

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110  
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A This return/report is for: [ ] a multiemployer plan [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [ ] a single-employer plan [X] a DFE (specify) G
B This return/report is: [ ] the first return/report [ ] the final return/report [ ] an amended return/report [ ] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. [ ]
D Check box if filing under: [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: OPEN HEALTH TRUST
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/2015
2a Plan sponsor's name (employer, if for a single-employer plan): OPEN HEALTH TRUST
2b Employer Identification Number (EIN): 47-6663415
2c Plan Sponsor's telephone number: 818-848-6022
2d Business code (see instructions):

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: Filed with authorized/valid electronic signature, Signature of plan administrator, Signature of employer/plan sponsor, and Signature of DFE.

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

Form 5500 (2024) v. 240311

<p><b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p><b>CAST &amp; CREW BENEFIT SERVICES, LLC</b></p> <p>2300 EMPIRE AVENUE, 5TH FLOOR BURBANK, CA 91504</p>	<p><b>3b</b> Administrator's EIN <b>35-2517115</b></p> <p><b>3c</b> Administrator's telephone number <b>818-848-6022</b></p>																				
<p><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:</p> <p><b>a</b> Sponsor's name</p> <p><b>c</b> Plan Name</p>	<p><b>4b</b> EIN</p> <p><b>4d</b> PN</p>																				
<p><b>5</b> Total number of participants at the beginning of the plan year</p>	<p><b>5</b> 1267</p>																				
<p><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>).</p> <p><b>a(1)</b> Total number of active participants at the beginning of the plan year .....</p> <p><b>a(2)</b> Total number of active participants at the end of the plan year .....</p> <p><b>b</b> Retired or separated participants receiving benefits.....</p> <p><b>c</b> Other retired or separated participants entitled to future benefits .....</p> <p><b>d</b> Subtotal. Add lines <b>6a(2)</b>, <b>6b</b>, and <b>6c</b>.....</p> <p><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....</p> <p><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....</p> <p><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) .....</p> <p><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) .....</p> <p><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><b>6a(1)</b></td><td style="text-align: right;">1170</td></tr> <tr><td><b>6a(2)</b></td><td style="text-align: right;">932</td></tr> <tr><td><b>6b</b></td><td style="text-align: right;">76</td></tr> <tr><td><b>6c</b></td><td style="text-align: right;">0</td></tr> <tr><td><b>6d</b></td><td style="text-align: right;">1008</td></tr> <tr><td><b>6e</b></td><td></td></tr> <tr><td><b>6f</b></td><td></td></tr> <tr><td><b>6g(1)</b></td><td></td></tr> <tr><td><b>6g(2)</b></td><td></td></tr> <tr><td><b>6h</b></td><td></td></tr> </table>	<b>6a(1)</b>	1170	<b>6a(2)</b>	932	<b>6b</b>	76	<b>6c</b>	0	<b>6d</b>	1008	<b>6e</b>		<b>6f</b>		<b>6g(1)</b>		<b>6g(2)</b>		<b>6h</b>	
<b>6a(1)</b>	1170																				
<b>6a(2)</b>	932																				
<b>6b</b>	76																				
<b>6c</b>	0																				
<b>6d</b>	1008																				
<b>6e</b>																					
<b>6f</b>																					
<b>6g(1)</b>																					
<b>6g(2)</b>																					
<b>6h</b>																					
<p><b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....</p>	<p><b>7</b></p>																				

**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

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

<p><b>a Pension Schedules</b></p> <p>(1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p> <p>(4) <input type="checkbox"/> <b>DCG</b> (Individual Plan Information) – Number Attached _____</p> <p>(5) <input type="checkbox"/> <b>MEP</b> (Multiple-Employer Retirement Plan Information)</p>	<p><b>b General Schedules</b></p> <p>(1) <input checked="" type="checkbox"/> <b>H</b> (Financial Information)</p> <p>(2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan)</p> <p>(3) <input checked="" type="checkbox"/> <b>A</b> (Insurance Information) – Number Attached <u>  2  </u></p> <p>(4) <input checked="" type="checkbox"/> <b>C</b> (Service Provider Information)</p> <p>(5) <input checked="" type="checkbox"/> <b>D</b> (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)</p>
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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 163156551

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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 <b>OPEN HEALTH TRUST</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>OPEN HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>47-6663415</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  
**STANDARD 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>35-0980405</b>	<b>61069</b>	<b>279238</b>	<b>1113</b>	<b>04/01/2024</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>4083</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

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

**JOSEPH E HENEHAN FIN AND INSUR SVCS** **685 EAST CARNEGIE #205**  
**SAN BERNARDINO, CA 92408**

<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	
<b>4083</b>			<b>3</b>

**(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
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	(c) Amount	(d) Purpose	

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

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

**Part II Investment and Annuity Contract Information**  
 Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

**6** Contracts With Allocated Funds:

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

**b** Premiums paid to carrier ..... **6b**

**c** Premiums due but unpaid at the end of the year ..... **6c**

**d** If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... **6d**  
 Specify nature of costs ▶

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

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

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

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

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>			
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>			
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>			
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>		0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>			
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>			
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>		0
	(4) Claims charged .....		<b>9b(4)</b>		
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --				
	(A) Commissions .....	<b>9c(1)(A)</b>			
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>			
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>			
	(D) Other expenses .....	<b>9c(1)(D)</b>			
	(E) Taxes .....	<b>9c(1)(E)</b>			
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>			
	(G) Other retention charges .....	<b>9c(1)(G)</b>			
	(H) Total retention .....		<b>9c(1)(H)</b>		0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>		
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>		
	(2) Claim reserves .....		<b>9d(2)</b>		
	(3) Other reserves .....		<b>9d(3)</b>		
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>			54786
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>			

Specify nature of costs.

**Part IV Provision of Information**

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

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

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

<p><b>A</b> Name of plan <b>OPEN HEALTH TRUST</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>OPEN HEALTH TRUST</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>47-6663415</b></p>	

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

**1 Coverage Information:**

(a) Name of insurance carrier  
**ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
95-4331852	62825	279238	932	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid <b>289050</b></p>	<p>(b) Total amount of fees paid <b>0</b></p>
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**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
**JOSEPH E HENEHAN FIN AND INSUR SVCS**      **685 EAST CARNEGIE #205**  
**SAN BERNARDINO, CA 92408**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
289050			3

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		5616940
<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> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

<b>A</b> Name of plan <b>OPEN HEALTH TRUST</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>OPEN HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>47-6663415</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

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

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

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

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

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

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

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

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

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

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

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

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

RSM US LLP

42-0714325

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	48203	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)

BANK OF AMERICA, N. A.

PO BOX 15284  
WILMINGTON, DE 19850

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
18 50	NONE	23668	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

**Part I Service Provider Information (continued)**

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

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

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

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

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

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

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

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

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

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

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

<b>a</b> Name: RSM US LLP	<b>b</b> EIN: 42-0714325
<b>c</b> Position: AUDITOR	
<b>d</b> Address: 515 SOUTH FLOWER STREET 17TH FLOOR LOS ANGELES, CA 90071	<b>e</b> Telephone: 213-330-4800

Explanation: BUSINESS DECISION

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

<b>A</b> Name of plan <u>OPEN HEALTH TRUST</u>	<b>B</b> Three-digit plan number (PN)	<u>501</u>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>OPEN HEALTH TRUST</u>	<b>D</b> Employer Identification Number (EIN) <u>47-6663415</u>	

<b>Part I</b>	<b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b> (Complete as many entries as needed to report all interests in DFEs)
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<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE:		
<b>b</b> Name of sponsor of entity listed in (a):		
<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)



<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	ADIRONDACK SCENIC, INC.	<b>c</b> EIN-PN 14-1566132-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	ANDERSON PROJECTS LLC	<b>c</b> EIN-PN 83-1822396-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	ARK TV PRODUCTIONS INC	<b>c</b> EIN-PN 87-4316636-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE ACE, INC	<b>c</b> EIN-PN 92-2968949-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE ASTRO, INC	<b>c</b> EIN-PN 92-2909912-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE CLEMENTINE, INC	<b>c</b> EIN-PN 92-2267749-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE DAWN, INC.	<b>c</b> EIN-PN 92-3964440-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE ECHO, INC	<b>c</b> EIN-PN 93-4033380-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE EQUATOR, INC	<b>c</b> EIN-PN 33-2469323-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE GATEWAY, INC.	<b>c</b> EIN-PN 93-2987994-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE GEMINI, INC	<b>c</b> EIN-PN 88-4424494-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE GRACE, INC	<b>c</b> EIN-PN 93-4020314-501

<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE HELIOS, INC	<b>c</b> EIN-PN 99-1930416-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE HERMES, INC	<b>c</b> EIN-PN 99-1709232-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE HONDO INC	<b>c</b> EIN-PN 87-3531035-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE HORIZON, INC	<b>c</b> EIN-PN 99-0903378-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE LEGENDS, INC	<b>c</b> EIN-PN 99-0509742-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE LUNA, INC	<b>c</b> EIN-PN 99-0542126-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE MARINER, INC	<b>c</b> EIN-PN 99-1967410-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE MERCURY, INC	<b>c</b> EIN-PN 88-4400369-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE MUSE, INC.	<b>c</b> EIN-PN 99-0541924-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE OMEGA, INC	<b>c</b> EIN-PN 92-1224064-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE PICTURES, INC.	<b>c</b> EIN-PN 20-8375195-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	BIG INDIE QUEST, INC	<b>c</b> EIN-PN 99-3766228-501

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE ROMAN HOLIDAY, INC	<b>c</b> EIN-PN 88-2479870-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE SIGMA, INC	<b>c</b> EIN-PN 92-0818078-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE SMITH, INC	<b>c</b> EIN-PN 85-4062116-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE SPIRIT, INC.	<b>c</b> EIN-PN 99-2306051-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE STARDUST, INC	<b>c</b> EIN-PN 99-2516709-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE VIKING, INC	<b>c</b> EIN-PN 99-4513307-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE VIPER, INC	<b>c</b> EIN-PN 99-2332098-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE VOYAGER, INC	<b>c</b> EIN-PN 99-0869377-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BIG INDIE WYTCHEs INC	<b>c</b> EIN-PN 87-3756943-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	BROADSIDE PRODUCTIONS, INC	<b>c</b> EIN-PN 92-3517343-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	CAMP BLOOD LLC	<b>c</b> EIN-PN 92-1778311-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	CATS CRADLE PRODUCTIONS, INC	<b>c</b> EIN-PN 92-2235526-501

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	CIRCUS DOG PRODUCTIONS, INC.	<b>c</b>	EIN-PN 95-4614004-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	CROOKED STUDIOS, LLC	<b>c</b>	EIN-PN 88-2118956-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	CROWN LEO PRODUCTIONS LLC	<b>c</b>	EIN-PN 88-4204895-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	CURB YOUR ENTHUSIASM, INC.	<b>c</b>	EIN-PN 95-4780451-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	DAISY BELLE PRODUCTIONS LLC	<b>c</b>	EIN-PN 93-1385112-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	DAY PUPPY INC	<b>c</b>	EIN-PN 88-3663033-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	DE-EVOLUTION2020 LLC	<b>c</b>	EIN-PN 87-3996062-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	DINO BONES PRODUCTIONS INC	<b>c</b>	EIN-PN 46-3682143-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	DOPAMINE SPARKLE LLC	<b>c</b>	EIN-PN 93-3706957-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	EGN S1 PRODUCTIONS, LLC	<b>c</b>	EIN-PN 93-3939501-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	EHM PRODUCTIONS	<b>c</b>	EIN-PN 71-0863910-501
<b>a</b>	Plan name	OPEN HEALTH TRUST		
<b>b</b>	Name of plan sponsor	ELECTRIC EFFECTS, INC.	<b>c</b>	EIN-PN 20-3715821-501

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	EMPIRE 3401, LLC	<b>c</b> EIN-PN 93-4272704-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	EMPIRE LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 99-1256953-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	EX LIBRIS PRODUCTIONS, INC.	<b>c</b> EIN-PN 61-1709460-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	EYE ON THE BALL ENTERPRISES, INC.	<b>c</b> EIN-PN 82-4202400-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FINDING LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 92-3009642-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FOX ALTERNATIVE ENTERTAINMENT, LLC	<b>c</b> EIN-PN 32-0596379-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FOX CORPORATION	<b>c</b> EIN-PN 83-1825597-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FOX SQUARE PRODUCTIONS	<b>c</b> EIN-PN 95-4065424-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FRIENDSHIP PRODUCTIONS INC.	<b>c</b> EIN-PN 93-3793094-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	FUN LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 86-3211033-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	G-NET MEDIA INC.	<b>c</b> EIN-PN 20-8007212-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	GOLDEN LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 93-2317113-501

<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	GSR-US PRODUCTIONS, LLC	<b>c</b> EIN-PN 30-1200322-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	HAIL LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 92-0777134-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	HALF-LIFE PRODUCTIONS, INC.	<b>c</b> EIN-PN 46-3682923-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	HEADSPACE, INC.	<b>c</b> EIN-PN 46-1777570-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	HERMANOS PRODUCTIONS, LLC	<b>c</b> EIN-PN 99-1873416-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	HOT COSTS LLC	<b>c</b> EIN-PN 83-1161530-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	JAMES THOMAS PRODS EVENTS & ENT, INC.	<b>c</b> EIN-PN 27-2305793-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	JAMES THOMAS PRODUCTIONS LLC	<b>c</b> EIN-PN 93-2917778-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	JELLYBEAN GHOST LLC	<b>c</b> EIN-PN 99-2001686-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	JOE CROSS FOR MAYOR LLC	<b>c</b> EIN-PN 93-3339201-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	LEVERAGE 2.0 TELEVISION PRODUCTIONS, INC	<b>c</b> EIN-PN 84-4300955-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	LIBERTY LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 93-3492564-501

**Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)**

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	LINCOLNWOOD DRIVE, LLC	<b>c</b> EIN-PN 46-3690507-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	LITTLE INDIE DEVELOPMENT, LLC	<b>c</b> EIN-PN 82-4245789-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	MAD LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 92-0792123-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	METRO-GOLDWYN-MAYER PICTURES INC.	<b>c</b> EIN-PN 95-4158381-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	METRO-GOLDWYN-MAYER STUDIOS INC.	<b>c</b> EIN-PN 95-4452285-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	MGM TELEVISION ENTERTAINMENT INC.	<b>c</b> EIN-PN 95-4495886-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	MONOCEROS MEDIA LLC	<b>c</b> EIN-PN 92-1734472-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	NEOASIA PRODUCTIONS INC.	<b>c</b> EIN-PN 84-2666864-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	NIGHTSHADE & RAVEN S2 PRODUCTIONS LLC	<b>c</b> EIN-PN 92-1879228-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	NINE PERFECT STRANGERS, LLC	<b>c</b> EIN-PN 84-1800500-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	OTTER CREEK PRODUCTIONS, LLC	<b>c</b> EIN-PN 84-3034237-501
<b>a</b> Plan name	OPEN HEALTH TRUST	
<b>b</b> Name of plan sponsor	PICROW STREAMING INC.	<b>c</b> EIN-PN 47-3867945-501

<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	PK PRODS., INC	<b>c</b> EIN-PN 92-1073811-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	POCKETACTION, LLC	<b>c</b> EIN-PN 84-2790114-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	POCKETTOONS, LLC	<b>c</b> EIN-PN 84-2057306-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	POCKETWATCH, INC	<b>c</b> EIN-PN 81-4115648-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	PRESIDENT CURTIS, INC	<b>c</b> EIN-PN 99-2291969-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	PROJECT G PRODUCTIONS, LLC	<b>c</b> EIN-PN 86-3487801-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	QUEENS LLC	<b>c</b> EIN-PN 82-2596201-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	RHD PRODUCTIONS LLC	<b>c</b> EIN-PN 88-2208690-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	RICK AND MORTY LLC	<b>c</b> EIN-PN 46-5288046-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	ROCART, INC.	<b>c</b> EIN-PN 95-4570753-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	ROYALTYHL5 LLC	<b>c</b> EIN-PN 93-2931174-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SESAME SEASON 54 PRODUCTIONS, INC.	<b>c</b> EIN-PN 88-0729335-501

<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SESAME SEASON 55 PRODUCTIONS INC	<b>c</b> EIN-PN 92-1734969-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SESAME SEASON 56 PRODUCTIONS INC	<b>c</b> EIN-PN 99-1477442-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SESAME WORKSHOP	<b>c</b> EIN-PN 13-2655731-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SHUTTERSTOCK STUDIOS, LLC	<b>c</b> EIN-PN 87-1840435-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SPEED BUMP LLC	<b>c</b> EIN-PN 99-4950700-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SPHERE ENTERTAINMENT GROUP, LLC.	<b>c</b> EIN-PN 36-4811028-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	SWEET STUFF 1 LLC	<b>c</b> EIN-PN 92-0290249-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	TCF US PRODUCTIONS 27, INC.	<b>c</b> EIN-PN 46-2311616-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	TESTA S1 PRODUCTIONS, LLC	<b>c</b> EIN-PN 95-4495886-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	THE TENNIS CHANNEL, LLC	<b>c</b> EIN-PN 95-4862326-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	THT S6 PRODUCTIONS LLC	<b>c</b> EIN-PN 92-0265834-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	TIMEPIECE PRODUCTIONS, LLC	<b>c</b> EIN-PN 27-2947603-501

<b>Part II</b>		<b>Information on Participating Plans (to be completed by DFEs, other than DCGs)</b>	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	TOEI DOGA ENTERTAINMENT LLC	<b>c</b> EIN-PN 61-1805670-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	TRUTH BE TOLD LLC	<b>c</b> EIN-PN 80-0967078-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	UNTYPICAL CONTENT DEVELOPMENT LLC	<b>c</b> EIN-PN 06-1562658-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	VICE MEDIA, LLC	<b>c</b> EIN-PN 83-0705661-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	VMP BIRDIE LLC	<b>c</b> EIN-PN 87-3373671-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	VMP BOOTY, LLC	<b>c</b> EIN-PN 87-2272889-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	VOX MEDIA PRODUCTIONS II, LLC	<b>c</b> EIN-PN 38-4008033-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	WILD LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 99-1333397-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	WOZ 1060, LLC	<b>c</b> EIN-PN 93-4854592-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	WRECKING LEO PRODUCTIONS LLC	<b>c</b> EIN-PN 92-2554273-501
<b>a</b>	Plan name	OPEN HEALTH TRUST	
<b>b</b>	Name of plan sponsor	WURST CASE SCENARIO, LLC	<b>c</b> EIN-PN 85-4307765-501
<b>a</b>	Plan name		
<b>b</b>	Name of plan sponsor		<b>c</b> EIN-PN

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>► File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>OPEN HEALTH TRUST</b>	<b>B</b> Three-digit plan number (PN) <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>OPEN HEALTH TRUST</b>	<b>D</b> Employer Identification Number (EIN) <b>47-6663415</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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**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>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>	7563731	0
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>		
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>		
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	0	9115185
<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>		
<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>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>		
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	7563731	9115185
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>		
<b>h</b> Operating payables.....	<b>1h</b>		
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>		
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	0	0
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	7563731	9115185

**Part II Income and Expense Statement**

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

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	5732255	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	1182834	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		6915089
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	263115	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>		
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		263115
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>		
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>		
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		0
(3) Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>		
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>		
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>		
<b>(B)</b> Other.....	<b>2b(5)(B)</b>		
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	<b>2b(6)</b>		
(7) Net investment gain (loss) from pooled separate accounts .....	<b>2b(7)</b>		
(8) Net investment gain (loss) from master trust investment accounts .....	<b>2b(8)</b>		
(9) Net investment gain (loss) from 103-12 investment entities .....	<b>2b(9)</b>		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds) .....	<b>2b(10)</b>		
<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>		7178204

**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>	5554879	
(3) Other.....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		5554879
<b>f</b> Corrective distributions (see instructions) .....	<b>2f</b>		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	<b>2g</b>		
<b>h</b> Interest expense.....	<b>2h</b>		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	<b>2i(1)</b>		
(2) Contract administrator fees .....	<b>2i(2)</b>		
(3) Recordkeeping fees .....	<b>2i(3)</b>		
(4) IQPA audit fees .....	<b>2i(4)</b>	48203	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>		
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	23668	
(7) Actuarial fees .....	<b>2i(7)</b>		
(8) Legal fees .....	<b>2i(8)</b>		
(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>		
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		71871
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	<b>2j</b>		5626750

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		1551454
<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: GRANT THORNTON LLP

(2) EIN: 36-6055558

**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.)			
<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?			
<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?			
<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?			
<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?			
<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?			
<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 \_\_\_\_\_.

# Open Health Trust

Financial Report  
December 31, 2024

## Contents

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<u>Schedule H, line 4i - schedule of assets (held at end of year)</u>	<u>11</u>

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**GRANT THORNTON LLP**

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Bellevue, WA 98004

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**REPORT OF INDEPENDENT CERTIFIED PUBLIC ACCOUNTANTS**

Plan Administrator and Plan Participants  
Open Health Trust

**Opinion**

We have audited the financial statements of Open Health Trust (the “Plan”), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statement of net assets – cash basis as of December 31, 2024, and the related statement of changes in net assets – cash basis for the year then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets – cash basis of the Plan as of December 31, 2024, and the changes in its net assets – cash basis for the year then, in accordance with the cash basis of accounting described in Note 2.

**Basis for opinion**

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

**Emphasis of matter – basis of accounting**

We draw attention to Note 2 of the financial statements, which describes the basis of accounting. The financial statements are prepared on the cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

**Responsibilities of management for the financial statements**

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the cash basis of accounting described in Note 2, and for determining that the cash basis of accounting is an acceptable basis for the preparation of the financial statements in the circumstances. Management is also responsible 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.

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 US 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 US GAAS, we:

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

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

**Supplemental schedule required by ERISA**

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of assets (held at end of year) as of December 31, 2024 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used

to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures. These additional procedures included 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 US GAAS.

In forming our opinion on the supplemental schedule, we evaluated whether the supplemental schedule, including its form and content, is 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 supplemental schedule 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.

**Other matter – auditor's report on the 2023 financial statements**

The Plan's statement of net assets – cash basis as of December 31, 2023 and the related statement of changes in net assets – cash basis for the year ended December 31, 2023 (not presented herein), were audited by other auditors. Those auditors expressed an unmodified opinion on those 2023 financial statements in their report dated September 27, 2024.

*Grant Thornton LLP*

Bellevue, Washington  
September 8, 2025

Open Health Trust

Statement of Net Assets Available for Benefits - Cash Basis  
December 31, 2024 and 2023

	2024	2023
<hr/>		
<b>Assets</b>		
<b>Cash</b>		
Noninterest-bearing	\$ -	\$ 7,563,731
Interest-bearing	9,115,185	-
<b>Total assets</b>	<u>9,115,185</u>	<u>7,563,731</u>
<b>Net assets available for benefits</b>	<u>\$ 9,115,185</u>	<u>\$ 7,563,731</u>

See notes to financial statements.

## Open Health Trust

### Statement of Changes in Net Assets Available for Benefits - Cash Basis Year Ended December 31, 2024

---

Net increase in net assets:	
Additions:	
Interest Income	\$ 263,115
Contributions:	
Employer contributions	5,732,255
Employee contributions	1,182,834
Total contributions	<u>6,915,089</u>
<b>Total additions</b>	<u>7,178,204</u>
Deductions:	
Insurance premiums, net of rebates	5,554,879
Administrative expenses	71,871
<b>Total deductions</b>	<u>5,626,750</u>
<b>Increase in net assets - available for benefits</b>	1,551,454
Net assets available for benefits:	
Beginning of the year	<u>7,563,731</u>
End of year	<u>\$ 9,115,185</u>

See notes to financial statements.

## Open Health Trust

### Notes to Financial Statements

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#### Note 1. Description of the Plan and Trust

Open Health (the Plan), was established effective January 1, 2015, and is a fully insured multiple employer welfare arrangement within the meaning of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and related Department of Labor's (DOL) guidance. The Plan is funded through the Open Health Trust (the Trust). Employer and employee insurance premiums are funded through the Trust.

The following description of the Plan and Trust provides only general information. Participating employers should refer to the Plan and Trust agreements for a more complete description of the provisions.

The Entertainment Industry Employers Association (EIEA), a nonprofit mutual benefit corporation organized under the California Nonprofit Mutual Benefit Corporation Law, sponsors the Plan. The Plan is intended to be an "Association Health Plan" within the meaning of ERISA and applicable DOL guidance. As sponsor of the Plan, the EIEA makes all regulatory filings with respect to the Plan, and otherwise maintains the Plan in accordance with ERISA and other applicable laws. The Trust is governed by a Trust agreement between Cast & Crew Benefit Services, LLC (CCBS) as the grantor of the Trust, and the EIEA (as sponsor of the Plan). The Trust agreement requires that the assets and income of the Trust be used for the exclusive benefit of Plan participants and their dependents and for the payment of reasonable plan administration expenses.

The EIEA has entered into an Administrative Services Agreement with CCBS (the "Administrative Services Agreement") to provide record-keeping and administrative services on behalf of the participating employers that adopt the Plan. Each participating employer must enter into the Open Health Participation Agreement (the Participation Agreement), which sets forth the employer contribution obligation to the Trust, identifies the administrative fees charged by the Plan, and specifies other terms and conditions of participation in the Plan. The Plan (as funded through the Trust) is designed to be a Group Insurance Arrangement, so a single Form 5500 is filed on behalf of all participating employers as provided by the DOL's regulations, thus relieving these participating employers of their separate Form 5500 filing obligations.

The Plan provides coverage for health (including prescription drug), dental, vision and life benefits to nonunion employees of participating employers operating in the entertainment industry. The Plan is designed to provide health coverage to the employees of participating employers in a manner that satisfies the requirements of the Patient Protection and Affordable Care Act.

**Contributions:** The Participation Agreement provides that the employers shall make contributions to the Trust for the benefit of the Plan participants. Contributions are made to cover premium payments to the Trust and applicable Plan administrative charges. The employers' contribution rates are determined annually by the EIEA benefits committee. Participating employers pay 100% of the cost of the lowest-cost plan option for project-based employees, and at least 50% of the cost of the lowest-cost plan option for staff employees. However, project-based employees may elect higher coverage levels and pay the cost of such higher coverage levels through direct payments to the Trust. Staff employees pay their portion of the cost of coverage through payroll deduction facilitated by the participating employer's payroll company. Administrative charges are paid by each participating employer to CCBS, pursuant to the Participation Agreement. Employees do not pay any of the administrative costs of the Plan (other than the statutory COBRA administration in the event COBRA coverage is elected).

## Open Health Trust

### Notes to Financial Statements

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**Employee Eligibility:** An employee's eligibility for coverage under the Plan depends on whether they are a Project-Based Employee or a Staff Employee. A Project-Based Employee becomes eligible if they work 130 hours in any calendar month during their initial employment period, with coverage beginning on the first day of the month following a two-month waiting period. Coverage continues through the remainder of the initial employment period or, if longer, one calendar month. Project-Based Employees who average 30 or more hours per week during a measurement period will be offered coverage for the following stability period, while those averaging less than 30 hours per week will not be offered coverage for that stability period, subject to the one-month minimum coverage requirement. For employees of a new participating employer, coverage will be offered, and if the standard timing does not meet ACA requirements, the Plan and Employer may implement a transition policy consistent with ACA measurement period rules.

Staff Employees are offered coverage on the first day of the month following their hire date (or as otherwise specified in the participation agreement for new participating employers), and coverage continues until termination of employment.

**Benefits:** The Plan provides benefits to employees of participating employers as described above. The benefits to be provided to the participants under the Plan are provided exclusively by fully insured policies held by the Trust.

#### Note 2. Significant Accounting Policies

**Basis of accounting:** The accompanying financial statements have been prepared on the cash basis of accounting. Therefore, additions and reductions are recognized only as cash received or paid, and receivables and payables are not reflected in the Trust's financial statements.

**Cash:** Cash includes amounts on deposit in financial institutions.

**Contributions:** Contributions from participating employers and their employees are recorded when the contributions are received.

**Insurance premiums and administrative expenses:** Premiums paid to Anthem Blue Cross and The Standard are recorded as insurance premiums paid in the statement of changes in net assets available for benefits - cash basis. Premiums paid are recorded when the payment is made by the Trust. Premiums recorded are net of rebates received. Administrative expenses are recorded when the payment is made by the Trust.

**Concentration of credit risk:** At times, the Trust may have deposits in excess of federally insured limits at one financial institution.

**Estimates:** The preparation of financial statements in accordance 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 and liabilities and changes therein, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

**Subsequent events:** The Trust's management has evaluated subsequent events through September 8, 2025, the date on which the financial statements were available to be issued.

In February 2025, the Trust initiated an investment of surplus cash totaling \$8 million. \$500,000 of the surplus was placed in a short-term cash equivalent portfolio to preserve liquidity and capital stability. The remaining \$7,500,000 of the surplus was invested in a diversified mutual funds portfolio.

## Open Health Trust

### Notes to Financial Statements

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#### **Note 3. Cash**

In March 2024, the Trust transitioned its operational cash holdings to an interest-bearing account in order to generate return on the Trust's assets. Prior to the transition, the Trust maintained its operational cash in a non-interest-bearing account. After the transition, the interest-bearing account earned interest of \$263,115 for the year ended December 31, 2024.

#### **Note 4. Insurance Premiums**

Premiums paid by the Trust for health-PPO, health-HMO, dental, vision and life coverage to Anthem Blue Cross and The Standard during the year ended December 31, 2024, are \$5,616,940 and \$54,786 respectively. Insurance rebates received during the year ended December 31, 2024 totaled \$116,847. These were related to premiums paid in 2023 and 2022.

#### **Note 5. Related-Party Transactions and Administrative Expenses**

The Plan has entered into the Administrative Services Agreement with CCBS pursuant to which CCBS provides various record-keeping services for the Plan. As directed by participating employers who are Cast & Crew Payroll, LLC (CCP) customers, CCP collects and remits participating employer contributions to the Trust. Of the total contributions remitted to the Trust for the year ended December 31, 2024, CCP collected and remitted \$4,380,941 to the Trust on behalf of participating employers.

Substantially all of the Plan's administrative expenses are paid directly to CCBS by participating employers pursuant to the Administrative Services Agreement. Expenses incurred by participating employers not paid through the Trust are excluded from these financial statements. The Trust permits payment of reasonable administrative expenses with Trust assets. Certain third parties perform record-keeping, audit and banking services, which are generally paid by the Trust. Total administrative expenses paid by the Trust totaled \$71,871 for the year ended December 31, 2024.

There are no intercompany balances that existed as of December 31, 2024 and 2023 which are not reflected in the accompanying statements of net assets available for benefits - cash basis.

#### **Note 6. Trust Termination**

Although it has not expressed any intention to do so, the EIEA as plan sponsor of the Plan may terminate the Trust at any time by written notice to the trustees and the EIEA. Upon such termination, the trustees shall cause the assets of the Trust to be paid to discharge the obligations of the Trust as of the date of its termination, and any remaining assets shall be: (a) applied to provide, either directly or through the purchase of insurance, welfare benefits to employees, or (b) distributed to employees of the participating employers, provided that the provision of such benefits, or the making of such distributions, shall be on the basis of objective and reasonable standards that do not result in unequal payments to similarly situated employees. In no event shall any assets of the Trust be distributed or revert to any participating employer.

#### **Note 7. Income Taxes**

The Trust was established effective November 17, 2014, and is a taxable trust under Internal Revenue Code Section 641. For the calendar year 2024, no federal or state income taxes were due, and no tax payments were made.

## Open Health Trust

### Notes to Financial Statements

---

#### **Note 7. Income Taxes (Continued)**

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if it has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. Management has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2024 and 2023, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. Generally, the statute of limitations for examination of U.S. federal or state tax returns is three years and is considered closed upon review by the taxing jurisdiction. There are no audits for any tax years in progress.

#### **Note 8. COBRA Subsidy**

The American Rescue Plan Act (“ARPA”) imposed on common law employers, including employer members of the EIEA, the obligation to provide a subsidy equal to 100% of the COBRA obligation of a qualifying COBRA beneficiary (the “ARPA COBRA Subsidy”) for a period of up to six months during the period beginning April 1, 2021, and ending on September 30, 2021. ARPA provided that such common law employers who paid the ARPA COBRA Subsidy will be reimbursed for their ARPA COBRA Subsidy expenses through refundable payroll tax credits.

The participating employers of the Plan contracted with the EIEA to pay the ARPA COBRA Subsidy payments to Anthem Blue Cross on their behalf. CCBS collected the participating employers’ ARPA COBRA Subsidy payments from the participating employers and transferred them to the EIEA when the EIEA was invoiced for the ARPA COBRA Subsidy amounts from Anthem Blue Cross.

While the majority of ARPA COBRA Subsidy payments were collected prior to 2024, ARPA COBRA Subsidy payments of \$6,248 were collected from participating employers and remitted to the Trust during the Plan year ended December 31, 2024. Such amounts are included in employer contributions in the statement of changes in net assets available for benefits – cash basis. The remaining balance of \$54,722 was deemed to be uncollectible and was written off by EIEA in 2024.

Supplemental Schedule

Open Health Trust

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

December 31, 2024

E.I.N #: 47-6663415 PLAN #: 501

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment (Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value)	Cost	Current Value
Open Health Trust	Bank of America	Interest-bearing cash account	\$ 9,115,185	\$ 9,115,185

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

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

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

a single-employer plan  a DFE (specify) G

**B** This return/report is:  the first return/report  the final return/report

an amended return/report  a short plan year return/report (less than 12 months)

**C** If the plan is a collectively-bargained plan, check here. . . . . ▶

**D** Check box if filing under:  Form 5558  automatic extension  the DFVC program

special extension (enter description)

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

**Part II Basic Plan Information—enter all requested information**

<p><b>1a</b> Name of plan OPEN HEALTH TRUST</p>	<p><b>1b</b> Three-digit plan number (PN) ▶ 501</p>
<p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)</p> <p>OPEN HEALTH TRUST</p> <p>2300 EMPIRE AVENUE, 5TH FLOOR</p> <p>BURBANK CA 91504</p>	<p><b>1c</b> Effective date of plan 01/01/2015</p> <p><b>2b</b> Employer Identification Number (EIN) 47-6663415</p> <p><b>2c</b> Plan Sponsor's telephone number 818-848-6022</p> <p><b>2d</b> Business code (see instructions)</p>

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

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

<b>SIGN HERE</b>		Date	
	Signature of plan administrator		Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		Date	
	Signature of employer/plan sponsor		Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>	<i>sally knutson</i>	9/9/2025	SALLY KNUTSON
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor CAST & CREW BENEFIT SERVICES, LLC  2300 EMPIRE AVENUE, 5TH FLOOR  BURBANK CA 91504	<b>3b</b> Administrator's EIN 35-2517115  <b>3c</b> Administrator's telephone number 818-848-6022
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<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
--	-----------------------------------

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	1,267
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<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).		
<b>a(1)</b> Total number of active participants at the beginning of the plan year .....	<b>6a(1)</b>	1,170
<b>a(2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b>	932
<b>b</b> Retired or separated participants receiving benefits .....	<b>6b</b>	76
<b>c</b> Other retired or separated participants entitled to future benefits .....	<b>6c</b>	0
<b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....	<b>6d</b>	1,008
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits .....	<b>6e</b>	
<b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....	<b>6f</b>	
<b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....	<b>6g(1)</b>	
<b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>	

<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	
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**8a** If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

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

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

**a Pension Schedules**

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

**b General Schedules**

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

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**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 000163156551

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Open Health Trust

SCHEDULE H, LINE 4i - SCHEDULE OF ASSETS (HELD AT END OF YEAR)

December 31, 2024

E.I.N #: 47-6663415 PLAN #: 501

(a)	(b)	(c)	(d)	(e)
	Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment (Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value)	Cost	Current Value
Open Health Trust	Bank of America	Interest-bearing cash account	\$ 9,115,185	\$ 9,115,185