

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
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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: ☒ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a single-employer plan ☐ a DFE (specify) _____
B	This return/report is: ☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C	If the plan is a collectively-bargained plan, check here. ▶ ☒
D	Check box if filing under: ☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description)
E	If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶ ☐

Part II	Basic Plan Information—enter all requested information
1a	Name of plan MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
1b	Three-digit plan number (PN) ▶ 501
1c	Effective date of plan 06/04/1964
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 OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND 1400 DISTRICT AVENUE SUITE 200 BURLINGTON, MA 01803-5236
2b	Employer Identification Number (EIN) 04-2214296
2c	Plan Sponsor's telephone number 781-272-1000
2d	Business code (see instructions) 236200

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.	07/27/2025	JOSEPH BONFIGLIO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/27/2025	THOMAS GUNNING
	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 ☒ 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 10936
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1) 10862 6a(2) 11214 6b 65 6c 6d 11279 6e 6f 6g(1) 6g(2) 6h
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7 561

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 4U

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

a Pension Schedules

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

b General Schedules

- (1) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 3
- (4) ☒ **C** (Service Provider Information)
- (5) ☒ **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
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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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 04-2214296	

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.
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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	G8132/C8132	10397	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

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

(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. Specify nature of costs ▶	6d	

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision) **b** ☐ Dental **c** ☐ Vision **d** ☒ Life insurance
e ☐ Temporary disability (accident and sickness) **f** ☐ Long-term disability **g** ☐ Supplemental unemployment **h** ☐ Prescription drug
i ☐ Stop loss (large deductible) **j** ☐ HMO contract **k** ☐ PPO contract **l** ☐ Indemnity contract
m ☒ Other (specify) ▶ **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	312789
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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
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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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 04-2214296

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.
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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	C9132/9132A	10852	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
5778	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
THE SEGAL COMP (EASTERN STATES),INC

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5778			3

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

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

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

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

(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. Specify nature of costs ▶	6d	

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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	462403
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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
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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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 04-2214296

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.
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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	GA02168		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	102362

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
THE UNION LABOR LIFE INSURANCE CO 8403 COLEVILLE RD
SILVER SPRING, MD 20910

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	102362	ASSET MANAGEMENT FEE	7

(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	19097005

6 Contracts With Allocated Funds:**a** State the basis of premium rates ▶**b** Premiums paid to carrier**6b****c** Premiums due but unpaid at the end of the year**6c****d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.**6d**

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity(3) ☐ other (specify) ▶**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee(3) ☐ guaranteed investment (4) ☐ other ▶**b** Balance at the end of the previous year**7b****c** Additions: (1) Contributions deposited during the year**7c(1)**

(2) Dividends and credits.....

7c(2)

(3) Interest credited during the year.....

7c(3)

(4) Transferred from separate account

7c(4)

(5) Other (specify below).....

7c(5)

▶

(6) Total additions

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

(1) Disbursed from fund to pay benefits or purchase annuities during year

7e(1)

(2) Administration charge made by carrier.....

7e(2)

(3) Transferred to separate account

7e(3)

(4) Other (specify below).....

7e(4)

▶

(5) Total deductions

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

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

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

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 04-2214296	

Part I	Service Provider Information (see instructions)
---------------	--

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
AFL-CIO HOUSING INVESTMENT TRUST
52-6220193

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
AMERICAN REALTY ADVISORS
33-0123114

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
DIMENSIONAL FUND ADVISORS LP
30-0447847

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation
FIRST EAGLE INVESTMENT MGMT, LLC
57-1156902

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

LAZARD ASSET MANAGEMENT

05-0530199

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

LOOMIS SAYLES TRUST COMPANY

20-8080381

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

NEWTOWER TRUST CO.

30-0872552

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

PAYDEN & RYGEL

95-3921788

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

ULLICO INVESTMENT COMPANY, LLC

8403 COLESVILLE ROAD - 13TH FLOOR
SILVER SPRING, MD 20910

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

ULLICO INV. ADVISORS, INC

90-0622302

(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

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)

CIGNA

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 38 49 50 56	NONE	3357642	Yes ☒ No ☐	Yes ☐ No ☒	0	Yes ☒ No ☐

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

EXPRESS SCRIPTS, INC

43-1420563

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	2106602	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DELTA DENTAL OF MA

04-6143185

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	682184	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)

HMC HEALTHWORKS INC.

2 PARK PLAZA, SUITE 1200
IRVINE, CA 92614

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	420800	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

THE SEGAL CO (EASTERN STATES), INC

13-1835864

(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 50	NONE	413679	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CMIT SOLUTIONS

27-0903009

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	201123	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 A

04-2214296

(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	NONE	176702	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEGAL ROITMAN, LLP

04-2489114

(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	163247	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BRIDGEWAY BENEFIT TECHNOLOGIES LLC

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	154023	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 B

04-2214296

(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	NONE	123982	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE C

04-2214296

(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	NONE	120037	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE D

04-2214296

(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	NONE	116656	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 E

04-2214296

(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	NONE	114982	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE F

04-2214296

(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	NONE	114976	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE G

04-2214296

(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	NONE	114564	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)

SCHULTHEIS & PANETTIERI LLP

13-1577780

(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	112524	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE H

04-2214296

(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	NONE	107971	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE I

04-2214296

(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	NONE	104413	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

04-2214296

(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	NONE	98706	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE K

04-2214296

(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	NONE	97798	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

617 MEDIA GROUP

90-1252805

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	94420	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)

STATE STREET GLOBAL ADVISORS

81-4017137

(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?
18 19 28 51 52 99	NONE	83382	Yes ☒ No ☐	Yes ☒ No ☐	0	Yes ☐ No ☒

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

EMPLOYEE L

04-2214296

(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	NONE	82748	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MEKETA INVESTMENT GROUP

04-2659023

(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	80038	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

04-2214296

(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	NONE	79279	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE N

04-2214296

(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	NONE	79014	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE O

04-2214296

(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	NONE	78570	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 P

04-2214296

(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	NONE	78075	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CORRENTE LAW CORPORATION

06-1484539

(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	ATTORNEY	78000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

O'REILLY, GROSSO, GROSS & JONES, PC

04-3318596

(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	78000	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 Q

04-2214296

(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	NONE	76362	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE R

04-2214296

(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	NONE	75443	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE S

04-2214296

(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	NONE	73379	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 T

04-2214296

(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	NONE	69048	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

STATE STREET BANK & TRUST CO.

04-1867445

(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 28 51 52 62 63 99	NONE	66372	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LOOMIS SAYLES & COMPANY

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?
28 51	NONE	63903	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 U

04-2214296

(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	NONE	63589	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE V

04-2214296

(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	NONE	60679	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE W

04-2214296

(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	NONE	58232	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 X

04-2214296

(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	NONE	54823	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE Y

04-2214296

(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	NONE	52786	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TELLIGEN INC

42-0992483

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	50808	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)

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 50	NONE	50644	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE Z

04-2214296

(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	NONE	45867	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AA

04-2214296

(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	NONE	45327	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 AB

04-2214296

(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	NONE	43944	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AC

04-2214296

(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	NONE	39648	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AD

04-2214296

(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	NONE	39232	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 AE

04-2214296

(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	NONE	38815	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AF

04-2214296

(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	NONE	32936	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AG

04-2214296

(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	NONE	31686	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 AH

04-2214296

(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	NONE	31327	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AI

04-2214296

(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	NONE	31118	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AJ

04-2214296

(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	NONE	30792	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 AK

04-2214296

(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	NONE	30323	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AL

04-2214296

(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	NONE	29988	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AM

04-2214296

(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	NONE	29790	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 AN

04-2214296

(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	NONE	28880	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AO

04-2214296

(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	NONE	28524	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

EMPLOYEE AP

04-2214296

(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	NONE	26194	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)

PBI

82-4722389

(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?
17 50	NONE	14250	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RANKIN & SULTAN

04-2917889

(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	12514	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KONICA MINOLTA PREMIER

94-1686094

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	11697	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)

THOMAS ANDREWS

04-2214296

(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?
20 50	NONE	9282	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PREMIER TECHNOLOGY SOLUTIONS

260 MADISON AVE, 8TH FL
NEW YORK, NY 10016

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	8673	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ZIX CORP

2711 NORTH HASKELL AVE. SUITE 2300
DALLAS, TX 75204

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	7674	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)

ROBERT HALF

2884 SAND HLL ROAD, SUITE 200
MENLO PARK, CA 94025

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	5972	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FEDERAL TELEPHONE COMM, INC.

11-3696189

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	5834	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ACCUFUND INC.

04-3578425

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	5773	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)

RHUMBLINE ADVISORS LP

04-3118582

(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	5167	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEGAL SELECT INS 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 ☒ No ☐	Yes ☐ No ☒	12397	Yes ☐ No ☒

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

UNION LABOR LIFE INS. CO

13-1423090

(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 52 72	NONE	0	Yes ☒ No ☐	Yes ☐ No ☒	0	Yes ☐ No ☒

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	3926

(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.
AMWINS BROKERAGE 13-4279678	INSURANCE 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	1632

(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.
RLI 37-0915434	INSURANCE 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	6219

(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.
ULLLICO/MARKEL 13-2988846	INSURANCE COMMISSIONS

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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND		B Three-digit plan number (PN) 501
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND		D Employer Identification Number (EIN) 04-2214296
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: SS INTERMED US CREDIT IDX NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 04-3508899-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12707159
a Name of MTIA, CCT, PSA, or 103-12 IE: SS MSCI ACWI EX USA NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 80-6103053-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 9361704
a Name of MTIA, CCT, PSA, or 103-12 IE: SS MSCI ACWI EX USA SL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 32-6039647-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 8341786
a Name of MTIA, CCT, PSA, or 103-12 IE: SS RUSSELL 1000 INDX NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 04-6809841-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 35416069
a Name of MTIA, CCT, PSA, or 103-12 IE: SS RUSSELL 2000 INDX NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 04-6809842-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 10194801
a Name of MTIA, CCT, PSA, or 103-12 IE: SS U.S. AGGREGATE BOND IDX NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 04-6928341-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 77133075
a Name of MTIA, CCT, PSA, or 103-12 IE: SS U.S. ST GOV/CRDT BD IDX NL CTF		
b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY		
c EIN-PN 27-6934633-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 74993535
For Paperwork Reduction Act Notice, see the Instructions for Form 5500.		
Schedule D (Form 5500) 2024 v. 240311		

a Name of MTIA, CCT, PSA, or 103-12 IE: SS U.S. TIPS INDX NL CTF

b Name of sponsor of entity listed in (a): STATE STREET GLOBAL ADVISORS TRUST COMPANY

c EIN-PN 02-6138231-001	d Entity code C	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 106151759
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a Name of MTIA, CCT, PSA, or 103-12 IE: RHUMBLINE QSI INDEX LLC

b Name of sponsor of entity listed in (a): RHUMBLINE ADVISORS CORP

c EIN-PN 26-0137355-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 35455397
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a Name of MTIA, CCT, PSA, or 103-12 IE: SENIOR FLOATING RATE FUND LLC

b Name of sponsor of entity listed in (a): LOOMIS SAYLES AND COMPANY, L.P.

c EIN-PN 82-0542784-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 12373403
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a Name of MTIA, CCT, PSA, or 103-12 IE: THE UNION LABOR LIFE INS CO SEP ACT

b Name of sponsor of entity listed in (a): THE UNION LABOR LIFE INSURANCE COMPANY

c EIN-PN 13-1423090-209	d Entity code P	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 19097005
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a Name of MTIA, CCT, PSA, or 103-12 IE: ULLICO INFRASTRUCTURE TAX-EXEMPT FD

b Name of sponsor of entity listed in (a): ULLICO INVESTMENT ADVISORS INC.

c EIN-PN 90-0622302-001	d Entity code E	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) 28572050
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a Name of MTIA, CCT, PSA, or 103-12 IE:

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

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

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

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

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

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

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

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

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

c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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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 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 04-2214296

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	33394625	26899229
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	16531422	13685552
(2) Participant contributions.....	1b(2)		
(3) Other	1b(3)	17711848	12546876
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	2385552	2789934
(2) U.S. Government securities	1c(2)	471187	564019
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	15441047	39322015
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)	531814	955510
(B) Common	1c(4)(B)	38265527	36200933
(5) Partnership/joint venture interests	1c(5)	23636500	20328157
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)	2081606	
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	302505257	334299888
(10) Value of interest in pooled separate accounts	1c(10)	17973048	19097005
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)	80554230	76400850
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	49061166	44791656
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)	4783468	3797845

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	574320	418485
f Total assets (add all amounts in lines 1a through 1e)	1f	605902617	632097954
Liabilities			
g Benefit claims payable	1g	22498000	23334000
h Operating payables	1h	741017	549395
i Acquisition indebtedness	1i	3983763	3698976
j Other liabilities	1j	6356659	3066541
k Total liabilities (add all amounts in lines 1g through 1j)	1k	33579439	30648912
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	572323178	601449042

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)	174473468	
(B) Participants	2a(1)(B)	1565960	
(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)		176039428
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	498204	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)	28586	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		526790
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)	176687	
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	2178449	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		2355136
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)	20434901	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	32408044	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		-11973143
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	20009699	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		15519946
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		1225804
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		7267958
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		665856
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		211637474

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	174760182	
(2) To insurance carriers for the provision of benefits	2e(2)	758719	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		175518901
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)	4322888	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	112524	
(5) Investment advisory and investment management fees	2i(5)	333792	
(6) Bank or trust company trustee/custodial fees	2i(6)	66372	
(7) Actuarial fees	2i(7)	413679	
(8) Legal fees	2i(8)	53267	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	187416	
(11) Other expenses	2i(11)	1502771	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		6992709
j Total expenses. Add all expense amounts in column (b) and enter total	2j		182511610

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		29125864
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name: **SCHULTHEIS AND PANETTIERI, LLP**

(2) EIN: **13-1577780**

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.)		☒	
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.)		☒	
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.)		☒	
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.)		☒	
e Was this plan covered by a fidelity bond?	☒		5000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		☒	
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?	☒		293082923
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?		☒	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	☒		
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.)	☒		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		☒	
l Has the plan failed to provide any benefit when due under the plan?		☒	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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



Schultheis & Panettieri LLP

Accountants and Consultants

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Independent Auditor's Report

Board of Trustees
Massachusetts Laborers' Health and Welfare Fund

Opinion

We have audited the accompanying financial statements of the Massachusetts Laborers' Health and 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 plan benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and plan benefit obligations for the years ended December 31, 2024 and 2023, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of the Plan as of December 31, 2024 and 2023, and the changes in net assets available for benefits and changes in plan benefit obligations for the years ended December 31, 2024 and 2023 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 generally accepted auditing standards, we:

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

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental information on pages 21 through 32 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental information on pages 33 through 35 is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

S. Schulteis & P. Panettieri, LLP

Hauppauge, New York
July 25, 2025

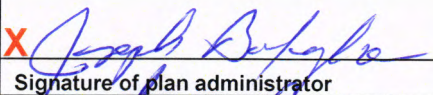
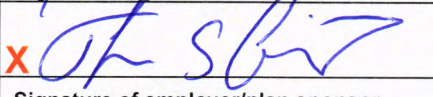
Form 5500 Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	Annual Return/Report of Employee Benefit Plan This form is required to be filed for employee benefit plans under sections 104 and 4065 of the 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
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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:	☒ a multiemployer plan ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) ☐ a single-employer plan ☐ a DFE (specify) _____
B This return/report is:	☐ the first return/report ☐ the final return/report ☐ an amended return/report ☐ a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here.	☒
D Check box if filing under:	☒ Form 5558 ☐ automatic extension ☐ the DFVC program ☐ special extension (enter description) _____
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here.	☐

Part II	Basic Plan Information—enter all requested information
1a Name of plan MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND	1b Three-digit plan number (PN) ▶ 501
	1c Effective date of plan 06/04/1964
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 OF MASSACHUSETTS LABORERS HEALTH AND WELFARE FUND 1400 DISTRICT AVENUE SUITE 200 BURLINGTON MA 01803-5236	2b Employer Identification Number (EIN) 04-2214296 2c Plan Sponsor's telephone number (781) 272-1000 2d Business code (see instructions) 236200

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	☒ 	☒ 07/28/25	☒ JOSEPH BONFIGLIO
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	☒ 	☒ 07/28/25	☒ Thomas Gunning
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address ☒ 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	10,936
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....		
	6a(1)	10,862
	6a(2)	11,214
	6b	65
	6c	
	6d	11,279
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7	561

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 4U

9a Plan funding arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ Trust (4) ☐ General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) ☒ Insurance (2) ☐ Code section 412(e)(3) insurance contracts (3) ☒ 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) ☒ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 3
- (4) ☒ **C** (Service Provider Information)
- (5) ☒ **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 _____

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF INTEREST BEARING CASH

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION INTEREST BEARING CASH		(d)	(e)
	INTEREST RATE	MATURITY DATE	COST	CURRENT VALUE
ARA CORE PROPERTY FUND LP - INTEREST BEARING CASH			\$ 687,690	\$ 687,690
BRIGADE HIGH YIELD FUND LP - INTEREST BEARING CASH			2,101,852	2,101,852
FIRST EAGLE GLOBAL VALUE FUND LP - INTEREST BEARING CASH			392	392
			<u>\$ 2,789,934</u>	<u>\$ 2,789,934</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF U.S. GOVERNMENT SECURITIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(a) / NOT APPLICABLE	(b)	(c) - DESCRIPTION		(d)	(e)
		U.S. GOVERNMENT SECURITIES			
	ISSUER	INTEREST RATE	MATURITY DATE	COST	CURRENT VALUE
	FIRST EAGLE GLOBAL VALUE FUND LP - U.S. GOV'T SECURITIES			\$ 246,081	\$ 564,019
				\$ 246,081	\$ 564,019

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE DEBT INSTRUMENTS - OTHER

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION			(d)	(e)
	CORPORATE DEBT INSTRUMENTS - OTHER				
ISSUER	INTEREST RATE	MATURITY DATE	PAR OR MATURITY VALUE	COST	CURRENT VALUE
ARA CORE PROPERTY FUND LP - CORPORATE DEBT - OTHER			\$ -	\$ 104,158	\$ 140,876
BRIGADE HIGH YIELD FUND LP - CORPORATE DEBT - OTHER			-	35,207,574	39,181,139
			<u>\$ -</u>	<u>\$ 35,311,732</u>	<u>\$ 39,322,015</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE STOCK - PREFERRED

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION PREFERRED STOCK NO. OF SHARES	(d) COST	(e) CURRENT VALUE
ARA CORE PROPERTY FUND LP - CORPORATE STOCK - PREFERRED	-	\$ 187,263	\$ 253,277
BRIGADE HIGH YIELD FUND LP - CORPORATE STOCK - PREFERRED	-	228,882	253,259
FIRST EAGLE GLOBAL VALUE FUND LP - CORPORATE STOCK - PREFERRED	-	<u>195,887</u>	<u>448,974</u>
		<u>\$ 612,032</u>	<u>\$ 955,510</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE STOCK - COMMON

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION COMMON STOCK NO. OF SHARES	(d) COST	(e) CURRENT VALUE
ARA CORE PROPERTY FUND LP - CORPORATE STOCK - COMMON	-	\$ 10,327,550	\$ 14,210,631
BRIGADE HIGH YIELD FUND LP - CORPORATE STOCK - OTHER	-	715,789	792,023
FIRST EAGLE GLOBAL VALUE FUND LP - CORPORATE STOCK - OTHER	-	<u>9,248,577</u>	<u>21,198,279</u>
		<u>\$ 20,291,916</u>	<u>\$ 36,200,933</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF PARTNERSHIPS/JOINT VENTURE INTERESTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION PARTNERSHIPS	(d)	(e)
		COST	CURRENT VALUE
MEPT EDGEMOOR L.P.		\$ 9,045,332	\$ 11,816,670
THE EMERGING WORLD INVESTORS L.P.		2,000,000	7,465,098
ARA CORE PROPERTY FUND LP - PARTNERSHIPS		<u>773,659</u>	<u>1,046,389</u>
		<u>\$ 11,818,991</u>	<u>\$ 20,328,157</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF COMMON/COLLECTIVE TRUST FUNDS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a)	(b)	(c) - DESCRIPTION COMMON/ COLLECTIVE TRUST FUNDS	(d)	(e)
	ISSUER	NO. OF SHARES	COST	CURRENT VALUE
*	STATE STREET RUSSELL 1000 INDEX NON-LENDING CTF	414,830	\$ 22,631,738	\$ 35,416,069
*	STATE STREET RUSSELL 2000 INDEX NON-LENDING CTF	125,079	4,953,649	10,194,801
*	STATE STREET U.S. TREASURY INFLATION PROTECTED SECURITIES (TIPS) INDEX NON-LENDING CTF	6,220,437	84,464,672	106,151,759
*	STATE STREET U.S. SHORT-TERM GOVERNMENT/CREDIT BOND INDEX NON-LENDING CTF	6,209,102	67,363,165	74,993,535
*	STATE STREET U.S. AGGREGATE BOND INDEX NON-LENDING CTF	4,558,962	74,629,787	77,133,075
*	STATE STREET INTERMEDIATE U.S. CREDIT INDEX NON-LENDING CTF	767,665	7,984,105	12,707,159
*	STATE STREET MSCI ACWI EX USA INDEX SECURITIES LENDING CTF	380,486	4,978,109	8,341,786
*	STATE STREET MSCI ACWI EX USA INDEX NON-LENDING CTF	368,006	4,991,179	9,361,704
			<u>\$ 271,996,404</u>	<u>\$ 334,299,888</u>

* PARTY-IN-INTEREST

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF POOLED SEPARATE ACCOUNTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION POOLED SEPARATE ACCOUNTS	(d)	(e)
ISSUER	UNITS	COST	CURRENT VALUE
ULLICO SEPARATE ACCOUNT W1	10,549,032	\$ 14,325,167	\$ 19,097,005
		\$ 14,325,167	\$ 19,097,005

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF 103-12 INVESTMENT ENTITIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION 103-12 INVESTMENT ENTITIES		(d)	(e)
	ISSUER	NO. OF SHARES	COST	CURRENT VALUE
	LOOMIS SAYLES SENIOR FLOATING RATE FUND LLC	578,662	\$ 578,662	\$ 12,373,403
	RHUMBLINE QSI INDEX LLC	771,322	15,000,000	35,455,397
	ULICO INFRASTRUCTURE FUND	25,000,000	<u>25,000,000</u>	<u>28,572,050</u>
			<u>\$ 40,578,662</u>	<u>\$ 76,400,850</u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF REGISTERED INVESTMENT COMPANIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a)	(b)	(c) - DESCRIPTION REGISTERED INVESTMENT COMPANIES	(d)	(e)
	ISSUER	NO. OF SHARES	COST	CURRENT VALUE
	AFL-CIO HOUSING INVESTMENT TRUST	18,166	\$ 20,672,971	\$ 17,704,920
	AMERICAN CENTY ETF TR	210	13,901	12,888
	AVANTIS EMERGING MARKETS	122	7,905	7,172
	DFA EMERGING MARKETS VALUE PORTFOLIO	296,088	7,836,973	8,855,994
	FEDERATED GOVT OBLIGS FUND-PREMIER CLASS	7,721	7,721	7,721
	FIDELITY GOVERNMENT PORTFOLIO-INSTITUTIONAL CLASS	1,482	27,851	31,796
	ISHARES CORE S&P SMALL CAP ETF	273	24,246	31,455
	ISHARES CORE US AGGREGATE BD ETF	657	66,194	63,663
	METRO WEST T/R BD CL I	2,993	28,580	24,905
	PAYDEN EMERGING MARKETS BOND FUND	1,440,724	20,384,632	16,104,783
*	SS INST US GOV'T MM FUND	4,818	4,818	4,818
	VANGUARD FTSE DEVELOPED MARKETS ETF	495	20,490	23,671
	VANGUARD FTSE EMERGING MARKETS ETF	329	15,151	14,489
	VANGUARD MID CAP ETF	222	40,531	58,637
	VANGUARD S&P 500 ETF	145	38,536	78,128
	VANGUARD TOTAL INTL BOND INDEX FUND ETF	711	36,706	35,021
	FIRST EAGLE GLOBAL VALUE FUND LP - REGISTERED INVESTMENT CO.	-	<u>755,494</u>	<u>1,731,595</u>
			<u>\$ 49,982,700</u>	<u>\$ 44,791,656</u>

* PARTY-IN-INTEREST

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF OTHER INVESTMENTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION OTHER INVESTMENTS	(d)	(e)
ISSUER		COST	CURRENT VALUE
BRIGADE HIGH YIELD FUND LP - OTHER INVESTMENTS		\$ 16,843	\$ 18,637
FIRST EAGLE GLOBAL VALUE FUND LP - OTHER INVESTMENTS		<u>1,648,867</u>	<u>3,779,208</u>
		<u>\$ 1,665,710</u>	<u>\$ 3,797,845</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, PAGE 4, PART IV, ITEM 4J - SCHEDULE OF REPORTABLE TRANSACTIONS DURING THE YEAR

(a) IDENTITY OF PARTY INVOLVED	(b) DESCRIPTION OF ASSET	(c) PURCHASE PRICE	(d) SELLING PRICE	(e) LEASE RENTAL	(f) EXPENSE INCURRED WITH TRANSACTION	(g) COST OF ASSET	(h) CURRENT VALUE OF ASSET ON TRANSACTION DATE	(i) NET GAIN OR (LOSS)
N/A	BRIGADE HIGH YIELD FUND LP	\$ 38,000,000	\$ -	\$ -	\$ -	\$ -	\$ 38,000,000	\$ -

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
FINANCIAL STATEMENTS
YEARS ENDED DECEMBER 31, 2024 AND 2023

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

YEARS ENDED DECEMBER 31, 2024 AND 2023

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Independent Auditor's Report

Board of Trustees
Massachusetts Laborers' Health and Welfare Fund

Opinion

We have audited the accompanying financial statements of the Massachusetts Laborers' Health and 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 plan benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and plan benefit obligations for the years ended December 31, 2024 and 2023, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and plan benefit obligations of the Plan as of December 31, 2024 and 2023, and the changes in net assets available for benefits and changes in plan benefit obligations for the years ended December 31, 2024 and 2023 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. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 generally accepted auditing standards, we:

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

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

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental information on pages 21 through 32 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

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

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

Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental information on pages 33 through 35 is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

S. Schulteis & P. Panettieri, LLP

Hauppauge, New York
July 25, 2025

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Assets		
Investments at fair value		
Corporate stock	\$ -	\$ 207,844
Partnership/joint venture interests	100,602,095	81,907,317
Common/collective trust funds	334,299,888	302,505,257
Pooled separate accounts	19,097,005	17,973,048
103-12 investment entities	76,400,850	80,554,230
Registered investment companies	<u>43,060,061</u>	<u>45,262,787</u>
Total investments	573,459,899	528,410,483
Receivables		
Employers' contributions	13,685,552	16,531,422
Related organizations - net	2,467,625	2,114,883
Prescription drug rebates	8,614,362	6,689,525
Medical Claims	-	8,068,617
Cash	26,899,229	33,394,625
Other assets	<u>388,226</u>	<u>516,375</u>
Total assets	<u>625,514,893</u>	<u>595,725,930</u>
Liabilities		
Accounts payable	342,119	466,134
Deferred compensation payable	<u>389,732</u>	<u>438,618</u>
Total liabilities	<u>731,851</u>	<u>904,752</u>
Net assets available for benefits	\$ <u><u>624,783,042</u></u>	\$ <u><u>594,821,178</u></u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
<i>Additions to net assets attributed to:</i>		
Investment income		
Net appreciation in fair value of investments	\$ 32,715,896	\$ 33,555,444
Interest/dividends	<u>2,882,150</u>	<u>2,976,302</u>
Total investment income	35,598,046	36,531,746
Less investment expenses	<u>(400,164)</u>	<u>(467,991)</u>
Net investment income	35,197,882	36,063,755
Contributions		
Employers'	174,473,468	168,554,854
Participants' - COBRA/Retiree	<u>1,565,960</u>	<u>1,770,493</u>
Total additions	<u>211,237,310</u>	<u>206,389,102</u>
<i>Deductions from net assets attributed to:</i>		
Benefits paid to or for participants		
Health care	173,753,182	148,953,645
Group life insurance premiums	313,043	315,460
Stop loss insurance premiums	445,676	366,088
Death	<u>171,000</u>	<u>165,000</u>
Total benefits paid	174,682,901	149,800,193
Administrative expenses	<u>6,592,545</u>	<u>6,341,593</u>
Total deductions	<u>181,275,446</u>	<u>156,141,786</u>
Net increase	29,961,864	50,247,316
Net assets available for benefits		
Beginning of year	<u>594,821,178</u>	<u>544,573,862</u>
End of year	<u><u>\$ 624,783,042</u></u>	<u><u>\$ 594,821,178</u></u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

STATEMENTS OF PLAN BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Amounts currently payable		
Claims payable and claims incurred but not reported	\$ <u>23,334,000</u>	\$ <u>22,498,000</u>
Postemployment benefit obligations		
Accumulated eligibility credits	<u>166,436,300</u>	<u>166,310,400</u>
Postretirement benefit obligations, net of amounts currently payable		
Retired participants	9,805,000	7,181,000
Other participants fully eligible for benefits	28,212,000	28,821,000
Participants not yet fully eligible for benefits	<u>29,842,000</u>	<u>28,971,000</u>
	<u>67,859,000</u>	<u>64,973,000</u>
Plan's total benefit obligations	\$ <u><u>257,629,300</u></u>	\$ <u><u>253,781,400</u></u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN PLAN BENEFIT OBLIGATIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Amounts currently payable		
Balance at beginning of year	\$ 22,498,000	\$ 18,838,000
Claims reported and approved for payment	175,518,901	153,460,193
Total benefits paid	<u>(174,682,901)</u>	<u>(149,800,193)</u>
Balance at end of year	<u>23,334,000</u>	<u>22,498,000</u>
 Postemployment benefit obligations		
Balance at beginning of year	166,310,400	162,323,000
Net change during year:		
Accumulated eligibility credits	<u>125,900</u>	<u>3,987,400</u>
Balance at end of year	<u>166,436,300</u>	<u>166,310,400</u>
 Postretirement benefit obligations, net of amounts currently payable		
Balance at beginning of year	64,973,000	60,594,000
Increase (decrease) in postretirement benefits attributed to:		
Benefits earned - service cost	2,983,000	3,068,000
Expected benefits paid net of retiree contributions	(3,236,000)	(2,959,000)
Interest	3,152,000	3,110,000
Actuarial experience losses (gains)	3,041,000	-
Changes in actuarial assumptions	(2,661,000)	1,160,000
Plan amendments	<u>(393,000)</u>	<u>-</u>
Balance at end of year	<u>67,859,000</u>	<u>64,973,000</u>
 Plan's total benefit obligations at end of year	<u>\$ 257,629,300</u>	<u>\$ 253,781,400</u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies

The following description of the Massachusetts Laborers' Health and Welfare Fund (the "Plan") provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

General

The Plan first became effective June 4, 1964 and is a welfare benefit plan established under an Agreement and Declaration of Trust pursuant to collective bargaining agreements between the Massachusetts Laborers' District Council of the Laborers' International Union of North America (the "Council") and various employers and employer associations in the construction industry in the states of Massachusetts, New Hampshire, Maine and Vermont. It is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA").

Management has evaluated subsequent events through the date of the auditor's report, the date the financial statements were available to be issued.

Purpose

The purpose of the Plan is to provide health and other benefits to eligible participants.

Benefits

Benefits are paid by means of a trust and group insurance contracts. The benefits include, but are not limited to medical, vision, dental, prescription drugs, life insurance, short term disability benefits, accidental death and dismemberment and member assistance. Actual benefits, including conditions and limitations thereto, are governed by the provisions of the Plan.

Participants consist of the following classes

Active participants and dependents

There are two benefit plans available for active members: Plan A and Plan B. Initial eligibility for each 6-month eligibility period is earned after the completion of 1000 hours (Plan A) or 700 hours (Plan B) of covered employment during the 12-month qualifying period. To continue eligibility, participants must earn either 1000 hours (Plan A) or 700 hours (Plan B) in a 12-month qualifying period for the next 6-month eligibility period. The 12-month qualifying period beginning October 1 and ending the subsequent September 30 earns coverage for the 6-month period beginning the following January 1. The 12-month qualifying period beginning April 1 and ending the subsequent March 31 earns coverage for the 6-month period beginning July 1.

Employees of the Council, participating unions and their related fringe benefit funds are also participants of the Plan.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies (cont'd)

Participants consist of the following classes (cont'd)

Retired participants and dependents

Participants receiving a pension from the Massachusetts Laborers' Pension Fund may continue medical and dental coverage for themselves and their eligible dependents by enrolling in the Retiree's Self-Pay Medical Program upon meeting certain criteria:

- a) The participant must have maintained their coverage through COBRA at their own cost, and
- b) The participant must not be eligible for Medicare.

Monthly rates are actuarially calculated and vary based upon type of benefit program coverage.

Inactive participants and surviving dependents

Participants who fail to meet eligibility requirements may pay to extend coverage for a maximum period of 18 months. Qualifying spouses and dependents may pay to extend coverage for a maximum period of up to 36 months. Monthly rates are actuarially calculated and vary based upon type of benefit program coverage.

Basis of accounting

The financial statements are presented on the accrual basis of accounting.

Investment valuation and income recognition

The Plan's investments are stated at fair value. See "Fair value measurements" footnote for additional information.

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

Use of estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from these estimates.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies (cont'd)

Reciprocal agreements

The Plan is a party to reciprocal agreements with other welfare funds of the Laborers' International Union of North America.

Administrative expense allocation

The administrative office is occupied by the Plan and various related organizations. Certain expenses not specifically applicable to a particular entity are allocated based on the estimated benefit received by each entity. Amounts reported as receivable from related organizations or payable to related organizations generally include balances for shared expenses.

Reimbursements received from related organizations for the years ended December 31, 2024 and 2023 were \$2,383,758 and \$2,566,050, respectively.

Employers' contributions receivable

Employers' contributions receivable is estimated based on receipts in the subsequent plan year that pertain to prior plan years.

The Plan, in its normal course of business, performs audits of the records of contributing employers to monitor compliance with their obligation to make contributions to the Plan. It is the Plan's policy that any employer contributions due to the Plan based on these procedures are recorded as income in the period in which such amounts are received.

Lease

The Plan assesses whether a contractual arrangement qualifies as a lease at inception and only reassesses its determination if the terms and conditions of the arrangement are modified. If an arrangement qualifies as a lease, the Plan evaluates whether it should be classified as an operating or financing lease.

For leases assessed as long-term, lease right-of-use assets represent the Plan's right to use the underlying asset for the lease term and lease liabilities represent the Plan's obligation to make lease payments arising from the leases. The Plan records a lease liability based on the future estimated cash payments discounted over the non-cancellable portion of the lease term. In the event an implicit discount rate is not readily determined in lease agreements, the Plan uses the risk-free Treasury rate at the lease commencement date in determining the present value of future lease payments. Lease right-of-use assets may include lease payments made and exclude lease incentives. Lease terms may include options to extend or terminate the lease when it is reasonably certain that the Plan will exercise that option. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies (cont'd)

Postretirement benefits obligations

Although the Plan has calculated and reported a postretirement benefit obligation, this amount is based on the assumption that the Plan will continue in its current form and that the Trustees will continue to provide benefits to retired participants. However, such benefits do not vest, and the Trustees reserve the right to amend the Plan to modify or discontinue any benefits. 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 participants' service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated participants and their beneficiaries and dependents, and (2) active participants and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan's participating employers and from existing trust assets. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected benefit obligation that is attributed to that participant's service in the industry rendered to the valuation date.

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

For 2024 measurement purposes, a 7.00% annual rate increase in the per capita cost of covered medical benefits was assumed and the rate was assumed to decrease gradually over a 10 year period to a long term rate of 4.50%. A 12.00% annual rate increase in the per capita cost of covered prescription drug benefits was assumed and the rate was assumed to decrease gradually over a 15 year period to a long term rate of 4.50%.

For 2023 measurement purposes, a 6.75% annual rate increase in the per capita cost of covered medical benefits was assumed and the rate was assumed to decrease gradually over a 9 year period to a long term rate of 4.50%. An 11.50% annual rate increase in the per capita cost of covered prescription drug benefits was assumed and the rate was assumed to decrease gradually over a 14 year period to a long term rate of 4.50%.

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

Average discount rate	2024 - 5.50%
	2023 - 4.75%

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies (cont'd)

Postretirement benefits obligations (cont'd)

Mortality rate - Pre-retirement	Pri-2012 Employee Headcount-Weighted Mortality Table set forward 1 year for males and no set-forward for females projected generationally from 2012 with the MP-2021 projection scale
Mortality rate - Healthy annuitants	Pri-2012 Healthy Retiree Headcount-Weighted Mortality Table set forward 1 year for males and no set-forward for females projected generationally from 2012 with the MP-2021 projection scale
Mortality rate - Disabled annuitants	Pri-2012 Health Retiree Headcount-Weighted Mortality Table set forward 4 years for males and females projected generationally from 2012 with the MP-2021 projection scale
Administrative exp. annual increase rate	3.00%

The foregoing assumptions are based on the premise 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 obligation.

The average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by one percentage point, it would increase the obligation as of December 31, 2024 and 2023 by \$5,906,000 and \$5,802,000, respectively.

Participants who have elected Retiree Self-pay coverage are required to make monthly contributions actuarially calculated based upon type of benefit program coverage. Projected retiree contributions as of December 31, 2024 and 2023 were \$94,869,700 and \$97,248,400, respectively. For 2024 and 2023 the contributions are expected to cover approximately 60% of the cost. Accumulated postretirement benefit obligations have been reported net of these amounts.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 1 - Description of Plan and Significant Accounting Policies (cont'd)

Other Plan benefits

Estimated claims payable and claims incurred but not reported are based on payments made in the subsequent plan year which pertain to prior plan years.

Plan obligations for accumulated eligibility of active participants are estimated annually at December 31st, based on historical claims cost data and projected claims for active participants' future claims. Such estimated amounts are reported in the accompanying statement of the Plan's benefit obligations at present value. Although the Plan has calculated and reported an obligation for accumulated eligibility, this amount is based on the assumption that the Plan will continue in its current form and that the Trustees will continue to provide benefits to active participants. However, such benefits do not vest, and the Trustees reserve the right to amend the Plan to modify or discontinue benefits. The amount reported as the accumulated eligibility obligation represents the estimated present value of those estimated future benefits that are attributed by the terms of the Plan to active participants' service rendered through December 31st.

Plan termination

The Trustees expect and intend to continue the Plan indefinitely, but reserve the right to amend or terminate it as provided for by the applicable Trust Agreement and Plan provisions. If the Plan is terminated, trust assets will be used to pay all expenses under the terms of the Plan in the order of priority specified in the Plan and as otherwise required by law.

Note 2 - 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 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy are described as follows:

Level 1 inputs to the valuation methodology are unadjusted quoted prices, in active markets, for identical assets that the Plan has the ability to access.

Level 2 inputs to the valuation methodology include: quoted prices for similar assets in active markets, quoted prices for identical or similar assets in inactive markets, inputs other than quoted prices that are observable for the asset, and inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset has a specified (contractual) term, the level 2 input must be observable for substantially the full term of the asset.

Level 3 inputs to the valuation methodology are unobservable and significant to the fair value measurement. Level 3 inputs are generally based on the best information available, which may include the reporting entity's own assumptions and data.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 2 - Fair value measurements (cont'd)

The asset'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 used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Registered investment companies: Valued at the closing price reported in the active market in which the securities are traded.

Investments measured at net asset value: Non-publicly traded corporate stock, partnerships, common/collective trusts, pooled separate accounts, 103-12 investment entities and non-publicly traded registered investment companies' values are estimated by the management of the investment entities.

The preceding methods may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in the tables below are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statements of net assets available for benefits.

The following table sets forth, by level within the fair value hierarchy, the Plan's investments, as of December 31, 2024, with fair value measurements on a recurring basis:

	<u>2024</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Investments at fair value				
Registered investment companies	\$ <u>25,355,141</u>	\$ <u>25,355,141</u>	\$ <u>-</u>	\$ <u>-</u>
Total assets in the fair value hierarchy	25,355,141	\$ <u><u>25,355,141</u></u>	\$ <u><u>-</u></u>	\$ <u><u>-</u></u>
Investments measured at net asset value	<u>548,104,758</u>			
Investments at fair value	\$ <u><u>573,459,899</u></u>			

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 2 - Fair value measurements (cont'd)

The following table sets forth, by level within the fair value hierarchy, the Plan's investments, as of December 31, 2023, with fair value measurements on a recurring basis:

	<u>2023</u>	<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>
Investments at fair value				
Registered investment companies	\$ <u>28,212,790</u>	\$ <u>28,212,790</u>	\$ <u>-</u>	\$ <u>-</u>
Total assets in the fair value hierarchy	28,212,790	\$ <u>28,212,790</u>	\$ <u>-</u>	\$ <u>-</u>
Investments measured at net asset value	<u>500,197,693</u>			
Investments at fair value	\$ <u>528,410,483</u>			

Note 3 - Cash

At times throughout the year the Plan may have, on deposit in banks, amounts in excess of FDIC insurance limits. The Plan has not experienced any losses in such accounts and the Trustees believe it is not exposed to any significant credit risks.

Note 4 - Partnerships/joint venture interests

The Plan invests in several partnerships. The fair value of the investments is determined by the management of each investment and is generally based on the estimated fair value of the underlying assets of each investment. The Plan records the investments at estimated fair value based on its capital shares, as reported on the annual K-1 Forms or available audited financial statements. The investments generally require the Plan to enter into agreements to contribute a minimum amount of capital. In addition, partnership investments may be subject to withdrawal restrictions. The individually significant investment in partnerships held by the Plan is as follows:

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 4 - Partnerships/joint venture interests (cont'd)

First Eagle Global Value Fund, LP is a Delaware limited partnership whose investment objective is to seek capital appreciation by investing primarily in equity securities of U.S. and non-U.S. issuers, using a strategy that can be characterized as a value approach. Redemptions may be made, upon at least 10 days' prior written notice, of some or all of the units held by a Limited Partner as of the last day of each month, subject to the discretion of the General Partner. Redemption requests of up to 90% of the Limited Partner's capital account will be paid in full within 5 days of the relevant redemption date. For redemption requests in excess of 90%, the remaining balance will be remitted promptly after the final calculation of the Net Asset Value per unit of the units redeemed. The estimated fair value of the Plan's investment as of December 31, 2024 and 2023 was \$27,100,542 and \$28,535,433, respectively.

During the year ended December 31, 2024, the Plan invested in Brigade High Yield Fund LP ("Brigade"), a Delaware limited partnership, organized for the purpose of trading and investing in securities. Brigade invests substantially all of its assets through a master-feeder structure in Brigade High Yield Fund Ltd., an investment company that has the same investment objectives as Brigade. Upon at least 15 days' prior written notice, a partner may withdraw all or a portion of its capital account as of the last business day of each month. Withdrawals will be processed on a first in, first out basis. Notwithstanding the foregoing, the General Partner may, in its sole discretion, waive or modify any terms related to withdrawals for certain large or strategic partners pursuant to a written agreement with the partner. The estimated fair value of the Plan's investment as of December 31, 2024 was \$42,047,114.

Note 5 - Common/collective trust funds

The Plan is invested in several common/collective trust funds. The fair value of the investments are determined by the management of each investment and are generally based on the estimated fair value of the underlying assets of each investment. The investments generally require the Plan to enter into agreements to contribute a minimum amount of capital. In addition, common/collective trust fund investments may be subject to withdrawal restrictions. Individually significant investments in common/collective trust funds held by the Plan are as follows:

State Street Global Advisors Trust Company, a wholly owned subsidiary of State Street Bank, manages the following individually significant State Street collective funds: State Street U.S. Treasury Inflation Protected Securities Index Non-Lending Common Trust Fund ("TIPS Fund"), State Street U.S. Aggregate Bond Index Non-Lending Common Trust Fund ("Bond Fund"), State Street U.S. Short-Term Government/Credit Bond Index Non-Lending Common Trust Fund (U.S. Short-Term Fund") and State Street Russell 1000 Index Non-Lending Common Trust Fund (Russell 1000 Index Fund) (known collectively as the "State Street Funds").

The per unit net asset value of the State Street Funds is determined each business day. Issuances and redemptions of the State Street Funds units may be made on such business days, based upon the closing market value on the valuation date of the investments bought or sold and the net asset value per unit of each of the State Street Funds.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 5 - Common/collective trust funds (cont'd)

The estimated fair value of the Plan's investment in the TIPS Fund as of December 31, 2024 and 2023 was \$106,151,759 and \$93,354,384, respectively.

The estimated fair value of the Plan's investment in the Bond Fund as of December 31, 2024 and 2023 was \$77,133,075 and \$71,565,442, respectively.

The estimated fair value of the Plan's investment in the U.S. Short-Term Fund as of December 31, 2024 and 2023 was \$74,993,535 and \$66,917,751, respectively.

The estimated fair value of the Plan's investment in the Russell 1000 Index Fund, as of December 31, 2024 and 2023 was \$35,416,069 and \$28,811,948, respectively.

Note 6 - Pooled separate accounts

The Plan is invested in a pooled separate account investment. The fair value of this type of investment is determined by the management of the investment and is generally based on the estimated fair value of the underlying assets of the investment. The investment generally requires investors to enter into an agreement to contribute a minimum amount of capital. In addition, pooled separate account investments may be subject to withdrawal restrictions. This investment was not individually significant to the Plan as of December 31, 2024 and 2023.

Note 7 - 103-12 Investment entities

The Plan is invested in 103-12 investment entities. The fair values of this type of investment are determined by the management of each investment and are generally based on the estimated fair value of the underlying assets of each investment. The investments generally require investors to enter into agreements to contribute a minimum amount of capital. In addition, 103-12 investment entity investments may be subject to withdrawal restrictions.

Ullico Infrastructure Tax-Exempt Fund, LP is a Delaware limited partnership designed to permit U.S. tax-exempt investors, including principally multiemployer plans subject to the Taft-Hartley Act, to commingle a portion of their assets for investment. Substantially all of the partnership's assets are invested in units issued by Ullico Infrastructure Master Fund, LP, a Delaware limited partnership. Redemptions may be made after the expiration of a four year lock-up period beginning on the limited partner's admission date to the partnership. Upon 45 days notice to the General Partner, the limited partner will be placed in a redemption queue. A limited partner who is next up in the redemption queue will be able to have all or a portion of its requested units redeemed. The estimated fair value of the Plan's investment as of December 31, 2024 and 2023 was \$28,572,050 and \$26,503,850, respectively.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 7 - 103-12 Investment entities (cont'd)

RhumbLine Advisers Limited Partnership manages the RhumbLine QSI Index LLC ("RhumbLine"). The net asset value of RhumbLine is determined daily ("Valuation Date"). Issuances and redemptions of RhumbLine units may be made on such days, based upon the closing value of the securities bought or sold as of the Valuation Date, adjusted for the related market effect and transaction costs, which are allocated to the applicable participant. The estimated fair value of the Plan's investment as of December 31, 2024 and 2023 was \$35,455,397 and \$31,247,776, respectively.

Note 8 - Risks and uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the financial statements.

The actuarial present value of benefit obligations are reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations 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 9 - Party-in-interest transactions

Certain Plan investments are held by the manager of the investment; therefore, transactions relating to those investments qualify as exempt party-in-interest transactions and are identified as such on the supplemental schedules of investments.

Note 10 - Employers' contributions

In accordance with collective bargaining agreements and participation agreements, employers are required to make contributions to the Plan on behalf of employees performing covered work. Contribution rates vary depending on the agreement, but are generally paid on an hourly basis.

Note 11 - Lease

The Plan, jointly with the Massachusetts Laborers' Pension Plan and the Massachusetts Laborers' Annuity Plan, lease office space from the Laborers' Pension/Burlington Investment Corporation, a related organization. The lease term is effective January 1, 2022 through December 31, 2026. The monthly base rent for the years ended December 31, 2024 and 2023 was \$27,407 and \$26,132, respectively.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 11 - Lease (cont'd)

The Plan's portion of the rent for the years ended December 31, 2024 and 2023 was 63% and 53% respectively. Additionally, the Plan pays its portion of additional rent comprised of insurance costs, utility charges, property taxes and its pro rata share of increases in operating costs with respect to the premises. Total occupancy expense for the years ended December 31, 2024 and 2023 was \$404,435 and \$363,468, respectively.

Note 12 - Other commitments

Effective January 1, 1994, the Plan established a non-qualified deferred compensation plan for a select group of the Plan's executive management employees for the purpose of providing deferred compensation benefits to such employees. The deferred compensation plan is an unfunded arrangement intended to satisfy the requirements for an eligible deferred compensation plan under section 457(b) of the Internal Revenue Code. As of December 31, 2024 and 2023, the estimated fair value of the deferred compensation plan's assets was \$389,732 and \$438,618, respectively.

Note 13 - Benefit obligations compared to net assets available for benefits

	<u>2024</u>	<u>2023</u>
Net assets available for benefits	\$ 624,783,042	\$ 594,821,178
Plan's total benefit obligations	<u>257,629,300</u>	<u>253,781,400</u>
Net assets available for benefits over Plan's total benefit obligations	<u>\$ 367,153,742</u>	<u>\$ 341,039,778</u>

Note 14 - Reconciliation of financial statements to Form 5500

For financial statement purposes, claims payable and claims incurred but not reported are presented on the Statement of Plan Benefit Obligations. This differs from the reporting requirements of the Department of Labor which requires that these liabilities be shown on the Statement of Net Assets Available for Benefits.

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 624,783,042	\$ 594,821,178
Less: claims payable and claims incurred but not reported	<u>23,334,000</u>	<u>22,498,000</u>
Net assets available for benefits as reported on Form 5500	<u>\$ 601,449,042</u>	<u>\$ 572,323,178</u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

Note 14 - Reconciliation of financial statements to Form 5500 (cont'd)

The net increase (decrease) in net assets available for benefits is also affected by the difference in the reporting requirements related to benefit obligations. For financial statement purposes the change in benefit liabilities between two years is shown on the Statement of Changes in Plan Benefit Obligations. For Form 5500 purposes this change is included in benefits paid.

For financial statement purposes, investment expenses are reported as a reduction of investment income. The reporting requirements of the Department of Labor require these fees be shown as administrative expenses.

The following is a reconciliation of the reclassifications:

	Per Financial Statements	Reclassification	Per Form 5500
Investment income	\$ 35,197,882	\$ 400,164	\$ 35,598,046
Contributions	<u>176,039,428</u>	<u>-</u>	<u>176,039,428</u>
Total additions	<u>211,237,310</u>	<u>400,164</u>	<u>211,637,474</u>
Benefits paid to or for participants	174,682,901	836,000	175,518,901
Administrative expenses	<u>6,592,545</u>	<u>400,164</u>	<u>6,992,709</u>
Total deductions	<u>181,275,446</u>	<u>1,236,164</u>	<u>182,511,610</u>
Net increase	<u>\$ 29,961,864</u>	<u>\$ (836,000)</u>	<u>\$ 29,125,864</u>

In addition to the above reclassifications, the Plan's investments have been reclassified for Form 5500 purposes in accordance with the Department of Labor's plan asset regulations. See the Schedule Reconciling the Statement of Net Assets Available for Benefits to Form 5500 on page 33.

Note 15 - Tax status

The trust funding the Plan has received an exemption letter from the IRS dated April 19, 1965, stating that the trust is tax exempt under the provisions of Section 501(c)(9) of the Internal Revenue Code ("IRC"). The Plan and trust are required to operate in conformity with the IRC to maintain the tax exempt status of the trust. The Trustees believe that the Plan, including amendments, is being operated in compliance with the applicable requirements of the IRC and, therefore, believe the related trust is tax exempt.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF INTEREST BEARING CASH

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION INTEREST BEARING CASH		(d)	(e)
	INTEREST RATE	MATURITY DATE	COST	CURRENT VALUE
ARA CORE PROPERTY FUND LP - INTEREST BEARING CASH			\$ 687,690	\$ 687,690
BRIGADE HIGH YIELD FUND LP - INTEREST BEARING CASH			2,101,852	2,101,852
FIRST EAGLE GLOBAL VALUE FUND LP - INTEREST BEARING CASH			392	392
			<u>\$ 2,789,934</u>	<u>\$ 2,789,934</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF U.S. GOVERNMENT SECURITIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(a) / NOT APPLICABLE	(b)	(c) - DESCRIPTION		(d)	(e)
		U.S. GOVERNMENT SECURITIES			
	ISSUER	INTEREST RATE	MATURITY DATE	COST	CURRENT VALUE
	FIRST EAGLE GLOBAL VALUE FUND LP - U.S. GOV'T SECURITIES			\$ 246,081	\$ 564,019
				\$ 246,081	\$ 564,019

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE DEBT INSTRUMENTS - OTHER

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(a) - NOT AFFEASIBLE	(b)	(c) - DESCRIPTION			(d)	(e)
		CORPORATE DEBT INSTRUMENTS - OTHER				
	ISSUER	INTEREST RATE	MATURITY DATE	PAR OR MATURITY VALUE	COST	CURRENT VALUE
	ARA CORE PROPERTY FUND LP - CORPORATE DEBT - OTHER			\$ -	\$ 104,158	\$ 140,876
	BRIGADE HIGH YIELD FUND LP - CORPORATE DEBT - OTHER			-	35,207,574	39,181,139
				\$ -	\$ 35,311,732	\$ 39,322,015

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE STOCK - PREFERRED

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION PREFERRED STOCK NO. OF SHARES	(d) COST	(e) CURRENT VALUE
ARA CORE PROPERTY FUND LP - CORPORATE STOCK - PREFERRED	-	\$ 187,263	\$ 253,277
BRIGADE HIGH YIELD FUND LP - CORPORATE STOCK - PREFERRED	-	228,882	253,259
FIRST EAGLE GLOBAL VALUE FUND LP - CORPORATE STOCK - PREFERRED	-	<u>195,887</u>	<u>448,974</u>
		<u>\$ 612,032</u>	<u>\$ 955,510</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF CORPORATE STOCK - COMMON

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b) ISSUER	(c) - DESCRIPTION COMMON STOCK NO. OF SHARES	(d) COST	(e) CURRENT VALUE
ARA CORE PROPERTY FUND LP - CORPORATE STOCK - COMMON	-	\$ 10,327,550	\$ 14,210,631
BRIGADE HIGH YIELD FUND LP - CORPORATE STOCK - OTHER	-	715,789	792,023
FIRST EAGLE GLOBAL VALUE FUND LP - CORPORATE STOCK - OTHER	-	<u>9,248,577</u>	<u>21,198,279</u>
		<u>\$ 20,291,916</u>	<u>\$ 36,200,933</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF PARTNERSHIPS/JOINT VENTURE INTERESTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION PARTNERSHIPS	(d)	(e)
ISSUER		COST	CURRENT VALUE
MEPT EDGEMOOR L.P.		\$ 9,045,332	\$ 11,816,670
THE EMERGING WORLD INVESTORS L.P.		2,000,000	7,465,098
ARA CORE PROPERTY FUND LP - PARTNERSHIPS		<u>773,659</u>	<u>1,046,389</u>
		<u>\$ 11,818,991</u>	<u>\$ 20,328,157</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF COMMON/COLLECTIVE TRUST FUNDS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a)	(b)	(c) - DESCRIPTION COMMON/ COLLECTIVE TRUST FUNDS	(d)	(e)
	ISSUER	NO. OF SHARES	COST	CURRENT VALUE
*	STATE STREET RUSSELL 1000 INDEX NON-LENDING CTF	414,830	\$ 22,631,738	\$ 35,416,069
*	STATE STREET RUSSELL 2000 INDEX NON-LENDING CTF	125,079	4,953,649	10,194,801
*	STATE STREET U.S. TREASURY INFLATION PROTECTED SECURITIES (TIPS) INDEX NON-LENDING CTF	6,220,437	84,464,672	106,151,759
*	STATE STREET U.S. SHORT-TERM GOVERNMENT/CREDIT BOND INDEX NON-LENDING CTF	6,209,102	67,363,165	74,993,535
*	STATE STREET U.S. AGGREGATE BOND INDEX NON-LENDING CTF	4,558,962	74,629,787	77,133,075
*	STATE STREET INTERMEDIATE U.S. CREDIT INDEX NON-LENDING CTF	767,665	7,984,105	12,707,159
*	STATE STREET MSCI ACWI EX USA INDEX SECURITIES LENDING CTF	380,486	4,978,109	8,341,786
*	STATE STREET MSCI ACWI EX USA INDEX NON-LENDING CTF	368,006	4,991,179	9,361,704
			<u>\$ 271,996,404</u>	<u>\$ 334,299,888</u>

* PARTY-IN-INTEREST

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF POOLED SEPARATE ACCOUNTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION POOLED SEPARATE ACCOUNTS	(d)	(e)
ISSUER	UNITS	COST	CURRENT VALUE
ULLICO SEPARATE ACCOUNT W1	10,549,032	\$ 14,325,167	\$ 19,097,005
		\$ 14,325,167	\$ 19,097,005

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF 103-12 INVESTMENT ENTITIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION 103-12 INVESTMENT ENTITIES	(d)	(e)
ISSUER	NO. OF SHARES	COST	CURRENT VALUE
LOOMIS SAYLES SENIOR FLOATING RATE FUND LLC	578,662	\$ 578,662	\$ 12,373,403
RHUMBLINE QSI INDEX LLC	771,322	15,000,000	35,455,397
ULICO INFRASTRUCTURE FUND	25,000,000	<u>25,000,000</u>	<u>28,572,050</u>
		<u>\$ 40,578,662</u>	<u>\$ 76,400,850</u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF REGISTERED INVESTMENT COMPANIES

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a)	(b)	(c) - DESCRIPTION REGISTERED INVESTMENT COMPANIES	(d)	(e)
	ISSUER	NO. OF SHARES	COST	CURRENT VALUE
	AFL-CIO HOUSING INVESTMENT TRUST	18,166	\$ 20,672,971	\$ 17,704,920
	AMERICAN CENTY ETF TR	210	13,901	12,888
	AVANTIS EMERGING MARKETS	122	7,905	7,172
	DFA EMERGING MARKETS VALUE PORTFOLIO	296,088	7,836,973	8,855,994
	FEDERATED GOVT OBLIGS FUND-PREMIER CLASS	7,721	7,721	7,721
	FIDELITY GOVERNMENT PORTFOLIO-INSTITUTIONAL CLASS	1,482	27,851	31,796
	ISHARES CORE S&P SMALL CAP ETF	273	24,246	31,455
	ISHARES CORE US AGGREGATE BD ETF	657	66,194	63,663
	METRO WEST T/R BD CL I	2,993	28,580	24,905
	PAYDEN EMERGING MARKETS BOND FUND	1,440,724	20,384,632	16,104,783
*	SS INST US GOV'T MM FUND	4,818	4,818	4,818
	VANGUARD FTSE DEVELOPED MARKETS ETF	495	20,490	23,671
	VANGUARD FTSE EMERGING MARKETS ETF	329	15,151	14,489
	VANGUARD MID CAP ETF	222	40,531	58,637
	VANGUARD S&P 500 ETF	145	38,536	78,128
	VANGUARD TOTAL INTL BOND INDEX FUND ETF	711	36,706	35,021
	FIRST EAGLE GLOBAL VALUE FUND LP - REGISTERED INVESTMENT CO.	-	<u>755,494</u>	<u>1,731,595</u>
			<u>\$ 49,982,700</u>	<u>\$ 44,791,656</u>

* PARTY-IN-INTEREST

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF OTHER INVESTMENTS

DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, LINE 4I - ASSETS HELD FOR INVESTMENT PURPOSES AT END OF YEAR

(a) NOT APPLICABLE

(b)	(c) - DESCRIPTION OTHER INVESTMENTS	(d)	(e)
ISSUER		COST	CURRENT VALUE
BRIGADE HIGH YIELD FUND LP - OTHER INVESTMENTS		\$ 16,843	\$ 18,637
FIRST EAGLE GLOBAL VALUE FUND LP - OTHER INVESTMENTS		<u>1,648,867</u>	<u>3,779,208</u>
		<u>\$ 1,665,710</u>	<u>\$ 3,797,845</u>

HOLDINGS OF CERTAIN INVESTMENTS WERE DETERMINED TO BE PLAN ASSETS FOR FORM 5500 PURPOSES AND ARE SEPARATELY IDENTIFIED HERE BASED ON THE ALLOCATION OF UNDERLYING ASSETS PROVIDED BY THE INVESTMENT MANAGER, AS OF THE DATE OF THEIR LATEST AUDITED FINANCIAL STATEMENTS.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

EIN 04-2214296, PLAN NO. 501

FORM 5500, SCHEDULE H, PAGE 4, PART IV, ITEM 4J - SCHEDULE OF REPORTABLE TRANSACTIONS DURING THE YEAR

(a) IDENTITY OF PARTY INVOLVED	(b) DESCRIPTION OF ASSET	(c) PURCHASE PRICE	(d) SELLING PRICE	(e) LEASE RENTAL	(f) EXPENSE INCURRED WITH TRANSACTION	(g) COST OF ASSET	(h) CURRENT VALUE OF ASSET ON TRANSACTION DATE	(i) NET GAIN OR (LOSS)
N/A	BRIGADE HIGH YIELD FUND LP	\$ 38,000,000	\$ -	\$ -	\$ -	\$ -	\$ 38,000,000	\$ -

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULE RECONCILING THE STATEMENT OF NET ASSETS AVAILABLE FOR BENEFITS TO FORM 5500

DECEMBER 31, 2024

	<u>Per Financial Statements</u>	<u>Reclassification</u>	<u>Per Form 5500</u>
Assets			
Investments			
Interest bearing cash	\$ -	\$ 2,789,934	\$ 2,789,934
U.S. government securities	-	564,019	564,019
Corporate debt instruments	-	39,322,015	39,322,015
Corporate stock	-	37,156,443	37,156,443
Partnership/joint venture interests	100,602,095	(80,273,938)	20,328,157
Common/collective trust funds	334,299,888	-	334,299,888
Pooled separate accounts	19,097,005	-	19,097,005
103-12 investment entities	76,400,850	-	76,400,850
Registered investment companies	43,060,061	1,731,595	44,791,656
Other investments	-	3,797,845	3,797,845
Receivables	24,767,539	1,464,889	26,232,428
Cash	26,899,229	-	26,899,229
Other assets	<u>388,226</u>	<u>30,259</u>	<u>418,485</u>
Total assets	<u>625,514,893</u>	<u>6,583,061</u>	<u>632,097,954</u>
Liabilities			
Operating payables	342,119	207,276	549,395
Acquisition indebtedness	-	3,698,976	3,698,976
Other liabilities	<u>389,732</u>	<u>2,676,809</u>	<u>3,066,541</u>
Total liabilities	<u>731,851</u>	<u>6,583,061</u>	<u>7,314,912</u>
Net assets available for benefits	\$ <u>624,783,042</u>	\$ <u>-</u>	624,783,042
Less benefit obligations currently payable			<u>23,334,000</u>
Net assets available to benefits Form 5500			\$ <u>601,449,042</u>

The Plan's holdings in various investments were determined to be plan assets for Form 5500 purposes. This schedule reconciles audited financial statement amounts, plus the Plan's share of amounts provided by the investment managers to the Form 5500 Schedule H amounts. In addition, for financial statement purposes, claims payable and claims incurred but not reported are presented on the Statement of Plan's Benefit Obligation. This differs from the reporting requirements of the Department of Labor which requires that these liabilities be shown on the Statement of Net Assets Available for Benefits.

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULES OF HEALTH CARE BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Hospital and medical	\$ 131,931,136	\$ 113,071,789
Prescription drug	25,570,104	24,103,337
Dental	8,532,742	8,319,632
Claims processing fees	6,599,618	1,984,224
Optical/hearing	843,658	886,677
Other medical benefits	99,601	454,367
Disability and related FICA	<u>176,323</u>	<u>133,619</u>
Total health care benefits	<u>\$ 173,753,182</u>	<u>\$ 148,953,645</u>

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Payroll	\$ 2,737,878	\$ 2,563,587
Payroll taxes	240,127	197,898
Employee benefits	1,344,883	1,167,859
Occupancy	404,435	363,468
Telephone	41,634	39,944
Office	113,020	117,805
Printing and postage	197,029	154,149
Legal	53,267	353,233
Accounting	112,524	92,125
Consulting	413,679	412,353
Computer	93,810	58,871
Outside services	516,984	529,562
Insurance	133,523	132,596
Conferences and meetings	187,416	185,285
Photo ID Program	25,719	11,768
Depreciation	113,479	112,279
Reimbursements from related organizations	<u>(136,862)</u>	<u>(151,189)</u>
Total administrative expenses	<u>\$ 6,592,545</u>	<u>\$ 6,341,593</u>