

<p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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 style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; font-weight: bold;">2024</p> <hr/> <p style="font-weight: bold;">This Form is Open to Public Inspection</p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan  a DFE (specify) \_\_\_\_\_

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

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

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

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

special extension (enter description)

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

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

<p><b>1a</b> Name of plan <u>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>501</u></p>
<p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</u></p> <p><u>321 RESEARCH PKWY</u> <u>STE 110</u> <u>MERIDEN, CT 06450</u></p>	<p><b>1c</b> Effective date of plan <u>10/01/1977</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>06-0860627</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>203-530-4370</u></p> <p><b>2d</b> Business code (see instructions) <u>238210</u></p>

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

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

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	09/19/2025	BRIAN T. MURPHY
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	4886
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	3812
	<b>6a(2)</b>	4070
	<b>6b</b>	1059
	<b>6c</b>	
	<b>6d</b>	5129
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	349

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

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

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

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

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

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

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

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

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

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

Receipt Confirmation Code \_\_\_\_\_

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

<p><b>A</b> Name of plan <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>06-0860627</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  
**STANDARD 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
35-0980405	61069	AL00006414	4750	01/01/2024	08/31/2024

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

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

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

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

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

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

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

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	(c) Amount	(d) Purpose	

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	450434
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

<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>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>06-0860627</b></p>	

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

**1 Coverage Information:**

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

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	SL10332	4305	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	4140459
<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>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>501</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>06-0860627</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  
**UNITED HEALTHCARE 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
36-2739571	79413	S5805, S5820	1234	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

**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 ▶

<b>6b</b>	
<b>6c</b>	
<b>6d</b>	

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1195217
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**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>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>06-0860627</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  
**ANTHEM BLUE CROSS BLUE SHIELD**

<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>35-0781558</b>	<b>28207</b>	<b>CT021GRS</b>	<b>1197</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	2194593
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

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

<b>A</b> Name of plan <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>06-0860627</b>	

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

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

**1 Information on Persons Receiving Only Eligible Indirect Compensation**

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

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

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

**THE VANGUARD GROUP**

**23-1945930**

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

**BLACKROCK ADVISORS, LLC**

**13-3806694**

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

**ARTISAN PARTNERS**

**39-1807188**

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

**NEUBERGER BERMAN GROUP LLC**

**61-1591182**

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

MORGAN STANLEY

20-8764829

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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)

ANTHEM HEALTH PLANS, INC

06-1475928

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 62	NONE	1726129	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	58596	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

ZENITH AMERICAN SOLUTIONS

52-1590516

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	1312427	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)

SOLXSYS ADMINISTRATIVE SOLUTIONS

82-2454243

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	746400	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

ZELIS

86-1040704

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	362161	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)

LABOR FIRST LLC

06-1750191

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
23 50 73	NONE	315724	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)

PRIME PAY

35-1720702

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	172370	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LOWER HUDSON VALLEY E.A.P.

13-3240307

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	162942	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)

ROBERT M. CHEVERIE & ASSOC., P.C.

06-1335139

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	144000	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)

GRAYSTONE CONSULTING LLC

32-0516279

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 50	NONE	125328	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

NOVAK FRANCELLA LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	85613	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)

HINGE HEALTH, INC.

81-1884841

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	81771	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)

THE SEGAL GROUP, INC.

06-0839113

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	68872	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

EATON VANCE MANAGEMENT

04-3101341

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	53199	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SAV-RX PRESCRIPTION SERVICES

86-1323040

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	48536	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)

MODERN ASSISTANCE PROGRAMS, INC.

04-3014235

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	45739	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SUN LIFE CAPITAL MANAGEMENT LLC

04-3132283

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 50	NONE	30401	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)

CBIZ-SAVITZ,INC

31-1582098

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	NONE	21450	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)

SANTANDER BANK

23-1237295

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
99 50	NONE	20198	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

LAPIER, DILLON & ASSOCIATES PC

32-0048525

(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	10883	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)

ALLEGRA PRINT & IMAGING

20-8067559

(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?
36 50	NONE	8412	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)

WEX, INC.

01-0526993

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	7588	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"/>

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

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

(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
ANTHEM HEALTH PLANS, INC	22 53 55	58596
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
MPL LLC  06-1537302	SALES AND BASE COMMISSION	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	(e) Describe the indirect compensation, including any formula used to determine the service provider's eligibility for or the amount of the indirect compensation.	

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

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

<b>SCHEDULE H</b> <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>	OMB No. 1210-0110  <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>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>06-0860627</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>	2437253	2092653
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	12703191	11462034
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	8976856	3907542
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	31350621	46384942
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>	12556788	11457346
<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>	3868157	3564088
<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>	47067951	60994062
<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>	118960817	139862667
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>	18739274	28912808
<b>h</b> Operating payables.....	<b>1h</b>	3201503	2948386
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>	468641	561585
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	22409418	32422779
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	96551399	107439888

**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>	93085340	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	10006617	
<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>		103091957
<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>	2515	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>	154658	
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>	141806	
<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>	68756	
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		367735
<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>	2622426	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		2622426
<b>(3)</b> Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	21064698	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	21179546	
<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>		-114848
<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>	725788	
<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>		3649095
<b>c</b> Other income .....	<b>2c</b>		106
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total .....	<b>2d</b>		110342259

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers .....	<b>2e(1)</b>	87571098	
(2) To insurance carriers for the provision of benefits .....	<b>2e(2)</b>	6687957	
(3) Other .....	<b>2e(3)</b>		
(4) Total benefit payments. Add lines <b>2e(1)</b> through <b>(3)</b> .....	<b>2e(4)</b>		94259055
<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>	2428575	
(3) Recordkeeping fees .....	<b>2i(3)</b>	35716	
(4) IQPA audit fees .....	<b>2i(4)</b>	60780	
(5) Investment advisory and investment management fees .....	<b>2i(5)</b>	30401	
(6) Bank or trust company trustee/custodial fees .....	<b>2i(6)</b>	125328	
(7) Actuarial fees .....	<b>2i(7)</b>	21450	
(8) Legal fees .....	<b>2i(8)</b>	147094	
(9) Valuation/appraisal fees .....	<b>2i(9)</b>		
(10) Other trustee fees and expenses .....	<b>2i(10)</b>	22804	
(11) Other expenses .....	<b>2i(11)</b>	2322567	
(12) Total administrative expenses. Add lines <b>2i(1)</b> through <b>(11)</b> .....	<b>2i(12)</b>		5194715
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total .....	<b>2j</b>		99453770

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line <b>2j</b> from line <b>2d</b> .....	<b>2k</b>		10888489
<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: **NOVAK FRANCELLA, LLC**

(2) EIN: **61-1436956**

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		5000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

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

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

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

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

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

**NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND**

FINANCIAL STATEMENTS

DECEMBER 31, 2024

**NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND**  
**FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION**

DECEMBER 31, 2024 AND 2023

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## INDEPENDENT AUDITOR'S REPORT

To the Participants and Trustees of the  
New England Electrical Workers Benefits Fund

### Opinion

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

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

### Basis for Opinion

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

### Responsibilities of Management for the Financial Statements

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

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

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

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

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

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the 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.

### **Report on Supplemental Information**

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

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

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

*Novak Francella LLC*

Bala Cynwyd, Pennsylvania  
September 17, 2025

# NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

## STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

	2024	2023
<b>ASSETS</b>		
<b>INVESTMENTS - at fair value</b>		
United States Government obligations	\$ 11,457,346	\$ 12,556,788
Corporate obligations	3,564,088	3,868,157
Mutual funds - equities	36,232,832	23,199,019
Exchange-traded funds	24,761,230	23,868,932
Mutual funds - money market	18,710,366	14,466,989
Cash and cash equivalents	48,371	87,591
Total investments	94,774,233	78,047,476
<b>RECEIVABLES</b>		
Employer and reciprocal contributions	11,462,034	12,703,191
Vacation/sick time contributions	1,761	642,203
Reimbursement benefit arrangement contributions	796,986	310,478
Stop loss reimbursements	802,650	6,615,621
Prescription rebates	1,559,675	1,317,260
Retiree drug subsidy - Medicare Part D	-	66,957
Lien reimbursements	3,668	4,832
Accrued interest	315,983	19,505
Total receivables	14,942,757	21,680,047
<b>PREPAID PREMIUMS</b>	426,819	-
<b>CASH</b>	29,718,858	19,233,294
Total assets	139,862,667	118,960,817
<b>LIABILITIES AND NET ASSETS</b>		
<b>LIABILITIES</b>		
Amounts due to other benefit plans under reciprocal agreements	2,295,337	3,191,808
Prepaid self-pay contributions	66,794	166,048
Accounts payable	653,049	9,695
Due to related party	30,086	-
Escrow liability	204,879	42,767
Transfer withdrawal payable	259,826	259,826
Total liabilities	3,509,971	3,670,144
<b>NET ASSETS AVAILABLE FOR BENEFITS</b>	\$ 136,352,696	\$ 115,290,673

See accompanying notes to financial statements.

## NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

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

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
<b>ADDITIONS</b>		
Investment income		
Net appreciation in fair value of investments	\$ 4,260,035	\$ 3,317,792
Interest and dividends	2,990,161	2,176,403
	7,250,196	5,494,195
Less investment expenses	(155,729)	(146,083)
Net investment income	7,094,467	5,348,112
<b>Contributions</b>		
Employer and reciprocals	106,290,440	101,104,847
Reciprocals paid	(15,991,567)	(13,071,827)
Self-pay	3,620,257	3,262,230
Vacation/sick time	2,786,467	3,645,562
Reimbursement benefit arrangement	6,386,360	4,199,849
Total contributions	103,091,957	99,140,661
Miscellaneous income	106	232
Total additions	110,186,530	104,489,005
<b>DEDUCTIONS</b>		
<b>Benefits</b>		
Paid directly to or on behalf of participants:		
Hospital, surgical and medical claims	58,426,676	58,976,247
Prescription drug benefits	14,041,755	12,326,799
Prescription drug rebates	(3,115,391)	(2,420,803)
Medicare Part D reimbursements	-	(149,654)
Vacation/sick benefits	3,759,851	2,999,523
Disability benefits	1,113,096	982,090
Employee assistance program	208,680	135,150
Death benefits	9,000	7,000
	74,443,667	72,856,352
Insurance premiums	7,003,681	7,694,729
Stop loss reimbursements/overaccrual	2,638,173	(5,216,409)
Total benefits expense	84,085,521	75,334,672
Fees mandated by the ACA	28,135	25,254
Administrative expenses	5,010,851	4,688,158
Total deductions	89,124,507	80,048,084

See accompanying notes to financial statements.

	<u>2024</u>	<u>2023</u>
NET INCREASE	\$ 21,062,023	\$ 24,440,921
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	<u>115,290,673</u>	<u>90,849,752</u>
End of year	<u><u>\$ 136,352,696</u></u>	<u><u>\$ 115,290,673</u></u>

See accompanying notes to financial statements.

**NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND**

**STATEMENTS OF BENEFIT OBLIGATIONS**

DECEMBER 31, 2024 AND 2023

	2024	2023
<b>AMOUNTS CURRENTLY PAYABLE</b>		
Claims payable and incurred but not reported	\$ 15,817,253	\$ 7,456,196
<b>OTHER OBLIGATIONS FOR CURRENT BENEFIT</b>		
COVERAGE - at present value of estimated amounts, net of amounts currently payable		
Reimbursement benefit arrangement unused balances	11,485,800	9,035,777
Vacation/sick time benefit obligations	1,609,755	2,247,301
Accumulated eligibility credits	39,970,069	24,435,335
	53,065,624	35,718,413
<b>POSTRETIREMENT BENEFIT OBLIGATIONS -</b>		
net of amounts currently payable		
Current retirees	32,702,241	34,050,122
Other participants fully eligible for benefits	14,257,070	14,795,476
Other participants not fully eligible for benefits	43,740,153	35,617,919
Total postretirement benefit obligations	90,699,464	84,463,517
<b>Total benefit obligations</b>	<b>\$ 159,582,341</b>	<b>\$ 127,638,126</b>

See accompanying notes to financial statements.

**NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND**

**STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
<b>AMOUNTS CURRENTLY PAYABLE</b>		
Balance at beginning of year	\$ 7,456,196	\$ 6,991,171
Increase during the year attributable to		
Changes in claims payable and incurred but not reported	<u>8,361,057</u>	<u>465,025</u>
Balance at end of year	<u>15,817,253</u>	<u>7,456,196</u>
<b>OTHER OBLIGATIONS FOR CURRENT BENEFIT</b>		
COVERAGE - at present value of estimated amounts, net of amounts currently payable		
Balance at beginning of year	35,718,413	32,545,693
Increase during the year attributable to		
Changes in reimbursement benefit arrangement unused balances	2,450,023	1,752,220
Changes in vacation/sick time benefit obligations	(637,546)	512,768
Changes in accumulated eligibility credits	<u>15,534,734</u>	<u>907,732</u>
Balance at end of year	<u>53,065,624</u>	<u>35,718,413</u>
<b>POSTRETIREMENT BENEFIT OBLIGATIONS -</b>		
net of amounts currently payable		
Balance at beginning of year	84,463,517	114,051,814
Increase (decrease) during the year attributable to		
Expected net benefits paid	(5,098,017)	(7,946,907)
Benefits earned	5,340,173	8,344,252
Change in discount period	3,890,939	5,503,918
Actuarial experience	12,493,821	1,898,114
Changes in actuarial assumptions	<u>(10,390,969)</u>	<u>(37,387,674)</u>
Balance at end of year	<u>90,699,464</u>	<u>84,463,517</u>
<b>TOTAL BENEFIT OBLIGATIONS</b>	<u>\$ 159,582,341</u>	<u>\$ 127,638,126</u>

See accompanying notes to financial statements.

# NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

## NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

### NOTE 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Method of Accounting** - The financial statements are prepared using the accrual basis of accounting.

**Investment Valuation and Income Recognition** - Investments in United States Government obligations, corporate obligations, mutual funds-equity, exchange-traded funds, mutual fund-money market and cash and cash equivalents are carried at fair value as provided by the investment custodian, which generally represents quoted market prices, net asset value of the mutual fund and exchange-traded fund as of the last business day of the year or valued using pricing models maximizing the use of observable inputs for similar securities, including yields on comparable securities with similar credit ratings. Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation includes the Plan's gains and losses on investments bought and sold as well as held during the year.

See Note 6 for discussion of fair value measurements.

**Contributions Receivable** - Employer contributions due but not paid prior to year end are recorded as contributions receivable. The Plan believes that the receivables are fully collectible; therefore, no allowance for credit losses is recorded.

**Benefit Obligations** - Claims payable, claims incurred but not reported, accumulated eligibility credits, and postretirement benefits were estimated by the Plan's consultant. These amounts are paid by the Plan only if claims are submitted and approved for payment.

**Payment of Benefit** - Benefit payments are recorded when paid.

**Reimbursement Benefit Arrangement (RBA)** - The RBA is set up for certain IBEW Local Union No. 223 participants of the Plan. As of September 1, 2018, IBEW Local Union No. 42 members are also eligible for this arrangement. As of June 1, 2019, IBEW Local Union No. 35 members are also eligible for this arrangement. As of September 1, 2020 IBEW Local Union No. 104 members are also eligible for this arrangement. As of April 1, 2021 IBEW Local Union No. 488 members are also eligible for this arrangement. The RBA is funded through employer contributions on behalf of a participant. A participant account is set up for each eligible participant which can only be used for unreimbursed eligible out-of-pocket expenses incurred on or after July 1, 2013. The remaining amount is not vested, and will be forfeited upon termination from the Plan, or other circumstances, as determined by the Plan's Trustees. A liability is included in the benefit obligations reported on the Statements of Benefit Obligations for the unused participant account balances at year end since the probability of payment could not be reasonably estimated. The change in unused participant account balances is reported as a change in the benefit obligation reported on the Statements of Changes in Benefit Obligations.

**NOTE 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)**

**Use of 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 certain reported amounts and disclosures in the financial statements. Actual results could differ from those estimates.

**Cash Concentration** - The Plan maintains its cash at one financial institution deemed to be credit worthy. Cash balance is insured by the Federal Deposit Insurance Company (FDIC) up to \$250,000 per bank. At December 31, 2024, the Plan's cash in excess of FDIC insurance coverage totaled \$32,648,400.

**NOTE 2. DESCRIPTION OF THE PLAN**

The following description of the New England Electrical Workers Benefits Fund (the Plan), a multiemployer health and welfare benefit fund, provides only general information. Participants should refer to the Plan agreement or Summary Plan Description for a more complete description of the Plan's provisions.

The Plan was formed under an agreement between the Contractors' Association and IBEW Local Unions 7, 42, 104, 223, 300, 490, 567, and 1837 located in the Northeast region of the United States.

Effective March 1, 2012, IBEW Local Union No. 35 Health Fund and Southern Connecticut IBEW Health Fund (488) merged with the Plan and participants began participating in the Plan.

The Plan covers all eligible members of the Unions employed under the terms of the collective bargaining agreement with employer members of the Contractors Association and Participating Employer's staff who are based in New England and who do electrical work. The Plan provides self-funded health benefits (hospital, surgical, major medical, hearing, vision, dental, death, prescription drugs, and disability) covering all participants, their beneficiaries, and covered dependents.

Stop loss insurance is provided by The Union Labor Life Insurance Company and life insurance and accidental death coverage is provided for eligible participants through Anthem. The attachment point is \$250,000. The premiums for stop loss are included in insurance premium payments in the accompanying statements of changes in net assets available for benefits. Stop loss refunds totaled \$3,174,798 and \$5,216,409 for the years ended December 31, 2024 and 2023, respectively.

The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plans' actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against claims paid. The Plan earned rebates of \$3,115,391 and \$2,420,803 for the years ended December 31, 2024 and 2023, respectively.

**NOTE 2. DESCRIPTION OF THE PLAN (continued)**

Effective July 1, 2013, IBEW Local Union No. 223 elected to participate in the New England Electrical Workers Benefit Fund “\$7.00 Plan” design. As a part of this new plan design, an allocation account was created for each participant. The allocation account can be used for unreimbursed eligible out-of-pocket expenses incurred on or after July 1, 2013.

Effective September 1, 2013, IBEW Local Union No. 567 elected to participate in the New England Electrical Workers Benefit Fund “\$7.00 Plan” design.

Effective January 5, 2014, IBEW Local Unions No. 42 and 104 elected to participate in the New England Electrical Workers Benefit Fund “\$7.00 Plan” design.

Effective September 1, 2015, the IBEW Local Union No. 104 Vacation/Sick Time Benefit Plan (Vacation/Sick Plan) was created under the Trust agreement by the Plan. See footnote 15 for further information.

Effective September 30, 2016, IBEW Local Union No. 1837 decided to withdraw from participation in the Plan. As of December 31, 2022, \$259,826 has not been transferred to the IBEW Local Union No. 1837.

Effective October 1, 2016, IBEW Local Union No. 567 decided to withdraw from participation in the Plan. During the year ended December 31, 2018, \$314,025 was transferred to the NECA/IBEW Medical Care Trust Fund on behalf of IBEW Local Union No. 567.

The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

**NOTE 3. FUNDING POLICY**

Employers contribute to the Plan based on hours worked or hours paid depending on the local, as agreed to in the collective bargaining agreement. Non-working members may elect (under Federal regulations) to stay in the plan for up to 18 months by purchasing benefits through COBRA, which requires a monthly self pay contribution at a rate approved by the Board of Trustees.

Contributions are accounted for as exchange transactions. The contributions are due on a monthly basis. It is the policy of the Trustees to pursue monies due.

Effective February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. The ARRA included changes to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue health coverage for individuals who have lost their jobs through involuntary termination.

#### **NOTE 4. PRIORITIES UPON TERMINATION**

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

#### **NOTE 5. TAX STATUS**

The Plan obtained its latest determination letter on April 30, 1971, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements under Section 501(c)(9) of the Internal Revenue Code and was, therefore, not subject to tax under present Federal income tax laws. The Plan has been amended since receiving the determination letter. The Plan's administrator and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability if the Plan has taken an uncertain position that, more likely than not, would not be sustained upon examination by the U.S. Federal, state, or local taxing authorities. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Typically, plan tax years will remain open for three years; however, this may differ depending upon the circumstances of the Plan.

#### **NOTE 6. FAIR VALUE MEASUREMENTS**

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

Basis of Fair Value Measurement:

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

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

## NOTE 6. FAIR VALUE MEASUREMENTS (continued)

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

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

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

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

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

Investments are stated at current market values as represented by the Plan's custodian. The market value of listed securities is determined by using quoted closing prices on security exchanges. The custodian uses prices obtained from an independent third-party pricing service to measure fair value of certain investment securities. The custodian validates prices from the pricing service using methods including comparison to internal valuation modes, and review of other relevant market data.

*Cash and Cash equivalents:* Cash equivalents consist of cash investments in money market funds. Cash investments in money market funds are valued under the market approach through the use of quoted market prices in an active market, which is the net asset value of the underlying funds and are classified within Level 1 of the valuation hierarchy.

*Corporate obligations:* The custodian uses prices obtained from an independent third-party pricing service to measure fair value of certain investment securities. The custodian validates prices received from the pricing service using methods including comparison to prices received from additional pricing services, comparison to quoted market prices, where available, comparison to internal valuation models, and review of other relevant market data. These are classified within Level 2 of the valuation hierarchy.

*U.S. Government obligations:* These investments are valued using an independent pricing vendor and are classified within Level 2 of the valuation hierarchy.

*Mutual funds and exchange-traded funds:* The mutual funds and exchange-traded funds investments are valued at their net asset value (NAV) of shares held by the Plan at year end and are classified within Level 1 of the valuation hierarchy.

**NOTE 6. FAIR VALUE MEASUREMENTS (continued)**

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
United States Government obligations	\$ 11,457,346	\$ -	\$ 11,457,346	\$ -
Corporate obligations	3,564,088	-	3,564,088	-
Mutual funds - equities	36,232,832	36,232,832	-	-
Exchange-traded funds	24,761,230	24,761,230	-	-
Mutual funds - money market	18,710,366 *	18,710,366	-	-
Cash and cash equivalents	48,371	48,371	-	-
	<u>\$ 94,774,233</u>	<u>\$ 79,752,799</u>	<u>\$ 15,021,434</u>	<u>\$ -</u>

\* One mutual fund comprises 13% of total assets.

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
United States Government obligations	\$ 12,556,788	\$ -	\$ 12,556,788	\$ -
Corporate obligations	3,868,157	-	3,868,157	-
Mutual funds - equities	23,199,019	23,199,019	-	-
Exchange-traded funds	23,868,932	23,868,932	-	-
Mutual funds - money market	14,466,989 *	14,466,989	-	-
Cash and cash equivalents	87,591	87,591	-	-
	<u>\$ 78,047,476</u>	<u>\$ 61,622,531</u>	<u>\$ 16,424,945</u>	<u>\$ -</u>

\* One mutual fund comprises 12% of total assets.

The availability of observable market data is monitored to assess the appropriate classification of financial instruments within the fair value hierarchy. Changes in economic conditions or model-based valuation techniques may require the transfer of financial instruments from one fair value level to another. In such instances, the transfer is reported at the beginning of the reporting period.

For the years ended December 31, 2024 and 2023, there were no transfers in or out of levels 1, 2, or 3.

**NOTE 7. RELATED PARTIES**

The New England Electrical Workers Money Purchase Plan and Trust (Money Purchase Plan) is related to the Plan through common Trustees.

As of December 31, 2024 the New England Electrical Workers Benefits Fund owed the New England Electrical Workers Money Purchase Plan and Trust (Money Purchase Plan) \$30,086 for contributions paid to the Fund which should have been paid to the Money Purchase Plan.

## **NOTE 7. RELATED PARTIES (continued)**

Certain Plan investments are shares of money market mutual funds managed by Morgan Stanley in 2024 and 2023. Morgan Stanley is the custodian of the Plan and therefore, these transactions qualify as party-in-interest transactions. These transactions have been denoted as such on the supplemental schedule of assets held at end of year.

The transactions identified above qualify as transactions which are exempt from the prohibited transaction rules of ERISA.

## **NOTE 8. BENEFIT OBLIGATIONS**

**Claims Payable** - Benefit obligations include health claims that have been processed and approved for payment, but not yet paid at the end of the period.

**Incurred but Not Reported Claims** - The benefit obligation for incurred but not reported claims represents amounts for claims submitted by participants after the end of the period which were incurred prior to the end of the period. The amount of the estimated obligation is determined based on (1) historical data regarding the time that typically elapses between the dates on which claims are incurred and the dates on which they are submitted and paid, and (2) available information about the amount of claims that were paid in one period but incurred in a prior period. This amount is determined by the Plan's consultant.

**Reimbursement Benefit Arrangement Unused Balances** - The amount of this benefit obligation represents the unused participant account balance at year end since the probability of payment could not be reasonably estimated.

**Vacation/Sick Time Benefits Payable** - Benefit obligations include vacation/sick time benefits that have been processed, approved for payment, and paid subsequent to the year end.

**Participants' Accumulated Eligibility** - Once participants have achieved initial eligibility, eligibility credits for future months, based on the number of hours worked, may be earned and accumulated. Participants may accumulate eligibility credits, which entitle them to a maximum of six months eligibility in addition to the current month's eligibility coverage. Effective September 30, 2013, members who participate in the "\$7 Plan" have four months eligibility in addition to their current month's eligibility coverage. This amount is determined by the Plan's consultant.

**Postretirement Benefits** - The Plan provides postretirement health benefits to retired participants. Participants that retire with a normal pension are able to maintain their eligibility for health coverage under this fund. The postretirement benefit obligation represents the total actuarial present value of those estimated future benefits that are attributed to participant service rendered to December 31, reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Postretirement benefits include future benefits expected to be paid to or for (1) current retirees and their beneficiaries and dependents, and (2) active participants and their beneficiaries and dependents after retirement from services with the participating employers. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service in the industry rendered to the valuation date.

## NOTE 8. BENEFIT OBLIGATIONS (continued)

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

For measurement purposes, a 6.20% annual rate of increase in the per capita cost of covered health care benefits was assumed at December 31, 2024 and 2023; the rate was assumed to gradually decrease by .10% per year, reaching an ultimate rate of 4.04% in 2075 and later years.

The following were other significant assumptions used in the valuations:

Weighted-average discount rate	5.500% for 2024 and 4.750% for 2023
Average retirement age	65 for 2024 and 2023
Mortality	1983 Group Annuity Mortality Table (Sex Distinct)

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

The change in assumptions is due to the change in discount rate from 4.750% at December 31, 2023 to 5.500% at December 31, 2024 and the assumed annual rate of medical increase has been modified to better reflect current medical and prescription drug trends. The per capita healthcare costs have been revised to reflect experience for the plan year ending December 31, 2024.

The health care cost trend rate assumption has a significant effect on the amounts reported. If the assumed rate increased by one percentage point, that would increase the net obligation by \$9,932,819 as of December 31, 2024 and \$9,863,683 as of December 31, 2023.

Effective September 1, 2013, the Plan offers a lower benefit tier (the "\$7 Plan"). Individual Local Unions can elect to participate in this plan design. Members who participate in this plan design can, upon retirement, elect to remain in that plan (at the premium in effect). It has been assumed that a member covered by the "\$7 Plan" will elect to remain in that plan upon retirement. At December 31, 2024 and 2023, IBEW Local Unions No. 42, 104, and 223, were participants in the "\$7 Plan".

At December 31, 2024, participants in the Local 223 and Local 488 silos have a 4-month hours bank. Active participants in all other silos have a 6-month hours bank.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) became effective January 1, 2006. The Act introduces a prescription drug benefit under Medicare (Medicare Part D) as well as a Federal subsidy to sponsors of retiree health care benefit plans that provide a benefit that is at least actuarially equivalent to Medicare Part D. The Plan has determined that benefits provided by the Plan are at least actuarially equivalent to Medicare Part D. No Medicare Part D subsidies were received during the year ended December 31, 2024. The Plan was entitled to Medicare Part D subsidies totaling \$149,654 for the year ended December 31, 2023 of which \$66,957 was receivable at year end.

**NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500**

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits per the financial statements	\$ 136,352,696	\$ 115,290,673
Benefit obligations currently payable and claims incurred but not reported	(15,817,253)	(7,456,196)
Reimbursement benefit arrangement unused balances	(11,485,800)	(9,035,777)
Vacation/sick time benefit obligations	<u>(1,609,755)</u>	<u>(2,247,301)</u>
Net assets available for benefits per Form 5500	<u>\$ 107,439,888</u>	<u>\$ 96,551,399</u>

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

Benefits paid to or for participants per the financial statements	\$ 84,085,521
Add: Amounts currently payable and claims incurred but not reported at December 31, 2024	15,817,253
Reimbursement benefit arrangement unused balances at December 31, 2024	11,485,800
Vacation/sick time benefit obligations at December 31, 2024	1,609,755
Less: Amounts currently payable and claims incurred but not reported at December 31, 2023	(7,456,196)
Reimbursement benefit arrangement unused balances at December 31, 2023	(9,035,777)
Vacation/sick time benefit obligations at December 31, 2023	<u>(2,247,301)</u>
Benefits paid to or for participants per Form 5500	<u>\$ 94,259,055</u>

**NOTE 10. RISKS AND UNCERTAINTIES**

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and credit risks. Due to the level of risks associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the Statement of Net Assets Available for Benefits.

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

#### **NOTE 11. PLAN AMENDMENTS**

Effective January 1, 2023, a change to Local 7 plan therapy benefits for Medicare eligible retirees, to be the same benefit as the therapy benefit for active and retired participants that are not Medicare eligible.

Effective January 1, 2023, the Local 223 Plan of Benefits calendar year dental maximum would be \$1,500 for all divisions of the Local 223 Plan of Benefits.

Effective April 1, 2023, Local 42 approved an increase in weekly short term disability benefit from \$800 to \$1,000 for the Local 42 Plan of Benefits.

Effective September 1, 2023, there are new musculoskeletal care benefits provided by Hinge Health.

Effective September 1, 2023, Modern Assistance was implemented to provide employee assistance services for Locals 7 and 223.

#### **NOTE 12. BENEFITS ADMINISTRATION**

The Plan has an agreement with Anthem Blue Cross Blue Shield of Connecticut (Elevance) to provide network access and discount claims repricing and payment services on behalf of the Plan's eligible active members and dependents. Participation by members in the network is voluntary and is available to all eligible members and their families, other than Medicare primary members, spouses and dependents.

The Plan has an agreement with Anthem Dental to provide access to dental network.

The Plan has life and accidental death and dismemberment insurance contracts with Anthem Life Insurance Company.

The Plan's prescription benefits are administered under an agreement with Sav-RX, Inc. Under this arrangement, the Board of Trustees determines the types and limits of covered prescriptions and is responsible for the funding of all prescription claims Sav-RX, Inc. provides processing services and administers actual payment of prescription benefits.

The Plan had an agreement with Union Labor Life Insurance Company to provide stop-loss insurance. The policy provided for reimbursement to the Plan of medical benefit claims exceeding \$250,000 per covered individual per year.

The Plan has an agreement with Anthem Health Inc. to provide utilization management and care management.

The Plan has an agreement with Lower Hudson Valley and Modern Assistance to provide employee assistance services.

The Plan has an agreement with Hinge Health for musculoskeletal care benefits.

**NOTE 12. BENEFITS ADMINISTRATION (continued)**

The Plan had an agreement with Zelis Claims Integrity to provide out of network claims re-pricing services.

The Plan has a contract with Zenith American Solutions (“Zenith”), a third-party administrator, to administer the Plan and administer the processing and payment of claims. The contract provides a monthly fee of \$161,133 effective January 1, 2023 and ending August 31, 2024, when their contract with Zenith was terminated.

On September 1, 2024, the Funds transferred the administration duties from Zenith to Solxsys Administrative Solutions, LLC. The Plan has a contract with Solxsys Administrative Solutions, LLC (“Solxsys”), a third-party administrator, to administer the Plan and administer the processing and payment of claims. The contract provides a monthly fee of \$158,000 effective September 1, 2024 and ending August 31, 2025, a monthly fee of \$164,320 effective September 1, 2025 and ending August 31, 2026; and a monthly fee of \$170,983 effective September 1, 2026 and ending August 31, 2027.

The Plan has an agreement with Zenith to administer the allocation accounts. For Local 223 accounts, the monthly fee was \$1,050 per month from January 1, 2023 to August 31, 2024. For Local 42 accounts, the monthly fee was \$1,730 from January 1, 2023 to August 31, 2024. For Local 35 accounts, the monthly fee was \$1,337 from January 1, 2023 to August 31, 2024. For Local 104 accounts, the monthly fee was \$4,746 per month from January 1, 2023 to August 31, 2024. For Local 488 accounts, the monthly fee was \$1,765 per month from January 1, 2023 to August 31, 2024.

The Plan has an agreement with Solxsys to administer the Local 104’s vacation fund. The agreement provides for a monthly fee of \$600 effective September 1, 2024 to December 31, 2024.

The Plan has an agreement with Zenith to administer the Local 104’s Vacation Fund. The agreement provides for a monthly fee of \$1,107 effective January 1, 2023 to August 31, 2024.

The Plan has an agreement with Solxsys to administer the Local 104's Vacation Fund. The agreement provides for a monthly fee of \$600 effective September 1, 2024 to December 31, 2024.

Effective February 1, 2021, the Board of Trustees approved an agreement with United Health Care/Labor First Medicare Advantage program to provide medical benefits to Medicare eligible retirees. The fees are being charged at \$162.79 per member per month.

Effective June 1, 2022, the Anthem Medicare Advantage Program was implemented.

**NOTE 13. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

The Plan is subject to certain fees mandated by the Patient Protection and Affordable Care Act. Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are equal to \$3.22 per covered life for each of the 2024 and 2023 calendar years. For the years ended December 31, 2024 and 2023, the Plan paid \$28,135 and \$25,254 in PCORI fees.

**NOTE 14. TRANSFER WITHDRAWAL PAYABLE**

Effective September 30, 2016, IBEW Local Union No. 1837 decided to withdraw from participation in the Plan. As of December 31, 2024, \$259,826 has not been transferred out of the Plan.

**NOTE 15. VACATION/SICK TIME BENEFIT PLAN**

The IBEW Local Union No. 104 Vacation/Sick Time Benefit Plan (Vacation/Sick Plan) was created on September 1, 2015 under the Trust Agreement by the Plan. The purpose of Vacation/Sick Time Benefit Plan is to provide members of IBEW Local Union No. 104 with an annual distribution to use for special purposes, like vacations. In addition, vacation benefits can be used for paid sick time. The money used for this benefit is contributed on members' behalf by signatory employers pursuant to a collective bargaining agreement with the IBEW Local Union No. 104 requiring such contributions. The benefits will be paid out twice a year. For the years ended December 31, 2024 and 2023, the contribution rate ranged from \$0.45 to \$1.18 based on classification of worker.

Effective September 1, 2024, contributions are no longer being remitted for the IBEW Local Union No. 104 Vacation/Sick Time Benefit Plan.

Activity for the year ended December 31, 2024 and 2023 is detailed below:

	<u>2024</u>	<u>2023</u>
Beginning balance, January 1,	\$ 3,074,480	\$ 2,437,446
Contributions	2,786,467	3,645,562
Benefits	(3,759,851)	(2,999,523)
Administrative expenses	<u>(11,658)</u>	<u>(9,005)</u>
Ending balance, December 31,	<u>\$ 2,089,438</u>	<u>\$ 3,074,480</u>

**NOTE 16. SUBSEQUENT EVENTS**

The Plan has evaluated subsequent events through September 17, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

**SUPPLEMENTAL INFORMATION**

# NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

## SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Professional fees		
Third party claims and administration expense	\$ 2,428,575	\$ 2,245,367
Legal fees	147,094	144,000
Actuarial fees	21,450	54,275
Consulting	68,872	-
Audit and accounting	60,780	59,470
Payroll compliance review fees	35,716	35,159
Anthem claims management fees	1,523,315	1,465,278
SAV-RX administration fee	48,536	43,167
Claims management fees	207,158	199,009
Child Vaccine Assessment fee	156,814	270,842
Bank charges	33,634	33,608
Miscellaneous	188,072	33,506
Printing	47,644	36,971
Trustee and meeting expenses	22,804	43,732
Postage	234	8,268
Insurance	8,529	7,866
Rent and storage expense	11,624	7,640
	<u>                    </u>	<u>                    </u>
Total administrative expenses	<u>\$ 5,010,851</u>	<u>\$ 4,688,158</u>

# NEW ENGLAND ELECTRICAL WORKERS BENEFITS FUND

## SCHEDULES OF CONTRIBUTIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

2024

<u>Local Union</u>	<u>Employers and Reciprocals</u>	<u>Reciprocals Paid</u>	<u>Self Pays</u>	<u>Vacation/ Sick Time</u>	<u>Reimbursement Benefit Arrangement</u>	<u>Total</u>
7	\$ 7,783,399	\$ (235,887)	\$ 392,470	\$ -	\$ -	\$ 7,939,982
35	10,869,629	(1,098,264)	776,989	-	490,711	11,039,065
42	25,809,949	(3,972,575)	275,577	-	1,687,771	23,800,722
104	46,416,500	(9,159,244)	664,660	2,786,467	3,114,277	43,822,660
223	7,819,836	(888,911)	618,380	-	794,016	8,343,321
488/So. Conn.	7,591,127	(636,686)	892,181	-	299,585	8,146,207
Total	<u>\$ 106,290,440</u>	<u>\$ (15,991,567)</u>	<u>\$ 3,620,257</u>	<u>\$ 2,786,467</u>	<u>\$ 6,386,360</u>	<u>\$ 103,091,957</u>

2023

Employers and Reciprocals	Reciprocals Paid	Self Pays	Vacation/ Sick Time	Reimbursement Benefit Arrangement	Total
\$ 7,330,504	\$ (62,992)	\$ 399,210	\$ -	\$ -	\$ 7,666,722
8,378,995	(303,527)	796,607	-	297,274	9,169,349
28,114,340	(3,284,581)	124,223	-	1,737,297	26,691,279
42,035,570	(8,101,209)	553,256	3,645,562	1,061,180	39,194,359
8,501,179	(969,439)	547,112	-	859,209	8,938,061
6,744,259	(350,079)	841,822	-	244,889	7,480,891
<u>\$ 101,104,847</u>	<u>\$ (13,071,827)</u>	<u>\$ 3,262,230</u>	<u>\$ 3,645,562</u>	<u>\$ 4,199,849</u>	<u>\$ 99,140,661</u>



(a)	(b)	(c)			(d)	(e)
Issuer, Borrower		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value
		Shares/ Type      Principal      Rate      Date				
<u>Mutual funds - equities (continued):</u>						
	Vanguard Short Term Federal (VSGDX)		309,862		\$ 3,379,425	\$ 3,145,101
	Vanguard Short Term TSY (VFIRX)		317,147		3,416,156	3,111,212
	Vanguard Value Index (VVIAX)		19,302		865,221	1,274,704
			Total mutual funds - equities		<u>32,043,249</u>	<u>36,232,832</u>
<u>Exchange-traded funds:</u>						
	Vanguard Growth ETF (VUG)		6,204		1,792,164	2,546,370
	Vanguard Int. High DVD YLD (VYMI)		32,406		2,104,067	2,199,719
	Vanguard Mid-Cap ETF Index (VO)		6,231		1,417,340	1,645,794
	Vanguard S&P 500 ETF (VOO)		4,456		1,821,728	2,400,937
	Vanguard Short-Term Treasury (VGSH)		187,348		11,197,485	10,899,907
	Vanguard Value ETF Index (VTV)		29,938		4,050,941	5,068,503
			Total exchange-traded funds		<u>22,383,725</u>	<u>24,761,230</u>
<u>Mutual funds - money market:</u>						
	Invesco Treasury PTF INSTL		18,710,366		<u>18,710,366</u>	<u>18,710,366</u>
<u>Cash and cash equivalents:</u>						
*	Morgan Stanley Private Bank		48,371		<u>48,371</u>	<u>48,371</u>
			Total investments		<u>\$ 88,020,433</u>	<u>\$ 94,774,233</u>

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

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE  
OF ASSETS HELD