#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

A This return/report is for:

**Annual Report Identification Information** 

X a multiemployer plan;

a single-employer plan;

For calendar plan year 2011 or fiscal plan year beginning

## 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 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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

and ending

a multiple-employer plan; or

a DFE (specify)

OMB Nos. 1210-0110 1210-0089

2011

This Form is Open to Public Inspection

12/31/2011

B This	return/report is:	the first return/report; an amended return/report;	<u> </u>	return/report; lan year return/report (less tha	an 12 months)	
C If the	plan is a collectively-bargained p				ACTAIN CONTRACT TO DESCRIPTION OF THE STATE	
D Chec	k box if filing under:	X Form 5558;		c extension;	the DFVC program;	
500	D : DI I C	special extension (enter de				
Part 12 Non	II   Basic Plan Informat ne of plan	ion—enter all requested inform	ation		1b Three digitales	
	ne of plan EELWORKERS HEALTH AN	ID WELFARE FIND			1b Three-digit plan number (PN) ▶	501
51	EBBWOKKEKO HEADIN AL	NEBITARE FORD			1c Effective date of pl 09/15/1944	an
	n sponsor's name and address, in eelworkers Health &	,	mployer, if for single	-employer plan)	2b Employer Identifica Number (EIN) 23-1317409	ation
				2c Sponsor's telephone number 412-562-2296		
60	Boulevard of the Al	lies 5th Fl			2d Business code (see instructions) 331110	Э
Pit	tsburgh PA	15905	***************************************		And the sales and the sales	
Caution	: A penalty for the late or incor	nplete filing of this return/repo	rt will be assessed	unless reasonable cause is	established.	
Under po	enalties of perjury and other pena nts and attachments, as well as t	lities set forth in the instructions, ne electronic version of this retur	I declare that I have n/report, and to the b	examined this return/report, in est of my knowledge and belie	cluding accompanying sche ef, it is true, correct, and con	dules,
SIGN	CM Wood	ward	10/12/17	Emily Woodward		
HEKE	Signature of plan administrat	or	Date	Enter name of individual sig	ning as plan administrator	
SIGN HERE	Signature of employer/plan s	Way ponsor	10/12/12 Date	Thomas Conway  Enter name of individual sig	ning as employer or plan so	onsor
SIGN HERE	,,,,,,,,	U		or mandal sig	g 25 omployer or plan op	5.1501
	Signature of DEE		Date	Enter name of individual sig	ning as DEE	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2011) v.012611

	Form 5500 (2011) Page <b>2</b>		
3a	CENTRAL DATA SERVICES INC ADMINISTRATORS		ninistrator's EIN 25-1352803
	60 BOULEVARD OF THE ALLIES 5TH FL	nur	ninistrator's telephone nber 112-201-2242
	PITTSBURGH PA 15222		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN the plan number from the last return/report:	and	4b EIN
а	Sponsor's name		4c PN
5	Total number of participants at the beginning of the plan year	5	45828
6	Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).		
а	Active participants	6a	47593
b	Retired or separated participants receiving benefits	6b	670
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a, 6b, and 6c	6d	48263
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were tess than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	314
	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes		
	Plan funding arrangement (check all that apply)  (1) Insurance (2) Code section 412(e)(3) insurance contracts (3) X Trust (4) General assets of the sponsor  (4) General assets of the sponsor  (5) Plan benefit arrangement (check all that apply)  (1) X Insurance (2) Code section 412(e)(3) insurance (3) X Trust (4) General assets of the sponsor  (4) General assets of the sponsor	nsurano	e contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number of the control of	er attac	neu. (See instructions)
а	Pension Schedules b General Schedules		
	(1) R (Retirement Plan Information) (1) X H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (4)	mation) er Inform	ation)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participation Information) - signed by the plan actuary (6) G (Financial Trans	-	

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

2011

► Insurance companies are require pursuant to ERISA sec			Form is Open to Public Inspection
For calendar plan year 2011 or fiscal pla	n year beginning 01/01/2011	and ending 12/31/3	2011
A Name of plan STEELWORKERS HEALTH AN	D WELFARE FUND	B Three-digit plan number (PN)	501
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D Employer Identification Numb	er (EIN)
Steelworkers Health &	Welfare Fund	23-1317409	

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

DAVIS VISION

	(c) NAIC (d) Contract or code identification number		(e) Approximate number of	Policy or contract year		
(b) EIN			persons covered at end of policy or contract year	(f) From	(g) To	
11-3051991	00000	USW-2,5,C2,C5	24320	01/01/2011	12/31/2011	

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	55552

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

DAVISVISION

159 EXPRESS STREET

(b) Amount of sales and base	F	ees and other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		ADMINISTRATION FEES	
0	55552		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	Fees a	nd other commissions paid	
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

Schedule A (Form 5500)	2011	Page 2 -	
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pair	d
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
		Fees and other commissions paid	(a) Occasization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, bro	oker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Page 3	е 3
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_	, ,.	Investment and Apprilia Contract Information				
۲	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivitible report.	dual contra	icts with each carrier	may be treated as a unit fo	r purposes of
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 el	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	nection wit	th 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	ating 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 (3) ☐ guaranteed investment (4) ☐ other ▶	te participa	ation guarantee		
	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				
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	7c(5)			
		<b>&gt;</b>				
		(6)Total additions	L		7c(6)	0
	d	Total of balance and additions (add b and c(6)).				0
		Deductions:				
	-	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account	1			
		(4) Other (specify below)				
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		13444144471447714744444444	7f	0

	Schedule A (Form 5500) 2011		Pag	je <b>4</b>			
Part I	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts at	re experience	e-rated as a unit. Whe	re contracts	loyee organizations(s), the cover individual employees,	_
8 Ben	efit and contract type (check all applicable boxes)						
a	Health (other than dental or vision)	<b>b</b> Dental	cΧ	Vision	(	d 🗌 Life insurance	
e [	Temporary disability (accident and sickness)	f Long-term disability	g∏	Supplemental unemp	loyment I	Prescription drug	
i	Stop loss (large deductible)	i HMO contract	ĸ∏	PPO contract		Indemnity contract	
m	Other (specify)	, U	U			L3 P	
٠	<b>_</b>						
9 Exp	erience-rated contracts:						
а	Premiums: (1) Amount received		9a(1)				
	(2) Increase (decrease) in amount due but unpai	d	9a(2)				
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)				
	(4) Earned ((1) + (2) - (3))				9a(4)	(	0
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)	(	0
	(4) Claims charged				9b(4)		_
С	Remainder of premium: (1) Retention charges (						
	(A) Commissions	Ţ	9c(1)(A)				
	(B) Administrative service or other fees	_	9c(1)(B)				
	(C) Other specific acquisition costs	-	9c(1)(C)			1	
	(D) Other expenses	ļ	9c(1)(D)				
	(E) Taxes	F-	9c(1)(E)			1	
	(F) Charges for risks or other contingencies	<u></u>	9c(1)(F)			1	
	(G) Other retention charges		9c(1)(G)			1	
	(H) Total retention	_			9c(1)(H)		0
	(2) Dividends or retroactive rate refunds. (These		-		9c(2)		_
d	Status of policyholder reserves at end of year: (*)	<u> </u>		· ·	9d(1)		
u	(2) Claim reserves	•			9d(2)		-
	(3) Other reserves				9d(3)		_
	Dividends or retroactive rate refunds due. (Do r				9e		-
40 No	onexperience-rated contracts:	ior monute amount entered	πι <b>σ(Σ</b> ).)	***************************************	36		_
IU NO	mexpenence-rated contracts.						

Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

retention of the contract or policy, other than reported in Part I, item 2 above, report amount.....

423592

10a

10b

<sup>12</sup> If 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

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

Insurance Information

File as an attachment to Form 5500.

2011

OMB No. 1210-0110

Pension Benefit Guaranty Co	rporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>					n is Open to Public Inspection
For calendar plan year 20	11 or fiscal plan	year beginning 01/01/2	011	and endin	g 12	2/31/201	.1
A Name of plan STEELWORKERS H	HEALTH AND	WELFARE FUND		B Three-digit plan number (PN)		501	
C Plan sponsor's name as shown on line 2a of Form 5500				D Employe	· Identificatio	n Number (	EIN)
Steelworkers H	iealth & W	Welfare Fund		23-1317	109		
	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	rrier						
HIGHMARK							
**************************************	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f) Fr	om	(g) To
23-1294723	54771	031500/01617693	38310		01/01/	2011	12/31/2011
2 Insurance fee and come descending order of the		tion. Enter the total fees and tota	I commissions paid. L	ist in item 3 th	e agents, br	okers, and o	other persons in
(a) Total a	amount of comn	nissions paid		(b) Total	amount of f	ees paid	
		0					7642104
3 Persons receiving com	missions and fe	es. (Complete as many entries a	as needed to report all	persons).			
	(a) Name a	nd address of the agent, broker, o	or other person to who	m commission	s or fees we	re paid	
HIGHMARK							

(b) Amount of sales and base	F		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		ADMINISTRATIVE FEES	
	7642104		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	Fees a		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code

Schedule A (Form 5500)	2011	Page <b>2 -</b>	
(a) Na	me and address of the agent, t	oroker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base	/ ) 6	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, i	proker, or other person to whom commissions or fees were pai	<u>d</u>
***			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions paid	(c) Ambun	(a) r dipose	0,000
(a) Na	me and address of the agent, I	broker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions para	(5) / 1110011	, contraction of the contraction	
1 M 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A			
(a) Na	me and address of the agent, I	broker, or other person to whom commissions or fees were pai	id
		Fees and other commissions paid	() ()
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent,	broker, or other person to whom commissions or fees were pai	<u>C</u>
		Fees and other commissions paid	
	(c) Amount		(e) Organization code
,			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code

•

Pa	q	е	3

Pa	rt l	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivithis report.	idual contra	cts with each carrier ma	y be treated as	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 el				
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier		,,	6b	
	¢	Premiums due but unpaid at the end of the year		***************************************	6c	
	d	If the carrier, service, or other organization incurred any specific costs in correction of the carrier to a climate and the carrier of the carrier to a climate and the carrier of the carrier to a climate and the carrier of the car			6d	
		retention of the contract or policy, enter amount			·	
		Specify flature of costs				
	e	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
		· · · · · · · · · · · · · · · · · · ·	annuny			
		(3) other (specify)				
	_f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating 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	ite participa	tion 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)			
		<b>•</b>				
		(6)Total additions	.,		7c(6)	0
	d	Total of balance and additions (add b and c(6)).		,.,	7d	0
	е	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)			
		<b>&gt;</b>				
		(5) Total deductions	<u> </u>		7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)				0
		Bulling at the end of the current year (adminor e(a) from a) annumentation	******		··· i	

Dage	Δ

Pa	art (II	Welfare Benefit Contract Informat If more than one contract covers the same qu		rama amplay	or(e) or mambare of th	ne same empl	lovee organizations(s) the	
		information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts	are experienc	ce rated as a unit. Wh	nere contracts	cover individual employee	s.
8	Benefit	and contract type (check all applicable boxes)						
	aX	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision	(	Life insurance	
	е П⊓	Temporary disability (accident and sickness)	f \(\begin{aligned} \Long-term \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	ty g. ☐	Supplemental unem	plovment 1	n Prescription drug	
		Stop loss (large deductible)	i HMO contract	, s∟ k[	i		Indemnity contract	
		Other (specify)	1 🗆 mine seminasi		]			
		Other (specify)						
9	Experie	nce-rated contracts:						
_	•	miums: (1) Amount received		9a(1)			1	
		Increase (decrease) in amount due but unpai		<del></del>				
		Increase (decrease) in unearned premium re-						
	(4)	Earned ((1) + (2) - (3))	.,,-,,-			. 9a(4)		0
	b Be	enefit charges (1) Claims paid		9b(1)				
	(2)	Increase (decrease) in claim reserves		9b(2)				
	(3)	Incurred claims (add (1) and (2))				<u>9b(3)</u>		0
	(4)	Claims charged		•••••		9b(4)		
	c Re	emainder of premium: (1) Retention charges (	on an accrual basis)					
		(A) Commissions	,,.,,	9c(1)(A)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		- //\/				
		(D) Other expenses						
		(E) Taxes		0 (4)(5)			4	
		(F) Charges for risks or other contingencies					-	
		(G) Other retention charges				0-/41/11		0
		(H) Total retention	· · · · · · · · · · · · · · · · · · ·	_				
		) Dividends or retroactive rate refunds. (These	<b>□</b> ·	لسا		<del></del>		
		atus of policyholder reserves at end of year: (						
	,	) Claim reserves				9d(2)		
	,	) Other reserves				9d(3)		
-40		vidends or retroactive rate refunds due. (Do r	ot include amount entere	d in c(2).)	***************************************	9e		—
70		xperience-rated contracts:				40	172183	= 1 2
		otal premiums or subscription charges paid to				<u>10a</u>	1/2103.	113
		the carrier, service, or other organization incur tention of the contract or policy, other than rep				10b		
		ify nature of costs	orrow iii arri, tom a aba	vo, roperi an		··		
	Opec	ary flature of costs 7						
Р	art IV	Provision of Information						
1	Did th	e insurance company fall to provide any infor	nation necessary to comp	lete Schedul	e A?	Yes	X No	
12	2. If the	answer to line 11 is "Yes," specify the informa	tion 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.

OMB No. 1210-0110

2011

Pension Benefit Guaranty Cor	poration	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>				rm is Open to Public Inspection
For calendar plan year 201	1 or fiscal pla	an year beginning 01/01	/2011	and ending	12/31/20	011
A Name of plan STEELWORKERS HEALTH AND WELFARE FUND			B Three-dig plan nun	git nber (PN)	501	
C Pian sponsor's name as				D Employer Identification Number (EIN) 23-1317409		
Steelworkers H Part I Informatic on a separate	n Concer	Welfare Fund ning Insurance Contrac . Individual contracts grouped a	t Coverage, Fees, a as a unit in Parts II and III	and Commis	ssions Provide infor	mation for each contract e A.
1 Coverage Information:						
(a) Name of insurance car FORT DEARBORN		SURANCE COMPANY				
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From	(g) To
36-2598882	71129	MUSWAl	2578		01/01/2011	12/31/2011
2 Insurance fee and commendescending order of the		nation. Enter the total fees and t	lotal commissions paid. I	ist in item 3 the	agents, brokers, and	other persons in
		nmissions paid		(b) Total amount of fees paid		
		2562	5			0
3 Persons receiving com	missions and	fees. (Complete as many entri-	es as needed to report all	persons).		
		and address of the agent, broke			s or fees were paid	
HEALTHCARE BENEFI 1501 REEDSDALE ST	TS INC					
SUITE 304						
PITTSBURGH	I	PA 15233				1
(b) Amount of sales an	d base	F <sub>1</sub>	ees and other commission	ns paid		
commissions pai		(c) Amount		(d) Purpose		(e) Organization code

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

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

Schedule A (Form 5500)	2011	Page 2 -	
(a) Nai	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	d
(h) Assessed of college and barro		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
			14
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were pa	iu .
/h) Amount of calco and book		Fees and other commissions paid	(e) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, t	proker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions pare	(4),		
(a) Na	me and address of the agent, I	broker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ame and address of the agent,	broker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

_		2
٣	aue	J

		Investment and Annuity Contrast Information				
Pa	ırt I	Where individual contracts are provided, the entire group of such indivi	dual contra	cts with each carrier may	y be treated as	a unit for purposes of
_		this report.			4	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		rent value of plan's interest under this contract in the general account at year	5			
		rent value of plan's interest under this contract in separate accounts at year er	nd		3	
ь		tracts With Allocated Funds:				
	а	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 cor	nection wit	h the acquisition or	6d	
		retention of the contract or policy, enter amount	*******************	.,	·{	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	d annuity			
	-		annuity			
		(3) other (specify)				
	_			, п		
	f	If contract purchased, in whole or in part, to distribute benefits from a termin			,	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts ma				
	а	Type of contract: (1) deposit administration (2) immedia	te participa	tion 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			. <u>7c(6)</u>	0
	d	Total of balance and additions (add b and c(6)).			. 7d	0
	e	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account				
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)		***************************************	. 7f	0

Schedule A (Form 5500) 2011	Page <b>4</b>
Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees information may be combined for reporting purposes if such contract the entire group of such individual contracts with each carrier may be accorded.	of the same employer(s) or members of the same employee organizations(s), the tracts are experience-rated as a unit. Where contracts cover individual employees, ay 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
e Temporary disability (accident and sickness) f Long-term of	disability g Supplemental unemployment h Prescription drug
i Stop loss (large deductible) j HMO contra	act k PPO contract I Indemnity contract
m ☑ Other (specify) ▶ADD, DEPSP, LTD, STD	
9 Experience-rated contracts:	0-(4)
a Premiums: (1) Amount received	
(2) Increase (decrease) in amount due but unpaid	
(3) Increase (decrease) in unearned premium reserve	
(4) Earned ((1) + (2) - (3))	7
b Benefit charges (1) Claims paid	
(2) Increase (decrease) in claim reserves	
(3) Incurred claims (add (1) and (2))	35(3)
(4) Claims charged	
c Remainder of premium: (1) Retention charges (on an accrual basis	
(A) Commissions	
(B) Administrative service or other fees	5 (4)(6)
(C) Other specific acquisition costs	- (1)
(D) Other expenses	
(E) Taxes	
(F) Charges for risks or other contingencies	9c(1)(F)
(G) Other retention charges	
(H) Total retention	
(2) Dividends or retroactive rate refunds. (These amounts were	paid in cash, or credited.) 9c(2)
d Status of policyholder reserves at end of year: (1) Amount held to p	rovide benefits after retirement
(2) Claim reserves	9d(2)
(3) Other reserves	9d(3)
e Dividends or retroactive rate refunds due. (Do not include amount	entered in c(2).)
10 Nonexperience-rated contracts:	
a Total premiums or subscription charges paid to carrier	10a 51250
b If the carrier, service, or other organization incurred any specific co	sts in connection with the acquisition or
retention of the contract or policy, other than reported in Part I, item	

Part IV Provision of Information					
11 Did the insurance company fail to provide ar	y information necessary to complete Schedule A?	Yes	X	No	

(Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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

pursuant to ERISA section 103(a)(2). Ins					n is Open to Public nspection		
For calendar plan year 201	1 or fiscal pla	an year beginning 01/01/	2011	and ending	12/3	1/201	1
A Name of plan STEELWORKERS F	HEALTH AN	ND WELFARE FUND		B Three-dig plan nun	git nber (PN)	•	501
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500	111111111111111111111111111111111111111	D Employer	Identification N	umber (8	EIN)
Steelworkers H	lealth &	Welfare Fund		23-13174	09		
Part I Information	on Concer	ning Insurance Contract . Individual contracts grouped as					
(a) Name of insurance call		BLUE SHIELD					
			(e) Approximate n	imber of	Pol	icy or co	ntract year
(p) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	it end of	(f) From		(g) To
54-0357120	71835	48846	9327		01/01/20	11	12/31/2011
2 Insurance fee and com- descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in item 3 the	agents, broker	s, and of	her persons in
(a) Total a	mount of cor	nmissions paid		(b) Total a	amount of fees	paid	
		0		·			6472951
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).			
NORTHROP GRUMMAN ONE HORNET WAY MS 158/D3 EL SEGUNDO		and address of the agent, broke	r, or other person to who	m commissions	s or fees were p	aid	
W. F. C.	1		ees and other commission	ns paid			
(b) Amount of sales ar commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
			ADMINISTRATION FEES				
		5311284					3
EXPRESS SCRIPTS,		and address of the agent, broke	r, or other person to who	m commissions	s or fees were p	aid	
,							
(b) Amount of sales ar	nd base	Fe	ees and other commission	ns paid			
commissions paid		(c) Amount		(d) Purpose			(e) Organization code
			PRESCRIPTION DR ADMINISTRATION		S AND REI	ATED	3
For Paperwork Reduction	n Act Notice	and OMB Control Numbers, s	ee the instructions for	Form 5500.		Sched	ule A (Form 5500) 2011 v.012611

Schedule A (Form 5500)	2011	Page 2 -	
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were paid	
// A		Fees and other commissions paid	(a) Organization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent, b	proker, or other person to whom commissions or fees were paid	İ
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	ame and address of the agent h	oroker, or other person to whom commissions or fees were paid	1
1-7	5		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) N	ame and address of the agent. h	proker, or other person to whom commissions or fees were paid	<u> </u>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

P	a	n,	Ξ.	3
	ч	ч	_	v

_					
Pa	ırt II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual this report.	lual contracts wit	h each carrier may be treated as a unit for	purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd	4	
5	Curr	ent value of plan's interest under this contract in separate accounts at year en	d	5	
~		racts 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		1 6- 1	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount			
		Specify nature of costs			
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	annuity		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan check	here 🕨 🗌	
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separa	te accounts)	
	а	Type of contract: (1) deposit administration (2) immediate	e participation gu	uarantee	
		(3) guaranteed investment (4) other			
		(e, [] generate			
	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)		
		•			
		ICVT-seal additions		7c(6)	0
	لہ	(6)Total additions		71	0
		Total of balance and additions (add b and c(6))  Deductions:			
	е		7e(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)		
		(2) Administration charge made by carrier	- 75		
		(3) Transferred to separate account	7e(3)		
		(4) Other (specify below)	10(7)		
		•			
		(5) Total deductions	******		0
	f	Balance at the end of the current year (subtract e(5) from d)	*******	7f	0

	Schedule A (Form 5500) 2011		Pag	je <b>4</b>		
Part	Welfare Benefit Contract Informat If more than one contract covers the same gu information may be combined for reporting p the entire group of such individual contracts	oup of employees of the saurposes if such contracts a	re experience	e-rated as a unit. Whe	re contracts	loyee organizations(s), the scover individual employees,
8 Ber	nefit and contract type (check all applicable boxes)					
а	X Health (other than dental or vision)	<b>b</b> Dental	с∏	Vision	(	d  ☐ Life insurance
е	<u></u>	f Long-term disability	, g∏	Supplemental unempl	ovment !	h 🛛 Prescription drug
_	, , , , , , , , , , , , , , , , , , , ,	i  HMO contract	- 🗀	PPO contract	o,o	I  Indemnity contract
i	Stop loss (large deductible)	I HIMO contract	ΝД	PPO Contract		I I indefinity contract
m	Other (specify)					
9 Exc	perience-rated contracts:					
	Premiums: (1) Amount received		9a(1)			]
	(2) Increase (decrease) in amount due but unpai	đ	9a(2)			
	(3) Increase (decrease) in unearned premium re-	ī				
	(4) Earned ((1) + (2) - (3))				9a(4)	0
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)	0
	(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)	0
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or 0	redited.)	9c(2)	
đ	Status of policyholder reserves at end of year: (	1) Amount held to provide t	enefits after	retirement	9d(1)	
	(2) Claim reserves	.,			9d(2)	
	(3) Other reserves			.,.,,	9d(3)	
е	Dividends or retroactive rate refunds due. (Do r	ot include amount entered	in c(2).)		9e	
10 N	onexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			10a	87645466
b	If the carrier, service, or other organization incurretention of the contract or policy, other than rep				10b	

Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If 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

#### 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

2011

Pension Benefit Guaranty Corporation	<ul> <li>Insurance companies are required to pursuant to ERISA section 1</li> </ul>		This Form is Open to Public Inspection	
For calendar plan year 2011 or fiscal pla	n year beginning 01/01/2011	and ending 12/31	/2011	
A Name of plan STEELWORKERS HEALTH AN	D WELFARE FUND	B Three-digit plan number (PN)	501	
C Plan sponsor's name as shown on lir	ne 2a of Form 5500	D Employer Identification Num	nber (EIN)	
Steelworkers Health &	Welfare Fund	23-1317409		

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

Coverage Information:

(a) Name of insurance carrier

HIGHMARK

	(-) NIAIC	(d) Contrast so	(e) Approximate number of	Policy or co	ntract year
(b) EIN	(c) NAIC (d) Contract or code identification number		persons covered at end of policy or contract year	(f) From	(g) To
23-1294723	54771	031500/01617693	36746	01/01/2011	12/31/2011

2 Insurance fee and commission information. Enter the total fees and descending order of the amount paid.	total commissions paid. List in item 3 the agents, brokers, and other persons in
(a) Total amount of commissions paid	(b) Total amount of fees paid
_	

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	sales and base Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			1
(a) Name	and address of the agent, broker, or o	ther person to whom commissions or fees we	ere paid

Fees an	d other commissions paid	
(c) Amount	(d) Purpose	(e) Organization code
:		
	(c) Amount	

Schedule A (Form 5500)	2011	Page <b>2 -</b>	•
(a) Naı	ne and address of the agent, br	roker, or other person to whom commissions or fees were pa	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
•			
		Face and they commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
	(-,-		
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pad	ie	3

p.	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contrac	ts with each carrier may	r	unit for purposes of
		ent value of plan's interest under this contract in the general account at year			4	
5	Current value of plan's interest under this contract in separate accounts at year end				5	
6	Contracts 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 deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan c	heck here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other				
		(b) [] gadranosa irrostinsia (ii) [] sinsi				
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year				
		(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)			
		<b>*</b>				
					70(6)	0
		(6)Total additions			7c(6)	
		Total of balance and additions (add b and c(6)).		***************************************	. 70	
	е	Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account				
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			. 7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			. 7f	0

*****	Schedule A (Form 5500) 2011		Paç	je <b>4</b>		
Part I	II Welfare Benefit Contract Informat If more than one contract covers the same guinformation may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts ar	re experienc	e-rated as a unit. Whe	ere contract	oloyee organizations(s), the s cover individual employees,
8 Ber	nefit and contract type (check all applicable boxes)					
а	Health (other than dentat or vision)	<b>b</b> Dental	c 🗌	Vision		d Life insurance
е	Temporary disability (accident and sickness)	f Long-term disability	, g ∏	Supplemental unemp	loyment	h X Prescription drug
i	Stop loss (large deductible)	i HMO contract	k∏	PPO contract		I Indemnity contract
m	Other (specify)	, .	لسا			
111	Other (specify)					
9 Exc	erience-rated contracts:					
•	Premiums: (1) Amount received		9a(1)			
	(2) Increase (decrease) in amount due but unpai	d	9a(2)			
	(3) Increase (decrease) in unearned premium re-	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))	<u></u>			9a(4)	0
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)	0
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (					_
	(A) Commissions	7-	9c(1)(A)			4
	(B) Administrative service or other fees	=	9c(1)(B)			4
	(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)		••••	<u>-</u>
	(G) Other retention charges				0~(4)(H)	0
	(H) Total retention		_		9c(1)(H)	
	(2) Dividends or retroactive rate refunds. (These	٠	_		9c(2)	
d		•			9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
40 e	Dividends or retroactive rate refunds due. (Do r	not include amount entered	ın c(2).)	***************************************	9e	
	onexperience-rated contracts:	aarriar			10a	45958997
a	, , ,				iva	13330337
b	retention of the contract or policy, other than rep				10b	

Part IV	Provision of Information			
	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

(Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor

### 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

Employee Benefits Security Admir	nistration	7 1 110 45 411 4	ttadimitorit to i oim obser	1		
Pension Benefit Guaranty Corpo	oration		re required to provide the information RISA section 103(a)(2).		n is Open to Public nspection	
For calendar plan year 2011	or fiscal plan y	ear beginning 01/01/2	2011 and ending	12/31/201	1	
A Name of plan STEELWORKERS HEALTH AND WELFARE FUND				B Three-digit plan number (PN) ▶ 501		
C Plan sponsor's name as	shown on line 2	a of Form 5500	D Employer Id	entification Number (E	EIN)	
Steelworkers He	ealth & We	elfare Fund	23-131740	9		
Part I Information on a separate	n Concernir Schedule A. In	g Insurance Contract ( dividual contracts grouped as	Coverage, Fees, and Commiss a unit in Parts II and III can be reported o	ions Provide Information a single Schedule /	ation for each contract A.	
1 Coverage Information:						
(a) Name of insurance carri	er					
4.5	(c) NAIC	(d) Contract or	(e) Approximate number of	Policy or co	ntract year	
(b) EIN	1=,	' a - cifi - si - a - a - a - a - a	persons covered at end of	(f) Erom	(a) To	

	code	idestalles riamoel	policy or contract year	1,,	(3) 17
23-1294723	54771	031500/01617693	88	01/01/2011	12/31/2011
2 Insurance fee and c descending order of		tion. Enter the total fees and total	commissions paid. List in item	3 the agents, brokers, and o	other persons in
(a) Tot	tal amount of comn	nissions paid	(b) T	otal amount of fees paid	

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	Fees an		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
İ			
(a) Name o	and address of the agent broker as a	ther person to whom commissions or fees we	ere naid

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

Schedule A (Form 5500)	2011	Page 2 -	
(a) Na	me and address of the agent, br	roker, or other person to whom commissions or fees were pa	id
	-		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
		Fees and other commissions paid	(a) Occanization
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent b	roker, or other person to whom commissions or fees were pa	aid
100)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	nme and address of the agent. h	roker, or other person to whom commissions or fees were pa	aid
(5)	carro according to the original according to		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Page	3
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Pa	art II	Where individual contracts are provided, the entire group of such indivi	idual contra	cts with each carrier	may be treated as a unit fo	r purposes of
		this report.			4	
		ent value of plan's interest under this contract in the general account at year				
		ent value of plan's interest under this contract in separate accounts at year en	************			
6		racts With Allocated Funds:				
	а	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 cor				
	ч	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)				
		· · · · · · · · · · · · · · · · · · ·				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan o	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts ma				
•	a	· ·		tion guarantee		
	а	Type of contract.		3		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
					7b	0
	<u>b</u> _	Balance at the end of the previous year			/D	
	С	Additions: (1) Contributions deposited during the year	1 - (0)			
		(2) Dividends and credits	1 1			
		(3) Interest credited during the year	1 - 145			
		(4) Transferred from separate account	7c(5)			
		(5) Other (specify below)	. 10(3)			
		•				
					7 - (0)	0
	_	(6)Total additions			7c(6)	0
		Total of balance and additions (add b and c(6))		***************************************	7d	
	е	Deductions:	7-(4)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier				
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			7f	0

	Schedule A (Form 5500) 2011		Pag	ge <b>4</b>		
Part II	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts a	re experienc	e-rated as a unit. W	here contract	oloyee organizations(s), the scover individual employees,
8 Bene	efit and contract type (check all applicable boxes					
а	Health (other than dental or vision)	<b>b</b> Dental	с	Vision		d Life insurance
eΓ	Temporary disability (accident and sickness)	f Long-term disability	, g∏	Supplemental unen	ployment	h Prescription drug
i [	Stop loss (large deductible)	i HMO contract	- 1	PPO contract	, ,	I ndemnity contract
' L		1 1 11110 contract	🗠	110 contidor		. П
m [	Other (specify)					
0 5	erience-rated contracts:	***				
	Premiums: (1) Amount received	Γ	9a(1)	1,		
	(2) Increase (decrease) in amount due but unpai	} <del>-</del>	9a(2)			7
	(3) Increase (decrease) in unearned premium re	- 1	9a(3)			1
	(4) Earned ((1) + (2) - (3))	_			9a(4)	0
	Benefit charges (1) Claims paid					
	(2) Increase (decrease) in claim reserves	r				
	(3) Incurred claims (add (1) and (2))				9b(3)	0
	(4) Claims charged				9b(4)	
С	Remainder of premium: (1) Retention charges (				· · · · · · · · · · · · · · · · · · ·	
_	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees		9c(1)(B)			
	(C) Other specific acquisition costs	T	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)	0
	(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (	1) Amount held to provide t	enefits after	retirement	9d(1)	
	(2) Claim reserves					
	(3) Other reserves				9d(3)	
е	Dividends or retroactive rate refunds due. (Do				9e	
10 No	nexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			10a	257112

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

10b

**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, item 2 above, report amount......

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor

## Insurance Information

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

OMB No. 1210-0110

Employee Benefits Security Administration File as an attachment to Form 5500.								
Pension Benefit Guaranty Corporation  Insurance companies are required to provide th pursuant to ERISA section 103(a)(2).			2).		orm is Open to Public Inspection			
For calendar plan year 2	011 or fiscal pla	n year beginning 01/01	/2011	2011 and ending 12.		011		
A Name of plan STEELWORKERS	HEALTH AN	D WELFARE FUND		B Three-digit plan number (PN)				
C Plan sponsor's name	as shown on lir	ne 2a of Form 5500		' '	D Employer Identification Number (EIN)			
Steelworkers				23-1317				
		ning Insurance Contrac Individual contracts grouped a						
1 Coverage Information	):							
(a) Name of insurance of DAVISVISION/								
	(c) NAIC	(d) Contract or	(e) Approximate n		Policy or	contract year		
(b) EIN	code	identification number		persons covered at end of policy or contract year		(g) To		
06-1041332	93440	USW-001,C01	23698		01/01/2011	12/31/2011		
2 Insurance fee and con descending order of the		nation. Enter the total fees and	total commissions paid. L	ist in item 3 t	he agents, brokers, an	d other persons in		
(a) Tota	I amount of com	ımissions paid		(b) Tota	al amount of fees paid			
		!	0			9247		
3 Persons receiving co		fees. (Complete as many entri						
HIGHMARK LIFE I PO 1840		and address of the agent, brok COMPANY	er, or other person to who	m commissic	ons or fees were paid			
HARTFORD	С	T 06144-1840	0					
(b) Amount of sales	and hase	F	ees and other commission	ns paid				
commissions p	,	(c) Amount		(d) Purpose		(e) Organization code		
			INSURANCE FEES					
	0	9247				3		
	(a) Name	and address of the agent, brok	er, or other person to who	m commissio	ons or fees were paid			
	(0), (4.11)							
(h) Amount of soles	and bass	F	ees and other commission	ns paid				
(b) Amount of sales commissions p		(c) Amount		(d) Purpose		(e) Organization code		
	i i		I			ı		

Schedule A (Form 5500)	2011	Page <b>2 -</b>	
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were pair	d
		Fees and other commissions paid	(a) Occasionism
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, brok	ker, or other person to whom commissions or fees were pai	d
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, brol	ker, or other person to whom commissions or fees were pai	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent, brol	ker, or other person to whom commissions or fees were pa	id
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

_	
⊬age	,

		1				
Pa	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivitins report.	dual contra	cts with each carrier m	ay be treated as a unit f	for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end	***************************************		
5	Curr	ent value of plan's interest under this contract in separate accounts at year er	nd br		5	
6	Cont	racts With Allocated Funds:	•••			
	a	State the basis of premium rates				
	b	Premiums paid to carrier		10,11,7,7,7,7,7,1011,1011,1011,1011,101	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 corretention of the contract or policy, enter amount	nnection wit	h the acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan o	check here		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶		tion guarantee		
	b	Balance at the end of the previous year			7b	0
	С	Additions: (1) Contributions deposited during the year				
		(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)	4,		
		•				
		(6)Total additions			7c(6)	0
	þ	Total of balance and additions (add b and c(6))			7d	0
	е	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				
		(4) Other (specify below)	. 7e(4)			
		•				
		(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			7f	0

	Schedule A (Form 5500) 2011		Pa	ge 4	***	
Part	II Welfare Benefit Contract Informat If more than one contract covers the same go information may be combined for reporting po the entire group of such individual contracts of	oup of employees of the surposes if such contracts	are experienc	e-rated as a unit. Whe	re contracts	loyee organizations(s), the cover individual employees,
8 Be	nefit and contract type (check all applicable boxes)					_
а	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision	(	🕽 🛛 Life insurance
е	Temporary disability (accident and sickness)	f \ Long-term disabili	ty g	Supplemental unemp	loyment h	Prescription drug
i	Stop loss (large deductible)	j HMO contract	k [	PPO contract		I Indemnity contract
m	Other (specify)	_	-			
9 Exp	erience-rated contracts:					
а	Premiums: (1) Amount received		9a(1)			_
	(2) Increase (decrease) in amount due but unpaid	t	9a(2)			
	(3) Increase (decrease) in unearned premium res	serve	9a(3)			
	(4) Earned ((1) + (2) - (3))				9a(4)	0
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)	0
	(4) Claims charged				9b(4)	
C	Remainder of premium: (1) Retention charges (	on an accrual basis)				The state of the s
	(A) Commissions		9c(1)(A)			
	(B) Administrative service or other fees	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9c(1)(B)			
	(C) Other specific acquisition costs		9c(1)(C)			j
	(D) Other expenses		9c(1)(D)		,	_
	(E) Taxes	***************************************				
	(F) Charges for risks or other contingencies.					1
	(G) Other retention charges		9c(1)(G)			
	(H) Total retention	***************************************			9c(1)(H)	0
	(2) Dividends or retroactive rate refunds. (These	e amounts were 🗌 paid ir	cash, or	credited.)	9c(2)	
d	Status of policyholder reserves at end of year: (	I) Amount held to provide	benefits after	retirement	9d(1)	
	(2) Claim reserves				9d(2)	
	(3) Other reserves				9d(3)	
е					9e	
10 N	onexperience-rated contracts:					
а	Total premiums or subscription charges paid to	carrier			10a	205479
b		red any specific costs in o	connection wi	th the acquisition or	10b	
5	Specify nature of costs		-			
•						

Part IV	Provision of Information		_	
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If 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

## 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

This	Form	is	Open to	Public		
Inspection						

Pension Benefit Guaranty Corpor	acon	<ul> <li>Insurance companies are pursuant to El</li> </ul>	re required to provide the RISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 2011	or fiscal plan	n year beginning 01/01/2	011	and end	ng	12/31/20	11	
A Name of plan STEELWORKERS HEA	ALTH AN	D WELFARE FUND	E	3 Three- plan n	digit umber (Pl	N) <b>&gt;</b>	501	
C Plan sponsor's name as s	hown on lin	e 2a of Form 5500		<b>)</b> Employ	er Identific	ation Number (	EIN)	
Steelworkers He	alth &	Welfare Fund		3-1317				
Part I Information on a separate S	Concerr Schedule A.	ning Insurance Contract C Individual contracts grouped as a	Coverage, Fees, and unit in Parts II and III ca	d Comm	n <b>issions</b> ted on a s	Provide Inforningle Schedule	nation for each contract A.	
1 Coverage Information:								
(a) Name of insurance carrie KAISER FOUNDATI		ITH PLANS INC.						
	(c) NAIC	(d) Contract or	(e) Approximate num			Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at e policy or contract y		(f)	From	(g) To	
94-1340523	00000	9170	37		10/0	1/2010	09/30/2011	
2 Insurance fee and commis descending order of the ar		ation. Enter the total fees and tota	al commissions paid. List	in item 3 t	he agents	, brokers, and	other persons in	
		missions paid		(b) Tot	al amount	of fees paid		
3 Persons receiving commis		fees. (Complete as many entries and address of the agent, broker,			ons or fees	s were paid		
		Fee	s and other commissions	naid		_,		
(b) Amount of sales and commissions paid	base –	(c) Amount		) Purpose			(e) Organization code	
	(a) Name	and address of the agent, broker,	or other person to whom	commissio	ons or fee:	s were paid		
(b) Amount of sales and	hase	Fee	es and other commissions	paid				
commissions paid	uase	(c) Amount	(c	) Purpose			(e) Organization code	

(a) Name	and address of the agent, b	roker, or other person to whom commissions or fees were pa	id
(6) (1211)	and dear odd or and again, a		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent. In	proker, or other person to whom commissions or fees were pa	id
(a) Numo	and dedicas or the again, o	, , , , , , , , , , , , , , , , , , , ,	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Name	and address of the agent, b	proker, or other person to whom commissions or fees were pa	liu .
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions paid	(C) Althount	(d) i dipose	
(a) Name	and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
			1
(a) Name	and address of the agent, t	broker, or other person to whom commissions or fees were pa	aid
(a) Name	and address of the agent, t	broker, or other person to whom commissions or fees were pa	aid
(a) Name	and address of the agent, t	broker, or other person to whom commissions or fees were pa	aid
(a) Name	and address of the agent, t	broker, or other person to whom commissions or fees were pa	aid
	and address of the agent, t		
(b) Amount of sales and base —		broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid  (d) Purpose	(e) Organization
	and address of the agent, t	Fees and other commissions paid	(e) Organization
<b>b</b> ) Amount of sales and base —		Fees and other commissions paid	(e) Organization

.

Page	3
, ugc	v

Pai	t II Investment and Annuity Contract Information		A	the teneral in	a wait for aureance of
	Where individual contracts are provided, the entire group of such indivi- this report.	idual contrac	ts with each carrier may	oe treated as	a unit for purposes of
4 (	Current value of plan's interest under this contract in the general account at year	end		4	
	Current value of plan's interest under this contract in separate accounts at year el			5	
6 (	Contracts With Allocated Funds:				
	a State the basis of premium rates				
	·				
!	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 corretention of the contract or policy, enter amount	nnection with	the acquisition or	6d	
	Specify nature of costs				
,	Part Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan cl	neck here 🕨 🗍		
7 (	Contracts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	eparate accounts)		
	a Type of contract: (1) deposit administration (2) immedia	ite participati	ion 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	T T			
	(2) Dividends and credits	. 7c(2)			
	(3) Interest credited during the year	. 7c(3)			
	(4) Transferred from separate account				
	(5) Other (specify below)	. 7c(5)			
	<b>&gt;</b>				
	(6)Total additions			. 7c(6)	0
	d Total of balance and additions (add b and c(6)).			. 7d	0
	e Deductions:	Γ			
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
	(2) Administration charge made by carrier	(-)			
	(3) Transferred to separate account				
	(4) Other (specify below)	7e(4)			
	•				
	·			-	
				70/5)	0
	(5) Total deductions			7e(5) 7f	0
	f Balance at the end of the current year (subtract e(5) from d)			<u>.                                    </u>	V

	Schedule A (Form 5500) 2011		Pag	e 4		
Part	Welfare Benefit Contract Informat If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the sa urposes if such contracts a	re experience	e-rated as a unit. Where contra	mployee organizations(s), the acts cover individual employees.	+
8 Bei	nefit and contract type (check all applicable boxes)				_	
а	X Health (other than dental or vision)	<b>b</b> Dental	c 🗌	Vision	d 🗌 Life insurance	
е	Temporary disability (accident and sickness)	f Long-term disability	g∏	Supplemental unemployment	h Prescription drug	
i	Stop loss (large deductible)	i HMO contract	k∏	PPO contract	I ndemnity contract	
		,			<u> </u>	
m	Other (specify)					
9 Evr	perience-rated contracts:					_
	Premiums: (1) Amount received	Γ	9a(1)			
-	(2) Increase (decrease) in amount due but unpai		9a(2)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	(3) Increase (decrease) in unearned premium re-		9a(3)			
	(4) Earned ((1) + (2) - (3))	`````		9a(4)	)	0
d	Benefit charges (1) Claims paid		9b(1)			
	(2) Increase (decrease) in claim reserves		9b(2)			
	(3) Incurred claims (add (1) and (2))			9b(3	)	0
	(4) Claims charged			9b(4)	)	
С		_				
	(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			0-/4\/	us l	0
	(H) Total retention	_				
_	(2) Dividends or retroactive rate refunds. (Thes	_	-		/	—
d	· · · · · · · · · · · · · · · · · · ·	•			<u> </u>	
	(2) Claim reserves				<i>t</i>	
	(3) Other reserves				<del></del>	—
	Dividends or retroactive rate refunds due. (Do r	not include amount entered	ın c(2).)	9e		—
	Ionexperience-rated contracts:			10a	3040	17
a	• • • • • • • • • • • • • • • • • • • •				3040.	
b	If the carrier, service, or other organization incu					

Part IV Provision of Information			
11 Did the insurance company fall to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If 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

2011

This Form is Open to Public

pursuant to ERISA section	103(a)(2). Inspection	
For calendar plan year 2011 or fiscal plan year beginning 01/01/2011	and ending 12/31/2011	
A Name of plan STEELWORKERS HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501	
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)	
Steelworkers Health & Welfare Fund	23-1317409	

Information Concerning Insurance Contract Coverage, Fees, and Commissions Provide Information for each contract Part I 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

CAREMARK-ARCELORMITTAL

	( ) 3/4/0	/-D Combined on	(e) Approximate number of	Policy or c	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end of policy or contract year	(f) From	(g) To
05-0340626	44611	2003700	11372	01/01/2011	12/31/2011

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	6000

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

CAREMARK-ARCELORMITTAL

(b) Amount of sales and base	Fe		
commissions paid	(c) Amount	(d) Purpose	(e) Organization cod
	F	REPORT FEE	
	6000		3

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

(h) Amount of solar and hass	Fees an	d other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			i

Schedule A (Form 5500)	2011	Page <b>2 -</b>	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base	<u></u>	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	ime and address of the agent, broke	er, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) N	ame and address of the agent, broke	er, or other person to whom commissions or fees were paid	1
(0)			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

~	
Page	٠

p.	art II	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivi- this report.	dual contracts	with each carrier may		ınit for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year o	end		4	
5	Curre	ent value of plan's interest under this contract in separate accounts at year er	nd		5	
6	Cont	racts 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 t	he acquisition or	6d	
		Specify nature of costs				
	е	Type of contract: (1) ☐ individual policies (2) ☐ group deferred (3) ☐ other (specify) ▶	3 annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan che	eck here 🕨 🗌		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts ma	intained in sep	parate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	te participatio	n 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				
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		•				
			İ			
		(6)Total additions			, 7c(6)	0
	٨	Total of balance and additions (add b and c(6)).			7d	0
		Deductions:			1	
	е		7e(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year	. 7e(2)			
		(2) Administration charge made by carrier	. 7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	· / C(4) L			
		<b>)</b>				
		(5) Total deductions			7e(5)	0
	f	Relance at the end of the current year (subtract e/5) from d)			7f	0

	Schedule A (Form 5500) 2011	Page <b>4</b>	
Pai	rt III Welfare Benefit Contract Information If more than one contract covers the same group of emplo information may be combined for reporting purposes if suc the entire group of such individual contracts with each car	yees of the same employer(s) or members of the same employee organizations(s), the th contracts are experience-rated as a unit. Where contracts cover individual employee tier may be treated as a unit for purposes of this report.	es,
8 (	Benefit and contract type (check all applicable boxes)		
	a Health (other than dental or vision) b Denta	I c Vision d Life insurance	
	e ☐ Temporary disability (accident and sickness) f ☐ Long-	term disability $\mathbf{g} \ \square$ Supplemental unemployment $\mathbf{h} \ \square$ Prescription drug	
	i Stop loss (large deductible) j HMO	contract k PPO contract I ☐ Indemnity contract	
	m Other (specify)	ليبنا	
	Tit Cities (specify)		
9 6	Experience-rated contracts:		
	a Premiums: (1) Amount received		
	(2) Increase (decrease) in amount due but unpaid		
	(3) Increase (decrease) in unearned premium reserve		
	(4) Earned ((1) + (2) - (3))		0
	b Benefit charges (1) Claims paid	9b(1)	
	(2) Increase (decrease) in claim reserves		
	(3) Incurred claims (add (1) and (2))	9b(3)	0
	(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		
	(C) Other specific acquisition costs		
	(D) Other expenses		
	(E) Taxes		
	(F) Charges for risks or other contingencies	9c(1)(F)	
	(G) Other retention charges	9c(1)(G)	
	(H) Total retention		<u> </u>
	(2) Dividends or retroactive rate refunds. (These amounts we		
	d Status of policyholder reserves at end of year: (1) Amount he		
	(2) Claim reserves		
	(3) Other reserves		
	e Dividends or retroactive rate refunds due. (Do not include an	nount entered in c(2).) 9e	
10	Nonexperience-rated contracts:	36337	E 2.C
	a Total premiums or subscription charges paid to carrier		526
	b If the carrier, service, or other organization incurred any spec retention of the contract or policy, other than reported in Part		

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	X No	

<sup>12</sup> If 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

#### 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

2011

Employee Benefits Security Administration	7 THE GO ON ALL CHINICITE LO	. 61111 00001		
Pension Benefil Guaranty Corporation	<ul> <li>Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</li> </ul>		This Form is Open to Public Inspection	
For calendar plan year 2011 or fiscal (	olan year beginning 01/01/2011	and ending	2/31/201	1
A Name of plan STEELWORKERS HEALTH	AND WELFARE FUND	B Three-digit plan number (PN)		501
C Plan sponsor's name as shown on		D Employer Identifical	tion Number (E	EIN)
Part I Information Conce	rning Insurance Contract Coverage, A. Individual contracts grouped as a unit in Parts			
1 Coverage Information:				
(a) Name of insurance carrier	DANIES INC			

UNITED CONCORDIA COMPANIES, INC.

	(c) NAIC	(d) Contract or	(e) Approximate number of Policy or contract y		intract year
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) From	(g) To
23-1661402	62294	0000450/0194961	28691	01/01/2011	12/31/2011

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
0	4170E

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

(b) Amount of sales and base	Fees and other commissions paid		
commissions paid	(c) Amount	(d) Purpose	(e) Organization code
		ASO FEES	
0	417955		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	Fees and other commissions		
commissions paid	commissions paid (c) Amount	(d) Purpose	(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2011

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Schedule A (Form 5500) 2011 Page 2 -			
(a) Na	me and address of the agent, broker	, or other person to whom commissions or fees were paid	
(b) Amount of sales and base	F	Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	1
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	]
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were paid	3
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Page	3
ı uyc	•

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contracts w	vith each carrier may be treated as a unit	t for purposes of
Curr	ent value of plan's interest under this contract in the general account at year of	nd	4	
	ent value of plan's interest under this contract in separate accounts at year er			
	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			
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	annuity		
f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan chect	k here	
7 Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in sepa	rate accounts)	
а	Type of contract: (1) deposit administration (2) immedia	te participation	guarantee	
_	(3) guaranteed investment (4) other			
	(5) Guaranteed investment			
b	Balance at the end of the previous year	***********************	7b	
С	Additions: (1) Contributions deposited during the year	7		
	(2) Dividends and credits	7 (0)		
	(3) Interest credited during the year	7c(3)		
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
	(6)Total additions	L	7c(6)	
d	Total of balance and additions (add b and c(6)).			(
e				
٦	(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			
	(4) Other (specify below)	7e(4)		
	(+) Other (appears below)	1.5(.)		
	r			
	(5) Total deductions			(
f	Balance at the end of the current year (subtract e(5) from d)		7f	(

		Schedule A (Form 5500) 2011			Pa	ge <b>4</b>	_		
Pa	art II	Welfare Benefit Contract Information If more than one contract covers the same ground information may be combined for reporting pure the entire group of such individual contracts with the entire group of such individual contracts with the entire group of such individual contracts with the entire group of such individual contracts with the entire group of such individual contracts.	up of en	such contracts a	are experient	ce-rated as a unit. Wh	ere contracts	loyee organiz cover individ	ations(s), the ual employees,
8	Bene	efit and contract type (check all applicable boxes)						(mm)	
	а	Health (other than dental or vision)	b X De	ental	c[	Vision	(	di 🗌 Life insu	rance
	e [	Temporary disability (accident and sickness)	f 🛮 Lo	ong-term disabilit	у <b>g</b> [	Supplemental unem	oloyment	h 🗌 Prescrip	tion drug
	ιĒ	Stop loss (large deductible)	ј∏ни	MO contract	k	PPO contract		I ndemnit	y contract
	m [	Other (specify)	· <u></u>		_	-			
9	Expe	erience-rated contracts:							
	a F	Premiums: (1) Amount received			9a(1)			1	
		(2) Increase (decrease) in amount due but unpaid			9a(2)			_	
		(3) Increase (decrease) in unearned premium rese	erve		9a(3)				
		(4) Earned ((1) + (2) - (3))		r			9a(4)		0
	b	Benefit charges (1) Claims paid			9b(1)			_	
		(2) Increase (decrease) in claim reserves		•	9b(2)		T 61 (6)		0
		(3) Incurred claims (add (1) and (2))					9b(3)	1	<u>U</u>
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (or			0 (4)(4)			4	
		(A) Commissions		ì	9c(1)(A)			-	
		(B) Administrative service or other fees		ì	9c(1)(B)			-	
		(C) Other specific acquisition costs		1	9c(1)(C) 9c(1)(D)		,		
		(D) Other expenses			9c(1)(E)			-	
		(E) Taxes			9c(1)(E)			-	
		(F) Charges for risks or other contingencies			- 1111-1			-	
		(G) Other retention charges					9c(1)(H)		0
		(H) Total retention			E.m.l				
	_	(2) Dividends or retroactive rate refunds. (These		- Lund				<u> </u>	
	d	Status of policyholder reserves at end of year: (1)					9d(1)		
		(2) Claim reserves					9d(2)	<u> </u>	
		(3) Other reserves					9d(3)		
	<u>e</u>	Dividends or retroactive rate refunds due. (Do no	t include	e amount entered	in ¢(2).}		. 9e		
7		onexperience-rated contracts:					40-	-	6292552
		Total premiums or subscription charges paid to ca					. 10a	<u> </u>	0292332
		retention of the contract or policy, other than repo					. 10b		· · · · · · · · · · · · · · · · · · ·
		If the carrier, service, or other organization incurrentention of the contract or policy, other than reposecify nature of costs					. 10b		

X No

☐ Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?......

Part IV Provision of Information

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

### **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

2011

Pension Benefit Guaranty C	orporation	<ul><li>Insurance companies ar pursuant to EF</li></ul>	ormation	This Form is Open to Public Inspection		
For calendar plan year 20	)11 or fiscal plan	year beginning 01/01/2	011 ar	nd ending	12/31/20	11
A Name of plan STEELWORKERS	HEALTH AND	WELFARE FUND	В	Three-digit plan number (PN	1) •	501
C Plan sponsor's name	as shown on line	2a of Form 5500	D Employer Identification Number (EIN)			
Steelworkers			<u> </u>	-1317409		
Part I Informat on a separa	ion Concerni ite Schedule A. I	ng Insurance Contract C ndividual contracts grouped as a	Coverage, Fees, and C a unit in Parts II and III can be	commissions reported on a si	Provide inforr ingle Schedule	mation for each contract e.A.
1 Coverage Information:						
(a) Name of insurance c		TH PLAN INC				
	1 () ), ()	<i>t.</i> 0. O	(e) Approximate number	of	Policy or c	contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered at end policy or contract year		From	(g) To
94-1340523	00000	9170	559 01/0		1/2011	12/31/2011
2 Insurance fee and con descending order of th		tion. Enter the total fees and tota	il commissions paid. List in i	tem 3 the agents	, brokers, and	other persons in
	amount of comm	nissions paid		(b) Total amount	of fees paid	
		6				
3 Persons receiving cor		es. (Complete as many entries a				
NUWEST INSURANCE P.O. BOX 18973		nd address of the agent, broker, of INC.	or other person to whom con	nmissions or fees	were paid	
IRVINE	CA	92623				
(b) Amount of sales	and base	Fee	s and other commissions pai	d		
commissions p		(c) Amount	(d) Purpose			(e) Organization code
	6					3
	(a) Name ar	nd address of the agent, broker,	or other person to whom con	nmissions or fees	s were paid	
(h) A ====== = f == 2 ==	and bone	Fee	s and other commissions pa	id		
(b) Amount of sales commissions p		(c) Amount		urpose		(e) Organization code
	1					

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500)	2011	Page 2 -					
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pair	d				
(b) Amount of sales and base Fees and other commissions paid (e							
commissions paid	(c) Amount	(d) Purpose	(e) Organization code				
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pai	ď				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent, b	oroker, or other person to whom commissions or fees were pai	d				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were pai	id				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Na	me and address of the agent. b	proker, or other person to whom commissions or fees were pai	id				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				

_	•
Page	- 3

Pai	rt II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivitins report.	dual contract	ts with each carrier may	be treated a	es a unit for purposes of
4 (	Curre	ent value of plan's interest under this contract in the general account at year	end		4	
5 (	Curre	ent value of plan's interest under this contract in separate accounts at year er	rdbr		5	
6 (	Cont	racts With Allocated Funds:				
i	а	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 corretention of the contract or policy, enter amount			6d	
		Specify nature of costs				
ı	е	Type of contract: (1) individual policies (2) group deferred (3) other (specify)	d annuity			
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan ch	neck here		
7 (	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in se	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immedia	ite participati	on guarantee		
		(3) guaranteed investment (4) other				
		√-, □ 3				
	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)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add b and c(6)).			7d	0
		Deductions:				
	-	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	<del></del>			
		(3) Transferred to separate account	- (0)			
		(4) Other (specify below)	. 7e(4)			
		<b>)</b>				
		(5) Total deductions			7e(5)	C
	f	Balance at the end of the current year (subtract e(5) from d)	****************		7f	C

	Schedule A (Form 5500) 2011		Pa	ge <b>4</b>	
Part III	Welfare Benefit Contract Informat If more than one contract covers the same gree information may be combined for reporting put the entire group of such individual contracts we	oup of employees of the surposes if such contracts a	re experienc	e-rated as a unit. Where cont	employee organizations(s), the tracts cover individual employees,
8 Bene	fit and contract type (check all applicable boxes)	_			rm)
a X	Health (other than dental or vision)	<b>b</b> Dental	င	Vision	d 📗 Life insurance
e [	Temporary disability (accident and sickness)	f Long-term disability	/ g 🛚	Supplemental unemploymen	nt h 🗌 Prescription drug
iΓ	Stop loss (large deductible)	j HMO contract	k	PPO contract	I  Indemnity contract
m [	Other (specify)	- 0	_	•	_
9 Expe	rience-rated contracts:			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
a P	remiums: (1) Amount received		9a(1)		
(	(2) Increase (decrease) in amount due but unpaid		9a(2)		
(	(3) Increase (decrease) in unearned premium res	erve	9a(3)		
į	(4) Earned ((1) + (2) - (3))			9a(4	<b>4</b> ) 0
b	Benefit charges (1) Claims paid		9b(1)		
	(2) Increase (decrease) in claim reserves		9b(2)		
	(3) Incurred claims (add (1) and (2))				
1	(4) Claims charged			9b(	4)
С	Remainder of premium: (1) Retention charges (o	n 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) O
	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.) 9c(	2)
d	Status of policyholder reserves at end of year: (1	) Amount held to provide t	penefits after	retirement9d(	1)
	(2) Claim reserves	•			
	(3) Other reserves				3)
е	Dividends or retroactive rate refunds due. (Do n				
	neyperience-rated contracts:				

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	X No	

1881767

10a

10b

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

Department of the Treasury Internal Revenue Service

Department of Labor

### 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

2011

Employee Benefits Security Ad	ministration	r The us and	attaoriment to 1 orini oc			
Pension Benefit Guaranty Co	orparation	Insurance companies a pursuant to 8	are required to provide t ERISA section 103(a)(2			m is Open to Public Inspection
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/	2011	and ending	12/31/20	11
A Name of plan STEELWORKERS	HEALTH AN	ID WELFARE FUND		B Three-digit plan number	(PN) <b>•</b>	501
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500		D Employer iden	itification Number	(EIN)
Steelworkers	Health &	Welfare Fund		23-1317409	<u>,</u>	
Part I Informati on a separa	on Concer te Schedule A	ning Insurance Contract Individual contracts grouped as	Coverage, Fees, a unit in Parts II and III	and Commissio can be reported on	ns Provide inforr a single Schedule	nation for each contract : A.
1 Coverage Information:						
(a) Name of insurance ca		YLVANIA				
	1	T	(e) Approximate n	umber of	Policy or o	ontract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	at end of	(f) From	(g) To
23-1667011	54798	04751	1008	01	./01/2011	12/31/2011
2 Insurance fee and condescending order of the		nation. Enter the total fees and to	tal commissions paid. L	ist in item 3 the age	ents, brokers, and	other persons in
(a) Total	amount of con	nmissions paid		(b) Total amo	unt of fees paid	
3 Persons receiving con		fees. (Complete as many entries				
	(a) Name	and address of the agent, broker				
(b) Amount of sales a			es and other commission			(e) Organization code
commissions paid		(c) Amount		(d) Purpose		(e) Organization code
	(a) Name	and address of the agent, broker	r, or other person to who	om commissions or	fees were paid	
40.4		Fe	ees and other commission	ons paid		
(b) Amount of sales a commissions p		(c) Amount		(d) Purpose		(e) Organization code

Schedule A (Form 5500) 2	2011	Page 2 -		
(a) Nam	ne and address of the agent,	broker, or other person to whom commissions or fees were pa	aid	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organiz	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Nam	ne and address of the agent,	broker, or other person to whom commissions or fees were pa	aid	
(b) Amount of sales and base	/a\	Fees and other commissions paid	(e) Organiz	
commissions paid	(c) Amount	(d) Purpose	coue	
			. 1 . 1	
(a) Nan	ne and address of the agent,	broker, or other person to whom commissions or fees were pa	aid	
(a) Nam  (b) Amount of sales and base commissions paid	ne and address of the agent,	Fees and other commissions paid  (d) Purpose		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organiz	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid	(e) Organiz code	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organiz code	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose broker, or other person to whom commissions or fees were page 1	(e) Organiz code	
(b) Amount of sales and base commissions paid  (a) Nan	(e) Amount ne and address of the agent.	Fees and other commissions paid  (d) Purpose  broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid	(e) Organiz code	
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose broker, or other person to whom commissions or fees were page 1	(e) Organiz code	
(b) Amount of sales and base commissions paid  (a) Nan  (b) Amount of sales and base commissions paid	(c) Amount ne and address of the agent, (c) Amount	Fees and other commissions paid  (d) Purpose  broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid  (d) Purpose	e) Organiz code	
(b) Amount of sales and base commissions paid  (a) Nan  (b) Amount of sales and base commissions paid	(c) Amount ne and address of the agent, (c) Amount	Fees and other commissions paid  (d) Purpose  broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid	e) Organiz code	
(b) Amount of sales and base commissions paid  (a) Nan  (b) Amount of sales and base commissions paid	(c) Amount ne and address of the agent, (c) Amount	Fees and other commissions paid  (d) Purpose  broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid  (d) Purpose	e) Organiz code	
(b) Amount of sales and base commissions paid  (a) Nan  (b) Amount of sales and base commissions paid	(c) Amount ne and address of the agent, (c) Amount	Fees and other commissions paid  (d) Purpose  broker, or other person to whom commissions or fees were particle.  Fees and other commissions paid  (d) Purpose	e) Organiz code aid (e) Organiz code	

Pa	art (	Where individual contracts are provided, the entire group of such indivi	idual contra	cts with each carrier ma	ry be treated as a ur	nit for purposes of
Á	C	this report.	and		4	
		rent value of plan's interest under this contract in the general account at year			5	
	*******	rent value of plan's interest under this contract in separate accounts at year el tracts With Allocated Funds:	па	,	<u>.,                                    </u>	
U	a	State the basis of premium rates				
	4	State the basis of premium rates.				
	b	Premiums paid to carrier			6b	
	c	Premiums due but unpaid at the end of the year			6c	
	ď	If the carrier, service, or other organization incurred any specific costs in cor				
	-	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)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	nating plan (	check here		
7		tracts With Unallocated Funds (Do not include portions of these contracts ma				
•	а	Type of contract: (1) deposit administration (2) mmedia				
	<b>u</b>	,,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,,		and gadianto		
		(3) guaranteed investment (4) other				
					76	
	b	Balance at the end of the previous year			7b	
	Ç	Additions: (1) Contributions deposited during the year	h =	.,,	-	
		(2) Dividends and credits	- (-)			
		(3) Interest credited during the year	` <del>}</del>			
		(4) Transferred from separate account	<del>- :::</del>			
		(a) Other (specify below)	1 10(0)			
		•				
					70(6)	0
		(6)Total additions			7c(6)	0
		Total of balance and additions (add b and c(6)).			/u	
	e	Deductions:  (1) Dishused from fined to pay handite or purchase appulition during year.	7e(1)			
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	7e(2)			
		(4) Other (specify below)				
		(T) Out of topology octow/manufactures (Special Contro				
		<i>r</i>				
			L			
	_	(5) Total deductions			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)			7f	0

Schedule A	. (Form 5500) 2011		Pag	ge <b>4</b>		
If more the	Benefit Contract Informa an one contract covers the same g n may be combined for reporting p group of such individual contracts	roup of employees of the a urposes if such contracts	are experienc	e-rated as a unit. W	here contracts	loyee organizations(s), the scover individual employees,
8 Benefit and contra	ct type (check all applicable boxes)					
a Health (other	r than dental or vision)	<b>b</b> X Dental	с∏	Vision		d 🗌 Life insurance
<u></u>	disability (accident and sickness)	f \(\sum_\) Long-term disabili	ıv g∏	Supplemental uner	nployment	h Prescription drug
1 , ,	arge deductible)	i HMO contract	k□	PPO contract		I Indemnity contract
님	,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1100001111001		
m Other (spec	iry) P					
9 Experience-rated of	ontracts:					
•	Amount received		9a(1)		-,	1
	decrease) in amount due but unpai					
	decrease) in unearned premium re				, , , , , , , , , , , , , , , , , , , ,	1
, ,	) + (2) - (3))		·		9a(4)	0
	es (1) Claims paid					
	decrease) in claim reserves					1
, ,	aims (add (1) and (2))				9b(3)	0
	arged					
	premium: (1) Retention charges (			***************************************		
	nissions		9c(1)(A)			-
, ,	nistrative service or other fees		9c(1)(B)			-
` '	specific acquisition costs		0 (4)(0)			
` '	expenses					-
` '	expenses		A (4) (-1)			-
	es for risks or other contingencies		1			-
(r ) Otters	retention charges		9c(1)(G)			-
	retention				9c(1)(H)	0
· , · · ·	or retroactive rate refunds. (Thes		_			
` '	·	<b>₩</b>			·	
•	cyholder reserves at end of year: (	•			1	
, ,	erves				9d(2)	
	erves					
***************************************	retroactive rate refunds due. (Do r	tot include amount entere	u in C(Z).)			
10 Nonexperience-r	ated contracts: ms or subscription charges paid to	oorrior.			10a	255052
•	ns or subscription charges paid to service, or other organization incu					1 200002
	service, or other organization incu he contract or policy, other than rep				10b	
Specify pature of	• • •		, . ~ p ~			

Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

<sup>12</sup> If 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.

OMB No. 1210-0110

2011

Conson Benefit Guaranty Gui	2010011	▶ Insurance companies all pursuant to E	re required to provide the RISA section 103(a)(2).	informatic	This For	m is Open to Public Inspection	
For calendar plan year 201	1 or fiscal plan	year beginning 01/01/2	2011	and end	ing 12/31/20	11	
A Name of plan STEELWORKERS HEALTH AND WELFARE FUND			E	Three- plan r	-digit number (PN)	501	
C Plan sponsor's name as	shown on line	2a of Form 5500	C	Employ	er Identification Number	(EIN)	
Steelworkers H	ealth & V	Welfare Fund	2	3-131	7409		
		ing Insurance Contract C					
1 Coverage Information:							
(a) Name of insurance care	rier						
CAREMARK-RG ST	TEEL SPAR	ROWS POINT					
	(c) NAIC	(d) Contract or	(e) Approximate numl		Policy or c	ontract year	
(b) EIN	code	identification number	persons covered at ea policy or contract ye		(f) From	(g) To	
05-0340626	44611	2004973	11372		01/01/2011	12/31/2011	
2 Insurance fee and communication descending order of the		tion. Enter the total fees and tota	al commissions paid. List	in item 3 1	the agents, brokers, and	other persons in	
(a) Total a	mount of comn	nissions paid		(b) Tot	al amount of fees paid		
3 Persons receiving comm		es. (Complete as many entries and address of the agent, broker,			ons or fees were paid		
	-	Foo	es and other commissions	oaid			
(b) Amount of sales and					/-\ Organization and		
commissions paid (c		(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name a	nd address of the agent, broker,	or other person to whom o	commissio	ons or fees were paid		
/h\ Amount of color on	- h	Fee	es and other commissions	paid			
(b) Amount of sales an commissions paid		(c) Amount		Purpose		(e) Organization code	
For Paperwork Reduction	Act Notice a	nd OMB Control Numbers, see	the instructions for For	m 5500.	Sche	edule A (Form 5500) 2011	

Schedule A (Form 5500)	2011	Page <b>2 -</b>	
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were p	paid
		Fees and other commissions paid	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
(a) Na	me and address of the agent, b	oroker, or other person to whom commissions or fees were p	paid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were	paid
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code
commissions peld	(c) Amount	(3) 1 3 post	
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were	paid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	ime and address of the agent. b	proker, or other person to whom commissions or fees were	paid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

Pa	art II	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivithis report.	idual contra	cts with each carrier ma	y be treated as a uni	it for purposes of
4	Curre	ent value of plan's interest under this contract in the general account at year	end		. 4	
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd		5	
6	Conti	racts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier				
	С	Premiums due but unpaid at the end of the year			6с	***************************************
	d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount	nnection wit	n the acquisition or	. 6d	
		Specify nature of costs				
		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 terminate				
7	Cont	racts With Unallocated Funds (Do not include portions of these contracts ma				
	а	, , , , , , , , , , , , , , , , , , ,	ate participa	tion guarantee		
		(3) ☐ guaranteed investment (4) ☐ other ▶				
		_				
					·	
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits				
		(3) Interest credited during the year				
		(4) Transferred from separate account	7c(4)			
		(5) Other (specify below)	. 7c(5)			
		<b>&gt;</b>				
		(6)Total additions			7c(6)	0
	d ·	Total of balance and additions (add b and c(6)).			7d	0
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	, <u>.</u>		
		(2) Administration charge made by carrier	<b>—</b>			
		(3) Transferred to separate account				
		(4) Other (specify below)				
		<b>)</b>				
		(C) Total daduations			7e(5)	0
	f	(5) Total deductions				0
	<u>f</u>	Balance at the end of the current year (subtract e(5) from d)			/ !	

Page	4

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 boxe	· . —	_	1			
a Health (other than dental or vision)	<b>b</b> Dental	c _	Vision		d Life insurance	
e Temporary disability (accident and sickness)	f Long-term disability	g[	Supplemental unemp	loyment	h 🛛 Prescription drug	
i Stop loss (large deductible)	j HMO contract	k┌	PPO contract		I Indemnity contract	
m Other (specify)					_	
9 Experience-rated contracts:						
a Premiums: (1) Amount received	<u>_</u>	9a(1)			_	
(2) Increase (decrease) in amount due but unpa	aid	9a(2)			_	
(3) Increase (decrease) in unearned premium re	eserve	9a(3)				
(4) Earned ((1) + (2) - (3))	_			9a(4)	0	
b Benefit charges (1) Claims paid	F*****	9b(1)			-	
(2) Increase (decrease) in claim reserves	_	9b(2)			1	
(3) Incurred claims (add (1) and (2))				9b(3)	0	
(4) Claims charged				9b(4)	<del></del>	
C Remainder of premium: (1) Retention charges		0-/4)/4)			-	
(A) Commissions	<del>}-</del>	9c(1)(A)	· · · · · · · · · · · · · · · · · · ·		-	
(B) Administrative service or other fees	<b>}</b> −	9c(1)(B) 9c(1)(C)			-	
(C) Other specific acquisition costs	-	9c(1)(D)			-	
(D) Other expenses(E) Taxes	-	9c(1)(E)			_	
(F) Charges for risks or other contingencies	<u></u>	9c(1)(F)			7	
(G) Other retention charges	· · · · · · · · · · · · · · · · · · ·	9c(1)(G)			1	
(H) Total retention	L			9c(1)(H)	0	
(2) Dividends or retroactive rate refunds. (The		,		9c(2)		
		ليسا	•	9d(1)		
d Status of policyholder reserves at end of year: (2) Claim reserves				9d(1)		
(3) Other reserves				9d(2)		
e Dividends or retroactive rate refunds due. (Do				90(3) 9e		
10 Nonexperience-rated contracts:	not include amount entered	III C(Z).)		<u> </u>		
Total premiums or subscription charges paid to	carrier			10a	6802584	
b If the carrier, service, or other organization inco				100		
retention of the contract or policy, other than re				10b		
Specify nature of costs						

X No

Yes

11 Did the insurance company fail to provide any information necessary to complete Schedule A?.....

Part IV Provision of Information

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided. 🕨

## **SCHEDULE A**

(Form 5500)

Department of the Treasury

Insurance Information

This schedule is required to be filed under section 104 of the

OMB No. 1210-0110

2044

Internal Revenue Service Employee Retirement			Income Security Act of 1974 (ERISA).				2011	
Department of Labor Employee Benefits Security Administration  File as an attach			attachment to Form 5500.					
Pension Benefit Guaranty Co	prporation		re required to provide the information This For RISA section 103(a)(2).				rm is Open to Public Inspection	
For calendar plan year 20	11 or fiscal pla	n year beginning 01/01/2	2011	and end	ding	12/31/20	11	
A Name of plan STEELWORKERS	HEALTH AN	D WELFARE FUND		B Three-digit plan number (PN)		N) <b>•</b>	501	
C Plan sponsor's name a	as shown on lir	ne 2a of Form 5500	D Employer Identification			ation Number	(EIN)	
Steelworkers	Health &	Welfare Fund		23-131	7409			
Part I Informati on a separa	on Conceri te Schedule A.	ning Insurance Contract ( Individual contracts grouped as	Coverage, Fees, a a unit in Parts II and III	nd Comr can be repo	nissions rted on a s	Provide infori ingle Schedule	mation for each contract e A.	
1 Coverage Information:								
(a) Name of insurance ca								
HARTFORD LIFE	AND ACC	L DENT						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or o	contract year	
(b) EIN	code	identification number	policy or contrac		(f)	From	(g) To	
06-0838648 70815 696995G			35861 07/01/201		1/2011	12/31/2011		
2 Insurance fee and com descending order of the		ation. Enter the total fees and total	al commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in	
(a) Total	amount of con	missions paid		(b) To	tal amount	of fees paid		
		24765					0	
3 Persons receiving com	missions and	fees. (Complete as many entries	as needed to report all	persons).				
HEALTHCARE BENEF 1501 REEDSDALE S SUITE 304	ITS INC TREET	and address of the agent, broker,	or other person to who	m commiss	ions or fees	s were paid		
PITTSBURGH	P	A 15233						
(b) Amount of sales a			ees and other commissions paid				(e) Organization code	
commissions pa	110	(c) Amount	(d) Purpose				(e) Organization code	
	24765						3	
	(a) Name	and address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid		
	(2) 1101110	and edge of the agon, or one,	, or other parents of					
(b) Amount of sales a	nd base	Fee	es and other commission	ns paid				
commissions pa		(c) Amount		(d) Purpose	3		(e) Organization code	

Schedule A (Form 5500)	2011	Page 2 -				
(a) Na	me and address of the agent, b	oroker, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent in	proker, or other person to whom commissions or fees were pa	aid			
(b) Amount of sales and base commissions paid	(e) Amount	Fees and other commissions paid (d) Purpose	(e) Organization code			
(a) Na	me and address of the agent, i	broker, or other person to whom commissions or fees were p	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Na	me and address of the agent, i	broker, or other person to whom commissions or fees were p	aid			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization			
commissions paid	(c) Amount	(d) Purpose	code			

_				
_	a	O	e	

P	art I	Investment and Annuity Contract Information				
		Where individual contracts are provided, the entire group of such indivithis report.	dual contra	cts with each carrier n	nay be treated as a	unit for purposes of
4	Curr	rent 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 er	nd	*1*1***	5	
6	Con	tracts With Allocated Funds:				
	а	State the basis of premium rates				
	L				6b	
	b C	Premiums paid to carrier  Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in cor				
	<u>.</u>	retention of the contract or policy, enter amount			6d	
		Specify nature of costs				
		_				
	6	Type of contract: (1) individual policies (2) group deferred	l annuity			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan o	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	te participa	tion 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) 7c(5)			
		(5) Other (specify below)	10(0)			
		(6)Total additions			7c(6)	0
	d	Total of balance and additions (add b and c(6)).				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				
		(4) Other (specify below)	7e(4)	***************************************		
		<b>&gt;</b>				
		(5) Total deductions				0
	f	Balance at the end of the current year (subtract e(5) from d)			7f	0

Page 4		
mployer(s) or memb	ıme employe	

	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		efit and contract type (check all applicable boxes)	. 🗂		_	1		• m	
	а	Health (other than dental or vision)	<b>b</b> Dental		c	Vision		d 🗵 Life insurance	
	е [	Temporary disability (accident and sickness)	f Long-ter	rm disability	g [	Supplemental ui	nemployment	h Prescription dru	ıg
	i	Stop loss (large deductible)	j HMO co	ntract	k[	PPO contract		I Indemnity contr	act
	m		· (.)		_	,		Lacard .	
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 res	erve		9a(3)				
		(4) Earned ((1) + (2) - (3))					9a(4)		0
	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)		0
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (o	n an accrual ba						
		(A) Commissions		<del></del>	c(1)(A)				
		(B) Administrative service or other fees		ļ	c(1)(B)				
		(C) Other specific acquisition costs			c(1)(C)				
		(D) Other expenses		·····	c(1)(D)	····		_	
		(E) Taxes		·····	c(1)(E)			_	
		(F) Charges for risks or other contingencies		_	c(1)(F)				
		(G) Other retention charges			c(1)(G)		0.41/41	,	0
		(H) Total retention		_	_			)	<u> </u>
		(2) Dividends or retroactive rate refunds. (These	amounts were	paid in ca	sh, or 📗	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1	) Amount held	to provide ber	refits after	retirement	9d(1)		
		(2) Claim reserves		,					
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amou	unt entered in	c(2).)		9e		
10	No	nexperience-rated contracts:							110161
	a Total premiums or subscription charges paid to carrier							412464	
	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, item 2 above, report amount								
	Specify nature of costs								
	•	·							

Part IV	Provision of Information			
11 Did the	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

Schedule A (Form 5500) 2011

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

## **SCHEDULE A**

(Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

(b) Amount of sales and base

commissions paid

### 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

2011

Pension I	Benefit Guaranty Co	rporation	<ul><li>Insurance companies pursuant to</li></ul>	are required to provide t ERISA section 103(a)(2		on		m is Open to Public Inspection
For calenda	ar plan year 201	11 or fiscal pla	an year beginning 01/01/	2011	and end	ling	12/31/20	11
A Name o	•	HEALTH AN	ND WELFARE FUND		B Three plan	-digit number (P	N) <b>&gt;</b>	501
C Plan spo	onsor's name a	s shown on lir	ne 2a of Form 5500		D Employ	er Identifi	cation Number	(EIN)
Steel			Welfare Fund		23-131			
Part I	Information on a separat	on Concer e Schedule A	ning Insurance Contract . Individual contracts grouped as	Coverage, Fees, as a unit in Parts II and III	and Comr can be repo	nissions rted on a s	Frovide inforn ingle Schedule	nation for each contract A.
1 Coverag	ge Information:							
• •	of insurance car	rrier						
(b)	) EINI	(c) NAIC	(d) Contract or	(e) Approximate n persons covered a				ontract year
(b) EIN (c) (c) (sAlc) code		code	identification number	policy or contract year		(f) From		(g) To
95-4402	957	00000	5000	206		01/0	)1/2011	12/31/2011
	ce fee and comi		nation. Enter the total fees and to	otal commissions paid. L	ist in item 3	the agents	, brokers, and	other persons in
	(a) Total a	amount of con	nmissions paid		(b) To	tal amount	of fees paid	
			0					6862
3 Persons	receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).			
		(a) Name	and address of the agent, broker	r, or other person to who	m commissi	ons or fee:	s were paid	
CORPORA:	ASBHEKE C LE DEBOSI,	TORY IRCLE	LLC 60674					
(h) Amo	ount of sales ar	nd hase	Fe	ees and other commission	ns paid			
	ommissions pai		(c) Amount		(d) Purpose	1		(e) Organization code
				BONUSES & MISC. BROKER.	COMPEN	SATION	PAID TO	3
		(a) Name	and address of the agent, broke	r, or other person to who	om commissi	ons or fee	s were paid	
		* *						-

Fees and other commissions paid

(d) Purpose

(c) Amount

(e) Organization code

Schedule A (Form 5500)	2011	Page <b>2 -</b>	
(a) Na	me and address of the agent, b	roker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	oroker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Na	me and address of the agent, b	proker, or other person to whom commissions or fees were pa	aid
		Fees and other commissions paid	(1)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code
			- 1.1
(a) Na	me and address of the agent, b	oroker, or other person to whom commissions or fees were pa	aid
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
/->N-			
(a) IVa	me and address or the agent, t	proker, or other person to whom commissions or fees were pa	diu
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code

P	а	a	e	3

Pá	art II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	dual contr	acts with e	ach carrier ma	y be treated as a	unit for purposes of
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 er	ıd			. 5	
		tracts With Allocated Funds:					
	а	State the basis of premium rates					
	ď	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 deferred (3) ☐ other (specify) ▶	I annuity				
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan	check her	e <b>•</b> [		
7	Cont	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in	separate	accounts)		
	а	Type of contract: (1) ☐ deposit administration (2) ☐ immedia (3) ☐ guaranteed investment (4) ☐ other ▶	te particip	ation guar	antee		
	b	Balance at the end of the previous year				. 7b	
	С	Additions: (1) Contributions deposited during the year					
		(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)				
		<b>&gt;</b>		.l			
		(6)Total additions				7c(6)	0
	d	Total of balance and additions (add b and c(6)).				. 7d	Õ
		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)	i ·	***************************************		
		(4) Other (specify below)	7e(4)	1			
		)		1			
		(5) Total deductions	L			7e(5)	0
	f	Balance at the end of the current year (subtract e(5) from d)				7E(3)	0
	_'_	Datance at the end of the current year (Subtract e(5) from d)			***************************************	4 11	V

		Schedule A (Form 5500) 2011		Paç	ge <b>4</b>	<del></del>	
P	art III	Welfare Benefit Contract Informat If more than one contract covers the same go information may be combined for reporting po the entire group of such individual contracts.	oup of employees of the surposes if such contracts a	are experienc	e-rated as a unit. Who	ere contracts	
8	Benef	it and contract type (check all applicable boxes)					
	аX	Health (other than dental or vision)	<b>b</b> 🗵 Dental	cX	Vision	(	d  Life insurance
	е П	Temporary disability (accident and sickness)	f Long-term disabilit	v a∏	Supplemental unemp	olovment I	h Prescription drug
	:	Stop loss (large deductible)	i HMO contract	, s⊟ k∏			I Indemnity contract
	' LJ		1 1 TIMO CONTIACE	, [	11 O COMMENT		· U machinity contract
	m 📙	Other (specify)					
9	Even	ence-rated contracts:					1
9		remiums: (1) Amount received	ſ	9a(1)			_
		2) Increase (decrease) in amount due but unpaid	<b>.</b>				
		3) Increase (decrease) in amount que out unpair 3) Increase (decrease) in unearned premium res				***************************************	
	,	4) Earned ((1) + (2) - (3))				9a(4)	(
		Benefit charges (1) Claims paid	r	···		30(4)	
		2) Increase (decrease) in claim reserves	ŀ				-
		3) Incurred claims (add (1) and (2))				9b(3)	C
	•	4) Claims charged				9b(4)	
	•	Remainder of premium: (1) Retention charges (c					
		(A) Commissions	·	9c(1)(A)	****		
		(B) Administrative service or other fees	ł	9c(1)(B)			
		(C) Other specific acquisition costs	i	9c(1)(C)			<u> </u>
		(D) Other expenses		9c(1)(D)			]
		(E) Taxes	ſ	9c(1)(E)			Ĩ
		(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 in	cash, or C	redited.)	9c(2)	
	d s	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)	
	(	2) Claim reserves				9d(2)	

9d(3)

9e

10a

10b

3280310

(2) Claim reserves.....

(3) Other reserves

a Total premiums or subscription charges paid to carrier ......

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, item 2 above, report amount......

e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).).....

Part IV	Provision of Information			
11 Did the		Yes	Χ	

10 Nonexperience-rated contracts:

Specify nature of costs

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

**Service Provider Information** 

OMB No. 1210-0110

2011

Department of the Treasury Internal Revenue Service	This schedule is required to be filed under sec Retirement Income Security Act of				
Department of Labor Employee Benefits Secunty Administration	orm 5500.	This Form is Open to Public Inspection.			
Pension Benefit Guaranty Corporation	07 02 2011	and pading	12/31/2011		
For calendar plan year 2011 or fiscal pla	n year beginning 01/01/2011	and ending	12/31/.	2011	
A Name of plan		B Three-digit		r 0.1	
	IR WELLIAMS SING	plan number (PN)	<u> </u>	501	
STEELWORKERS HEALTH AN	D WELFARE FUND				
C Plan sponsor's name as shown on lin	ne 2a of Form 5500	D Employer Identificati	on Number (E	in)	
Steelworkers Health &	Welfare Fund	23-1317409			
Part I Service Provider Info	rmation (see instructions)				
a Check "Yes" or "No" to indicate wheth indirect compensation for which the p     b If you answered line 1a "Yes," enter received only eligible indirect compensation.	the name and EIN or address of person who provided you complete as many entries as needed (see	of this Part because they rece ons for definitions and condition iding the required disclosures instructions).	for the service	X Yes No	
(b) Enter na	me and EIN or address of person who provided yo	u disclosure on eligible indirec	t compensatio	n	
(b) Enter nai	me and EIN or address of person who provided you	a disclosures on eligible indired	ct compensatio	วก	
(b) Enter na	me and EIN or address of person who provided you	u disclosures on eligible indire	ct compensation	on	

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

.

answered	"Yes" to line 1a above	e, complete as many e	entries as needed to list ead	Indirect Compensation on person receiving, directly or i e plan or their position with the	ndirectly, \$5,000 or more in to	otal compensation
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		a) Enter name and EIN or			
CENTRAL	DATA SERVICE	S, INC.		25-1352803		
(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?
	NONE	839320	Yes No X	Yes No		Yes 📗 No 📗
	***************************************		a) Enter name and EIN or	address (see instructions)		
UNITED	STEELWORKERS		a) Enter hame and Envior	25-0818080		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or	(d) Enter direct compensation paid by the plan. If none,	(e) Did service provider receive indirect compensation? (sources	(f) Did indirect compensation include eligible indirect compensation, for which the	(g) Enter total indirect compensation received by service provider excluding	(h) Did the service provider give you a formula instead of
13	person known to be a party-in-interest	enter -0	other than plan or plan sponsor)	plan received the required disclosures?	eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	an amount or estimated amount?
	NONE			🗂 🗖		
		151577	Yes No 🛛	Yes No		Yes No
		1513//				
		(	<ul> <li>a) Enter name and EIN or</li> </ul>	address (see instructions)		
MARGARE	T STOUT			23-1317409		
(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?
***************************************	NONE	60000	Yes No 🛭	Yes [] No []		Yes No

Page 3 -

Schedule C (Form 5500) 2011

	Schedule C (Form 550	00) 2011		Page <b>4</b>			
	***************************************	(	a) Enter name and EIN or	address (see instructions)			
DIANE	PICKLE			23-1317409			
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be	(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	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required	(g) Enter total indirect compensation received by service provider excluding eligible indirect	(h) Did the service provider give you a formula instead of an amount or	
30	a party-in-interest		sponsor)	disclosures?	compensation for which you answered "Yes" to element (f). If none, enter -0	estimated amount?	
	NONE						
		60000	Yes No X	Yes No		Yes No	
			a) Enter name and FIN or	address (see instructions)			
ELTZABI	ETH LOHNER		a, Emeritano ano Em er	25-1317409			
(b) Service Code(s)	(c) Relationship to employer, 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?	
	NONE	52800	Yes No 🛚	Yes No		Yes No	
		(	a) Enter name and EIN or	address (see instructions)			
JOANNE	M. MOROCCO			25-1317409			
						!	
(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?	
	NONE	52800	Yes 🗌 No 🛚	Yes No		Yes No	

-					·····	
		(	<ul><li>a) Enter name and EIN or</li></ul>	address (see instructions)		
RICHMON	ND CAPITAL MAN	NAGEMENT		54-1288566		,
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 50	NONE	37236	Yes No 🛛	Yes 📗 No 📗		Yes No
· · · · · · · · · · · · · · · · · · ·	1					
		(	a) Enter name and EIN or	52-0969534		
(b) Service	(c) Relationship to	(d) Enter direct	<b>(e)</b> Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service
Code(s) 29 50	employer, employee organization, or person known to be a party-in-interest	compensation paid by the plan. If none, enter -0	receive indirect compensation? (sources other than plan or plan sponsor)	include eligible indirect compensation, for which the plan received the required disclosures?	compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	provider give you a formula instead of an amount or estimated amount?
	NONE	36983	Yes No 🗓	Yes 📗 No 🗍		Yes No
	***************************************	(	a) Enter name and EIN or	address (see instructions)		
TNNOVES	ST PORTFOLIO S			84-1612955		
(b) Service Code(s) 28	(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?
51 70	NONE	34661	Yes No X	Yes No		Yes No

Page 4

Schedule C (Form 5500) 2011

;	Schedule C (Form 550	0) 2011		Page 4		
		(:	a) Enter name and EIN or	address (see instructions)		
MCELHAN	EY & ASSOCIAT	CES, LLC		38-3806684		
(b)	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	(h) Did the service
Service Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest	enter-o	sponsor)	disclosures?	compensation for which you	estimated amount?
10			·		answered "Yes" to element (f), If none, enter -0	
10					(1). If thorie, enter -o-:	
	NONE					
			Yes 🗌 No 🛚	Yes 🗍 No 🗍		Yes No
		28000				
		(-	a) Enter name and EIN or	address (see instructions)		
AMEDICE	RV TRUST & FI	NANCIAI	,	25-0851535		
	111001 4 11	415 54 147 161 4 4 161				
/6.\	(-)	(4)	(a)	/5	(a)	(h)
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(f) Did indirect compensation	(g) Enter total indirect	Did the service
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a formula instead of
	organization, or person known to be	by the plan. If none, enter -0-,	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	an amount or
	a party-in-interest		sponsor)	disclosures?	compensation for which you	estimated amount?
28		A-11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-			answered "Yes" to element (f). If none, enter -0	
19						
50	NONE		V [] N- []	Yes No		Yes \ No \
		10000	Yes No 🛚	res   NO		I LES [] NO []
	<u> </u>	12339				l
		(	<ul> <li>a) Enter name and EIN or</li> </ul>	address (see instructions)		
		<del>*************************************</del>				
/I= \	(-)	(4)	(c)	(f)	(g)	(h)
(b) Service	(c) Relationship to	(d) Enter direct	(e) Did service provider	(1) Did indirect compensation	(9) Enter total indirect	Did the service
Code(s)	employer, employee	compensation paid	receive indirect	include eligible indirect	compensation received by	provider give you a
	organization, or person known to be	by the plan. If none, enter -0	compensation? (sources other than plan or plan	compensation, for which the plan received the required	service provider excluding eligible indirect	formula instead of an amount or
	a party-in-interest	entel "0".	sponsor)	disclosures?	compensation for which you	
					answered "Yes" to element (f). If none, enter -0	***************************************
					(1). It hone, enter -0	
		To the same of the				l v m » m
			Yes No	Yes   No		Yes   No

Part I	Service Provider Information (continued)			
If you re or provi questio provide	eported on line 2 receipt of indirect compensation, other than eligible indirect compens ides contract administrator, consulting, custodial, investment advisory, investment mains for (a) each source from whom the service provider received \$1,000 or more in indirect gave you a formula used to determine the indirect compensation instead of an amountries as needed to report the required information for each source.	nagement, broker, or recordkeeping lirect compensation and (b) each so	g services, answer the following surce for whom the service	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility he indirect compensation.	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
	(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation	
	(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.	

Page 5

Schedule C (Form 5500) 2011

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Part II Service Providers Who Fail or Refuse to Provide Information						
4 Provide, to the extent possible, the following information for ea this Schedule.	, and the second					
(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	(c) Describe the information that the service provider failed or refused to provide				
	Code(s)					

	Schedule C (Form 5500) 2011	Page 7
Pa	art III Termination Information on Accou	ntants and Enrolled Actuaries (see instructions)
a	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ex	planation:	
	Name:	b EIN:
С	Position:	
d	Address:	e Telephone:
Ex	planation:	
	Name:	b Ein:
С	Position:	
d	Address:	e Telephone:
E>	xplanation:	
a	Name:	b EIN;
С	Posítion;	
d	Address:	e Telephane:
	xplanation:	

a c d

Name: Position: Address:

Explanation:

b EIN;

e Telephone:

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation

#### **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.

2011

OMB No. 1210-0110

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation	Inspection
For calendar plan year 2011 or fiscal plan year beginning 01/01/2011	and ending 12/31/2011
A Name of plan STEELWORKERS HEALTH AND WELFARE FUND	B Three-digit plan number (PN) → 501
C Plan sponsor's name as shown on line 2a of Form 5500	D Employer Identification Number (EIN)
Steelworkers Health & Welfare Fund	23-1317409

#### Part I Asset and Liability Statement

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. MTlAs, 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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1054361	698163
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	803874	400488
C General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	3960474	13480875
(2) U.S. Government securities	1c(2)	2957771	3381117
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	6453631	6643217
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	24607497	23544882
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	43353	54762

1d E	imployer-related investments:		(a) Beginning of Year	(b) End of Year
(*	1) Employer securities	1d(1)	0	0
	2) Employer real property	1d(2)		
e B	Buildings and other property used in plan operation	1e	74636	72071
fτ	otal assets (add all amounts in lines 1a through 1e)	1f	39955597	48275575
	Liabilities			
gв	Benefit claims payable	1g	0	0
h c	Operating payables	1h	356098	550746
j A	cquisition indebtedness	1i		
jc	Other liabilities	1j	644583	2060990
kт	otal liabilities (add all amounts in lines 1g through1j)	1k	1000681	2611736
	Net Assets			
I N	let assets (subtract line 1k from line 1f)	11	38954916	45663839

### Part II Income and Expense Statement

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 receiv	able in cash from: (A) Employers	2a(1)(A)	523940197	
(B) Participants		2a(1)(B)	4007017	
(C) Others (include	ling rollovers)	2a(1)(C)		
(2) Noncash contributi	ons	2a(2)		
(3) Total contributions	. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		527947214
b Earnings on investme	ents:			
(1) Interest:				
<ul><li>(A) Interest-beari certificates of</li></ul>	ng cash (including money market accounts and deposit)	2b(1)(A)	4473	
(B) U.S. Governn	nent securities	2b(1)(B)	164619	
(C) Corporate de	ot instruments	2b(1)(C)	346064	
(D) Loans (other	than to participants)	2b(1)(D)		
(E) Participant los	ans	2b(1)(E)		
(F) Other		2b(1)(F)	2841	
(G) Total interest.	Add lines 2b(1)(A) through (F)	2b(1)(G)		517997
(2) Dividends: (A) Pre	ferred stock	2b(2)(A)		
(B) Common stoo	k	2b(2)(B)		
(C) Registered in	vestment company shares (e.g. mutual funds)	2b(2)(C)	576804	
(D) Total dividend	is. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		576804
(3) Rents		2b(3)		
(4) Net gain (loss) on	sale of assets: (A) Aggregate proceeds	2b(4)(A)	6966817	
(B) Aggregate ca	rrying amount (see instructions)	2b(4)(B)	6711888	
(C) Subtract line	2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		254929

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Page	

		(a) Amount	(b) Total
2b (5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	158534	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		158534
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		-1454779
C Other income	2c		8009738
d Total income. Add all income amounts in column (b) and enter total	2d		536010437
Expenses			
Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)	527676505	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		527676505
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses: (1) Professional fees	2i(1)	226949	
(2) Contract administrator fees	2i(2)	839320	
(3) Investment advisory and management fees	2i(3)	84236	
(4) Other	2i(4)	474504	
(5) Total administrative expenses. Add lines 2i(1) through (4)	2i(5)		1625009
j Total expenses. Add all expense amounts in column (b) and enter total	2j	-	529301514
Net Income and Reconciliation	L		
k Net income (loss). Subtract line 2j from line 2d	2k		6708923
Transfers of assets:		-	
	21(1)	†	
(1) To this plan	21(2)	-	
(z) From this plan	,(-)		
Part III Accountant's Opinion			
3 Complete lines 3a through 3c if the opinion of an independent qualified public a attached.	ccountant is	s attached to this Form 5500. Comple	ete line 3d if an opinion is not
a The attached opinion of an independent qualified public accountant for this plan	n is (see ins	tructions):	
(1) X Unqualified (2) Qualified (3) Disclaimer (4)	Adverse		
b Did the accountant perform a limited scope audit pursuant to 29 CFR 2520.103	-8 and/or 10	03-12(d)?	Yes X No
C Enter the name and EIN of the accountant (or accounting firm) below:			
(1) Name: MCELHANEY & ASSOCIATES, LLC		(2) EIN: 38-3806684	
d The opinion of an independent qualified public accountant is <b>not attached</b> because (1) This form is filed for a CCT, PSA, or MTIA. (2) It will be attached because the control of the c		next Form 5500 pursuant to 29 CFR 2	2520.104-50.

Page	4
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Dat	rt IV	Compliance Questions						
4		CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5.						
		103-12 IEs also do not complete 4j and 4l. MTIAs also do not complete 4l.			<b>1</b> 1-	A		
_	_	the plan year:		Yes	No	Amo	unt	
а	period	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.)			х			
b	close o	Vere any loans by the plan or fixed income obligations due the plan in default as of the lose of the plan year or classified during the year as uncollectible? Disregard participant loans ecured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is hecked.)			Х			
С	Were a	any leases to which the plan was a party in default or classified during the year as ectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4b 4c		Х			
d	reporte	there any nonexempt transactions with any party-in-interest? (Do not include transactions at on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is ad.)	4d		х			
е	Was th	nis plan covered by a fidelity bond?	4e	Х			500000	
f		e plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused id or dishonesty?	4f		Х			
g		e plan hold any assets whose current value was neither readily determinable on an shed market nor set by an independent third party appraiser?	4g		Х			
h		e plan receive any noncash contributions whose value was neither readily ninable on an established market nor set by an independent third party appraiser?	4h		х			
i		e plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, se instructions for format requirements.)	4i	Х				
j	value (	any plan transactions or series of transactions in excess of 5% of the current of plan assets? (Attach schedule of transactions if "Yes" is checked, and structions for format requirements.)	4j	Х				
k		all the plan assets either distributed to participants or beneficiaries, transferred to another or brought under the control of the PBGC?	4k		Х			
1	Has th	e plan failed to provide any benefit when due under the plan?	41		Х			
m		s an individual account plan, was there a blackout period? (See instructions and 29 CFR 01-3.)	4m		Х			
n		vas answered "Yes," check the "Yes" box if you either provided the required notice or one exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n					
5a	Has a resolution to terminate the plan been adopted during the plan year or any prior plan year?     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.)						ilities were	
	5b(1) i	b(1) Name of plan(s)		5b(2) EIN(s)			5b(3) PN(s)	
					······································			
				***************************************				
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