

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110  
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan: 32BJ NORTH HEALTH FUND
1b Three-digit plan number (PN): 501
1c Effective date of plan: 06/01/1948
2a Plan sponsor's name (employer, if for a single-employer plan): BOARD OF TRUSTEES, 32BJ NORTH HEALTH FUND
2b Employer Identification Number (EIN): 13-1699839
2c Plan Sponsor's telephone number: 212-539-2778
2d Business code (see instructions): 561790

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.

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Rows include Kevin Starvis (plan administrator), William Schur (employer/plan sponsor), and a blank row for DFE.

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

|   |  |      |
|---|--|------|
| <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:<br><b>a</b> Sponsor's name<br><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>                                   | 2620 |
| <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> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits.....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><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) .....<br><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) .....<br><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>                               | 2589 |
|   | <b>6a(2)</b>                               | 2718 |
|   | <b>6b</b>                                  | 26   |
|   | <b>6c</b>                                  |      |
|   | <b>6d</b>                                  | 2744 |
|   | <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>                                   | 661  |

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

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

|   |   |
|---|---|
| <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>1</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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**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**

|   |  |  |
|---|--|--|
| <b>A</b> Name of plan<br><b>32BJ NORTH 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<br><b>BOARD OF TRUSTEES, 32BJ NORTH HEALTH FUND</b> |  | <b>D</b> Employer Identification Number (EIN)<br><b>13-1699839</b> |

**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  
**METROPOLITAN LIFE INSURANCE COMPANY**

| <b>(b)</b> EIN    | <b>(c)</b> NAIC code | <b>(d)</b> Contract or identification number | <b>(e)</b> Approximate number of persons covered at end of policy or contract year | <b>Policy or contract year</b> |                   |
|-------------------|----------------------|--|--|--------------------------------|-------------------|
|                   |                      |  |  | <b>(f)</b> From                | <b>(g)</b> To     |
| <b>13-5581829</b> | <b>65978</b>         | <b>0158095</b>                               | <b>2667</b>  | <b>01/01/2024</b>              | <b>12/31/2024</b> |

**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 |
|---|--------------------------------------|

**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>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> Purpose |                              |
|  |  |                    |                              |

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

| <b>(b)</b> Amount of sales and base commissions paid | <b>Fees and other commissions paid</b> |                    | <b>(e)</b> Organization code |
|--|--|--------------------|------------------------------|
|  | <b>(c)</b> Amount                      | <b>(d)</b> 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>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> |           |  |
| <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> | 149979 |
| (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> | 149979 |
| <b>b</b> Benefit charges (1) Claims paid .....   |                 | <b>9b(1)</b> | 68090  |
| (2) Increase (decrease) in claim reserves .....  |                 | <b>9b(2)</b> | -24880 |
| (3) Incurred claims (add (1) and (2)) .....  |                 | <b>9b(3)</b> | 43210  |
| (4) Claims charged .....   |                 | <b>9b(4)</b> | 48660  |
| <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> |              | 2458   |
| (E) Taxes .....  | <b>9c(1)(E)</b> |              | 2964   |
| (F) Charges for risks or other contingencies .....   | <b>9c(1)(F)</b> |              | 22512  |
| (G) Other retention charges .....  | <b>9c(1)(G)</b> |              | 78835  |
| (H) Total retention .....  | <b>9c(1)(H)</b> |              | 106769 |
| (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> | 49211  |
| (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> |
| <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. ▶

|  |  |   |
|--|--|---|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br><b>▶ File as an attachment to Form 5500.</b> | <small>OMB No. 1210-0110</small><br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection.</b> |
|--|--|---|

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

|   |  |            |
|---|--|------------|
| <b>A</b> Name of plan<br><b>32BJ NORTH 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<br><b>BOARD OF TRUSTEES, 32BJ NORTH HEALTH FUND</b> | <b>D</b> Employer Identification Number (EIN)<br><b>13-1699839</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**

**23-1945930**

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

**T. ROWE PRICE** **233 PARK AVE S**  
**NEW YORK, NY 10003**

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

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

ANTHEM HEALTHCHOICE ASSURANCE INC

23-7391136

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 14 50               | NONE  | 1303357  | 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)

BUILDING SERVICE 32BJ HEALTH FUND

13-2928869

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 14 50               | AFFILIATE   | 1281393  | 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)

RAAB, STURM & GANCHROW, LLP

13-1566077

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29 50                  | NONE  | 120442   | 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)

SCHULTHEIS & PANETTIERI, LLP

13-1577780

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 50                  | NONE  | 116135   | 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)

WITHUMSMITH+BROWN, PC

22-2027092

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 10 50                  | NONE  | 79400  | 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)

DELTA DENTAL

5073 RITTER ROAD  
MECHANICSBURG, PA 17055

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 50                  | NONE  | 73425  | 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)

THE SEGAL COMPANY

13-1835864

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 11 50                  | NONE  | 64750  | 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)

SLEVIN & HART, PC

52-1078613

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 29 50                  | NONE  | 35400  | 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)

MEKETA INVESTMENT GROUP INC

04-2659023

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 27 51                  | NONE  | 34167  | 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)

SEGAL SELECT INSURANCE SERVICES

46-0619194

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 22 53                  | NONE  | 28110  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                  | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | 0   | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |

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

H&H GRAPHIC PRINTING COMMUNICATIONS

27-0771521

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 36 50                  | NONE  | 22896  | 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)

JPMORGAN CHASE

13-4994650

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 50                  | NONE  | 12513  | 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)

OPTUMRX, INC.

33-0441200

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 13 50                  | NONE  | 8232   | 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)

MOUNT VERNON PRINTING COMPANY

52-1193840

| (b)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>Did the service provider give you a formula instead of an amount or estimated amount? |
|------------------------|---|--|--|--|---|--|
| 36 50                  | NONE  | 7382   | 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)<br>Service Code(s) | (c)<br>Relationship to employer, employee organization, or person known to be a party-in-interest | (d)<br>Enter direct compensation paid by the plan. If none, enter -0-. | (e)<br>Did service provider receive indirect compensation? (sources other than plan or plan sponsor) | (f)<br>Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures? | (g)<br>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)<br>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.

| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
|---|--|---|
| SEGAL SELECT INSURANCES, INC.                                       | 22 53  | 3227                                      |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
| CHUBB<br><br>13-1963496   | COMMISSION FEES  |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
|   |  |   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
|   |  |   |
| (a) Enter service provider name as it appears on line 2             | (b) Service Codes (see instructions)   | (c) Enter amount of indirect compensation |
|   |  |   |
| (d) Enter name and EIN (address) of source of indirect compensation | (e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation. |   |
|   |  |   |

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

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

| <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><br><b>(Form 5500)</b><br><br><small>Department of the Treasury<br/>Internal Revenue Service</small><br><br><small>Department of Labor<br/>Employee Benefits Security Administration</small><br><br><small>Pension Benefit Guaranty Corporation</small> | <b>Financial Information</b><br><br>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).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110<br><br><b>2024</b><br><br><b>This Form is Open to Public Inspection</b> |
|--|--|---|

|   |  |
|---|--|
| 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<br><b>32BJ NORTH 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<br><b>BOARD OF TRUSTEES, 32BJ NORTH HEALTH FUND</b> | <b>D</b> Employer Identification Number (EIN)<br><b>13-1699839</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.

|  |                 | (a) Beginning of Year | (b) End of Year |
|--|-----------------|-----------------------|-----------------|
| <b>a</b> Total noninterest-bearing cash .....  | <b>1a</b>       | 2706304               | 5100595         |
| <b>b</b> Receivables (less allowance for doubtful accounts):                                       |                 |                       |                 |
| <b>(1)</b> Employer contributions .....  | <b>1b(1)</b>    | 4611444               | 5143054         |
| <b>(2)</b> Participant contributions .....   | <b>1b(2)</b>    |                       |                 |
| <b>(3)</b> Other .....   | <b>1b(3)</b>    | 881443                | 775614          |
| <b>c</b> General investments:  |                 |                       |                 |
| <b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....   | <b>1c(1)</b>    | 14026                 | 6008            |
| <b>(2)</b> U.S. Government securities .....  | <b>1c(2)</b>    |                       |                 |
| <b>(3)</b> Corporate debt instruments (other than employer securities):                            |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(3)(A)</b> |                       |                 |
| <b>(B)</b> All other .....   | <b>1c(3)(B)</b> |                       |                 |
| <b>(4)</b> Corporate stocks (other than employer securities):                                      |                 |                       |                 |
| <b>(A)</b> Preferred .....   | <b>1c(4)(A)</b> |                       |                 |
| <b>(B)</b> Common .....  | <b>1c(4)(B)</b> |                       |                 |
| <b>(5)</b> Partnership/joint venture interests .....   | <b>1c(5)</b>    |                       |                 |
| <b>(6)</b> Real estate (other than employer real property) .....                                   | <b>1c(6)</b>    |                       |                 |
| <b>(7)</b> Loans (other than to participants) .....  | <b>1c(7)</b>    |                       |                 |
| <b>(8)</b> Participant loans .....   | <b>1c(8)</b>    |                       |                 |
| <b>(9)</b> Value of interest in common/collective trusts .....                                     | <b>1c(9)</b>    |                       |                 |
| <b>(10)</b> Value of interest in pooled separate accounts .....                                    | <b>1c(10)</b>   |                       |                 |
| <b>(11)</b> Value of interest in master trust investment accounts .....                            | <b>1c(11)</b>   |                       |                 |
| <b>(12)</b> Value of interest in 103-12 investment entities .....                                  | <b>1c(12)</b>   |                       |                 |
| <b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....        | <b>1c(13)</b>   | 51383167              | 61721341        |
| <b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) ..... | <b>1c(14)</b>   |                       |                 |
| <b>(15)</b> Other .....  | <b>1c(15)</b>   |                       |                 |

| 1d Employer-related investments:                                  |       | (a) Beginning of Year | (b) End of Year |
|---|-------|-----------------------|-----------------|
| (1) Employer securities.....                                      | 1d(1) |                       |                 |
| (2) Employer real property.....                                   | 1d(2) |                       |                 |
| e Buildings and other property used in plan operation.....        | 1e    | 258607                | 264905          |
| f Total assets (add all amounts in lines 1a through 1e).....      | 1f    | 59854991              | 73011517        |
| <b>Liabilities</b>  |       |                       |                 |
| g Benefit claims payable.....                                     | 1g    | 5654100               | 5141800         |
| h Operating payables.....   | 1h    | 1629535               | 978163          |
| i Acquisition indebtedness.....                                   | 1i    |                       |                 |
| j Other liabilities.....  | 1j    | 0                     | 121536          |
| k Total liabilities (add all amounts in lines 1g through 1j)..... | 1k    | 7283635               | 6241499         |
| <b>Net Assets</b>   |       |                       |                 |
| l Net assets (subtract line 1k from line 1f).....                 | 1l    | 52571356              | 66770018        |

**Part II Income and Expense Statement**

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

| Income   |          | (a) Amount | (b) Total |
|--|----------|------------|-----------|
| <b>a Contributions:</b>  |          |            |           |
| (1) Received or receivable in cash from: (A) Employers.....                                  | 2a(1)(A) | 53565128   |           |
| (B) Participants.....  | 2a(1)(B) |            |           |
| (C) Others (including rollovers).....  | 2a(1)(C) |            |           |
| (2) Noncash contributions.....   | 2a(2)    |            |           |
| (3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....                   | 2a(3)    |            | 53565128  |
| <b>b Earnings on investments:</b>  |          |            |           |
| (1) Interest:  |          |            |           |
| (A) Interest-bearing cash (including money market accounts and certificates of deposit)..... | 2b(1)(A) |            |           |
| (B) U.S. Government securities.....  | 2b(1)(B) |            |           |
| (C) Corporate debt instruments.....  | 2b(1)(C) |            |           |
| (D) Loans (other than to participants).....  | 2b(1)(D) |            |           |
| (E) Participant loans.....   | 2b(1)(E) |            |           |
| (F) Other.....   | 2b(1)(F) | 161286     |           |
| (G) Total interest. Add lines 2b(1)(A) through (F).....                                      | 2b(1)(G) |            | 161286    |
| (2) Dividends:   |          |            |           |
| (A) Preferred stock.....   | 2b(2)(A) |            |           |
| (B) Common stock.....  | 2b(2)(B) |            |           |
| (C) Registered investment company shares (e.g. mutual funds).....                            | 2b(2)(C) | 2001869    |           |
| (D) Total dividends. Add lines 2b(2)(A), (B), and (C).....                                   | 2b(2)(D) |            | 2001869   |
| (3) Rents.....   | 2b(3)    |            |           |
| (4) Net gain (loss) on sale of assets:   |          |            |           |
| (A) Aggregate proceeds.....  | 2b(4)(A) |            |           |
| (B) Aggregate carrying amount (see instructions).....  | 2b(4)(B) |            |           |
| (C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....                          | 2b(4)(C) |            |           |
| (5) Unrealized appreciation (depreciation) of assets:  |          |            |           |
| (A) Real estate.....   | 2b(5)(A) |            |           |
| (B) Other.....   | 2b(5)(B) |            |           |
| (C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....                 | 2b(5)(C) |            |           |

|   |               | (a) Amount | (b) Total |
|---|---------------|------------|-----------|
| (6) Net investment gain (loss) from common/collective trusts .....                              | <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> |            | 1308292   |
| <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>     |            | 57036575  |

**Expenses**

|   |               |          |          |
|---|---------------|----------|----------|
| <b>e</b> Benefit payment and payments to provide benefits:                                  |               |          |          |
| (1) Directly to participants or beneficiaries, including direct rollovers .....             | <b>2e(1)</b>  |          |          |
| (2) To insurance carriers for the provision of benefits .....                               | <b>2e(2)</b>  | 129485   |          |
| (3) Other .....   | <b>2e(3)</b>  | 40786754 |          |
| (4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....                 | <b>2e(4)</b>  |          | 40916239 |
| <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>  | 1281393  |          |
| (2) Contract administrator fees .....   | <b>2i(2)</b>  |          |          |
| (3) Recordkeeping fees .....  | <b>2i(3)</b>  | 116135   |          |
| (4) IQPA audit fees .....   | <b>2i(4)</b>  | 79400    |          |
| (5) Investment advisory and investment management fees .....                                | <b>2i(5)</b>  | 34167    |          |
| (6) Bank or trust company trustee/custodial fees .....                                      | <b>2i(6)</b>  | 4552     |          |
| (7) Actuarial fees .....  | <b>2i(7)</b>  | 66000    |          |
| (8) Legal fees .....  | <b>2i(8)</b>  | 35401    |          |
| (9) Valuation/appraisal fees .....  | <b>2i(9)</b>  |          |          |
| (10) Other trustee fees and expenses .....  | <b>2i(10)</b> |          |          |
| (11) Other expenses .....   | <b>2i(11)</b> | 304626   |          |
| (12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....        | <b>2i(12)</b> |          | 1921674  |
| <b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total ..... | <b>2j</b>     |          | 42837913 |

**Net Income and Reconciliation**

|   |              |  |          |
|---|--------------|--|----------|
| <b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> ..... | <b>2k</b>    |  | 14198662 |
| <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: WITHUMSMITH+BROWN, PC

(2) EIN: 22-2027092

**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.)   |     |    |         |
| <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.  |     |    |         |

**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 \_\_\_\_\_.



**32BJ NORTH HEALTH FUND**  
**Financial Statements**  
**December 31, 2024 and 2023**  
**With Independent Auditor's Reports**

**32BJ North Health Fund**  
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**December 31, 2024 and 2023**

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## INDEPENDENT AUDITOR'S REPORT

To the Trustees and Participants of  
32BJ North Health Fund:

### Report on the Audit of the Financial Statements

#### Opinion

We have audited the financial statements of the 32BJ North Health Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974, which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, information regarding the 32BJ North Health Fund's net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and benefit obligations for the years then ended in accordance with accounting principles generally accepted in the United States of America.

#### Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the 32BJ North Health Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

#### Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the 32BJ North Health Fund'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 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 32BJ North Health Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the 32BJ North Health Fund's ability to continue as a going concern for a reasonable period of time.

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

*Withum Smith + Brown, PC*

July 31, 2025

**32BJ North Health Fund**  
**Statements of Net Assets Available for Benefits**  
**December 31, 2024 and 2023**

|                                       | <u>2024</u>          | <u>2023</u>          |
|---------------------------------------|----------------------|----------------------|
| <b>Assets</b>                         |                      |                      |
| Investments - at fair value           | \$ 61,727,349        | \$ 51,397,193        |
| Cash                                  | <u>5,100,595</u>     | <u>2,706,304</u>     |
| Receivables                           |                      |                      |
| Employers' contributions              | 5,143,054            | 4,611,444            |
| Pharmacy rebate                       | 775,214              | 608,975              |
| Interest and dividends                | 400                  | 58                   |
| Due from affiliates - net             | <u>-</u>             | <u>272,410</u>       |
| Total receivables                     | <u>5,918,668</u>     | <u>5,492,887</u>     |
| Property and equipment - net          | 252,337              | 246,040              |
| Prepaid expenses                      | <u>12,568</u>        | <u>12,567</u>        |
| Total assets                          | <u>73,011,517</u>    | <u>59,854,991</u>    |
| <b>Liabilities</b>                    |                      |                      |
| Accounts payable and accrued expenses | 978,163              | 1,629,535            |
| Due to affiliates - net               | <u>121,536</u>       | <u>-</u>             |
| Total liabilities                     | <u>1,099,699</u>     | <u>1,629,535</u>     |
| Net assets available for benefits     | <u>\$ 71,911,818</u> | <u>\$ 58,225,456</u> |

The Notes to Financial Statements are an integral part of these statements.

**32BJ North Health Fund**  
**Statements of Changes in Net Assets Available for Benefits**  
**Years Ended December 31, 2024 and 2023**

|  | <u>2024</u>          | <u>2023</u>          |
|--|----------------------|----------------------|
| <b>Additions</b>                                   |                      |                      |
| Investment income                                  |                      |                      |
| Net appreciation in fair value of investments      | \$ 1,308,292         | \$ 3,138,444         |
| Interest and dividends                             | <u>2,001,869</u>     | <u>1,522,664</u>     |
|  | 3,310,161            | 4,661,108            |
| Investment expenses                                | <u>(38,719)</u>      | <u>(37,519)</u>      |
| Net investment income                              | <u>3,271,442</u>     | <u>4,623,589</u>     |
| Employers' contributions                           | <u>53,565,128</u>    | <u>49,767,484</u>    |
| Other interest income and liquidated damages       | <u>161,286</u>       | <u>217,380</u>       |
| Total additions                                    | <u>56,997,856</u>    | <u>54,608,453</u>    |
| <b>Deductions</b>                                  |                      |                      |
| Benefits paid                                      | 41,428,539           | 46,204,746           |
| Administrative expenses                            | <u>1,882,955</u>     | <u>1,735,033</u>     |
| Total deductions                                   | <u>43,311,494</u>    | <u>47,939,779</u>    |
| <b>Change in net assets available for benefits</b> | 13,686,362           | 6,668,674            |
| <b>Net assets available for benefits</b>           |                      |                      |
| Beginning of year                                  | <u>58,225,456</u>    | <u>51,556,782</u>    |
| End of year  | <u>\$ 71,911,818</u> | <u>\$ 58,225,456</u> |

The Notes to Financial Statements are an integral part of these statements.

**32BJ North Health Fund**  
**Statements of Benefit Obligations**  
**December 31, 2024 and 2023**

---

|   | <u>2024</u>         | <u>2023</u>         |
|---|---------------------|---------------------|
| Claims payable and claims incurred but not reported | \$ <u>5,141,800</u> | \$ <u>5,654,100</u> |

The Notes to Financial Statements are an integral part of these statements.

**32BJ North Health Fund**  
**Statements of Changes in Benefit Obligations**  
**Years Ended December 31, 2024 and 2023**

---

|  | <u>2024</u>         | <u>2023</u>         |
|--|---------------------|---------------------|
| Claims payable and claims incurred but not reported at beginning of year | \$ 5,654,100        | \$ 5,368,400        |
| Net change in claims payable and claims incurred but not reported        | <u>(512,300)</u>    | <u>285,700</u>      |
| Claims payable and claims incurred but not reported at the end of year   | <u>\$ 5,141,800</u> | <u>\$ 5,654,100</u> |

The Notes to Financial Statements are an integral part of these statements.

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

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**1. PLAN DESCRIPTION AND FUNDING**

The following brief description of the 32BJ North Health Fund (the “Plan”) is provided for general information purposes only. Participants should refer to the Plan’s summary plan description for a complete description of the Plan’s provisions.

**General**

The Plan is a multiemployer, employee welfare benefit plan that was established under the terms of collective bargaining agreements between 32BJ SEIU (the Union”), the Bronx Realty Advisory Board, Inc., the Boiler Service Maintenance, and Repair Association of New York, Inc. and other employer and employer associations. The Plan provides health and other benefits to eligible participants employed in the building service industry who are covered under collective bargaining agreements, or participation agreements covering the participant. The Plan is administered by a Board of Trustees (“Trustees”) with equal representation by the employers and the Union. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”).

**Plan Benefits**

The Plan provides health benefits (i.e., medical, hospital, mental health, substance abuse, prescription drug, dental, and vision), life insurance, accidental death and dismemberment, and short-term disability benefits to participants and their eligible dependents, in accordance with the controlling plan documents. Generally, coverage becomes effective the first day of employments after the completion of 90 consecutive days of covered employment as long as the participant remains in covered employment with the same employer working full time, in accordance with collective agreements or participation agreements.

Participants who lose their health care coverage due to a change in active work status or a reduction in work hours are entitled to continue their coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). COBRA coverage can continue for up to 18, 29, or 36 months depending on the COBRA qualifying event, as defined in the summary plan description, at the participant's expense. Certain participants who became disabled while working in covered employment may continue coverage for up to 30 months, at the Plan’s expense.

**Plan Funding**

The Plan's primary sources of income are earnings from investments and contributions made by contributing employers in accordance with collective bargaining agreements or participation agreements. These agreements provide that the employers contribute to the Plan at a fixed rate on behalf of each covered employee.

**Insured Benefits**

The Plan fully insures the life insurance benefits (basic, supplemental, and dependent) and accidental death and dismemberment benefits (basic, supplemental, and spousal). The Plan purchases annual insurance contracts for these insured benefits. In addition, the Plan purchases stop loss insurance to actively manage catastrophic medical claims.

**Self-Insured Benefits**

All other Plan benefits are self-insured. The claims for self-insured benefits are processed by the Plan’s third-party claims processors under administrative services only arrangements. The claims processors pay claims directly to or on behalf of participants and are then reimbursed by the Plan. Ultimate responsibility for payments to providers and participants is retained by the Plan. The Plan uses a pharmacy benefit manager (“PBM”), which periodically makes refunds to the Plan based on the Plan’s actual utilization pattern of specific drugs.

**32BJ North Health Fund  
Notes to Financial Statements  
December 31, 2024 and 2023**

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**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

The following are significant accounting policies followed by the Plan:

**Basis of Presentation**

The accompanying financial statements have been prepared under the accrual basis of accounting.

**Use of Estimates**

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and claims incurred but not reported ("IBNR"), and disclosure of contingent assets and liabilities at the date of the financial statements and changes therein during the reporting period. Actual results could differ from those estimates.

**Employers' Contributions Receivable**

The Plan reports as employers' contributions receivable any contributions due that relate to work completed on or before December 31. Management of the Plan evaluates participating employers' contributions receivable periodically for potential uncollectible amounts based on the likelihood of collection. As of December 31, 2024 and 2023, there were no allowances for uncollectible amounts established.

**Investment Valuation and Income Recognition**

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. The Trustees determine the Plan's valuation policies utilizing information provided by its investment advisers and custodian. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation in fair value of investments includes the Plan's realized and unrealized gains and losses on investments bought and sold as well as held during the year.

**Property and Equipment**

Property and equipment are capitalized at cost and presented net of accumulated depreciation and amortization. Expenditures for maintenance and repairs are expensed as incurred, while the cost of additions and improvements that extend the life of the asset are capitalized.

Depreciation and amortization are provided on the straight-line method over the estimated useful life of the related assets. The estimated useful life is as follows:

| <u>Description</u>              | <u>Estimated Life (Years)</u> |
|---------------------------------|-------------------------------|
| Computer equipment and software | 10                            |

**Recognition of Benefits**

Benefits are recognized when paid.

**Payment of Benefits**

Premiums paid are recorded as group insurance premiums on the accompanying statements of changes in net assets available for benefits. Premiums not yet paid at year-end are included as an amount currently payable on the accompanying statements of benefit obligations.

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

---

Claim payments are recorded when paid by the third-party claims processor. Amounts due to claims processors that have not been reimbursed by the Plan are included in accounts payable and accrued expenses on the accompanying statements of net assets available for benefits.

**Refunds and Rebates**

Prescription refunds due from the Plan's PBM are recorded when earned. Refunds due at year-end are recorded as a receivable on the statement of net assets available for benefits, with the offset being netted against claims paid. Pharmacy rebates totaled \$2,978,526 and \$2,517,135 for the years ended December 31, 2024 and 2023, respectively, and have been netted against claims paid in the accompanying statement of changes in net assets available for benefits.

**Expenses**

Expenses incurred in connection with the administration of the Plan are recorded as deductions in the accompanying statements of changes in net assets available for benefits. Certain investment-related expenses are included in net appreciation in fair value of investments and are not readily available. Payments to or for participants and group insurance premiums represent amounts paid to or for participants for benefits. Benefits administrative fees and administrative expenses represent costs not directly related to health benefits but are associated with the general operation of the Plan.

**Subsequent Events**

In preparing these financial statements, management of the Plan has evaluated events and transactions that occurred after December 31, 2024 for potential recognition or disclosure in the financial statements. These events and transactions were evaluated through July 31, 2025, the date that the financial statements were available to be issued, and no items have come to the attention of management that require recognition or disclosure.

**3. PLAN'S BENEFIT OBLIGATIONS**

Claims payable represent amounts reported at year-end, which have not yet been paid from the net assets of the Plan. The estimated liability for claims incurred but not reported is based on estimates provided by the Plan's independent consulting actuary, which are determined by applying a combination of lag factors developed from the Plan's actual experience and the standardized industry lag factors to actual claims paid.

**4. RISKS AND UNCERTAINTIES**

Due to various risks (e.g., interest rate, market, credit) associated with certain investments and the level of uncertainty related to changes in the value of investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported on the statements of net assets available for benefits.

Financial instruments that potentially subject the Plan concentrations of credit risk include cash, accounts receivable and investments. While management of the Plan attempt to limit any financial exposure by maintaining accounts at high quality financial institutions, cash and investment balances exceed the federally insured limit of \$250,000 and \$500,000, respectively. Any loss incurred or lack of access to such funds could have a significant adverse impact on the Plan's financial condition results of operations, and cash flows. Credit risk associated with accounts receivable is considered limited due to the large number of employers that make up the receivable balance and historical high collection rate of receivables.

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

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**5. FAIR VALUE MEASUREMENTS**

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

*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 quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, 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.

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

The asset 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 the relevant observable inputs and minimize the use of the unobservable inputs.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the end of the reporting period. During the years ended December 31, 2024 and 2023, there were no transfers in or out of Level 3.

The following is a description of the valuation methodologies used for assets measured at fair value. The valuation methodologies were not changed during the years ended December 31, 2024 and 2023.

*Registered Investment Companies:* Shares in registered investment companies are valued based on closing quoted market prices in active markets in which the securities are traded.

*Short-Term Investments:* Shares in short-term investments are stated at cost, using a constant price (or amortized cost) of \$1 per unit of participation, which approximates fair value.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31:

|                                 | <b>2024</b>          |                 |                |                             |
|---------------------------------|----------------------|-----------------|----------------|-----------------------------|
|                                 | <u>Level 1</u>       | <u>Level 2</u>  | <u>Level 3</u> | <u>Total<br/>Fair Value</u> |
| Registered investment companies | \$ 61,721,341        | \$ -            | \$ -           | \$ 61,721,341               |
| Short-term investments          | -                    | 6,008           | -              | 6,008                       |
| Total investments               | <u>\$ 61,721,341</u> | <u>\$ 6,008</u> | <u>\$ -</u>    | <u>\$ 61,727,349</u>        |

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

|                                 | <b>2023</b>          |                  |                | <b>Total<br/>Fair Value</b> |
|---------------------------------|----------------------|------------------|----------------|-----------------------------|
|                                 | <b>Level 1</b>       | <b>Level 2</b>   | <b>Level 3</b> |                             |
| Registered investment companies | \$ 51,383,167        | \$ -             | \$ -           | \$ 51,383,167               |
| Short-term investments          | -                    | 14,026           | -              | 14,026                      |
| Total investments               | <u>\$ 51,383,167</u> | <u>\$ 14,026</u> | <u>\$ -</u>    | <u>\$ 51,397,193</u>        |

**6. PROPERTY AND EQUIPMENT**

At December 31, property and equipment consisted of the following:

|   | <b>2024</b>       | <b>2023</b>       |
|---|-------------------|-------------------|
| Computer equipment and software           | \$ 1,009,753      | \$ 944,666        |
| Accumulated depreciation and amortization | (757,416)         | (698,626)         |
| Total property and equipment, net         | <u>\$ 252,337</u> | <u>\$ 246,040</u> |

Depreciation and amortization expense for the years ended December 31, 2024 and 2023 totaled \$58,790 and \$83,089, respectively, and is included in administrative expenses on the statements of changes in net assets available for benefits.

**7. RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS**

The Plan shares office space, payroll, certain computer equipment and software, and certain administrative expenses with affiliated funds. Shared expenses are allocated in proportion to the benefit derived by each entity based on an analysis of the related expenses. The Plan's share of these expenses, which are included in administrative expenses on statements of changes in net assets available for benefits, totaled \$1,596,732 and \$1,438,292 for the years ended December 31, 2024 and 2023, respectively.

At December 31, the Plan had the following amounts due from and due to affiliated entities:

|                                    | <b>2024</b>         | <b>2023</b>       |
|------------------------------------|---------------------|-------------------|
| Due from affiliates                |                     |                   |
| Building Service 32BJ Health Fund  | \$ -                | \$ 333,638        |
| 32BJ North Legal                   | -                   | 3,898             |
| Total due from affiliates          | <u>-</u>            | <u>337,536</u>    |
| Due to affiliates                  |                     |                   |
| Building Service 32BJ Health Fund  | 38,125              | -                 |
| Building Service 32BJ Pension Fund | 345                 | -                 |
| 32BJ North Pension Fund            | 83,066              | 65,126            |
|                                    | <u>121,536</u>      | <u>65,126</u>     |
| Due from (to) affiliates - net     | <u>\$ (121,536)</u> | <u>\$ 272,410</u> |

Amounts due to affiliates are noninterest bearing and due on demand.

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

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The Plan holds investments managed by BNY Mellon, the Plan’s custodian. These transactions qualify as party-in-interest transactions; however, they are exempt from the prohibited transactions rules under ERISA and the Internal Revenue Code (“IRC”).

**8. TAX STATUS**

The Internal Revenue Service (the “IRS”) recognized the Plan as exempt from federal income taxation under Section 501(a) of the IRC, as described at Section 501(c)(9), as stated in its latest determination letter dated February 4, 2005. 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’s administrator believes that the Plan currently is designed and being operated in compliance with the applicable requirements of the IRC.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken and recognize an income tax liability if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. Management has evaluated the tax positions taken by the Plan and concluded that as of December 31, 2024 and 2023 there are no uncertain positions taken or expected to be taken that would require recognition in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits in progress for any tax periods. In addition, there have been no tax-related interest or penalties for the periods presented in these financial statements.

**9. PLAN TERMINATION**

It is the intent of the Trustees to continue the Plan in full force and effect. However, the Plan may be terminated in the manner prescribed by the governing documents in accordance with applicable law. In the event that the Plan terminates, the net assets of the Plan will be used for the payment of benefits and administrative expenses as prescribed by ERISA and its related regulations and will not revert to any employer, the Union or any other union under any condition.

The Trustees have the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules, including the rules for extended or continuing eligibility.

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

The following is a reconciliation of net assets available for benefits per the financial statements at December 31 to Form 5500:

|  | <u>2024</u>          | <u>2023</u>          |
|--|----------------------|----------------------|
| Net assets available for benefits per the financial statements | \$ 71,911,818        | \$ 58,225,456        |
| Claims payable and claims incurred but not reported            | <u>(5,141,800)</u>   | <u>(5,654,100)</u>   |
| Net assets available for benefits per Form 5500                | <u>\$ 66,770,018</u> | <u>\$ 52,571,356</u> |

**32BJ North Health Fund**  
**Notes to Financial Statements**  
**December 31, 2024 and 2023**

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

|  |                      |
|--|----------------------|
| Total cost of benefits paid per the financial statements | \$ 41,428,539        |
| Claims payable and claims incurred but not reported:     |                      |
| End of year  | 5,141,800            |
| Beginning of year  | <u>(5,654,100)</u>   |
| Total cost of benefits paid per Form 5500                | <u>\$ 40,916,239</u> |

## **SUPPLEMENTARY INFORMATION**

**REPORT ON SUPPLEMENTARY INFORMATION REQUIRED BY THE DEPARTMENT OF  
LABOR'S RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE UNDER THE  
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

**INDEPENDENT AUDITOR'S REPORT**

To the Trustees and Participants of  
32BJ North Health Fund:

We have audited the financial statements of 32BJ North Health Fund as of and for the years ended December 31, 2024 and 2023, and have issued our report thereon dated July 31, 2025, which contained an unmodified opinion on the financial statements.

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying supplemental schedule H, line 4i - schedule of assets (held at end of year) as of December 31, 2024 and schedule H, line 4j - schedule of reportable transactions for the year ended December 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("ERISA"). Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America.

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.

*Withum Smith+Brown, PC*

July 31, 2025

**32BJ North Health Fund**  
**Schedule H, Line 4i - Schedule of Assets (Held at End of Year)**  
**EIN# 13-1699839, Plan# 501**  
**December 31, 2024**

| (a) | (b) Identity of Issue, Borrower,<br>or Similar Party | (c) Description of Investment Including Maturity Date,<br>Rate of Interest, Collateral, Par, or Maturity Value |            |                     |                  | (d) Cost  | (e) Current<br>Value |                       |
|-----|--|--|------------|---------------------|------------------|-----------|----------------------|-----------------------|
|     |  | Description  | Collateral | Rate of<br>Interest | Maturity<br>Date |           |                      | Par/Maturity<br>Value |
|     | <b><u>Interest-Bearing Cash</u></b>                  |  |            |                     |                  |           |                      |                       |
| *   | DREYFUS TRE PR CSH MGT INV 674                       | Cash   | N/A        | N/A                 | N/A              | 6,008     | \$ 6,008             | \$ 6,008              |
|     | <b><u>Registered Investment Companies</u></b>        |  |            |                     |                  |           |                      |                       |
|     | T ROWE PR INST HI YLD-INST                           | Registered Investment Company  | N/A        | N/A                 | N/A              | 299,451   | 2,533,434            | 2,344,703             |
|     | VANGUARD S/T BND INDX-INST                           | Registered Investment Company  | N/A        | N/A                 | N/A              | 1,302,821 | 13,566,174           | 13,197,579            |
|     | VANGUARD S/T INFL PROT-INST                          | Registered Investment Company  | N/A        | N/A                 | N/A              | 310,278   | 7,879,893            | 7,539,744             |
|     | VANGUARD TOT INT ST IDX-ADM                          | Registered Investment Company  | N/A        | N/A                 | N/A              | 2,593,075 | 26,710,839           | 24,582,348            |
|     | VANGUARD TTL BD MKT IDX-INST                         | Registered Investment Company  | N/A        | N/A                 | N/A              | 145,022   | 4,449,084            | 4,595,761             |
|     | VANGUARD TTL STK MKT-INST                            | Registered Investment Company  | N/A        | N/A                 | N/A              | 67,077    | 5,135,938            | 9,461,206             |
|     |  |  |            |                     |                  |           | <u>60,275,362</u>    | <u>61,721,341</u>     |
|     |  |  |            |                     |                  |           | <u>\$ 60,281,370</u> | <u>\$ 61,727,349</u>  |

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

See Independent Auditor's Report on Supplementary Information Required by the Department of Labor's Rules and Regulations for Reporting and Disclosure Under the Employee Retirement Income Security Act of 1974.

**32BJ North Health Fund**  
**Schedule H, Line 4j - Schedule of Reportable Transactions**  
**EIN# 13-1699839, Plan# 501**  
**Year Ended December 31, 2024**

| (a) | (b) Identity<br>of Party<br>Involved   | (c) Description of Asset<br>(Include Interest Rate and<br>Maturity in Case of a Loan) | (d)<br>Purchase<br>Price | (e)<br>Selling<br>Price | (f)<br>Lease<br>Rental | (g) Expense<br>Incurred with<br>Transaction | (h)<br>Cost of<br>Asset | (i) Current Value<br>of Asset on<br>Transaction Date | (j)<br>Net Gain<br>or (Loss) |
|-----|--|---|--------------------------|-------------------------|------------------------|---|-------------------------|--|------------------------------|
|     | <i>Single reportable security transactions exceeding 5% of Plan assets:</i>    |   |                          |                         |                        |   |                         |  |                              |
|     | None noted   |   |                          |                         |                        |   |                         |  |                              |
|     | <i>Series of reportable security transactions exceeding 5% of Plan assets:</i> |   |                          |                         |                        |   |                         |  |                              |
| *   | BANK OF NEW YORK MELLON  | DREYFUS TRE PR CSH MGT INV 674  | 16,842,828               | N/A                     | N/A                    | N/A   | 16,842,828              | 16,842,828   | N/A                          |
| *   | BANK OF NEW YORK MELLON  | DREYFUS TRE PR CSH MGT INV 674  | N/A                      | 16,850,846              | N/A                    | N/A   | 16,850,846              | 16,850,846   | -                            |
|     | BANK OF NEW YORK MELLON  | BNY MELLON CASH RESERVE   | 7,750,000                | N/A                     | N/A                    | N/A   | 7,750,000               | 7,750,000  | N/A                          |
|     | BANK OF NEW YORK MELLON  | BNY MELLON CASH RESERVE   | N/A                      | 7,750,000               | N/A                    | N/A   | 7,750,000               | 7,750,000  | N/A                          |
|     | VANGUARD   | VANGUARD TTL BD MKT IDX-INST  | 5,039,165                | N/A                     | N/A                    | N/A   | 5,039,165               | 5,039,165  | N/A                          |

\* Represents a party-in-interest to the Plan

See Independent Auditor's Report on Supplementary Information Required by the Department of Labor's Rules and Regulations for Reporting and Disclosure Under the Employee Retirement Income Security Act of 1974.

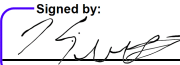
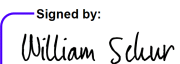
|   |   |  |
|---|---|--|
| <p><b>Form 5500</b></p> <p>Department of the Treasury<br/>Internal Revenue Service</p> <hr/> <p>Department of Labor<br/>Employee Benefits Security<br/>Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p> | <p><b>Annual Return/Report of Employee Benefit Plan</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<br/>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> |
|---|---|--|

|   |  |
|---|--|
| <b>Part I</b>   | <b>Annual Report Identification Information</b>  |
| For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024                |  |
| <b>A</b> This return/report is for:   | <input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)<br><input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) ____ |
| <b>B</b> This return/report is:   | <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report<br><input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)  |
| <b>C</b> If the plan is a collectively-bargained plan, check here. . . . .                                | <input checked="" type="checkbox"/>  |
| <b>D</b> Check box if filing under:   | <input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program<br><input type="checkbox"/> special extension (enter description)   |
| <b>E</b> If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . | <input type="checkbox"/>   |

|  |  |  |     |   |  |  |  |
|--|--|--|-----|---|--|--|--|
| <b>Part II</b>   | <b>Basic Plan Information—enter all requested information</b>  |  |     |   |  |  |  |
| <b>1a</b> Name of plan<br>32BJ North Health Fund   | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>1b</b> Three-digit plan number (PN) ▶</td> <td style="width:20%; text-align: center;">501</td> </tr> <tr> <td><b>1c</b> Effective date of plan<br/>06/01/1948</td> <td></td> </tr> </table>   | <b>1b</b> Three-digit plan number (PN) ▶                     | 501 | <b>1c</b> Effective date of plan<br>06/01/1948              |  |  |  |
| <b>1b</b> Three-digit plan number (PN) ▶   | 501  |  |     |   |  |  |  |
| <b>1c</b> Effective date of plan<br>06/01/1948   |  |  |     |   |  |  |  |
| <b>2a</b> Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>Board of Trustees, 32BJ North Health Fund<br><br>25 West 18th Street<br><br>New York NY 10011 | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:80%;"><b>2b</b> Employer Identification Number (EIN)<br/>13-1699839</td> <td></td> </tr> <tr> <td><b>2c</b> Plan Sponsor's telephone number<br/>(212) 539-2778</td> <td></td> </tr> <tr> <td><b>2d</b> Business code (see instructions)<br/>561790</td> <td></td> </tr> </table> | <b>2b</b> Employer Identification Number (EIN)<br>13-1699839 |     | <b>2c</b> Plan Sponsor's telephone number<br>(212) 539-2778 |  | <b>2d</b> Business code (see instructions)<br>561790 |  |
| <b>2b</b> Employer Identification Number (EIN)<br>13-1699839   |  |  |     |   |  |  |  |
| <b>2c</b> Plan Sponsor's telephone number<br>(212) 539-2778  |  |  |     |   |  |  |  |
| <b>2d</b> Business code (see instructions)<br>561790   |  |  |     |   |  |  |  |

**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> | <p>Signed by:</p>  <p>5875DA86415848D</p> <p><b>Signature of plan administrator</b></p>    | Date | Kevin Starvis<br>Enter name of individual signing as plan administrator       |
| <b>SIGN HERE</b> | <p>Signed by:</p>  <p>6C82F35C45C84CF</p> <p><b>Signature of employer/plan sponsor</b></p> | Date | William Schur<br>Enter name of individual signing as employer or plan sponsor |
| <b>SIGN HERE</b> | <p><b>Signature of DFE</b></p>  | Date | Enter name of individual signing as DFE                                       |

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

|  |  |       |
|--|--|-------|
| <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:<br><b>a</b> Sponsor's name<br><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>                                   | 2,620 |
| <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> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits .....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> . .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> . .....<br><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) .....<br><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) .....<br><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>                               | 2,589 |
|  | <b>6a(2)</b>                               | 2,718 |
|  | <b>6b</b>                                  | 26    |
|  | <b>6c</b>                                  |       |
|  | <b>6d</b>                                  | 2,744 |
|  | <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>                                   | 661   |

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

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

|   |   |
|---|---|
| <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>1</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.

---

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

---

**32BJ North Health Fund**

**EIN 13-1699839**

**Plan No. 501**

**Plan Year Ended December 31, 2024**

**Form 5500, Schedule H, Part III**

**Financial Statements used to formulate IQPA's opinion**

**The entire report has been attached to the Accountant's Opinion**

**32BJ North Health Fund**

**EIN 13-1699839**

**Plan No. 501**

**Plan Year Ended December 31, 2024**

**Form 5500, Schedule H, Part IV, Line 4i  
Schedule of Assets (Held at End of Year)**

**See attachment to the Accountant's Audit Report attached at Accountant's Opinion**

**32BJ North Health Fund**

**EIN 13-1699839**

**Plan No. 501**

**Plan Year Ended December 31, 2024**

**Form 5500, Schedule H, Part IV, Line 4j  
Schedule of Reportable Transactions**

**See attachment to the Accountant's Audit Report attached at Accountant's Opinion**