9) Other expenses 9 c(1)(C) (1) Other expenses 9 c(1)(C) (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) 9 c(2) d Siatus of policyholder reserves are not of year: (1) Amount held to provide benefits after retirement 9 d(2) 3) Other reserves 9 d(3) d Siatus of policyholder reserves are not of year: (1) Amount held to provide benefits after retirement or subscription charges paid to carrier. 9 cell (1) Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2)). 9 cell Dividends or retroactive rate refunds due. (Do not include	8	Bene	efit a	nd contract type (check all applicable boxes)						
i		а	He	ealth (other than dental or vision)	b X Dental	С	Vision		d Life insura	nce
i		е	Те	emporary disability (accident and sickness)	f Long-term disabili	ty g	Supplemental unem	ployment	h Prescriptio	n drug
9 Experience-rated contracts: a Premiums: (1) Amount received. (2) Increase (decrease) in amount due but unpaid. (3) Increase (decrease) in unwarred premium reserve. (4) Earned ((1) + (2) - (3)) b Benefit charges (1) Claims paid. (2) Increase (decrease) in claim reserves. (3) Incurred claims (add (1) and (2)). (4) Claims charged. (4) Camed refine (1) Retention charges (on an accrual basis) - (A) Commissions. (B) Administrative service or other fees. (C) Other specific acquisition costs. (B) Administrative service or other fees. (C) Other specific acquisition costs. (E) Taxes. (B) Commissions. (C) Other reserves. (E) Taxes. (C) Other reserves. (E) Taxes. (C) Other retreation charges. (E) Taxes. (C) Other retreation charges. (E) Total retention. (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited). (2) Claim reserves. (3) Other reserves. (4) Commissions. (5) Other reserves. (6) Other reserves and of year. (1) Amount held to provide benefits after retirement (2) Other reserves. (3) Other reserves. (4) Earned (1)		ι Γ	Sto	op loss (large deductible)	<u>=</u>				I X Indemnity	contract
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(B) Administrative service or other fees		C				9c(1)(A)			-	
(C) Other specific acquisition costs				()					_	
(D) Other expenses				()					-	
(E) Taxes									-	
(F) Charges for risks or other contingencies				` , '					_	
(G) Other retention charges				()					_	
(H) Total retention									_	
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d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement					_	_				
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e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		a			•					
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 133401 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?			. ,							
10 Nonexperience-rated contracts: a Total premiums or subscription charges paid to carrier		_	` '							
a Total premiums or subscription charges paid to carrier	40				ot include amount entere	d in line 9c(2)	.)	9e		
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	10									
retention of the contract or policy, other than reported in Part I, line 2 above, report amount		а	Tota	al premiums or subscription charges paid to c	arrier			10a		133401
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?								10b		
Part IV Provision of Information 11 Did the insurance company fail to provide any information necessary to complete Schedule A?					orted in Part I, line 2 abov	e, report amo	ount	100		
11 Did the insurance company fail to provide any information necessary to complete Schedule A?										
	Pa	art l	٧	Provision of Information						
				insurance company fail to provide any inform	ation necessary to comp	lete Schedule	A?	Yes	X No	
								1		

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

OMB No. 1210-0110

mmar. and to FDICA ===tion 400(=\0)						rm is Open to Public Inspection	
For calendar plan year 202		and en	ding 05/3	1/2024			
A Name of plan HAYNES MECHANICAL	EFITS PLAN	B Three	e-digit number (PN) •	505		
C Plan sponsor's name a HAYNES MECHANICAL	SYSTEMS, IN	C.		84-	-1318272	ation Number	
		rning Insurance Contract. A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		DMPANY					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a		(6)		contract year
	code	identification number	policy or contrac	•	()	From	(g) To
36-2739571	79413	305080	278	278 06/01/2023			05/31/2024
2 Insurance fee and communication descending order of the		ation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	orokers, and o	other persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
	40074 0						
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	` '	and address of the agent, broke	•		ions or fees	were paid	
CHERRY CREEK INSURA	NCE AGENC		NVERNESS DRIVE WES LEWOOD, CO 80112-500				
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code
	40074						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
						·	
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(0)		,	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

F	Part	Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier ma	y be treated a	s a unit for purposes of
4		this report.		1 4	
		ent value of plan's interest under this contract in the general account at year		5	
_		ent value of plan's interest under this contract in separate accounts at year er tracts With Allocated Funds:	10	่อ	
U	a	State the basis of premium rates •			
	u	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 con			
	-	retention of the contract or policy, enter amount.	•	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
		(6) [] Silici (Specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin-	ating plan shock here		
_		· · · · · · · · · · · · · · · · · · ·	<u> </u>		
1		tracts With Unallocated Funds (Do not include portions of these contracts mai			
	а		te participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	С	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)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
		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)		
		>			
		(C) Total deductions		7o(5)	0
	f	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	art	Welfare Benefit Contract Information If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such cont employees, the entire group of such individual contracts with each care.	racts are ex	хре	rience-rated as a un	it. Where co	ontract	s cover individual
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	С	:П	Vision		d X	Life insurance
	е	Temporary disability (accident and sickness) f Long-term disabili	ty g	īĒ	Supplemental unem	nplovment	h⊟	Prescription drug
	i	Stop loss (large deductible) j HMO contract	, s k		PPO contract			Indemnity contract
	m	☐ Other (specify) ► ACCIDENTAL DEATH & DISMEMBERMENT					ш	
	[
9	Ехре	perience-rated contracts:						
		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		9b(1)					
		(2) Increase (decrease) in claim reserves	9b(2)					
		(3) Incurred claims (add (1) and (2))				9b(3)		(
		(4) Claims charged				9b(4)		
	С	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 paid ir	cash, or	С	redited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide	benefits aft	ter ı	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include amount entered	d in line 9c((2) .))	9e		
10	No	lonexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		19342
	b	If the carrier, service, or other organization incurred any specific costs in c	onnection v	with	the acquisition or			
		retention of the contract or policy, other than reported in Part I, line 2 above				10b		
	Spe	ecify nature of costs.						
P	art	IV Provision of Information				-	_	
11	Dic	id the insurance company fail to provide any information necessary to comp	lete Schedu	ule	A?	Yes	X No)
12	lf t	the answer to line 11 is "Yes," specify the information not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

n						m is Open to Public Inspection		
For calendar plan year 202	23 or fiscal pla	an year beginning 06/01/2023		and en	ding 05/31			
A Name of plan HAYNES MECHANICAL	SYSTEMS, IN	NC. HEALTH & WELFARE BEN	EFITS PLAN		e-digit number (PN)	<u> </u>	505	
C Plan sponsor's name as shown on line 2a of Form 5500 HAYNES MECHANICAL SYSTEMS, INC. D Employer Identification Number (EII 84-1318272					(EIN)			
		erning Insurance Contra A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance car VISION SERVICE PLAN	rrier							
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a		(0)	-	ontract year	
	code	identification number	policy or contrac	t year	(1)	rom	(g) To	
06-1227840	39616	30057820	15	1	06/01/2023		05/31/2024	
2 Insurance fee and communication descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3	the agents, b	rokers, and o	ther persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		1093					0	
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).				
	` '	and address of the agent, broke	•		ions or fees w	vere paid		
CHERRY CREEK INSURA	NCE AGENC		NVERNESS DR W STE 8 LEWOOD, CO 80112-500					
(b) Amount of sales ar	nd base	F	ees and other commissio	ns paid				
commissions pai	d	(c) Amount		(d) Purpose	е		(e) Organization code	
	1093						3	
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees w	vere paid		
	(4)	a aaa	., c. s psssss			.o.o para		
(b) Amount of sales ar	nd base	Ę	ees and other commissio	ns paid				
commissions pai		(c) Amount		(d) Purpose	е		(e) Organization code	

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(0)		,	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II			idual contracto with cook corrier w	ov he treeted o	a a unit for numacos of
		Where individual contracts are provided, the entire group of such individual this report.	idual contracts with each carrier m	ay be treated as	s a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
_		ent value of plan's interest under this contract in separate accounts at year e			
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferre	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a terminate	nating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	0
	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)	0
	Ь	Total of balance and additions (add lines 7b and 7c(6)).		7d	0
		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)		
		•			
		(-)		70/5\	0
	,	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	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 reportin employees, the entire group of such individua	g purposes if such cont	tracts are	expe	erience-rated as a uni	t. Where co	ontracts cover individ	lual
8	Rene	efit and contract type (check all applicable boxes)	a contracto with cach of	arrier may		ireated as a armit for pr	arposco or t	по горога	
Ü	a [Dental		c X	Vision		d Life insurance	2
	L	-							
	е		Long-term disabili	-	g∐		ployment	h Prescription of	-
	İ	Stop loss (large deductible)	HMO contract		k 📗	PPO contract		I Indemnity cor	ntract
	m	Other (specify)							
								_	
9	Expe	erience-rated contracts:						_	
		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)				_	
		(3) Increase (decrease) in unearned premium reser		9a(3)			0-(4)		
	-	(4) Earned ((1) + (2) - (3))					. 9a(4)		
		Benefit charges (1) Claims paid		9b(1)				_	
		(2) Increase (decrease) in claim reserves					0h/3\		
		(3) Incurred claims (add (1) and (2))(4) Claims charged					9b(3) 9b(4)		
		Remainder of premium: (1) Retention charges (on					35(4)		
	·	(A) Commissions	•	9c(1)(/	Δ)				
		(B) Administrative service or other fees		9c(1)(I					
		(C) Other specific acquisition costs		9c(1)(0					
		(D) Other expenses		9c(1)(I	_				
		(E) Taxes		9c(1)(E	Ξ)				
		(F) Charges for risks or other contingencies		9c(1)(F	=)				
		(G) Other retention charges		9c(1)(0	3)				
		(H) Total retention	<u></u>		<u></u>		9c(1)(H))	
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid ir	n cash, or		credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entere	d in line 9	c(2).)	9e		
10		nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to car	rier				10a		18367
	b	If the carrier, service, or other organization incurred					10h		
	Spe	retention of the contract or policy, other than report cify nature of costs.	ed in Part I, line 2 abov	e, report	amo	unt	10b		
	Opo	ony manane or coole.							
Р	art I	IV Provision of Information							
11	Did	the insurance company fail to provide any information	tion necessary to comp	lete Sche	dule	A?	Yes	X No	
12	l If th	he answer to line 11 is "Yes," specify the information	n not provided.						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

nn. t + FDICAt 400(-)(0)						m is Open to Public Inspection	
For calendar plan year 202	23 or fiscal pla	an year beginning 06/01/2023		and en	nding 05/31/20		
A Name of plan HAYNES MECHANICAL	A Name of plan HAYNES MECHANICAL SYSTEMS, INC. HEALTH & WELFARE BEN				e-digit number (PN)	<u> </u>	505
C Plan sponsor's name as shown on line 2a of Form 5500 HAYNES MECHANICAL SYSTEMS, INC. D Employer Identification Number (EIN 84-1318272					EIN)		
	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 ca CIGNA HEALTH AND LIFE		E COMPANY					
/b) FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year
(b) EIN	code	identification number	persons covered a policy or contract		(f) Fro	om	(g) To
59-1031071	67369	HC110568	5.	2	06/01/2023		05/31/2024
2 Insurance fee and communication descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, brok	cers, and ot	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
1661 0							
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	• • •	and address of the agent, broke		m commiss	sions or fees wer	e paid	
CHERRY CREEK INSURA	INCE AGENO		NVERNESS DRIVE W LEWOOD, CO 80112				
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa	id	(c) Amount		(d) Purpose	e		(e) Organization code
	1661						3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	sions or fees wer	e paid	
	(4)	<u></u>	.,			o paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(0)		,	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier ma	v he treated	Las a unit for numosas of
		this report.	iddai coilliacts with each camer ma	y De litealeC	i as a unii ioi puiposes oi
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	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)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
		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)		
)			
		•			
		(-)		7-/5\	0
	,	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

	art	If more than one contract covers the same group of emp the information may be combined for reporting purposes employees, the entire group of such individual contracts	if such contracts are	ехре	erience-rated as a ur	it. Where co	ntracts o	cover individual
8	Ben	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) b Denta	l	С	Vision		d 📙 Li	fe insurance
	е	Temporary disability (accident and sickness) f Long-t	erm disability	g	Supplemental uner	nployment	h P	rescription drug
	ιĒ	Stop loss (large deductible) j HMO	contract	k 🗌	PPO contract		ı∐ın	demnity contract
	m	X Other (specify) ►HOSPITAL CARE		Ш]		- □	,
	•••• [dilei (specify)						
9	Exne	erience-rated contracts:						
•		Premiums: (1) Amount received	9a(1)				╡	
	u ,	(2) Increase (decrease) in amount due but unpaid					╡	
		(3) Increase (decrease) in unearned premium reserve					_	
		(4) Earned ((1) + (2) - (3))				9a(4)		(
	b	Benefit charges (1) Claims paid						
	-	(2) Increase (decrease) in claim reserves					7	
		(3) Incurred claims (add (1) and (2))				9b(3)		(
		(4) Claims charged				9b(4)		
	С	Remainder of premium: (1) Retention charges (on an accrual l						
		(A) Commissions	- 4014	۹)			7	
		(B) Administrative service or other fees	- 400				7	
		(C) Other specific acquisition costs	2 (4) (4				7	
		(D) Other expenses	0-/4\/	D)				
		(E) Taxes	9c(1)(l	Ξ)				
		(F) Charges for risks or other contingencies	9c(1)(l	=)				
		(G) Other retention charges	9c(1)(3)				
		(H) Total retention				9c(1)(H)		(
		(2) Dividends or retroactive rate refunds. (These amounts were	re paid in cash, or		credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held	d to provide benefits	after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not include am	ount entered in line 9	c(2).	.)	9e		
10) No	nexperience-rated contracts:						
	а	Total premiums or subscription charges paid to carrier				10a		1102
	b	If the carrier, service, or other organization incurred any specif	ic costs in connection	n with	h the acquisition or			
	_	retention of the contract or policy, other than reported in Part I	, line 2 above, report	amo	unt	10b		
	Spe	cify nature of costs.						
P	art	IV Provision of Information						
		the insurance company fail to provide any information necessing	ary to complete Sche	dule	A?	Yes	X No	
		he answer to line 11 is "Yes," specify the information not provid			_			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

pursuant to ERISA section 103(a)(2).							Inspection
For calendar plan year 202	23 or fiscal pla	n year beginning 06/01/2023		and en	ding 05/3	31/2024	•
A Name of plan HAYNES MECHANICAL	SYSTEMS, IN	C. HEALTH & WELFARE BENE	EFITS PLAN		e-digit number (Pl	N) •	505
C Plan sponsor's name as shown on line 2a of Form 5500 HAYNES MECHANICAL SYSTEMS, INC. D Employer Identification Number (EIN) 84-1318272					EIN)		
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 car CIGNA HEALTH AND LIFE		E COMPANY					
/L) FIN	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
59-1031071	67369	Al110737	6	0	06/01/202	23	05/31/2024
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
1724 0							
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
CHERRY CREEK INSURA	NCE AGENC		NVERNESS DRIVE W EWOOD, CO 80112				
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions pai	d	(c) Amount		(d) Purpose	е		(e) Organization code
	1724						3
	(a) Name a	and address of the agent, broke	r. or other person to who	m commiss	ions or fees	were paid	
		,	, , , , , , , , , , , , , , , , , , , ,				
(b) Amount of sales ar	nd hase	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose			(e) Organization code

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(0)		,	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II		II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indiv	idual contracts with each carrier ma	v he treated	Las a unit for numosas of
		this report.	iddai coilliacts with each camer ma	y De litealeC	i as a unii ioi puiposes oi
4	Curr	ent value of plan's interest under this contract in the general account at year	end	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5	
6	Con	tracts With Allocated Funds:			
	а	State the basis of premium rates			
	b	Premiums paid to carrier		6b	
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with the acquisition or	6d	
		Specify nature of costs			
	е	Type of contract: (1) individual policies (2) group deferred	d annuity		
		(3) other (specify)			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	<u> </u>		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
		(3) guaranteed investment (4) other			
	b	Balance at the end of the previous year		7b	
	С	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)	0
	d	Total of balance and additions (add lines 7b and 7c(6))		7d	0
		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)		
)			
		•			
		(-)		7-/5\	0
	,	(5) Total deductions		7e(5)	0
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0

P	art	Welfare Benefit Contract Information If more than one contract covers the same group of the information may be combined for reporting purp employees, the entire group of such individual contr	oses if such contra	acts are expe	erience-rated as a unit	t. Where co	ontracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	Dental	С	Vision		d Life insurance
	е	Temporary disability (accident and sickness) f L	ong-term disability	, g∏	Supplemental unem	plovment	h Prescription drug
	i F		IMO contract	- <u>-</u>	PPO contract	, .,	I Indemnity contract
	_ L	Other (specify) ACCIDENTAL INJURY	IIVIO CONTIACT	κ	11 O contract		I I indemnity contract
	m	Other (specify)					
<u> </u>	Evne	erience-rated contracts:					
9		Premiums: (1) Amount received	Г	9a(1)			_
		(2) Increase (decrease) in amount due but unpaid	<u> </u>	9a(1)			_
		(3) Increase (decrease) in unearned premium reserve		9a(3)			
		(4) Earned ((1) + (2) - (3))	_			. 9a(4)	0
	b	Benefit charges (1) Claims paid		9b(1)		. Ja(+)	
		(2) Increase (decrease) in claim reserves					
		(3) Incurred claims (add (1) and (2))				9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on an acc		•••••		35(4)	
	·	(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	<u> </u>	9c(1)(E)			
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges					
		(H) Total retention	·			9c(1)(H)	0
		(2) Dividends or retroactive rate refunds. (These amount	_	_		9c(2)	
	d	Status of policyholder reserves at end of year: (1) Amour	_			9d(1)	
	u	(2) Claim reserves	•			9d(1)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not includ				9e	
10		nexperience-rated contracts:	c amount ontorea	30(2) .	<i>,</i> ,	<u> </u>	
. •	a	Total premiums or subscription charges paid to carrier				10a	11460
		, , , , , , , , , , , , , , , , , , , ,				100	11400
	b	If the carrier, service, or other organization incurred any sertention of the contract or policy, other than reported in I				10b	
	Spe	cify nature of costs.		,			-
D	art l	V Provision of Information					
	art					Vas	V Na
		the insurance company fail to provide any information ne		te Schedule	A?	Yes	× No
12	If t	he answer to line 11 is "Yes," specify the information not p	rovided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

						Inspection	
For calendar plan year 202	23 or fiscal pla	n year beginning 06/01/2023		and en	ding 05/3	31/2024	•
A Name of plan HAYNES MECHANICAL	SYSTEMS, IN	C. HEALTH & WELFARE BENE	EFITS PLAN		e-digit number (Pl	N) •	505
C Plan sponsor's name as shown on line 2a of Form 5500 HAYNES MECHANICAL SYSTEMS, INC. D Employer Identification Number (EIN) 84-1318272						EIN)	
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 car CIGNA HEALTH AND LIFE		E COMPANY					
a > =	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contract		(f)	From	(g) To
59-1031071	67369	CI110707	7	78 06/01/2023		23	05/31/2024
2 Insurance fee and communication descending order of the		ation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
2208 0							
3 Persons receiving com	missions and f	ees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
CHERRY CREEK INSURA	NCE AGENC		IVERNESS DRIVE W EWOOD, CO 80112				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions pai		(c) Amount		(d) Purpose	e		(e) Organization code
	2208						3
	(a) Name a	and address of the agent, broker	r, or other person to who	m commiss	ions or fees	were paid	
			,				
(b) Amount of sales ar	nd base	Fe	es and other commission	ns paid			
commissions paid (c) Amount				(d) Purpose			(e) Organization code

(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Food and other commissions paid	(0)
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization
commissions paid	(c) Amount	(u) r uipose	code
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
·			
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(0)		,	
			T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
commissions paid			0000
(a) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid	
(a) Nai	ne and address of the agent, broker	, or other person to whom commissions or rees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Part II			idual contracts with each carrier ma	v he treated	as a unit for nurnoses of			
	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	Curr	ent value of plan's interest under this contract in the general account at year	end	4				
5	Curr	ent value of plan's interest under this contract in separate accounts at year e	nd	5				
6	Con	tracts With Allocated Funds:						
	а	State the basis of premium rates						
	b	Premiums paid to carrier		6b				
	С	Premiums due but unpaid at the end of the year		6c				
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount.	nnection with the acquisition or	6d				
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan, check here					
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in separate accounts)					
	а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee					
		(3) guaranteed investment (4) other						
	b	Balance at the end of the previous year		7b				
	С	Additions: (1) Contributions deposited during the year	7c(1)	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)					
)						
	(C)Tatal additions			7c(6)	0			
	Ч	(6)Total additions		7d	0			
		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)	0			
	f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7 f	0			

P	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	Ben	nefit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision) b Dental	С	: [Vision		d	Life insurance	
	е	Temporary disability (accident and sickness) f Long-term disabil	lity g	Ē	Supplemental unem	plovment	h∏	Prescription drug	
	i	Stop loss (large deductible) j HMO contract	··· , s		PPO contract		ı	Indemnity contract	
	m	D VOLUNTARY ORITION HANGE		· L	, i i o dominado		- Ш	macrimity contract	
	••••	Other (specify)							
9	Expe	perience-rated contracts:							
Ū		Premiums: (1) Amount received	9a(1)						
	.	(2) Increase (decrease) in amount due but unpaid	9a(2)	1					
		(3) Increase (decrease) in unearned premium reserve	9a(3)						
		(4) Earned ((1) + (2) - (3))				9a(4)		(
	b		9b(1)	T		04(4)			
	~	(2) Increase (decrease) in claim reserves		_					
		(3) Incurred claims (add (1) and (2))		!		9b(3)			
		(4) Claims charged				9b(4)			
	_					30(4)			
	С		00/1)///	. 1					
		(A) Commissions	9c(1)(A)				_		
		(B) Administrative service or other fees	9c(1)(B) 9c(1)(C)						
		(C) Other specific acquisition costs	9c(1)(D)	_					
		(D) Other expenses	9c(1)(E)	_					
		(E) Taxes	9c(1)(F)	_					
		(F) Charges for risks or other contingencies	9c(1)(G)	_					
		(G) Other retention charges				00/1\/	`	(
		(H) Total retention	_	_		9c(1)(H	'		
		(2) Dividends or retroactive rate refunds. (These amounts were paid i				9c(2)			
	d					9d(1)			
		(2) Claim reserves				9d(2)			
		(3) Other reserves				9d(3)			
	е	()	ed in line 9c((2).	. <u>)</u>	9e			
10	No	onexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carrier				10a		1469	
	b								
	_	retention of the contract or policy, other than reported in Part I, line 2 abo	ve, report ar	mo	unt	10b			
	Spe	ecify nature of costs.							
D	art	IV Provision of Information							
				_			□	<u> </u>	
		id the insurance company fail to provide any information necessary to comp	olete Schedu	ule	A?	Yes	X N	0	
12	lf t	the answer to line 11 is "Yes," specify the information not provided.							

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

2023

This Form is Open to Public Inspection

Part I	Annual Report Id	lentification Information								
For cale	ndar plan year 2023 or fisc	cal plan year beginning 06/01/20)23	and ending	05/31/2	024				
A This	return/report is for:	-	box must provide participating form instructions.)							
		X a single-employer plan	a DFE (specify	·)		,				
B This	return/report is:	the first return/report	the final return							
		an amended return/report	a short plan ye	ear return/report (less	than 12 mon	nths)				
C If the	plan is a collectively-barga	ained plan, check here			▶ 🗍					
D Chec	k box if filing under:	Form 5558	automatic exte	automatic extension			DFVC program			
	gg	special extension (enter description	n)							
E If this	E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here									
Part II	Basic Plan Inforr	nation—enter all requested information	on							
	ne of plan	SYSTEMS, INC. HEALTH &		FITS PLAN		1b Three-digit plan number (PN) ▶	505			
		21012112, 2110, 112112111 a	,,	1 1 2 1 1 1 1 1	,	1c Effective date of plan 06/01/2022				
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)					:	2b Employer Identification Number (EIN) 84-1318272				
HAYNES MECHANICAL SYSTEMS, INC. 5700 S QUEBEC ST STE 210						2c Plan Sponsor's telephonumber 303-779-2012				
						2d Business code (see instructions) 238220				
GRI	EENWOOD VILLAGE									
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	Dubbic Finn		12/10/2024	12:59 PM PST DEBBIE FINN						
HERE	Signature of plan admi	nistrator	Date	Enter name of individual signi		as plan administrator				
SIGN HERE										

Date

Date

Signature of employer/plan sponsor

Signature of DFE

SIGN HERE Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

	Form 5500 (2023) Page 2							
3a	Plan admir	administrator's name and address 🗵 Same as Plan Sponsor			3b Administrator's EIN			
							ninistrator's telephone nber	
4		e and/or EIN of the plan sponsor or the plan name has changed plan sponsor's name, EIN, the plan name and the plan number fr				4b EIN	I	
a c	Sponsor's name Plan Name					4d PN		
5	Total numb	per of participants at the beginning of the plan year				5	220	
6		participants as of the end of the plan year unless otherwise stat 6c , and 6d).	ed (welfare plar	ns com	nplete only lines 6a(1),			
a(1) Total nu	umber of active participants at the beginning of the plan year $$				6a(1)	220	
a(2) Total nu	umber of active participants at the end of the plan year				6a(2)	226	
b	Retired	or separated participants receiving benefits					2	
С	Other re	etired or separated participants entitled to future benefits				6c	0	
d	Subtota	al. Add lines 6a(2) , 6b , and 6c				6d	228	
е	Deceas	sed participants whose beneficiaries are receiving or are entitled	to receive bene	efits		6e		
f		Add lines 6d and 6e				6f		
g	comple	r of participants with account balances as of the beginning of the te this item)				6g(1)		
g		r of participants with account balances as of the end of the plan te this item)				6g(2)		
h	Numbe	r of participants who terminated employment during the plan yea	r with accrued l	benefi	ts that were			
7		an 100% vestedotal number of employers obligated to contribute to the plan (onl				6h		
8a		provides pension benefits, enter the applicable pension feature of					nstructions:	
b								
9а	Plan fundir	ng arrangement (check all that apply) Insurance	96 Plan be (1)	enefit :	arrangement (check all that Insurance	at apply)		
	(2)	Code section 412(e)(3) insurance contracts	(2)	Ħ	Code section 412(e)(3)	insurance	e contracts	
	(3)	Trust	(3)		Trust			
	(4) X	General assets of the sponsor	(4)	X	General assets of the sp	ponsor		
10	Check all a	applicable boxes in 10a and 10b to indicate which schedules are	attached, and,	where	indicated, enter the number	ber attach	ed. (See instructions)	
а	Pension S		b Gener	al Scl		,		
	(1)	R (Retirement Plan Information)	(1)	님	H (Financial Information	•		
	(2)	MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		I (Financial Information			
	_	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	A (Insurance Informatio		ber Attached	
	 □	actuary	(4)	Ш	C (Service Provider Info	ormation)		
	(3)	SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(5)		D (DFE/Participating Pla	an Inform	ation)	
	(4)	DCG (Individual Plan Information) – Number Attached	(6)		G (Financial Transaction	n Schedu	les)	
	(5)	MEP (Multiple-Employer Retirement Plan Information)						

Receipt Confirmation Code