

<p><b>Form 5500</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p>This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).</p> <p>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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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**

<p><b>1a</b> Name of plan <u>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</u></p> <p><u>620 F STREET, NW</u> <u>WASHINGTON, DC 20004</u></p>	<p><b>1c</b> Effective date of plan <u>07/05/1988</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>52-6397805</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>202-783-3788</u></p> <p><b>2d</b> Business code (see instructions) <u>238100</u></p>

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

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

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	07/23/2025	AMBER MATHES
	<b>Signature of plan administrator</b>	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	07/23/2025	JEREMIAH SULLIVAN, JR.
	<b>Signature of employer/plan sponsor</b>	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	<b>Signature of DFE</b>	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	4431
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	4116
	<b>6a(2)</b>	4113
	<b>6b</b>	302
	<b>6c</b>	
	<b>6d</b>	4415
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	521

**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

<b>9a</b> Plan funding arrangement (check all that apply)	<b>9b</b> Plan benefit arrangement (check all that apply)
(1) <input type="checkbox"/> Insurance	(1) <input checked="" type="checkbox"/> Insurance
(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts	(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts
(3) <input checked="" type="checkbox"/> Trust	(3) <input checked="" type="checkbox"/> Trust
(4) <input type="checkbox"/> General assets of the sponsor	(4) <input type="checkbox"/> 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)

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

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

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**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.

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**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 \_\_\_\_\_

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<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>52-6397805</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**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	C9695	4427	01/01/2024	12/31/2024

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

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;">0</p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

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

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

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

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

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(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.

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

**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>b</b> Balance at the end of the previous year .....			<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>			
	<b>7c(2)</b>			
	<b>7c(3)</b>			
	<b>7c(4)</b>			
	<b>7c(5)</b>			
	(6) Total additions .....			
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....			<b>7d</b>	
<b>e</b> Deductions:				
	<b>7e(1)</b>			
	<b>7e(2)</b>			
	<b>7e(3)</b>			
	<b>7e(4)</b>			
(5) Total deductions .....		<b>7e(5)</b>	0	
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....			<b>7f</b>	

**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) **▶ STOP LOSS**

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	2170840
<b>b</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. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

<p><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<p><b>A</b> Name of plan <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>52-6397805</b></p>	

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**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	G3200	4280	10/01/2023	09/30/2024

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

<p><b>(a)</b> Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p><b>(b)</b> Total amount of fees paid</p> <p style="text-align: center;">0</p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

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

(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	

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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end.....	<b>5</b>	

**6** Contracts With Allocated Funds:

**a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> 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 ▶	<b>6d</b>	

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
	<b>7c(6)</b>	<b>0</b>
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
	<b>7e(5)</b>	<b>0</b>
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	157522
<b>b</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. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

**A** Name of plan  
**BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND**

**B** Three-digit plan number (PN) ▶ **501**

**C** Plan sponsor's name as shown on line 2a of Form 5500  
**BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND**

**D** Employer Identification Number (EIN)  
**52-6397805**

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

**1** Coverage Information:

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	C4468	3976	10/01/2023	09/30/2024

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</b> Total amount of fees paid
0	0

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

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

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

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

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

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

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

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

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

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

(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.

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

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

**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:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	19354
<b>b</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.	<b>10b</b>	

**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. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<b>A</b> Name of plan <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>52-6397805</b>	

**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

**THE VANGUARD GROUP INC.**

**23-1945930**

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

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

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

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

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

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

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

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

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

UNITED HEALTHCARE

36-2739571

(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	NONE	2165782	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

IUBAC

53-0038250

(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 14 15	EMPLOYEE ORGANIZATION	1443723	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

EYEMEDS

86-0773195

(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	NONE	286804	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

CHERION INC.

13-4215617

(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	NONE	243050	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FUIMAN MOGILA LLP

5 PENN PLAZA 23RD FL  
NEW YORK, NY 10001

(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	NONE	90933	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

UMR INC.

39-1995276

(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	NONE	72073	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

OPTUM FINANCIAL INC

P.O BOX 84019  
CHICAGO, IL 60689

(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?
99	NONE	70319	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CALIBRE CPA GROUP PLLC

47-0900880

(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	NONE	56135	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BRIDGEWAY BENEFIT TECHNOLOGY LLC

3000 SOUTH LENOLA RD  
MAPLE SHADE, NJ 08052

(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	NONE	36908	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SCHEFFEL & COMPANY

322 STATE STREET  
ALTON, IL 62002

(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 49	NONE	22900	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SAV-RX

47-0527013

(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	NONE	21334	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ALAN BILLER & ASSOCIATES

535 MIDDLEFIELD RD, SUITE 230  
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?
17	NONE	21250	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

INNOVATIVE SOFTWARE & SOLUTIONS INC

3000 SOUTH LENOIA RD  
MAPLE, NJ 08052

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 49	NONE	19401	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CHERION INC.

13-4215622

(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	NONE	13561	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

**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.

<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
<b>(a)</b> Enter service provider name as it appears on line 2	<b>(b)</b> Service Codes (see instructions)	<b>(c)</b> Enter amount of indirect compensation
<b>(d)</b> Enter name and EIN (address) of source of indirect compensation	<b>(e)</b> Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

**Part II Service Providers Who Fail or Refuse to Provide Information**

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

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

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

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

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

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

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> 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)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  <b>► File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b>	<b>B</b> Three-digit plan number (PN) <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>52-6397805</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
---------------	--------------------------------------

**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
<b>a</b> Total noninterest-bearing cash .....	309416	12660
<b>b</b> Receivables (less allowance for doubtful accounts):		
<b>(1)</b> Employer contributions .....	5170305	5257232
<b>(2)</b> Participant contributions .....		
<b>(3)</b> Other .....	5744672	3953479
<b>c</b> General investments:		
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	20599650	19606945
<b>(2)</b> U.S. Government securities .....		
<b>(3)</b> Corporate debt instruments (other than employer securities):		
<b>(A)</b> Preferred .....		
<b>(B)</b> All other .....		
<b>(4)</b> Corporate stocks (other than employer securities):		
<b>(A)</b> Preferred .....		
<b>(B)</b> Common .....		
<b>(5)</b> Partnership/joint venture interests .....		
<b>(6)</b> Real estate (other than employer real property) .....		
<b>(7)</b> Loans (other than to participants) .....		
<b>(8)</b> Participant loans .....		
<b>(9)</b> Value of interest in common/collective trusts .....		
<b>(10)</b> Value of interest in pooled separate accounts .....		
<b>(11)</b> Value of interest in master trust investment accounts .....		
<b>(12)</b> Value of interest in 103-12 investment entities .....		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	24040480	25819957
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....		
<b>(15)</b> Other .....		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	55864523	54650273
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>	7682872	6123524
<b>h</b> Operating payables.....	<b>1h</b>	9964431	9015000
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>		
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	17647303	15138524
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	38217220	39511749

**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.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	71654352	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	4430951	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		76085303
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	1574126	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		1574126
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		
<b>(3)</b> Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		787202
<b>c</b> Other income .....	<b>2c</b>		
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	<b>2d</b>		78446631

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	<b>2e(1)</b>	69521611	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	4771826	
(3) Other.....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		74293437
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	<b>2g</b>		
<b>h</b> Interest expense.....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>		
(2) Contract administrator fees .....	<b>2i(2)</b>	1413614	
(3) Recordkeeping fees .....	<b>2i(3)</b>		
(4) IQPA audit fees .....	<b>2i(4)</b>	56135	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>		
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>		
(7) Actuarial fees .....	<b>2i(7)</b>	197961	
(8) Legal fees .....	<b>2i(8)</b>	90933	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>	42009	
(11) Other expenses.....	<b>2i(11)</b>	1058013	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		2858665
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	<b>2j</b>		77152102

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		1294529
<b>l</b> Transfers of assets:			
(1) To this plan.....	<b>2l(1)</b>		
(2) From this plan .....	<b>2l(2)</b>		

**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: CALIBRE CPA GROUP PLLC

(2) EIN: 47-0900880

**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
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		1000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> 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.		X	

**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.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> 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 \_\_\_\_\_.



**BRICKLAYERS AND ALLIED CRAFTWORKERS  
INTERNATIONAL HEALTH PLAN**

**UNITED STATES PLAN**

FINANCIAL STATEMENTS

DECEMBER 31, 2024





**BRICKLAYERS AND ALLIED CRAFTWORKERS  
INTERNATIONAL HEALTH PLAN**

**UNITED STATES PLAN**

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

YEARS ENDED DECEMBER 31, 2024 AND 2023

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## INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the  
Bricklayers and Allied Craftworkers  
International Health Plan - United States Plan

### Opinion

We have audited the accompanying financial statements of the Bricklayers and Allied Craftworkers International Health Plan - United States Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits for the years then ended, 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 of Bricklayers and Allied Craftworkers International Health Plan - United States Plan as of December 31, 2024 and 2023, and the changes in its net assets available for benefits for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### Basis for Opinion

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

### Responsibilities of Management for the Financial Statements

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



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


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

### **Auditor's Responsibilities for the Audit of the Financial Statements**

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

In performing an audit in accordance with GAAS, we:

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



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

### **Supplemental Schedules Required by ERISA**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of assets (held at end of year) and reportable transactions on pages 14 and 15 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplemental information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

*Calibre CPA Group, PLLC*

Bethesda, MD  
July 8, 2025



## BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH PLAN

### UNITED STATES PLAN

#### STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

	2024	2023
<b>Assets</b>		
Investments		
Mutual funds	\$ 25,819,957	\$ 24,040,480
Receivables		
Contributions	5,257,232	5,170,305
Due from ULLICO	3,822,017	5,612,478
Due from Canadian Plan	73,325	43,217
Other receivables	-	9,524
Total receivables	9,152,574	10,835,524
Prepaid expenses	26,275	18,943
Property and equipment - at cost (net of accumulated depreciation of \$122,849 and \$92,638 at December 31, 2024 and 2023, respectively)	31,862	60,510
Cash	19,619,605	20,909,066
Total assets	54,650,273	55,864,523
<b>Liabilities</b>		
Accounts payable for administrative expenses	512,904	322,303
Accrued HRA benefits	8,006,023	9,288,510
Deferred self-pay contributions	219,061	181,237
Due to related organizations	277,012	172,381
Total liabilities	9,015,000	9,964,431
<b>Net assets available for benefits</b>	\$ 45,635,273	\$ 45,900,092

See accompanying notes to financial statements.



## BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH PLAN

### UNITED STATES PLAN

#### STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
<b>Additions</b>		
Investment income		
Interest and dividends	\$ 1,574,126	\$ 1,207,864
Net appreciation in fair value of investments	<u>787,202</u>	<u>1,315,000</u>
Total investment income	2,361,328	2,522,864
Employer contributions	71,654,352	67,868,883
Self-pay contributions	<u>4,430,951</u>	<u>4,003,760</u>
Total additions	<u>78,446,631</u>	<u>74,395,507</u>
<b>Deductions</b>		
Cost of benefits		
Self-funded benefits		
Health claims	62,859,195	54,927,659
Optical claims	289,749	284,593
Dental claims	1,984,658	1,914,529
Prescription drugs	<u>5,947,357</u>	<u>6,235,437</u>
Total self-funded benefits	71,080,959	63,362,218
Group insurance premiums	586,986	336,840
Stop loss premiums	<u>2,019,057</u>	<u>1,869,244</u>
Total benefits paid	73,687,002	65,568,302
Claims processing fees	<u>2,165,783</u>	<u>2,249,426</u>
Total cost of benefits	<u>75,852,785</u>	<u>67,817,728</u>
Administrative expenses		
Reimbursement for administrative services provided by related organization	1,443,722	1,467,343
Professional fees	442,062	456,000
Office expense	957,612	933,277
Rent	216	1,498
Insurance	3,152	5,058
Travel and meeting expenses	42,009	52,258
Administrative costs allocated to Canadian Plan	<u>(30,108)</u>	<u>(43,217)</u>
Total administrative expenses	<u>2,858,665</u>	<u>2,872,217</u>
Total deductions	<u>78,711,450</u>	<u>70,689,945</u>
<b>Net change</b>	(264,819)	3,705,562
<b>Net assets available for benefits</b>		
Beginning of year	<u>45,900,092</u>	<u>42,194,530</u>
End of year	<u>\$ 45,635,273</u>	<u>\$ 45,900,092</u>

See accompanying notes to financial statements.



## BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH PLAN

### UNITED STATES PLAN

#### NOTES TO FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2024 AND 2023

#### NOTE 1. DESCRIPTION OF THE PLAN

The following description of the Bricklayers and Allied Craftworkers International Health Plan - United States Plan (the Plan) provides only general information. Participants should refer to the Summary Plan Description for more complete information.

The Plan covers employees in jobs covered by collective bargaining agreements, officials and employees of local unions and retired members. Unemployed participants and their dependents are allowed to continue their eligibility after they cease employment by paying monthly self-pay premiums. The Plan provides benefits such as life and accidental death and dismemberment insurance, hospital, surgical, medical, optical, dental, and drug benefits. Benefit levels vary and the benefits are provided by the Plan and various insurance providers.

#### NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Method of Accounting** - The financial statements were prepared using the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP). Under this basis, revenue is recognized when earned and expenses are recognized when incurred.

**Contributions Receivable** - Employer contributions due and not paid prior to year-end are recorded as contributions receivable. An allowance for uncollectible contributions receivable was estimated based on delinquent contributions. An allowance of \$58,532 and \$81,618 was recorded at December 31, 2024 and 2023, respectively.

**Benefits** - Vision, prescription drug, dental benefits and certain health benefits are processed by insurance companies but the responsibility for payments to participants and providers is retained by the Plan. Life insurance benefits are provided by a fully-insured insurance contract. Benefit payments to participants are recorded upon distribution.

**Unpaid Claims** - Claims for optical, prescription drug, dental and most health benefits processed and paid by insurance companies for which the Plan has not yet reimbursed the insurance company and claims reported prior to year-end but not paid by year end are included in the benefit obligation information presented in Note 9 as an obligation of the Plan.



## NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

**Administrative Expenses** - Administrative expenses are paid by the Plan.

**Investment Valuation and Income Recognition** - The Plan's investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

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

**Property and Equipment** - Property and equipment is recorded at cost. Depreciation is computed by the straight-line method over the estimated useful lives of the related assets, which is generally five years.

**Estimates** - The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires the Plan's management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations, and changes therein; claims incurred but not reported; eligibility credits; claims payable; and disclosure of contingent assets and liabilities. Actual results may differ from those estimates.

**Postretirement Benefits** - Depending on the specific terms covering a local union's participation in the Plan, a retired participant may be entitled to continue coverage on a self-payment basis. Retired participants pay the full cost of providing postretirement benefit obligations.

A current participant qualifies for continuing coverage if he or she meets the following requirements: a) has experienced active eligibility prior to retirement, b) is retired, eligible for or receiving a monthly pension from the Bricklayers and Trowel Trades International Pension Fund, or a pension fund maintained by the International Union of Bricklayers and Allied Craftworkers (BAC) or one of its local unions, c) is at least age 55 or eligible for a disability pension and not yet eligible for Medicare on the effective date of the pension, and d) is making self-payments on or before the 15th day of each month prior to the eligibility month. The coverage may include all benefits available to active participants. The cost of postretirement benefits charged monthly to retired participants ranges from \$168 to \$2,300 depending on the coverage provided and the geographical location of the retired participant.

Since the retired participants are fully funding their benefits, the postretirement benefit obligation is zero. Therefore, no net postretirement benefit obligation is reported in Note 9 at December 31, 2024 or 2023.



## NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

**Accumulated Eligibility Benefit Obligation** - Eligibility is earned based upon the hours worked by a participant and is calculated on a quarterly basis. One quarter or three months is the maximum amount of eligibility that may be accumulated. The Plan's accumulated eligibility benefit obligation at December 31, 2024 and 2023 is based on the average claims amount for the year and the average number of participants who lost eligibility during the year, which were both estimated by the Plan's management.

## NOTE 3. TAX STATUS

The Internal Revenue Service (IRS) has advised that the Plan qualifies for exemption from income tax under Section 501(c)(9) of the Internal Revenue Code (IRC).

The Plan obtained its latest determination letter in September 1989 in which the IRS stated that the Plan, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended since receiving the determination letter. However, the Plan administrator and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC. Therefore, no provision for income taxes has been included in the Plan's financial statements.

The Plan follows authoritative guidance for accounting for uncertainty in income taxes included in Accounting Standards Codification (ASC) Topic *Income Taxes*. These provide consistent guidance for the accounting for uncertainty in income taxes recognized in an entity's financial statements and prescribe a threshold of "more likely than not" for recognition and derecognition of tax positions taken or expected to be taken in a tax return. The Plan performed an evaluation of uncertain tax positions for the years ended December 31, 2024 and 2023, and determined that there were no matters that would require recognition in the financial statements.

## NOTE 4. STOP-LOSS INSURANCE

The Plan has coverage under a stop-loss insurance policy, which provides protection against catastrophic claims. The policy provides for the coverage of claims incurred by individual participants that exceed \$500,000 and \$410,000, respectively, during the years ended December 31, 2024 and 2023. The amount to be paid by the insurance company with respect to any individual over a lifetime is unlimited.

For the years ended December 31, 2024 and 2023, the stop-loss refunds totaled \$2,448,109 and \$3,055,147, respectively, and are included with health claims in the statements of changes in net assets available for benefits. Stop-loss refunds of \$3,822,017 and \$5,612,478 were receivable from the insurance company as of December 31, 2024 and 2023, respectively.

## NOTE 5. INVESTMENTS AND FAIR VALUE MEASUREMENTS

Accounting standards provide the framework for measuring fair value which 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 (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

- Level 1 Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Plan has the ability to access.
- Level 2 Inputs to the valuation methodology include other significant observable inputs including:
- Quoted prices for similar assets or liabilities in active markets;
  - Quoted prices for identical or similar assets or liabilities in inactive markets;
  - Inputs other than quoted prices that are observable for the asset or liability; and
  - Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

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

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

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

The following table sets forth by level, within the fair value hierarchy, the Plan's assets as of December 31, 2024:

Description	12/31/2024	Quoted Market Price for Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	\$ 25,819,957	\$ 25,819,957	\$ -	\$ -



## NOTE 5. INVESTMENTS AND FAIR VALUE MEASUREMENTS (CONTINUED)

The following table sets forth by level, within the fair value hierarchy, the Plan's assets as of December 31, 2023:

Description	12/31/2023	Quoted Market Price for Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Mutual funds	<u>\$ 24,040,480</u>	<u>\$ 24,040,480</u>	<u>\$ -</u>	<u>\$ -</u>

Following is a description of the valuation methodology used for assets at fair value. There have been no changes in methodology used at December 31, 2024 and 2023.

*Mutual funds* - The fair value of the Plan's investments in mutual funds are valued using the quoted prices of identical investments on the active markets they are traded.

## NOTE 6. PRIORITIES UPON TERMINATION

It is the intent of the Board of Trustees (Trustees) to continue the Plan in full force and effect. However, in order to safeguard against any unforeseen contingencies, the right to discontinue the Plan is reserved to the Trustees. In the event of termination, the Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining plan assets will be distributed in such manner as will in the opinion of the Trustees bring about the purpose of the Plan. Termination shall not permit any part of the Plan's assets to be used for or diverted to purposes other than the exclusive benefit of the participants.

## NOTE 7. FUNDING POLICY

The Plan is financed by employer contributions, contributions from retirees and other self-paying participants. The contribution rates as specified in the Plan's collective bargaining agreements range from \$3.7 to \$11.15 per hour in 2024 and \$3.5 to \$10.60 per hour in 2023.

## NOTE 8. RELATED PARTIES AND PARTIES-IN-INTEREST

BAC provides computer processing, accounting, and other administrative services on an allocated cost basis to the Plan. BAC is also a participating employer in the Plan. As such, these transactions are considered party-in-interest transactions under ERISA.

Three officers of BAC are also Trustees of the Plan.

## NOTE 8. RELATED PARTIES AND PARTIES-IN-INTEREST (CONTINUED)

The Plan reimburses BAC for its share of the Human Resource and Health Management Unit. Amounts billed by BAC for these services are reported as reimbursement for administrative services provided by related organization on the accompanying statements of changes in net assets available for benefits and totaled \$1,443,722 and \$1,467,343 for the years ended December 31, 2024 and 2023, respectively.

Net amounts owed to BAC at December 31, 2024 and 2023 for these services, included under the caption due to related organizations on the accompanying statements of net assets available for benefits, were comprised of the following:

	<u>2024</u>	<u>2023</u>
BAC	<u>\$277,012</u>	<u>\$172,381</u>

The Plan provides computer processing, accounting and other administrative services on an allocated cost basis to the Bricklayers and Allied Craftworkers International Health Plan - Canadian Plan (the Canadian Plan). Administrative expenses allocated to the Canadian Plan shown in the accompanying statements of changes in net assets available for benefits for the years ended December 31, 2024 and 2023 are \$30,108 and \$43,217, respectively. At December 31, 2024 and 2023, the Canadian Plan owed the Plan \$73,325 and \$43,217, respectively. In addition, the Plan collects contributions from certain Canadian Plan participants who work in the United States and then transfers these contributions to the Canadian Plan.

## NOTE 9. BENEFIT OBLIGATIONS

The following table presents the components of the Plan's benefit obligations and the related changes in the Plan's benefit obligations:

	<u>Year Ended December 31,</u>	
	<u>2024</u>	<u>2023</u>
<b>Benefit obligations</b>		
Amounts currently payable		
Claims payable, claims incurred but not reported, and premiums due to insurers	\$ 6,123,524	\$ 7,682,872
Postemployment benefit obligations, net of amounts currently payable		
Accumulated eligibility credits	430,347	491,267
Postretirement benefit obligations	<u>-</u>	<u>-</u>
Plan's total benefit obligations	<u>\$ 6,553,871</u>	<u>\$ 8,174,139</u>



**NOTE 9. BENEFIT OBLIGATIONS (CONTINUED)**

	Year Ended December 31,	
	<u>2024</u>	<u>2023</u>
<b>Change in benefit obligations</b>		
Amounts currently payable		
Balance at beginning of year	\$ 7,682,872	\$ 8,913,062
Claims reported and approved for payments, including benefits reclassified from benefit obligations	72,127,654	64,338,112
Claims paid and group insurance premiums paid	<u>(73,687,002)</u>	<u>(65,568,302)</u>
Balance at end of year	<u>6,123,524</u>	<u>7,682,872</u>
Postemployment benefit obligations, net of amount currently payable		
Accumulated eligibility credits		
Balance at beginning of year	491,267	501,864
Change attributable to benefits earned	<u>(60,920)</u>	<u>(10,597)</u>
Balance at end of year	<u>430,347</u>	<u>491,267</u>
Plan's total benefit obligations	<u>\$ 6,553,871</u>	<u>\$ 8,174,139</u>

**NOTE 10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500**

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 45,635,273	\$ 45,900,092
Benefit obligations currently payable	<u>(6,123,524)</u>	<u>(7,682,872)</u>
Net assets available for benefits per the Form 5500	<u>\$ 39,511,749</u>	<u>\$ 38,217,220</u>



**NOTE 10. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500  
(CONTINUED)**

The following is a reconciliation of benefits paid to or for participants and dependents per the financial statements to the Form 5500 for the year ended December 31, 2024:

Benefits paid to or for participants and dependents per the financial statements	\$ 73,687,002
Add: amounts currently payable at end of year	6,123,524
Less: amounts payable at beginning of year	<u>(7,682,872)</u>
 Benefits paid to or for participants and dependents per the Form 5500	 <u>\$ 72,127,654</u>

**NOTE 11. UNINSURED CASH BALANCES**

The Plan maintains its cash in various deposit accounts. Cash balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 per bank. The Plan's cash balances exceed the amount insured by the FDIC by approximately \$19,500,000 at December 31, 2024.

**NOTE 12. SUBSEQUENT EVENTS**

Subsequent events have been evaluated through July 8, 2025, which is the date the financial statements were available to be issued. This review and evaluation revealed no material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.



## BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH PLAN

### UNITED STATES PLAN

#### SCHEDULE OF ASSETS (HELD AT END OF YEAR)

DECEMBER 31, 2024

Form 5500, Schedule H, Line 4i

E.I.N. 52-6397805  
Plan No. 501

(a)	(b) Identity of issuer, borrower, lessor or similar party	(c) Description of investment including maturity date, rate of interest, collateral, par/maturity value or shares			(d) Cost	(e) Current value	
		Collateral	Maturity date	Rate of interest			Par/ Maturity value or shares
	Mutual funds						
	Baird Aggregate Bond	N/A	N/A	N/A	388,000	\$ 4,425,572	\$ 3,896,553
	Payden Low Duration Fund	N/A	N/A	N/A	477,663	4,974,175	4,870,576
	Vanguard Stock Market Index	N/A	N/A	N/A	34,394	2,655,404	4,915,174
	JP Morgan Core Bond Fund	N/A	N/A	N/A	368,885	3,939,406	3,888,637
	PIMCO Income Fund	N/A	N/A	N/A	368,917	4,086,602	4,130,145
	Neuberger Berman (PF) Strategic Multi-Sector Fixed Income Fund LLC	N/A	N/A	N/A	367,793	<u>3,700,000</u>	<u>4,118,872</u>
	Total mutual funds					<u>23,781,159</u>	<u>25,819,957</u>
	Total assets (held at end of year)					<u>\$ 23,781,159</u>	<u>\$ 25,819,957</u>

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

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

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

OMB Nos. 1210 - 0110  
1210 - 0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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

- A** This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- B** This return/report is:  a single-employer plan  a DFE (specify) \_\_\_\_\_  
 the first return/report  the final return/report  
 an amended return/report  a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here .....
- 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

<b>1a</b> Name of plan <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH FUND</b>	<b>1b</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>2a</b> 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) <b>BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL H</b>  <b>620 F STREET, NW</b>  <b>WASHINGTON DC 20004</b>	<b>1c</b> Effective date of plan <b>07/05/1988</b>  <b>2b</b> Employer Identification Number (EIN) <b>52-6397805</b>  <b>2c</b> Plan Sponsor's telephone number <b>(202) 783-3788</b>  <b>2d</b> Business code (see instructions) <b>238100</b>

**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.

<b>SIGN HERE</b>	 <small>Amber Mathes (Jul 14, 2025 12:37:28 EDT)</small>	<b>07/23/2025</b>	<b>AMBER MATHES</b>
	<b>Signature of plan administrator</b>	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		<b>07/23/2025</b>	<b>JEREMIAH SULLIVAN, JR.</b>
	<b>Signature of employer/plan sponsor</b>	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	<b>Signature of DFE</b>	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)  
v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
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<b>4</b> 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: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
--	-----------------------------------

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	4,431
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	4,116
<b>a (2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	4,113
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b>	302
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c .....	<b>6d</b>	4,415
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e .....	<b>6f</b>	
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	521

**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**

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

<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information) (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)	<b>b General Schedules</b> (1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) - Number Attached <u>  3  </u> (4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)
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# BRICKLAYERS AND ALLIED CRAFTWORKERS INTERNATIONAL HEALTH PLAN

## UNITED STATES PLAN

### SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Line 4j

E.I.N. 52-6397805  
Plan No. 501

(a) Identity of Party Involved	(b) Description of Asset (include interest rate and maturity in case of a loan)	(c) Purchase Price	(d) Selling Price	(e) Lease Rental	(f) Expenses Incurred With Transaction	(g) Cost of Asset	(h) Current Value of Asset on Transaction Date	(i) Net Gain or Loss
N/A	Baird Aggregate Bond	\$ 153,739	N/A	N/A	N/A	\$ 153,739	\$ 153,739	N/A
N/A	JP Morgan Core Bond Fund	156,654	N/A	N/A	N/A	156,654	156,654	N/A
N/A	PIMCO Income Fund	250,583	N/A	N/A	N/A	250,583	250,583	N/A
N/A	Neuberger Berman (PF) Strategic Multi-Sector Fixed Income Fund LLC	N/A	N/A	N/A	N/A	N/A	N/A	N/A