Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

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

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/10/1987

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

77 HUYSHOPE AVENUE
2ND FLOOR
HARTFORD, CT 06106

2b Employer Identification Number (EIN) 06-1188411

2c Plan Sponsor's telephone number 860-728-1100

2d Business code (see instructions) 623000

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	07/16/2025	DAVID PICKUS
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/16/2025	ELLEN BARNES
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	5679
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	4818
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	4960
b	Retired or separated participants receiving benefits	**6b**	858
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5818
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	53

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

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

4A 4B 4D 4E 4F 4L 4Q 4U

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

D Employer Identification Number (EIN)
06-1188411

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	G2989/C-4279	5818	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	318902
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

D Employer Identification Number (EIN)
06-1188411

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
SIERRA HEALTH AND LIFE INSURANCE CO

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
94-0734860	71420	H2001	545	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
37415	0

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

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

LABOR FIRST, LLC
1000 MIDLANTIC DRIVE, SUITE 100
MOUNT LAUREL, NJ 08054

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
37415			

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

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

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	666152
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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OMB No. 1210-0110

2024

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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

D Employer Identification Number (EIN)
06-1188411

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

1 Coverage Information:

(a) Name of insurance carrier
THE UNION LABOR LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	SL10442	3282	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	1478951
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan	**B** Three-digit plan number (PN) ▶	
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN		501
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number (EIN)	
BOARD OF TRUSTES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD	06-1188411	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

NORTHERN TRUST COMPANY

36-1561860

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

MPL LLC

109 SANFORD STREET
HAMDEN, CT 06514

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

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

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

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

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

ANTHEM

06-1475928

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50 15 62	NONE	1231672	Yes [X] No [ ]	Yes [ ] No [X]	60189	Yes [ ] No [X]

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

EMPIRX

47-1226691

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50 62 99	NONE	336587	Yes [X] No [ ]	Yes [ ] No [X]	0	Yes [X] No [ ]

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

BASYS INC

52-4796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	223986	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

EMPLOYEE E

06-1188411

(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?
30 50	EMPLOYEE	201449	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MILLIMAN USA

91-0675641

(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?
11 16 50	NONE	161435	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EMPLOYEE I

06-1188411

(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?
30 50	EMPLOYEE	134539	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

EMPLOYEE K

06-1188411

(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?
30 50	EMPLOYEE	127339	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EMPLOYEE C

06-1188411

(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?
30 50	EMPLOYEE	109560	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DELTA DENTAL

22-1896118

(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?
13 50	NONE	105878	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

LAW FIRM OF JOHN CREANE

06-0941734

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	104158	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE P

06-1188411

(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?
30 50	EMPLOYEE	83340	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE A

06-1188411

(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?
30 50	EMPLOYEE	82803	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EMPLOYEE R

06-1188411

(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?
30 50	EMPLOYEE	81261	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE S

06-1188411

(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?
30 50	EMPLOYEE	80800	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE D

06-1188411

(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?
30 50	EMPLOYEE	70041	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EMPLOYEE J

06-1188411

(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?
30 50	EMPLOYEE	68987	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

NOVAK FRANCELLA LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	64738	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE N

06-1188411

(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?
30 50	EMPLOYEE	56635	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EMPLOYEE M

06-1188411

(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?
30 50	EMPLOYEE	53842	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE O

06-1188411

(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?
30 50	EMPLOYEE	51360	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE G

06-1188411

(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?
30 50	EMPLOYEE	51283	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

EMPLOYEE H

06-1188411

(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?
30 50	EMPLOYEE	51035	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EMPLOYEE B

06-1188411

(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?
30 50	EMPLOYEE	41132	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EMPLOYEE T

06-1188411

(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?
30 50	EMPLOYEE	39037	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

HINGE HEALTH, INC.

81-1884841

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	38135	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WRIGHT INVESTORS

06-0931761

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	37388	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CLAIMS TECHNOLOGIES INC

42-1414040

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	31800	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

MARSHALL COMPUTERS

03-0366924

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	27520	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

EMPLOYEE Q

06-1188411

(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?
30 50	EMPLOYEE	26972	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BANK OF AMERICA

94-1687665

(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 99	NONE	26491	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

NORTHERN TRUST COMPANY

36-1561860

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 50	NONE	21908	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LOOMIS SAYLES & COMPANY, LP

04-3200030

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 51	NONE	21832	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MARCO CONSULTING

36-3555078

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 50	NONE	18125	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

PC CONNECTION INC

02-0513618

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	15014	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

VIVEKA HEALTH

104 W 14TH ST
NEW YORK, NY 10011

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	15000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

NEWTOWER TRUST COMPANY

30-0872552

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 52	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	14346	Yes [ ] No [X]

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

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

BEHAVIORAL HEALTH CONSULTANTS, LLC

06-1563820

(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?
23 50	NONE	12625	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DAVIS VISION

11-3051991

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	12393	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

SEGAL SELECT INSURANCE SERVICES INC

46-0619194

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22 53	NONE	0	Yes [X] No [ ]	Yes [ ] No [X]	10425	Yes [ ] No [X]

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
ANTHEM	22 53 55	60189

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
MPL, LLC 06-1537302	SALES & BASE COMMISSION

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
NEWTOWER TRUST COMPANY	28 52	14346

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
BGO DIVERSIFIED US PROPERTY 26-3781187	INVESTMENT MANAGEMENT

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
SEGAL SELECT INSURANCE SERVICES INC	22 53	3005

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
TRAVELERS 06-0566090	INSURANCE BROKERAGE COMMISSIONS

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
SEGAL SELECT INSURANCE SERVICES INC	22 53	5266

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
CHUBB 13-1963496	INSURANCE BROKERAGE COMMISSIONS

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
SEGAL SELECT INSURANCE SERVICES INC	22 53	2154

(d) Enter name and EIN (address) of source of indirect compensation	**(e)** Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.
EUCLID 45-3957469	INSURANCE BROKERAGE COMMISSIONS

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

DFE/Participating Plan Information

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan or DFE sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

D Employer Identification Number (EIN)
06-1188411

Part I Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)
(Complete as many entries as needed to report all interests in DFEs)

a Name of MTIA, CCT, PSA, or 103-12 IE: MFB NTGI-QM DAILY RUSSELL 1000 FD

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

c EIN-PN 45-6138592-001 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 14694974

a Name of MTIA, CCT, PSA, or 103-12 IE: NHIT INTERMEDIATE DURATION FIXED IN

b Name of sponsor of entity listed in (a): LOOMIS SAYLES TRUST COMPANY, LLC

c EIN-PN 20-8080381-004 | **d** Entity code C | **e** Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 31724017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part II **Information on Participating Plans (to be completed by DFEs, other than DCGs)**
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN
a Plan name	
b Name of plan sponsor	**c** EIN-PN

SCHEDULE H (Form 5500)

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.**

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTES-NEW ENGLAND HEALTH CARE EMPL WELFARE FD

D Employer Identification Number (EIN)
06-1188411

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.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1215487	1060588
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	3854749	2978079
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	3587344	2156159
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	7663967	15541897
(2) U.S. Government securities	1c(2)	19788217	0
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	8240530	0
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)	1730198	1665559
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)	2450750	0
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	10005990	46418991
(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)	2021843	94689
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	35695	77521
f Total assets (add all amounts in lines 1a through 1e)	1f	60594770	69993483
Liabilities			
g Benefit claims payable	1g	4587600	6321900
h Operating payables	1h	84441	104396
i Acquisition indebtedness	1i		
j Other liabilities	1j	2512220	19303
k Total liabilities (add all amounts in lines 1g through1j)	1k	7184261	6445599
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	53410509	63547884

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	45140765	
(B) Participants	2a(1)(B)	660322	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		45801087
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	556730	
(B) U.S. Government securities	2b(1)(B)	245532	
(C) Corporate debt instruments	2b(1)(C)	268724	
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		1070986
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	30784	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		30784
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	78552676	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	77788825	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		763851
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	569554	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		569554

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		1968964
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		2282187
d Total income. Add all **income** amounts in column (b) and enter total	2d		52487413
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	35090672	
(2) To insurance carriers for the provision of benefits	2e(2)	2500137	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		37590809
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)	1459307	
(2) Contract administrator fees	2i(2)	1737290	
(3) Recordkeeping fees	2i(3)	59038	
(4) IQPA audit fees	2i(4)	37500	
(5) Investment advisory and investment management fees	2i(5)	140089	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	161435	
(8) Legal fees	2i(8)	104158	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	1060412	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		4759229
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		42350038
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		10137375
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] Unmodified **(2)** [ ] Qualified **(3)** [ ] Disclaimer **(4)** [ ] Adverse

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

(1) [ ] DOL Regulation 2520.103-8 **(2)** [ ] DOL Regulation 2520.103-12(d) **(3)** [X] neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

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

(1) Name: NOVAK FRANCELLA, LLC **(2)** EIN: 61-1436956

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

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

Part IV Compliance Questions

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

During the plan year:

		Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	**4a**		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)	**4b**		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	**4c**		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		1000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4g**	X		1665559
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	**4j**	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	**4n**		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) ..... ☐ Yes ☐ No ☐ Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE FUND

FINANCIAL STATEMENTS

DECEMBER 31, 2024

NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE FUND

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

CONTENTS

Novak Francella LLC | CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees
New England Health Care Employees
Welfare Fund

Opinion

We have audited the financial statements of the New England Health Care Employees Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023 and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and of benefit obligations of the New England Health Care Employees Welfare Fund as of December 31, 2024 and 2023 and the changes in net assets available for benefits and benefit obligations for the years, then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the New England Health Care Employees Welfare Fund 's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the New England Health Care Employees Welfare Fund 's ability to continue as a going concern for a reasonable period of time.

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

Report on Supplemental Information

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

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

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

Novak Francella LLC

Killingworth, Connecticut
July 1, 2025

New England Health Care Employees
Welfare Fund

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
Assets		
Investments - at fair value		
United States Government and agency securities	$ -	$ 19,788,217
Corporate bonds	-	8,240,530
Registered investment company	94,689	2,021,843
Common trust fund	46,418,991	10,005,990
Partnership	1,665,559	1,730,198
Cash equivalents	15,541,897	7,663,967
Investments on loan	-	2,450,750
Total investments	63,721,136	51,901,495
Receivables		
Employer contributions, net of allowance for credit losses of $-0- (2024 and 2023)	2,978,079	3,854,749
Accrued income	76,321	239,445
Due from Pension Fund	113,281	117,164
Subrogation and lien refunds	14,289	14,289
Medicare subsidy rebates	19,895	54,119
ACA Reinsurance Fee refund receivable	420,317	-
Stop loss receivable	856,924	-
Prescription rebate receivable	587,019	508,340
Total receivables	5,066,125	4,788,106
Property and equipment - net	77,521	35,695
Other assets		
Cash	1,060,588	1,215,487
Prepaid expenses	68,113	155,592
Cash collateral under securities lending program	-	2,498,395
Total other assets	1,128,701	3,869,474
Total assets	69,993,483	60,594,770

See accompanying notes to financial statements.

Liabilities and Net Assets	2024	2023
Liabilities		
Accounts payable	$ 104,396	$ 84,441
Due to broker for securities purchased	19,303	13,825
Obligation to refund cash and non-cash collateral	-	2,498,395
Total liabilities	123,699	2,596,661
Net assets available for benefits	$ 69,869,784	$ 57,998,109

See accompanying notes to financial statements.

New England Health Care Employees Welfare Fund

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
Additions		
Investment income		
Net appreciation in fair value of investments	$ 3,156,128	$ 2,384,140
Interest	1,250,630	1,284,411
	4,406,758	3,668,551
Less investment fees	(140,089)	(131,980)
Net investment income	4,266,669	3,536,571
Contributions		
Employers	45,140,765	42,915,345
Self-pay members	660,322	750,700
Total contributions	45,801,087	43,666,045
Other income		
Benefits recovered	1,388	2,358
Subrogation and lien refunds	94,100	117,258
Stop loss recovered	1,500,154	-
Interest on employer contributions	43,380	17,010
Miscellaneous income	10,341	2,050
ACA Reinsurance Fee refund	420,317	-
Anthem credits on fees	-	130,942
Medicare subsidy rebate	160,298	144,279
EmpiRx reimbursement	50,000	-
Antitrust litigation proceeds	2,209	-
Total other income	2,282,187	413,897
Total additions	52,349,943	47,616,513
Deductions		
Benefits	33,356,372	25,289,110
Insurance and administrative service fees	4,252,475	4,307,921
Administrative expenses	2,869,421	2,642,318
Total deductions	40,478,268	32,239,349
Net increase	11,871,675	15,377,164
Net assets available for benefits		
Beginning of year	57,998,109	42,620,945
End of year	$ 69,869,784	$ 57,998,109

See accompanying notes to financial statements.

New England Health Care Employees Welfare Fund

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Claims payable	$ 654,289	$ 1,624,724
Other obligations for current benefit coverage at present value of estimated amounts:		
Claims incurred but not reported	5,667,611	2,962,876
Accumulated eligibility credits	3,476,100	2,942,700
	9,143,711	5,905,576
Total obligations other than postretirement benefit obligations	9,798,000	7,530,300
Postretirement benefit obligations:		
Current retirees, spouses, and beneficiaries	17,014,558	11,759,874
Other participants fully eligible for benefits	4,404,900	3,234,584
Other participants not fully eligible for benefits	501,726	438,716
	21,921,184	15,433,174
Total benefit obligations	$ 31,719,184	$ 22,963,474

See accompanying notes to financial statements.

New England Health Care Employees
Welfare Fund

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries, and dependents:		
Balance at beginning of the year	$ 1,624,724	$ 609,412
Claims reported and approved for payment	34,901,122	28,922,556
Claims and insurance premiums paid	(35,871,557)	(27,907,244)
Balance at end of year	654,289	1,624,724
Other obligations for current benefits coverage, at present value of estimated amounts:		
Balance at beginning of year	5,905,576	7,251,588
Net changes during the year		
Claims incurred but not reported	2,704,735	(1,231,712)
Accumulated eligibility credits	533,400	(114,300)
Balance at end of year	9,143,711	5,905,576
Total obligations other than postretirement benefit obligations	9,798,000	7,530,300
Postretirement benefit obligation:		
Balance at beginning of year	15,433,174	16,390,017
Increase (decrease) during the year attributable to		
Benefits earned and other changes	7,829,692	(1,505,457)
Changes in actuarial assumptions	(1,341,682)	548,614
Balance at end of year	21,921,184	15,433,174
Total benefit obligations	$ 31,719,184	$ 22,963,474

See accompanying notes to financial statements.

NOTE 1. DESCRIPTION OF PLAN

General - The New England Health Care Employees Welfare Fund (the Plan) was established in December 1986, pursuant to an agreement and declaration of trust adopted by the New England Health Care Employees Union, District 1199, and certain employers with whom District 1199 had collective bargaining agreements. The Plan is maintained pursuant to collective bargaining agreements which provide for each employer's rate of contributions and the job classifications for which contributions are payable and certain other terms governing contributions. The Plan was established to provide health care benefits to the Plan's participants and their dependents who meet certain Plan eligibility requirements. The Plan is non-contributory except as noted below. The Plan is administered by a Board of Trustees consisting of an equal number of representatives of both the contributing employers and the sponsoring union.

Contributions to the Plan are calculated on gross payroll and made by contributing employers at the rates established by the collective bargaining agreements.

The costs of the postretirement benefit plan are shared by the Plan's participating employers and retirees. Employees hired before January 1, 1992, whose employers were contributing employers before that date, may be eligible for retiree benefits as outlined in the Summary Plan Description booklet. Employees hired on or after January 1, 1992 are not eligible for any retiree benefit coverage.

The average monthly participant premiums by wage class ("WC") for pre-Medicare retirees and spouses are assumed to be as follows:

	December 31, 2024		
	WC I	WC II	WC III
Employee	$ 693	$ 542	N/A
Spouse	168	131	N/A

	December 31, 2023		
	WC I	WC II	WC III
Employee	$ 702	$ 550	$ 411
Spouse	170	133	N/A

NOTE 1. DESCRIPTION OF PLAN (continued)

Participants of Women & Infants Hospital - Participants are no longer eligible for active health benefits under the Welfare Fund as of February 1, 2002. However, participants who were eligible for active benefits on January 31, 2002 will be eligible for retiree benefits upon retirement. These retiree benefits require monthly contributions for both pre-Medicare and post-Medicare benefits.

The average monthly premiums required for retired participants from Women & Infants Hospital were assumed to be as follows:

	December 31, 2024		
	Pre-Medicare		Medicare
	Retired prior to 2/1/02	Retired on or after 2/1/02	All Retirees
Employee	See table on previous page	$ 1,123	$ 399
Spouse	See table on previous page	1,302	399

	December 31, 2023		
	Pre-Medicare		Medicare
	Retired prior to 2/1/02	Retired on or after 2/1/02	All Retirees
Employee	See table on previous page	$ 1,039	$ 261
Spouse	See table on previous page	1,196	261

Plan Benefits - The following brief description of the benefits provided under the Plan is included for general information purposes only. Participants should refer to the Summary Plan Description for more complete information.

Contributions to the Plan are used to pay health, vision, hearing aid, dental, prescription drug, disability, death, accidental death and dismemberment, scholarships and mental health and substance abuse benefits to eligible members and their dependents. The Plan also pays certain medical benefits for eligible retired members.

Participants no longer eligible under normal provisions of the Plan may obtain continuing coverage through self-payment contributions at a fixed premium level, based on the coverage selected by the participants.

The Union Labor Life Insurance Company (ULLICO) has issued the Plan group insurance policies, to provide coverage for the death and accidental death and dismemberment benefits. During the years ended December 31, 2024 and 2023, the Plan paid $318,902 and $314,675, respectively, in premiums for this coverage.

Benefits Changes - On December 7, 2023, the Board of Trustees approved to eliminate Wage Class III benefits and members will automatically default to Wage Class II benefits effective June 1, 2024.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Valuation of Investments and Income Recognition - The Trustees have appointed investment managers and an investment custodian. Subject to an investment policy adopted by the Trustees, the investment managers have discretionary authority concerning purchases and sales of investments, which consist of U.S. Government and Agency securities, corporate bonds, common trust fund, registered investment company, partnership, and cash equivalents. These investments are stated at fair value, based on quoted market prices, or valued based on pricing models maximizing the use of observable inputs for similar securities, as represented by the investment custodian.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on ex-dividend date. Net appreciation (depreciation) includes the Plan's gain and loss on investments bought and sold as well as held during the year.

See Note 14 for discussion of fair value measurements.

Securities Lending - The Welfare Fund has an agreement authorizing its custodian, Northern Trust, to act as agent in the lending of the Plan's securities to third parties. Under this arrangement, securities are lent to firms which also have a contractual agreement with Northern Trust regarding security loans. Collateral in the form of cash, government securities, equities, certificates of deposit or letters of credit is provided to Northern Trust by the borrower in values greater than the loaned securities. The security is delivered to the borrower simultaneously, while the collateral is invested by Northern Trust in a commingled collateral pool account. The duration of these transactions is overnight but can be renewed the next day. At the conclusion of the loan, the borrower returns the security to Northern Trust. Northern Trust divests the collateral to enable payment to the borrowing firm of both principal and a rebate in consideration of the collateral. The Plan earns the spread between the earnings on the collateral and the rebate to the borrower, less Northern Trust's fee as agent. During the years ended December 31, 2024 and 2023, the Plan's net earnings from these transactions were $3,815 and $5,383, respectively.

As agent, Northern Trust establishes and reviews the credit limits of each borrower. Collateral is valued daily to ensure adequate security. If necessary, additional collateral must be furnished to Northern Trust to cover any shortfalls. The Welfare Fund retains ownership of the loaned securities throughout the transaction.

Although the Plan's securities lending activities are collateralized as described above, and although the terms of the securities lending agreement with the custodial bank requires the bank to comply with government rules and regulations related to the lending of securities held by ERISA plans, the securities lending program involves both market and credit risks. In this context, market risk refers to the possibility that the borrowers of securities will be unable to collateralize their loan upon a sudden material change in the fair value of the loaned securities or the collateral, or that the bank's investment of cash collateral received from the borrowers of the Plan's securities may be subject to unfavorable market fluctuations. Credit risk refers to the possibility that counter-parties involved in the securities lending program may fail to perform in accordance with the terms of their contracts.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

To date, the Plan has experienced no losses in connection with the securities lending program.

As of December 31, 2024, and 2023, the fair value of the securities loaned, by investment type, was as follows:

	2024	2023
Corporate bonds	$ -	$ 2,450,750

On December 31, 2024 and 2023, respectively, collateral received for loaned securities was held in cash and non-cash in the amounts of $-0- and $2,498,395.

In order to present the statement of net assets available for benefits in accordance with accounting principles generally accepted in the United States of America the fair value of loaned securities is separately identified. Cash and non-cash received as collateral is reflected as an asset and the obligation to refund the cash and non-cash collateral is reflected as a liability.

Employer Contributions - Employer contributions are based on a percentage of bargaining unit gross wages, as reported by employers, at rates contractually agreed upon between each employer and the sponsoring union.

The allowance for credit losses represents the estimated losses that may be incurred in the collection of specific employer contributions receivable.

The Plan charges interest and penalties for delinquent payment of contributions. These charges are not recognized as income until they are collected by the Plan.

Payment of Benefits - Benefit payments are recorded when paid.

Administrative Expense Allocation - The Plan is affiliated with the New England Health Care Employees Pension Fund (the Pension Fund). Certain common costs are paid by the Plan. A portion of these expenses are allocated to, and reimbursed by, the Pension Fund in accordance with policies established by the Trustees. Total expenses allocated to the Pension Fund by the Plan were $1,026,055 and $925,738 for the years ended December 31, 2024 and 2023, respectively.

Disability Benefits Reimbursement - The Pension Fund reimburses the Plan in instances where a participant's pension benefit is approved with an effective date falling during the same period that the participant receives weekly short-term disability payments from the Plan. The amount of the reimbursement is the monthly pension benefit, or the amount of the short-term disability benefits paid by the Plan in a given month, whichever is less. Reimbursement from the Pension Fund totaled $-0- for the years ended December 31, 2024 and 2023.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Stop Loss Coverage - The Plan had entered into a stop loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount as well as its aggregate exposure for all claims). Premiums for stop loss insurance are included in premium payments in the accompanying statements of changes in net assets available for benefits. Stop loss refunds totaled $1,500,154 and $-0- for the years ended December 31, 2024 and 2023, respectively.

Refunds - Effective January 1, 2021 the Plan utilized a pharmacy benefit manager (PBM) which periodically made refunds to the Plan based on the Plan's actual utilization pattern of drugs. Prior to January 1, 2021, the agreement with the PBM did not refund the rebates to the Plan. Refunds due from the Plan's PBM were recorded when earned. Refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against claims paid. Pharmacy rebates totaling $1,136,037 and $989,850 have been netted with claims paid in the accompanying statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023, respectively.

Estimates - The preparation of financial statements, in conformity with accounting principles generally accepted in the United States of America, requires the plan administrator to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results may differ from these estimates.

Property and Equipment - Property and equipment are recorded at cost and are being depreciated on a straight-line basis over estimated useful live of the assets, ranging from five to seven years.

Credit Risk - The Plan maintains its cash with a financial institution deemed to be credit worthy. Cash balance is insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 in a single bank. As of December 31, 2024, cash on deposit with Bank of America totaling $1,118,772 exceeded FDIC coverage in a single bank by $868,772.

NOTE 3. BENEFIT OBLIGATIONS

(In Part): Summary of Significant Accounting Policies

Postretirement Benefit Obligations - The Plan has adopted the provisions of FASB ASC 965, "Accounting and Reporting by Health and Welfare Benefit Plans". The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the plan to employees' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future for current eligible plan participants. Postretirement benefits include future benefits to be paid to or for eligible 1) currently retired or terminated employees and their beneficiaries and dependents and 2) active employees and their beneficiaries and dependents after retirement from service with participating employers.

NOTE 3. BENEFIT OBLIGATIONS (continued)

The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing Plan assets. Prior to an active employee's eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service rendered to the valuation date.

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

For measurement purposes, the annual rate of increase in the per capita cost of covered health care benefits for 2024 was assumed to be as follows:

Increase in Fiscal Year	Pre-Medicare WCI and W&I Hospital Trend	Medicare WCI (MAPD) Trend	Pre-Medicare Medical & Vision Trend	Medicare Medical & Vision Trend	Medicare W&I Hospital Trend	Medicare Prescription Drug & Vision Trend
2025	6.10%	7.00%	5.50%	4.80%	8.10%	8.40%
2026	5.70%	6.40%	5.30%	4.80%	6.80%	6.90%
2027	5.20%	5.70%	5.10%	4.90%	5.40%	5.50%
2028	5.10%	5.50%	5.00%	4.80%	5.20%	5.30%
2029	4.90%	5.40%	4.90%	4.70%	5.00%	5.10%
2030	4.80%	5.20%	4.70%	4.60%	4.90%	4.90%
2031	4.60%	5.00%	4.60%	4.50%	4.70%	4.70%
2032	4.50%	4.80%	4.50%	4.40%	4.50%	4.50%
2033	4.40%	4.60%	4.30%	4.20%	4.30%	4.30%
2034	4.20%	4.40%	4.10%	4.10%	4.10%	4.10%
2035 - 2036	4.10%	4.40%	4.10%	4.10%	4.10%	4.10%
2037 - 2046	4.10%	4.30%	4.10%	4.10%	4.10%	4.10%
2047 - 2048	4.20%	4.30%	4.10%	4.10%	4.10%	4.10%
2049	4.20%	4.30%	4.20%	4.10%	4.10%	4.10%
2050 - 2059	4.20%	4.20%	4.20%	4.10%	4.10%	4.10%
2060	4.20%	4.20%	4.20%	4.10%	4.20%	4.20%
2061 - 2064	4.20%	4.20%	4.20%	4.10%	4.10%	4.10%
2065	4.10%	4.10%	4.10%	4.10%	4.10%	4.10%
2066	4.10%	4.10%	4.10%	4.00%	4.00%	4.00%
2067	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
2068	4.00%	4.00%	4.00%	3.90%	4.00%	4.00%
2069 - 2070	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%
2071	3.90%	3.80%	3.80%	3.80%	3.80%	3.80%
2072	3.80%	3.80%	3.80%	3.80%	3.80%	3.80%
2073	3.80%	3.80%	3.80%	3.70%	3.70%	3.70%
2074+	3.70%	3.70%	3.70%	3.70%	3.70%	3.70%

NOTE 3. BENEFIT OBLIGATIONS (continued)

The following were other significant assumptions used in the valuation as of December 31, 2024 and 2023:

Weighted-average discount rate of 5.35% and 4.70% as of December 31, 2024 and 2023, respectively.

Consumer price index rate of 2.30%.

Charges for administration, retention (if applicable), and other non-benefit costs were included in the assumed benefit costs.

The coverage election assumption represents estimates of future experience in the Plan. Assumed 80% of Women & Infants Hospital active employee and 55% of all other active employees will elect medical coverage at retirement. Assumed 40% of active employees will be married and elect medical coverage for their spouse at retirement.

Mortality assumptions were based on the PRI-2012 Amount-Weighted Mortality Table with Blue Collar Adjustment with Scale MP-2021. The PRI-2012 contingent Mortality Table was reflected for current beneficiaries.

Probabilities of retirement are consistent with the Pension Fund and are as follows:

Age	Participants without 62 & 25 or 90 Points	Participants with 62 & 25 or 90 Points
55-57	1%	10%
58-59	2%	5%
60-61	2%	10%
62-64	6%	15%
65-67	30%	30%
68-69	25%	25%
70 and over	100%	100%

Rationale - We have relied on the assumptions contained in the January 1, 2024 pension valuation.

Health Care Reform - The Patient Protection and Affordable Care Act of 2010 (ACA) has been reflected in this analysis, including the anticipation of fees and surcharges effective in future years.

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

The Plan's deficiency of net assets over benefit obligations at December 31, 2024 and 2023, relates to the postretirement benefit obligation, the funding of which will be done on a pay as you go basis by the contribution rate provided by the current bargaining agreements. The Trustees have the right to terminate or change the terms of the plan at any time.

NOTE 3. BENEFIT OBLIGATIONS (continued)

The weighted-average health care cost-trend assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point in each year, it would increase the obligation as of December 31, 2024 and 2023, by $1,741,884 and $1,214,196, respectively.

Other Benefit Obligations - Benefit claims currently payable include the Plan's liability for claims incurred as of December 31, 2024 and 2023, respectively, but not reported, and the Plan's liability for claims reported as of December 31, 2024 and 2023, respectively, but not yet processed. The Plan's liability for claims incurred but not yet reported is estimated by the Plan's actuary utilizing actuarial methods which take into consideration prior claims experience and the expected time period from the date such claims are incurred to the date that the related claims are submitted and paid. Health claims incurred by retired participants but not reported at year end are included in claims incurred but not reported.

Plan obligations at December 31, 2024 and 2023 also include accumulated eligibility of participants as estimated by the Plan's actuary in accordance with accepted actuarial principles. This estimate is based on average claim costs incurred during the respective plan year and the number of months of continued eligibility beyond the plan year end.

NOTE 4. PROPERTY EQUIPMENT

	December 31,				Depreciable
	2024		2023		Lives
Furniture and fixtures	$ 102,885		$ 102,885		
Accumulated depreciation	98,402	$ 4,483	96,244	$ 6,641	5 years
Computer hardware	308,554		238,927		
Accumulated depreciation	238,960	69,594	219,972	18,955	5 years
Computer software	314,904		312,909		
Accumulated depreciation	311,460	3,444	309,701	3,208	5 years
Telephone system	20,477		29,710		
Accumulated depreciation	20,477	-	23,401	6,309	5 years
Leasehold improvements	14,670		14,670		
Accumulated depreciation	14,670	-	14,088	582	5 years
		$ 77,521		$ 35,695	

Depreciation expense totaled $27,179 and $11,506 for the years ended December 31, 2024 and 2023, respectively.

NOTE 5. BENEFIT ADMINISTRATION

The Plan has an agreement through December 31, 2024 with Anthem Blue Cross/Blue Shield of Connecticut to provide network access and discount claims repricing and payment services on behalf of the Plan's eligible members and their dependents. Participation by members in the network is voluntary and is available to all eligible active and retired members and their families, other than Medicare primary members and their spouses and dependents. Effective January 1, 2019, the Plan entered into an agreement with Anthem for precautionary and case management services.

Subsequent to year end, on January 1, 2025 the Plan terminated Anthem and retained United Health Care to provide network access and discount claims repricing and payment services on behalf of the Plan's eligible members and their dependents.

Effective January 1, 2019, the Plan entered into an agreement with EmpiRx to administer prescription benefits and review specialty medications. Under this agreement, the Board of Trustees determines the types and limits of covered prescriptions and is responsible for the funding of all prescription claims. This agreement automatically extends for one year periods unless terminated by either party.

The Plan has an agreement with Delta Dental to administer dental benefits. Under this agreement, the Board of Trustees determines the types and limits of covered services. Delta Dental provides processing services and administers actual payment of dental benefits. This agreement automatically extends for one year periods unless terminated by either party.

The Plan has an agreement with Davis Vision, Inc. to administer vision care benefits. Under this agreement, the Board of Trustees determines the types and limits of covered services. Davis Vision, Inc. provides processing services and administers actual payment of vision care benefits.

The Plan provides accidental death and dismemberment and life insurance coverage through policies with ULLICO (see Note 1).

The Plan has a stop loss insurance contract with ULLICO. The policy provides for reimbursement to the Plan of medical benefits claims exceeding $325,000 per covered individual with a $250,000 aggregating specific deductible.

The Plan has a Group Medicare Advantage Plan for health care and prescription drug coverage with United Health Care. Subsequent to year end, dental benefits were added to the Group Medicare Advantage Plan.

The Plan has an agreement with Hinge Health to provide Musculoskeletal Care effective January 1, 2024.

NOTE 6. EMPLOYER CONTRIBUTIONS RECEIVABLE

Employer contributions receivable represents uncollected contributions for covered employment prior to the Plan's year end and are as follows:

	December 31	
	2024	2023
Collections subsequent to year end, unpaid contributions, legal proceedings, delinquency schedules	$ 2,978,079	$ 3,854,749
Payroll audits	-	-
	2,978,079	3,854,749
Less allowance for credit losses	-	-
	$ 2,978,079	$ 3,854,749

The allowance for credit losses was established based on an assessment of the collectability of contributions receivable. There were $-0- of uncollectible credit losses written off during the years ended December 31, 2024 and 2023.

NOTE 7. AFFILIATED ACTIVITIES

The Plan is related to the New England Health Care Employees Union, District 1199, SEIU and the New England Health Care Employees Union District 1199 and The Connecticut Nursing Homes Training and Upgrading Fund. These related parties contribute to the Plan on a monthly basis on behalf of their eligible employees. The total contributions from these related parties are as follows:

	Years Ended December 31	
	2024	2023
New England Health Care Employees Union District 1199, SEIU	$ 1,079,086	$ 1,016,272
New England Health Care Employees Union District 1199, and The Connecticut Nursing Homes Training and Upgrading Fund	163,784	166,631
	$ 1,242,870	$ 1,182,903

NOTE 8. PLAN TERMINATION

The Trustees expect and intend to continue the Plan indefinitely but reserve the right to amend or terminate it. In the event the Plan terminates, the Trustees shall first apply the net assets to any obligations outstanding and any remaining balance in such manner as will best effectuate the purpose of the Plan.

NOTE 8. PLAN TERMINATION (continued)

Under no circumstances shall any portion of the Plan, directly or indirectly, revert or accrue to the benefit of any contributing employer or the union.

NOTE 9. TAX STATUS

The Plan received its latest determination letter with respect to its trust agreement ("Trust"), on April 10, 1987, in which the Internal Revenue Service stated that the Trust, as then designed, was exempt from federal income tax under Section 501(c)(9) of the Internal Revenue Code. The Trust has been amended since receiving this determination letter. However, the Plan's legal counsel believes that the Trust is currently designed, and the Plan administrator believes that the Trust is currently being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, they believe that the Trust is tax-exempt under Section 501(c)(9) of the Internal Revenue Code as of the financial statement date.

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

NOTE 10. OBLIGATION UNDER OPERATING LEASE

The Plan leases its facilities from the New England Health Care Employees Union, District 1199 Holding Company, LLC, a related party, under an annual fixed rental agreement through June 30, 2027. The monthly rent was $8,323 effective July1, 2023. Rent expense totaled $99,876 and $99,213 for the years ended December 31, 2024 and 2023, respectively. Rent expense allocated to the Pension Fund totaled $32,917 and $32,740 for the years ended December 31, 2024 and 2023, respectively. The rent is based on a market analysis performed by an independent third party.

At December 31, 2024, the future minimum annual payments under this lease agreement are as follows:

Years Ending December 31,	Amount
2025	$ 49,938

The Plan had a fifty-one month operating lease agreement for mailing equipment. This agreement provided for quarterly payments of $1,638 plus tax and fees through the third quarter of 2024. The Plan entered into a new 66 month lease for mailing equipment effective fourth quarter 2024 through first quarter 2030. This agreement provides for quarterly payments of $1,606 plus tax and fees. Equipment rent expense totaled $5,228 and $6,551 for the years ended December 31, 2024 and 2023, respectively. Equipment rent expense allocated to the Pension Fund totaled $1,725 and $2,293 for the years ended December 31, 2024 and 2023, respectively.

NOTE 10. OBLIGATION UNDER OPERATING LEASE (continued)

At December 31, 2024, the future minimum annual payments under this lease agreement are as follows:

Year Ending December 31,	Amount
2025	$ 6,420
2026	6,420
2027	6,420
2028	6,420
2029	6,420
Thereafter	3,210
	$ 35,310

NOTE 11. RELATED PARTY TRANSACTIONS

The Plan paid certain expenses related to the Plan operations and investment activity to various service providers. The Plan holds shares of Northern Trust GI-QM Daily Russell 1,000 Index Fund, Northern Trust FDS Gov't Asset Portfolio and Bank of America Temporary Federated Gov't Obligations Fund. Both Northern Trust and Bank of America are custodians of the Plan's investment. These transactions are party-in-interest transactions which are exempt from the prohibited transaction rules of ERISA.

NOTE 12. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and sector risks. Due to the level of risks associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

The Plan's benefit obligations are reported based on certain assumptions pertaining to interest rates, health care inflation rates and participant demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term could be material to the financial statements.

NOTE 13. RECONCILIATION TO FINANCIAL STATEMENTS TO FORM 5500

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

	December 31, 2024	December 31, 2023
Net assets available for benefits per the financial statements	$ 69,869,784	$ 57,998,109
Benefit obligations currently payable	(6,321,900)	(4,587,600)
Net assets available for benefits per the Form 5500	$ 63,547,884	$ 53,410,509

The following is a reconciliation of benefits paid to participants per the financial statements to the Form 5500:

	Year Ended December 31, 2024
Benefits paid to participants per the financial statements	$ 35,856,509
Add: Amounts currently payable at December 31, 2024	6,321,900
Less: Amounts currently payable at December 31, 2023	(4,587,600)
Benefits paid to participants per the Form 5500	$ 37,590,809

Amounts currently payable to or for participants, dependents and beneficiaries are recorded on the Form 5500 for benefit claims that have been processed and approved for payment prior to December 31, but not yet paid as of that date and for claims incurred but not reported as of that date.

NOTE 14. FAIR VALUE MEASUREMENTS

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

Basis of Fair Value Measurement:

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

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

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

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

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

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

The level in the fair value hierarchy, within which the fair value measurement is classified, is determined based on the lowest level input that is significant to the fair value measure in its entirety.

The following is a description of the valuation methodologies used for assets and liabilities measured at fair value, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Registered Investment Company: The registered investment company investments are valued at their net asset value (NAV) of shares held by the Plan at year end and are classified within level 1 of the valuation hierarchy.

Common Trust Funds:

- Daily Russell 1000 Equity Index Fund investments are stated at fair value for those listed on recognized securities exchange. For securities not listed on recognized exchange, are generally valued at the most recent quoted bid price. The primary investment objective is to approximate the risk and return characteristics of the Russell 1000® Index. This index is commonly used to represent the large cap segment of the U.S. equity market.

- NHIT Intermediate Duration Fixed Income Trust investments are valued at fair value for securities listed on a securities exchange for which market quotations are readily available are valued at the last sale price or official closing price on each business day. For investments not listed on securities exchange, or, if there has been no sale that day, secondary sources will be used. The investment objective is to outperform the Bloomberg Capital Intermediate U.S. Government/Credit Index.

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

Cash Equivalents: Cash equivalents are invested in a money market fund. As permitted by compliance with certain conditions under Rule 2a-7 of the 1940 Act, securities are valued at amortized cost, which approximates fair value, and are categorized as Level 1 of the valuation hierarchy.

US Government and Agency Securities and Corporate Bonds: The custodian uses prices obtained from an independent third party pricing service to measure fair value of these investments. The custodian validates prices received from the pricing service using methods including comparison to prices received from additional pricing services, comparison to quoted market prices, where available, comparison to internal valuation models, and review of other relevant market data. These are classified within Level 2 of the valuation hierarchy.

Limited Partnership: BGO Diversified U.S. Property Fund LP. Reference Note 14; sub note c.

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2024:

	Fair Value of Measurements December 31, 2024			
	Total	Level 1	Level 2	Level 3
Registered investment company - cash equivalents	$ 94,689	$ 94,689	$ -	$ -
Cash equivalents	15,541,897	15,541,897	-	-
Total assets in the fair value hierarchy	15,636,586	$15,636,586	$ -	$ -
Investments measured at net asset value	48,084,550			
Total investments at fair value	$63,721,136			

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2023:

	Fair Value of Measurements December 31, 2023			
	Total	Level 1	Level 2	Level 3
Registered investment company - cash equivalents	$ 2,021,843	$2,021,843	$ -	$ -
U.S. Government and Agency Securities	19,788,217	-	19,788,217	-
Corporate bonds	10,691,280	-	10,691,280	-
Cash equivalents	7,663,967	7,663,967	-	-
Total assets in the fair value hierarchy	40,165,307	$9,685,810	$30,479,497	$ -
Investments measured at net asset value	11,736,188			
Total investments at fair value	$51,901,495			

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

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

Transfers between Levels

For years ended December 31, 2024 and 2023, there were no significant transfers between Levels 1 and 2 and no transfers in or out of Level 3.

The following table summarized investments measured at fair value based on NAV per share as of December 31, 2024.

	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
MFB NTGI-QM Daily Russell 1000 Equity Index FD-Lending	$ 14,694,974	N/A	a	b
NHIT Intermediate Duration Fixed income Trust	31,724,017	N/A	d	d
BGO Diversified US Property Fund LP	1,665,559	N/A	c	c

a - daily
b - A redemption resulting from the aggregate daily activities of Participants generally requires same-day notice. A redemption initiated by the Committee requires up to three business days' notice, depending on the applicable Fund. Redemption is generally settled in cash on the business day following the redemption date but may be settled in kind three business days following the redemption date.
c - Because BGO Diversified is an open-end fund, providing liquidity for all investors is a principal objective of the Fund. As of a Valuation Date, the Manager shall use commercially reasonable best efforts to accommodate all Redemption Notices based on available liquidity, as determined in the Manager's good faith judgment, in accordance with the following:

(i)First, to fully satisfy those Redemption Notices that remain outstanding with respect to prior Scheduled Redemption Date and those Redemption Notices whose Scheduled Redemption Date is such Valuation Date; and,
(ii)Second, to satisfy those Redemption Notices on a pro rata basis with respect to which that Valuation Date precedes the respective Scheduled Redemption Date.

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

As described in the Limited Partnership Agreement, the Manager intends that the Fund's redemption policies will be consistent with MEPT's policies regarding the allocation of available cash for the redemption of interests in MEPT, and the Fund's redemption policies may be modified from time to time at the discretion of the Manager so as to maintain consistency with those policies. For the avoidance of doubt, in determining each Limited Partner's pro rata share of amounts paid to satisfy Redemption Notices, the pro rata share allocable to MEPT and any other Limited Partner that is a collective investment vehicle managed by the Manager or an Affiliate of the Manager shall be determined individually to each investor in MEPT or such other collective investment vehicle that has made a withdrawal request as if such withdrawal request was made directly by such investor as a Class B Limited Partner.
d - units can be redeemed on any valuation date as for the transaction cutoff time.

The following table summarized investments measured at fair value based on NAV per share as of December 31, 2023.

	Fair Value	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
MFB NTGI-QM Daily Russell 1000 Equity Index FD-Lending	$10,005,990	N/A	a	b
BGO Diversified US Property Fund LP	1,730,198	N/A	c	c

a - daily
b - A redemption resulting from the aggregate daily activities of Participants generally requires same-day notice. A redemption initiated by the Committee requires up to three business days' notice, depending on the applicable Fund. Redemption is generally settled in cash on the business day following the redemption date but may be settled in kind three business days following the redemption date.
c - Because BGO Diversified is an open-end fund, providing liquidity for all investors is a principal objective of the Fund. As of a Valuation Date, the Manager shall use commercially reasonable best efforts to accommodate all Redemption Notices based on available liquidity, as determined in the Manager's good faith judgment, in accordance with the following:

(i)First, to fully satisfy those Redemption Notices that remain outstanding with respect to prior Scheduled Redemption Date and those Redemption Notices whose Scheduled Redemption Date is such Valuation Date; and,
(ii)Second, to satisfy those Redemption Notices on a pro rata basis with respect to which that Valuation Date precedes the respective Scheduled Redemption Date.

NOTE 14. FAIR VALUE MEASUREMENTS (continued)

As described in the Limited Partnership Agreement, the Manager intends that the Fund's redemption policies will be consistent with MEPT's policies regarding the allocation of available cash for the redemption of interests in MEPT, and the Fund's redemption policies may be modified from time to time at the discretion of the Manager so as to maintain consistency with those policies. For the avoidance of doubt, in determining each Limited Partner's pro rata share of amounts paid to satisfy Redemption Notices, the pro rata share allocable to MEPT and any other Limited Partner that is a collective investment vehicle managed by the Manager or an Affiliate of the Manager shall be determined individually to each investor in MEPT or such other collective investment vehicle that has made a withdrawal request as if such withdrawal request was made directly by such investor as a Class B Limited Partner.

NOTE 15. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN

Employees of the New England Health Care Employees Welfare Fund (the Plan) and the New England Health Care Employees Pension Fund (the Pension Fund), together referred to as the (the Benefits Funds) participate in one multiemployer defined benefit pension plan under the terms of a participation agreement that covers its non-collectively bargained employees. The Plan remits the contributions to this multiemployer defined benefit pension plan for the shared employees on behalf of the Benefits Funds. The Pension Fund reimburses the Plan for its share of the contributions based on a cost allocation study. The risks of participating in this multiemployer defined benefit pension plan are different from a single-employer plan in the following aspects:

a. Assets contributed to the multiemployer defined benefit pension plan by one employer may be used to provide benefits to employees of other participating employers.

b. If a participating employer stops contributing to the multiemployer defined benefit pension plan, the unfunded obligations of the multiemployer defined benefit pension plan may be borne by the remaining participating employers.

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

The Plan's participation in the multiemployer defined benefit pension plan for the annual periods ended December 31, 2024 and 2023, are outlined in the table below. The zone status is based on information that the Plan received from the multiemployer defined benefit pension plan and is certified by the multiemployer defined benefit pension plan's actuary. Among other factors, pension plans in the red zone are generally less than 65 percent funded, pension plans in the yellow zone are less than 80 percent funded, and pension plans in the green zone are at least 80 percent funded.

NOTE 15. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN (continued)

Legal Name of Pension Plan	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Pension Protection Act Zone Status				Expiration Date of Collective Bargaining Agreement
			Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	
New England Health Care Employees Pension Fund	22-3071963	001	Red as of 12/31/24	No	Red as of 12/31/23	No	*

*****The full-time employees of the Plan participate in the New England Health Care Employees Pension Fund through a participation agreement between the Plan and the New England Health Care Employees Pension Fund. The participation agreement does not have an expiration date.

Legal Name of Pension Plan	Contributions to the Pension Plan		Contributions to the Pension Plan greater than 5% of total Pension Plan Contributions (Plan year ending)		Employer Contribution Rates		Number of Employees Covered by Plan	
	12/31/2024	12/31/2023			12/31/2024	12/31/2023	12/31/2024	12/31/2023
New England Health Care Employees Pension Fund	$ 113,065	$ 102,897	No, Plan year ending 12/31/2024.	No, Plan year ending 12/31/2023.	9.50% of gross payroll	9.50% of gross payroll	27	27

Legal Name of Pension Plan	Funding Improvement Plan or Rehabilitation Plan Implemented or Pending?	Surcharge paid to Pension Plan by Plan ?	Minimum contributions required in future by CBA, statutory requirements, or other contractual	
			No?	If yes, description
New England Health Care Employees Pension Fund	Pending	Yes	No	N/A

NOTE 16. MULTIEMPLOYER PLAN PROVIDING POSTRETIREMENT BENEFITS OTHER THAN PENSIONS

The Plan contributed to one multiemployer defined benefit health and welfare plan that provides postretirement benefits during the years ended December 31, 2024 and 2023 for its full-time employees. The Plan's contributions to the welfare plan on behalf of its full-time employees, contribution rates and number of employees covered were as follows:

Legal Name of Plan providing postretirement benefits other than pension	Contributions to Plan		Employer contribution rates		Number of employees covered by Plan	
	12/31/2024	12/31/2023	12/31/2024	12/31/2023	12/31/2024	12/31/2023
New England Health Care Employees Welfare Fund	$ 232,017	$ 216,119	20% of gross payroll	20% of gross payroll	27	27

NOTE 17. SUBSEQUENT EVENTS

Subsequent events have been evaluated through July 1, 2025 which is the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

New England Health Care Employees Welfare Fund

Schedules of Administrative Expense Allocation

Years Ended December 31, 2024 and 2023

As described in Note 2, the New England Health Care Employees Welfare Fund pays certain common costs for the New England Health Care Employees Pension Fund. These expenses are allocated to the Pension Fund in accordance with policies established by the Trustees.

The following is a schedule of the total expenses incurred on behalf of the Pension Fund and allocated to that Fund:

	2024	2023
Expenses		
Salaries - office	$ 659,890	$ 606,159
Employee benefits - Health	114,277	106,447
Employee benefits - Pension	60,374	50,388
Payroll taxes	53,124	48,842
Office supplies and expenses	35,767	19,642
Rent - office	32,959	32,740
Bank charges	23,660	20,702
Professional fees	23,894	12,482
Telephone	6,245	6,023
Postage and mailing	4,297	14,313
Property tax	4,164	2,595
Conference and meetings	3,367	441
Data processing	2,312	2,098
Rent - equipment	1,725	2,866
Total	$ 1,026,055	$ 925,738

New England Health Care Employees
Welfare Fund

Schedules of Benefits and Insurance and Administrative Service Fees

Years Ended December 31, 2024 and 2023

	2024	2023
Benefits		
Health claims	$ 25,768,691	$ 17,731,540
Prescription drug program	6,428,026	6,358,285
Dental	773,799	792,235
Disability	180,595	172,212
Vision	139,596	158,899
Scholarship	59,500	68,500
Disability - TDI	6,165	7,439
	$ 33,356,372	$ 25,289,110
Insurance and administrative service fees		
Stop loss premiums	$ 1,478,951	$ 1,602,443
Retiree supplemental premiums	702,284	685,478
Life insurance premiums	318,902	314,675
Patient research fee	15,048	15,538
Administrative service fees:		
Network access/claims repricing fees - Anthem	1,077,558	1,069,516
Prescription drug program	336,587	316,961
Managed care program	154,114	153,619
Dental program - Delta Dental	105,878	106,034
Behavioral health managed care	12,625	21,720
Vision program - Davis Vision	12,393	13,689
Hinge Health	38,135	-
Disability managed care	-	8,248
	$ 4,252,475	$ 4,307,921

New England Health Care Employees Welfare Fund

Schedules of Administrative Expenses

Years Ended December 31, 2024 and 2023

	2024	2023
Salaries - office	$ 1,104,711	$ 1,008,517
Data processing	286,214	266,919
Employee benefits - health	232,017	216,119
Office supplies and expense	180,640	176,395
Actuarial and consulting services	161,435	217,398
Employee benefits - pension	122,579	102,897
Dues assessment - PPO savings	114,286	76,022
Legal	104,158	92,035
Payroll taxes	89,690	81,920
Printing	88,263	54,858
Rent - office	66,917	66,473
Insurance and bonding	58,375	44,198
Postage and mailing	50,744	62,471
Audit	37,500	37,500
Claims audit	31,800	31,800
Bank charges	30,017	26,745
Depreciation	27,179	11,506
Accounting - employer audits	24,257	15,541
Conferences and meetings	22,497	17,693
Telephone	12,678	12,227
Property taxes	8,454	5,268
Employee travel	4,330	3,621
Rent - equipment	3,503	5,819
Accounting services	2,981	7,075
Loss on asset disposal	2,619	-
Dues and subscriptions	1,577	1,301
Total administrative expenses	$ 2,869,421	$ 2,642,318

NEW ENGLAND HEALTH CARE EMPLOYEES
WELFARE FUND

SCHEDULE OF ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

Form 5500, Schedule H, Item 4i

EIN 06-1188411
Plan No. 501

(a)	(b) Issuer, Borrower	(c) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			(d) Cost	(e) Current Value
		Type	Shares/ Principal	Interest Rate / Maturity Date		
		Partnership				
	The BGO Diversified US Property Fund LP		2,000,000		$ 2,006,706	$ 1,665,559
		Common trust funds:				
	NHIT Intermediate Duration Fixed income Trust		2,032,288		30,829,810	31,724,017
*	MFB NTGI-QM Com Daily Russell 1000 Eqty Index Federal Lending		31,987		9,757,824	14,694,974
			Total common trust funds		40,587,634	46,418,991
		Registered investment company:				
*	Northern Instal FDS Government Assets Portfolio		94,689		94,689	94,689
		Cash and cash equivalents:				
	Federated Government Obligations Fund		14,891,897		14,891,897	14,891,897
*	Bank of America Temporary Overnight Deposit Dreyfus Gov't Cash Mgmt		650,000		650,000	650,000
			Total cash and cash equivalents		15,541,897	15,541,897
			Total investments		$ 58,230,926	$ 63,721,136

* A party-in-interst as defined by ERISA.

NEW ENGLAND HEALTH CARE EMPLOYEES
WELFARE FUND

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Item 4j

EIN 06-1188411
Plan No. 501

a)	(b) Description	(c) Purchase Price	(d) Selling Price	(g) Cost of Assets	(h) Current Value of Assets	(i) Net Gain (Loss) on Transaction
	Single Transactions					
	United States Treas. NTS 1.125% due 8/31/28	N/A	$ 5,752,013	$ 5,649,522	$ 5,752,013	$ 102,491
	United States Treas. NTS 1.625% due 5/15/26	N/A	6,778,598	6,693,302	6,778,598	85,296
	NHIT Intermediate Duration Fixed Income Trust	$ 30,850,894	N/A	30,850,894	30,850,894	N/A
*	Northern Instal FDS Government	30,701,696	N/A	30,701,696	30,701,696	N/A
*	Northern Instal FDS Government	N/A	30,850,894	30,850,894	30,850,894	-
	Series of Transactions					
*	Bank of America Temporary Overnight Deposit	21,327,348	N/A	21,327,348	21,327,348	N/A
*	Bank of America Temporary Overnight Deposit	N/A	20,777,348	20,777,348	20,777,348	-
	Federated Govt Oblig Fund Premier Class	24,398,376	N/A	24,398,376	24,398,376	N/A
	Federated Govt Oblig Fund Premier Class	N/A	17,070,446	17,070,446	17,070,446	-
	United States Treas. NTS 1.125% due 8/31/28	N/A	679,097	672,271	679,097	6,826
	United States Treas. NTS 1.125% due 8/31/28	366,164	N/A	366,164	366,164	N/A
	United States Treas. NTS 1.625% due 5/15/26	2,316,336	N/A	2,316,336	2,316,336	N/A
	United States Treas. NTS 1.625% due 5/15/26	N/A	2,946,328	2,917,452	2,946,328	28,876
	United States Treas. NTS 0.000% due 5/02/24	819,383	N/A	819,383	819,383	N/A
	United States Treas. NTS 0.000% due 5/02/24	N/A	2,454,725	2,454,725	2,454,725	-
	United States Treas. NTS 3.875% due 5/31/33	313,640	N/A	313,640	313,640	N/A
	United States Treas. NTS 3.875% due 5/31/33	N/A	2,779,314	2,780,630	2,779,314	(1,316)
*	Northern Instal FDS Government	1,189,913	N/A	1,189,913	1,189,913	N/A
*	Northern Instal FDS Government	N/A	2,967,870	2,967,870	2,967,870	-
	NHIT Intermediate Duration Fixed Income Trust	N/A	21,832	21,084	21,832	748
	United States Treas. NTS 1.625% due 5/15/31	1,379,526	N/A	1,379,526	1,379,526	N/A
	United States Treas. NTS 1.625% due 5/15/31	N/A	2,850,293	2,835,555	2,850,293	14,738

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

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110
1210 - 0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

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

C If the plan is a collectively-bargained plan, check here ▶ [X]

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

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

Part II Basic Plan Information - enter all requested information

1a Name of plan
NEW ENGLAND HEALTH CARE EMPLOYEES WELFARE PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 04/10/1987

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEES-NEW ENGLAND HEALTH CARE EMPL WELFA

77 HUYSHOPE AVENUE
2ND FLOOR
HARTFORD CT 06106

2b Employer Identification Number (EIN) 06-1188411

2c Plan Sponsor's telephone number 860-728-1100

2d Business code (see instructions) 623000

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

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

SIGN HERE	Signature of plan administrator	Date 7-16-2025	DAVID PICKUS Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date 7-16-2025	ELLEN BARNES Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

418401 11-25-24

07070714 758412 30180A 2024.04000 BOARD OF TRUSTEES-NEW ENGL 30180A_1

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	5679
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a (1)	Total number of active participants at the beginning of the plan year	**6a(1)**	4818
a (2)	Total number of active participants at the end of the plan year	**6a(2)**	4960
b	Retired or separated participants receiving benefits	**6b**	858
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	5818
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f	Total. Add lines **6d** and **6e**	**6f**	
g (1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	53

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

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

9a Plan funding arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

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

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

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

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

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

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

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

Receipt Confirmation Code _____

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS