Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for:
- [X] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [X]

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA &

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 03/01/1952

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FUND OF PHILA & VICIN

2500 MCCLELLAN AVENUE, SUITE 140
PENNSAUKEN, NJ 08109

2b Employer Identification Number (EIN)
23-1392600

2c Plan Sponsor's telephone number
856-382-2400

2d Business code (see instructions)
525100

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	09/26/2025	MARIA SCHEELER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	8572
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	8572
a(2) Total number of active participants at the end of the plan year	**6a(2)**	8899
b Retired or separated participants receiving benefits	**6b**	
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	8899
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	281

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 4D 4E 4F 4L

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[X] Trust	**(3)**	[X] Trust
(4)	[ ] General assets of the sponsor	**(4)**	[ ] General assets of the sponsor

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

a Pension Schedules

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

b General Schedules

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

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

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

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

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

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

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA &

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FUND OF PHILA & VICIN

D Employer Identification Number (EIN)
23-1392600

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
DEARBORN NATIONAL 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
36-2598882	71129	VF023360	6356	11/01/2023	10/31/2024

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
47414	0

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

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

CBIZ BENEFITS & INSURANCE SRVCS
P.O. BOX 632886
CINCINNATI, OH 45263

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
47414			

(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		
	(c) Amount	(d) Purpose	(e) Organization code

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

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

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

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

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

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

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

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

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

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

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

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

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

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

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

Part III Welfare Benefit Contract Information

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

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [ ] Dental
- **c** [ ] Vision
- **d** [X] 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** [X] Other (specify) ▶ ACCIDENTAL DEATH & DISMEMBERMENT

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	474139
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2024** **This Form is Open to Public Inspection.**

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

A Name of plan
TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA &

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FUND OF PHILA & VICIN

D Employer Identification Number (EIN)
23-1392600

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).. . . . . [X] 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

BANNER RIDGE PARTNERS LP

84-2225682

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

BLACKSTONE ALTERNATIVE SOLUTIONS

26-0288589

(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)

ADMINISTRATIVE SERVICE PROFESSIONAL

20-4056745

(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 50	NONE	4401000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

HORIZON HEALTHCARE SERVICES, INC.

22-0999690

(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 15 50	NONE	2381903	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CAPITAL RX

35-2612946

(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	1043389	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

GUARDIAN NURSES HEALTHCARE ADVOCATE

57-1187937

(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 49 50	NONE	464677	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

SWORD HEALTH

83-4333673

(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 15 50	NONE	341925	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

AETNA LIFE INSURANCE COMPANY

06-6033492

(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	322623	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

ZELIS CLAIMS INTEGRITY INC.

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 15 50	NONE	320501	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

COLOR HEALTH, INC.

46-3353585

(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	262852	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

STEVENS & LEE

23-1886296

(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	253777	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

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

CALL A DOCTOR PLUS (DOXA DBA)

47-4868271

(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	253342	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CASTLIGHT HEALTH, INC.

26-1989091

(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	228454	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

BANNER RIDGE PARTNERS LP

84-2225682

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51 52	NONE	210652	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [ ] No [X]

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)

MARKOWITZ & RICHMAN

23-2111581

(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	142468	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

RBC WEALTH MANAGEMENT

41-1416330

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 50 51	NONE	141636	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

TOTAL CARE NETWORK, INC.

23-2740082

(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 15 16 50	NONE	129859	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

ZELIS PAYMENTS HOLDINGS, LLC

45-2579291

(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 49 50	NONE	99541	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

WITHUMSMITH+BROWN, PC

22-2027092

(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	74880	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

FOSTER & FOSTER, INC.

59-1921114

(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 16 50	NONE	73025	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

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	60000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LV PRINT CENTER LLC

93-1517255

(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 49 50	NONE	50740	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

PHARMACY INVESTIGATORS & CONSULTANT

83-1412332

(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	50000	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

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

FAIR HEALTH, INC.

90-0524293

(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	42500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

NATIONAL VISION ADMINISTRATORS, LLC

74-3033381

(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 65	NONE	35008	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

WILLIAM EINHORN

23-1392600

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
20 31 50	NONE	15500	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

Part I Service Provider Information (continued)

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

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation

(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.

(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.

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

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

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

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

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

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

Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)

(complete as many entries as needed)

a	Name: WITHUMSMITH+BROWN, PC	**b** EIN:	22-2027092
c	Position: IQPA		
d	Address: 4600 EAST WEST HIGHWAY, SUITE 900 BETHESDA, MD 20814-3423	**e** Telephone:	301-272-6000

Explanation: FUND TRUSTEES CHANGED ACCOUNTANT THROUGH NORMAL BIDDING PROCESS

a	Name:	**b** EIN:	
c	Position:		
d	Address:	**e** Telephone:	

Explanation:

a	Name:	**b** EIN:	
c	Position:		
d	Address:	**e** Telephone:	

Explanation:

a	Name:	**b** EIN:	
c	Position:		
d	Address:	**e** Telephone:	

Explanation:

a	Name:	**b** EIN:	
c	Position:		
d	Address:	**e** Telephone:	

Explanation:

SCHEDULE H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA &

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FUND OF PHILA & VICIN

D Employer Identification Number (EIN)
23-1392600

Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	7442294	8257487
(2) Participant contributions	1b(2)	46608	44072
(3) Other	1b(3)	628207	3066912
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	9814621	6704701
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		6952543
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	140491833	140785053
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)	2694860	

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
e Buildings and other property used in plan operation	1e	2079393	111264
f Total assets (add all amounts in lines 1a through 1e)	1f	163197816	165922032
Liabilities			
g Benefit claims payable	1g	13557000	13254000
h Operating payables	1h	244105	347035
i Acquisition indebtedness	1i		
j Other liabilities	1j	890981	868362
k Total liabilities (add all amounts in lines 1g through1j)	1k	14692086	14469397
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	148505730	151452635

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: **(A)** Employers	2a(1)(A)	116424804	
(B) Participants	2a(1)(B)	602684	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		117027488
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	78083	
(B) U.S. Government securities	2b(1)(B)	262497	
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		340580
(2) Dividends: **(A)** Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)	6464425	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		6464425
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	45620748	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	44564716	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		1056032
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)	-3167729	
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		-3167729

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1058049
c Other income	2c		130763
d Total income. Add all **income** amounts in column (b) and enter total	2d		122909608
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	113805936	
(2) To insurance carriers for the provision of benefits	2e(2)	434446	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		114240382
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	4401000	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	134880	
(5) Investment advisory and investment management fees	2i(5)	210652	
(6) Bank or trust company trustee/custodial fees	2i(6)	141636	
(7) Actuarial fees	2i(7)	73025	
(8) Legal fees	2i(8)	396940	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	45496	
(11) Other expenses	2i(11)	318692	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		5722321
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		119962703
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		2946905
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) [X] 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)** [X] 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
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)	4a		X	
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.)	4b		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)	4c		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)	4d		X	
e Was this plan covered by a fidelity bond?	4e	X		500000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g	X		6952543
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	4i	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	4j	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4k		X	
l Has the plan failed to provide any benefit when due under the plan?	4l		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	4m			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.	4n			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] No

If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

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

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

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

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

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

FINANCIAL STATEMENTS

DECEMBER 31, 2024

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

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Novak Francella LLC | CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Teamsters Health and Welfare Fund of
Philadelphia and Vicinity

We have audited the financial statements of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity (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 the related statements of changes in net assets available for benefits and of changes in benefit obligations for the year then ended, and the related notes to the financial statements.

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

Basis for Opinion

We conducted our audit 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 audit. 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 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.

Other matter - 2023 financial statements

The financial statements of the Plan as of and for the year ended December 31, 2023 were audited by other auditors whose report dated August 5, 2024, expressed an unmodified opinion on those statements.

Report on Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule of Assets Held at End of Year, Schedule of Reportable Transactions, 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 and Schedule of Reportable Transactions 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 audit 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 15, 2025

Teamsters Health and Welfare Fund of Philadelphia and Vicinity

Statements of Net Assets Available for Benefits

December 31, 2024 and 2023

	2024	2023
Assets		
Investments - at fair value		
United States Government and Government Agency obligations	$ -	$ 44,156,638
Mutual funds - fixed income	140,785,053	94,322,359
Limited partnerships	6,952,543	4,707,696
Interest-bearing cash	6,704,701	9,814,621
Total investments	154,442,297	153,001,314
Receivables		
Employer contributions	8,257,487	7,442,294
Participants' contributions (COBRA)	44,072	46,608
Accrued investment income	579,519	628,207
Other receivable	14,661	-
Total receivables	8,895,739	8,117,109
Cash advance deposits	1,977,453	1,930,613
Prepaid expenses	495,279	37,516
Other assets	111,264	111,264
Total assets	165,922,032	163,197,816
Liabilities and Net Assets		
Liabilities		
Accrued administrative expenses	347,035	244,105
Deferred participant and COBRA contributions	868,362	890,981
Total liabilities	1,215,397	1,135,086
Net assets available for benefits	$ 164,706,635	$ 162,062,730

See accompanying notes to financial statements.

Teamsters Health and Welfare Fund of Philadelphia and Vicinity

Statements of Changes in Net Assets Available for Benefits

Years Ended December 31, 2024 and 2023

	2024	2023
Additions		
Investment income		
Net appreciation (depreciation) in fair value of investments	$ (1,053,648)	$ 8,895,631
Interest and dividends	6,805,005	4,152,223
	5,751,357	13,047,854
Less investment expenses	(352,288)	(138,428)
Investment income - net	5,399,069	12,909,426
Contributions		
Employer contributions	116,424,804	114,624,008
Participant and COBRA contributions	602,684	607,484
Total contributions	117,027,488	115,231,492
Other income	130,763	-
Total additions	122,557,320	128,140,918
Deductions		
Cost of benefits		
Medical, surgical, x-ray, lab work and hospitalization	81,853,963	84,850,200
Prescription, net of rebates	20,869,680	20,453,976
Dental	5,063,740	4,533,263
Disability	805,363	835,400
Death	434,446	448,620
Vision	226,475	241,120
Disease management and behavior health	884,940	840,318
	110,138,607	112,202,897
Benefit provider administrative fees	4,358,046	4,112,356
Fees mandated by the ACA	46,729	44,232
Total cost of benefits	114,543,382	116,359,485
Administrative expenses	5,370,033	4,641,299
Total deductions	119,913,415	121,000,784
Net increase	2,643,905	7,140,134
Net assets available for benefits		
Beginning of year	162,062,730	154,922,596
End of year	$ 164,706,635	$ 162,062,730

See accompanying notes to financial statements.

Teamsters Health and Welfare Fund of Philadelphia and Vicinity

Statements of Benefit Obligations

December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries and dependents		
Self-insured claims, insurance premiums payable and claims incurred but not reported	$ 13,254,000	$ 13,557,000
Other obligations for current benefit coverage at present value of estimated amounts - net of amounts currently payable		
Accumulated eligibility credits	20,701,000	21,033,000
Postretirement benefit obligations - net of amounts currently payable		
Current retirees	3,892,200	4,212,000
Other participants fully eligible for benefits	437,500	511,700
Other participants not fully eligible for benefits	46,000	61,600
Death benefits under total disability claims	450,400	516,500
Total postretirement benefit obligations	4,826,100	5,301,800
Total benefit obligations	$ 38,781,100	$ 39,891,800

See accompanying notes to financial statements.

Teamsters Health and Welfare Fund of Philadelphia and Vicinity

Statements of Changes in Benefit Obligations

Years Ended December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries, and dependents		
Balance at beginning of year	$ 13,557,000	$ 13,447,800
Increase (decrease) during the year attributable to changes in self-insured claims, insurance premiums payable, and claims incurred but not reported	(303,000)	109,200
Balance at end of year	13,254,000	13,557,000
Other obligations for current benefit coverage - at present value of estimated amounts, net of amounts currently payable		
Balance at beginning of year	21,033,000	21,576,500
(Decrease) during the year attributable to changes in accumulated eligibility credits	(332,000)	(543,500)
Balance at end of year	20,701,000	21,033,000
Postretirement benefit obligations - net of amounts currently payable		
Balance at beginning of year	5,301,800	5,444,000
Increase (decrease) during the year attributable to		
Service cost	38,200	38,800
Interest cost	239,800	248,800
Expected benefit payments	(371,500)	(384,700)
Change in actuarial experience	2,200	(73,200)
Change in actuarial assumptions	(384,400)	28,100
Balance at end of year	4,826,100	5,301,800
Total benefit obligations	$ 38,781,100	$ 39,891,800

See accompanying notes to financial statements.

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF PLAN

The Teamsters Health and Welfare Fund of Philadelphia and Vicinity (the Plan) is a multiemployer, defined benefit health and welfare plan that was established under the terms of collective bargaining agreements between the employers and Teamsters local unions (the local unions), primarily located in southeastern Pennsylvania, New Jersey and Delaware. The Plan covers all eligible employees working for employers who have a collective bargaining agreement with local unions under which the employers have agreed to make contributions to the Plan on the employees' behalf in accordance with negotiated hourly rates.

The Plan is generally non-contributory but does provide for participant contributions under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The Plan provides health and other benefits to eligible participants who are covered under collective bargaining agreements, or other written agreements, with the local unions. The Plan is administered by a Board of Trustees with equal representation by the employers and the local unions and is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Plan provides health benefits (medical, dental, prescription drug, behavioral health and substance abuse treatment, vision, and life insurance), short-term disability and death benefits for covered employees and their beneficiaries and covered dependents. Generally, to be eligible for benefits, an employee must be employed by a contributing employer or employers and be working within the jurisdiction of a local union which is a party to the Plan either 15 days in the month that is two months prior to the month of medical treatment or 180 days in the 12-month period that is two months prior to the month of medical treatment. Alternatively, some employees enjoy benefit eligibility during the same month that an employer remits a stated contractual amount of contributions. Retired participants are entitled to death benefits to be paid to their beneficiaries provided their employer has not decertified and/or has not ceased participation in the Plan in favor of another group health program at the time of death.

Information about eligibility, benefit provisions, and the priority order of participants' claims to the assets of the Plan upon termination is contained in the Summary Plan Description. Copies are available from the Plan Administrator.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Investment Valuation and Income Recognition - Investments in United States Government and Government Agency obligations and mutual fund are carried at fair value as provided by the investment custodian, which generally represents quoted market prices or net asset value of the fund as of the last business day of the year. The limited partnerships in are carried at estimated fair value as reported on their Schedule K-1's.

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 (depreciation) in fair value of investments included the Plan's gains and losses on investments bought and sold as well as held during the year.

Contributions Receivable - Contributions due and not paid prior to the year end are recorded as contributions receivable. Allowance for uncollectible accounts is considered unnecessary and is not provided.

Contributions from Participants (Cobra) - Participants who become ineligible for coverage under the Plan's eligibility requirements can continue their coverage through COBRA. Contribution amounts are determined by the Plan's actuary in accordance with COBRA regulations. Contribution revenue is recognized in the period the benefits are provided to the participant.

Deferred Contributions - Deferred contributions represent cash received for contributions for the portion not yet earned based on the work period.

Benefit Obligations - Claims incurred but not reported, accumulated eligibility credits, and postretirement benefits were estimated by the Plan's consultant.

Cash Advance - The Plan is required to maintain a cash advance reserve with Horizon Blue Cross, which can be drawn against to reduce future claim payments, when claims paid to Horizon exceed the total of claims paid and other charges. The cash advance has been included as an asset of the Plan until such amounts are used to pay claims. The cash advance will be returned to the Plan, less any outstanding claims, should the insurance contract terminate.

Rebates - Rebates due from the Plan's Pharmacy Benefit Manager are recorded when earned. Pharmacy rebates totaling $9,601,125 and $8,834,920 have been netted with prescription claims paid in the accompanying Statements of Changes in Net Assets Available for Benefits for the years ended December 31, 2024 and 2023, respectively.

Payments of Benefits - Self-funded claims and premiums are paid for medical, dental, prescription drug, behavioral health and substance abuse treatment, vision, disability, life insurance, short-term disability and death benefits are recorded when paid by the Plan in the accompanying Statements of Changes in Net Assets Available for Benefits. Amounts due at year end for claims payable or incurred but not reported are reported on the Statements of Benefit Obligations.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

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

NOTE 3. 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 a 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 4. TAX STATUS

The Plan obtained its latest determination letter on June 17, 1953, 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 Trustees 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 5. FUNDING POLICY

The Plan is funded by employer contributions as specified in the collective bargaining agreements. Employer contributions are accounted for as exchange transactions. The contributions amounts are based upon remittance reports filed by the employers.

The Trustees have established a policy requiring audits of payroll records of employers who are selected by random sampling and judgmental methods. Special audits include those performed on employers that have withdrawn from the Plan and those performed at the request of covered employers. These audits are conducted on employers' payroll records based upon reports filed with the Plan for the calendar year prior to the audit date. These audits are in addition to the Plan's normal verification procedures applied to contributions reports filed for the current year.

NOTE 6. CASH CONCENTRATIONS

Interest-bearing cash at December 31, 2024 and 2023, consisted of the following:

	2024	2023
Fulton Bank:		
Regular checking	$ 258,787	$ -
Benefit account	(239,838)	-
Sweep account	6,161,928	-
	6,180,877	-
Republic Bank:		
Regular checking	-	244,539
Benefit account	-	(483,927)
Sweep account	-	6,345,528
	-	6,106,140
RBC - Principal cash:	523,824	3,708,481
Total	$ 6,704,701	$ 9,814,621

The Plan places its cash with a financial institution deemed to be creditworthy. At year end December 31, 2024, cash balances with Fulton Bank and RBC exceeded the insured deposit limit of $250,000 in a single bank by $5,930,877 and $273,824, respectively.

NOTE 7. 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.

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.

NOTE 7. FAIR VALUE MEASUREMENTS (continued)

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.

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
Mutual funds - fixed income	$ 140,785,053	$ 140,785,053	$ -	$ -
Interest-bearing cash	6,704,701	6,704,701	-	-
Total assets in the fair value hierarchy	147,489,754	$ 147,489,754	$ -	$ -
Investments measured at NAV	6,952,543			
Total investments	$ 154,442,297			

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
United States Government and Government Agency obligations	$ 44,156,638	$ 44,156,638	$ -	$ -
Mutual funds - fixed income	94,322,359	94,322,359	-	-
Interest-bearing cash	9,814,621	9,814,621	-	-
Total assets in the fair value hierarchy	148,293,618	$ 148,293,618	$ -	$ -
Investments measured at NAV	4,707,696			
Total investments	$ 153,001,314			

In accordance with Subtopic 820-10, certain investments that are measured at fair value using the net asset value per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the statement of net assets available for benefits.

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 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. FAIR VALUE MEASUREMENTS (continued)

The unfunded commitments and redemption information are as follows at December 31, 2024:

	Fair Value	Unfunded Commitments		Redemption Frequency	Redemption Notice Period
Limited partnerships:					
Blackstone BSOF Parallel Offshore Fund Ltd.	$ 144,438	$ 1,711,463	*	(a)	(a)
Banner Ridge Small Buyouts I (Offshore), LP	3,166,168	1,358,418		(b)	(b)
Banner Ridge Secondary Fund IV (Offshore), LP	3,641,937	3,554,337		(b)	(b)
Total	$ 6,952,543	$ 6,624,218			

The unfunded commitments and redemption information are as follows at December 31, 2023:

	Fair Value	Unfunded Commitments		Redemption Frequency	Redemption Notice Period
Limited partnerships:					
Blackstone BSOF Parallel Offshore Fund Ltd.	$ 229,237	$ 1,788,882	*	(a)	(a)
Banner Ridge Secondary Fund IV (Offshore), LP	4,478,459	2,516,258		(b)	(b)
Total	$ 4,707,696	$ 4,305,140			

(a) - The fund is organized for the primary purpose to achieve attractive, risk-adjusted returns by investing in a portfolio of assets that may be sourced by Blackstone Alternative Solutions and/or managed certain managers or advisors that invest or trade in a wide variety of securities and financial instruments. Redemption payments may be in cash or in-kind or in any combination of the foregoing. Payments of redemption proceeds will generally be made at the earliest practicable date following the Consolidated Fund's receipt of proceeds from the liquidation of the applicable investment.

(b) - The fund is organized for the purpose of purchasing, selling, investing and trading in securities primarily issued by investment funds that are managed by independent portfolio managers through secondary and primary transactions. Redemption is not allowed for these investments.

* - While there is still an unfunded commitment to the BSOF Fund, the BSOF Fund has been closed and the Plan does not anticipate any additional capital will actually be called for this BSOF Fund.

NOTE 7. FAIR VALUE MEASUREMENTS (continued)

The Blackstone BSOF Parallel Offshore Fund Ltd., Banner Ridge Small Buyouts I (offshore, LP, and Banner Ridge Secondary Fund IV (Offshore), LP are measured at fair value, without adjustment by the Plan, based on the net asset value (NAV) or NAV equivalent as of December 31, 2024 and 2023.

NOTE 8. RELATED PARTY TRANSACTIONS

The Fund and the Teamsters Pension Trust Fund of Philadelphia and Vicinity maintain a corporation known as Administrative Service Professionals, inc. ("ASP"). The Fund owns 72% of ASP. ASP provides administrative services to the Plan for a negotiated fixed amount, based upon the number of members. During 2024 and 2023, the Plan paid ASP $4,401,000 and $3,797,000, respectively, which is included in administrative expenses on the statements of changes in net assets available for benefits.

The above transactions qualify as party-in-interest transactions which are exempt from the prohibited transaction rules of ERISA.

NOTE 9. ACTIVE PARTICIPANTS' ACCUMULATED ELIGIBILITY

Active participants who have worked the minimum required days in a given Work Period are eligible for health benefits during the corresponding Benefit Period. Generally, to be eligible for benefits, a participant must be employed by a contributing employer or employers and be working within the jurisdiction of a local union which is a party to the Plan either 15 days in the month that is two months prior to the month of medical treatment or 180 days in the 12-month period that is two months prior to the month of medical treatment. Alternatively, some employees enjoy benefit eligibility during the same month that an employer remits a stated contractual amount of contributions.

At December 31, 2024 and 2023, the active participants had earned an accumulated eligibility for benefits in 2024 and 2023 in the amount of $20,701,000 and $21,033,000, respectively.

The estimated liability for accumulated eligibility is based upon the average monthly cost of benefits per participant multiplied by the number of months of benefits earned for a future period by the end of the plan year.

NOTE 10. POSTRETIREMENT BENEFITS

The Plan currently provides certain retired participants with post-retirement death benefits. Those retirees eligible for these benefits must meet defined requirements, such as retiring on or after July 1, 1973 and must have been eligible for Health and Welfare Fund benefits under the Fund's Plan covering active employees for at least 36 months of the 60 months preceding the effective date of retirement.

NOTE 10. POSTRETIREMENT BENEFITS (continued)

Life insurance coverage is provided to retired participants, as well as totally disabled participants. Retiree Death Benefits are $1,000 paid upon the death of certain retirees to any designated beneficiary. $500 is paid upon the death of certain retiree's spouses to the retiree, provided the eligible participant survives the spouse. Disabled Death Benefits are $3,000 paid upon the death of a totally disabled retiree to any designated beneficiary. The total and permanent disability death benefit described in the current Plan has been amended to provide that those individuals who became eligible for the total and permanent disability death benefit after the effective date of November 1, 2014 will remain eligible for it until reaching age 65, assuming the individual satisfies all other eligibility requirements for the benefit, at which point they will become eligible for the Retiree Death Benefit. There is no change to the benefit for those participants who were eligible for the total and permanent disability death benefit as of November 1, 2014, provided that they continue to satisfy all other eligibility requirements for the benefit.

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 or terminated participants and their beneficiaries and dependents, and (2) active participants and their beneficiaries and dependents after retirement from service 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.

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, or retirement) between the valuation date and the expected date of payment.

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

Weighted-average discount rate: 5.40% for 2024 and 4.65% for 2023

Rates of retirement:

Age	Rate	Age	Rate
55	50 %	64 - 65	30%
56 - 61	10 %	66	50%
62	25 %	67 - 69	25%
63	40 %	70+	100%

Mortality: The Head count-weighted PRI-2012 Employee and Healthy Retiree and Disabled Retiree rate Tables projected generationally from 2012 with Scale MP-2020.

NOTE 10. POSTRETIREMENT BENEFITS (continued)

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 following changes in actuarial assumptions were made in the December 31, 2024 valuation:

The discount rate was changed from 4.65% to 5.40% in accordance with corporate AAA bond rates as of the measurement date.

NOTE 11. DEPOSITS WITH SERVICE PROVIDERS

The Plan has an advanced deposit with Horizon totaling $1,977,453 and $1,930,613 for the Plan years ended December 31, 2024 and 2023, respectively. This deposit was required by Horizon as part of the arrangement between Horizon and the Plan, effective July 1, 2003. The deposit is reviewed annually by Horizon during the renewal period July 1st of each year to determine whether the amount on deposit is adequate. Under the terms of this arrangement, the deposit is used to fund claims that are paid by Horizon on behalf of the Plan that have not yet been invoiced.

NOTE 12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

The following is a reconciliation of net assets available for benefits as reported on the financial statements as of December 31, 2024 and 2023, to the balances as reported on Form 5500:

	2024	2023
Net assets available for benefits as reported on the financial statements	$ 164,706,635	$ 162,062,730
Benefit obligations currently payable and claims incurred but not reported	(13,254,000)	(13,557,000)
Net assets available for benefits as reported on Form 5500	$ 151,452,635	$ 148,505,730

NOTE 12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (continued)

The following is a reconciliation of total benefits as reported on the financial statements for the year ended December 31, 2024, to the balance reported on Form 5500:

Total benefits as reported on the financial statements	$ 114,543,382
Less: Amounts reported as fees mandated by the ACA - 2023	
Add: Amounts currently payable and claims incurred but not reported - 2024	13,254,000
Less: Amounts currently payable and claims incurred but not reported - 2023	(13,557,000)
Total benefits as reported on Form 5500	$ 114,240,382

Benefit obligations currently payable and claims incurred but not reported at December 31, 2024 and 2023, are included in the Statements of Benefit Obligations in the financial statements but are included as liabilities on Form 5500.

NOTE 13. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market, and sector risks. Due to the level of risk 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 14. 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 (ACA). Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are effective for seven years, through 2018, and are equal to $2 per covered life for the 2013 calendar year. Effective December 20, 2019, the PCORI fee has been extended for 10 years and will be imposed through the year 2029. The fee will be indexed based on increases in the projected per capita amount of national health expenditures. For the year ended December 31, 2024 and 2023, the Plan paid $46,729 and $44,232, respectively, in PCORI fees.

NOTE 15. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through September 15, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

Teamsters Health & Welfare Fund of Philadelphia and Vicinity

Schedules of Administrative Expenses

Years Ended December 31, 2024 and 2023

	2024	2023
Administrative fees	$ 4,401,000	$ 3,797,000
Actuarial fees	73,025	141,353
Accounting, auditing, and government filings	134,880	65,000
Legal fees	396,940	270,918
Postage and delivery	87,369	98,754
Office supplies and expense	68,477	48,173
Stationery and printing	34,605	32,634
Data processing	47,714	64,396
Dues and subscriptions	5,173	4,963
Insurance	75,354	75,447
Conference and meetings	45,496	42,661
Total administrative expenses	$ 5,370,033	$ 4,641,299

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

SCHEDULE OF ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

Form 5500, Schedule H, Line 4i

EIN:23-1392600
Plan No: 501

(a)	(b)	(c)			(d)	(e)
	Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value
		Type	Shares/ Principal	Interest Rate	Maturity Date	
		Mutual funds - fixed income:				
	Guggenheim Total Return Bond Fund		2,830,901			$ 69,470,439	$ 66,384,617
	Lord Abbett Short Duration Income Fund		2,158,078			8,943,869	8,330,183
	PGIM Total Return Bond Fund		5,589,670			70,302,662	66,070,253
		Total mutual funds - fixed income				148,716,970	140,785,053
		Limited partnerships:					
	Blackstone BSOF Parallel Offshore Fund Ltd		1			99,128	144,438
	Banner Ridge Small Buyouts I (Offshore), L.P.		1			2,641,582	3,166,168
	Banner Ridge Secondary Fund IV (Offshore), L.P.		1			654,694	3,641,937
		Total limited partnerships				3,395,404	6,952,543
		Interest-bearing cash:					
	Republic Bank Checking Account		258,787	1.51 %		258,787	258,787
	Republic Bank Benefit Account		(239,838)	1.64		(239,838)	(239,838)
	Republic Bank Sweep Account		6,161,928	1.14		6,161,928	6,161,928
*	RBC Insured Deposits		523,824	4.21		523,824	523,824
		Total interest-bearing cash				6,704,701	6,704,701
		Total investments				$ 158,817,075	$ 154,442,297

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

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Line 4j

EIN:23-1392600
Plan No: 501

(a)	(b) Description of Asset	(c) Purchase Price	(d) Selling Price	(e) Cost of Asset	(f) Current Value of Asset	(g) Net Gain (Loss) on Transaction
	Guggenheim Total Return Bond Fund	$ 27,512,631	N/A	$ 27,512,631	$ 27,512,631	N/A
	Guggenheim Total Return Bond Fund	N/A	$ 1,400,000	1,531,775	1,400,000	$ (131,775)
	PGIM Total Return Bond Fund	27,588,693	N/A	27,588,693	27,588,693	N/A
	PGIM Total Return Bond Fund	N/A	1,550,000	1,759,389	1,550,000	(209,389)
	United States Treasury Note Maturity Date 12/31/2023 Rate 2.250%	N/A	22,105,000	21,738,022	22,105,000	366,978
	United States Treasury Note Maturity Date 01/15/2024 Rate 0.125%	N/A	22,105,000	21,415,946	22,105,000	689,054

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110
1210 - 0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

A This return/report is for: [X] a multiemployer plan [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
[ ] a single-employer plan [ ] a DFE (specify) _____

B This return/report is: [ ] the first return/report [ ] the final return/report
[ ] an amended return/report [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here ▶ [X]

D Check box if filing under: [X] Form 5558 [ ] automatic extension [ ] the DFVC program
[ ] special extension (enter description)

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

Part II Basic Plan Information - enter all requested information

1a Name of plan
TEAMSTERS HEALTH & WELFARE FUND OF PHILADELPHIA &

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 03/01/1952

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
BOARD OF TRUSTEES OF TEAMSTERS HEALTH & WELFARE FU

2500 MCCLELLAN AVENUE, SUITE 140

PENNSAUKEN NJ 08109

2b Employer Identification Number (EIN) 23-1392600

2c Plan Sponsor's telephone number 856-382-2400

2d Business code (see instructions) 525100

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

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

SIGN HERE	X Maria Scheeler	09/26/25	MARIA SCHEELER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:
a Sponsor's name
c Plan Name

4b EIN

4d PN

5 Total number of participants at the beginning of the plan year	**5**	8,572
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a (1) Total number of active participants at the beginning of the plan year	**6a(1)**	8,572
a (2) Total number of active participants at the end of the plan year	**6a(2)**	8,899
b Retired or separated participants receiving benefits	**6b**	
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	8,899
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	
g (1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	281

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 4D 4E 4F 4L

9a Plan funding arrangement (check all that apply)
- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [ ] General assets of the sponsor

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

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

b General Schedules
- **(1)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information - Small Plan)
- **(3)** [X] **A** (Insurance Information) - Number Attached 1
- **(4)** [X] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS