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
MM&P HEALTH AND BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 08/01/1950

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)
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

700 MARITIME BLVD.
LINTHICUM HEIGHTS, MD 21090

2b Employer Identification Number (EIN) 13-6696938

2c Plan Sponsor's telephone number 410-850-8500

2d Business code (see instructions) 483000

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.	10/07/2025	DONALD JOSBERGER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/07/2025	DANNY DEFANTI
	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**	5343
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)**	3783
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	3874
b	Retired or separated participants receiving benefits	**6b**	1526
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	5400
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**	71

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F 4H 4K 4L 4Q 4T 4U

9a Plan funding 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

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 6
- **(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
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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
PRUDENTIAL

(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
22-1211670	68241	48403-LTC	70	09/01/2023	08/31/2024

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

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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

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

Part II Investment and Annuity Contract Information

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

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** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☒ Other (specify) ▶ LONG-TERM CARE

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	186945
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 ☒ No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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
AETNA 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
06-6033492	60054	700285	14	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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	(c) Amount	**(d)** Purpose	

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	(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** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☒ Other (specify) ▶ LONG-TERM CARE

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	26734
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 ☒ No

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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OMB No. 1210-0110

2024

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

A Name of plan
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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
AMALGAMATED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5501223	60216	26MD05	3332	07/01/2023	06/30/2024

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

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

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

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

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

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

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	(c) Amount	**(d)** Purpose	

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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** [ ] Other (specify) ▶

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**	144947
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.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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

1 Coverage Information:

(a) Name of insurance carrier
THE NORTH RIVER 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
22-1964135	21105	NR402927	3061	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
17277	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

SEGAL COMPANY, INC
333 W 34TH STREET
NEW YORK, NY 10001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
17277			3

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

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

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

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

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

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

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

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

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

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

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

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

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** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

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**	431915
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.			**10b**	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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
RELIASTAR 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
41-0451140	67105	EXRK	988	04/01/2023	03/31/2024

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
72409	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

THE SEGAL COMPANY EASTERN STATES IN
PO BOX 4058 CHURCH STREET STATION
NEW YORK, NY 10261-4058

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
72409	0		3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(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** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

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	2068843
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.			10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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

1 Coverage Information:

(a) Name of insurance carrier
THE NORTH RIVER 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
22-1964135	21105	NR402964	557	07/01/2023	06/30/2024

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

(a) Total amount of commissions paid	**(b)** Total amount of fees paid
44896	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

SEGAL COMPANY, INC
333 W 34TH STREET
NEW YORK, NY 10001

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	**(d)** Purpose	**(e)** Organization code
44896			3

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(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** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [X] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

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**	1122411
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.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [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
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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

PIMCO

33-0629048

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

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

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

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)

CIGNA

06-0303370

(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 31 38 49 62 56 50	NONE	948670	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

SLEVIN & HART

52-1708613

(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 56	NONE	495184	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE SEGAL COMPANY

13-1835864

(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 53	NONE	302437	Yes [X] No [ ]	Yes [ ] No [X]	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)

MULTIPLAN

13-3068979

(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	267313	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

PATRICK MCCULLOUGH

13-6696938

(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?
35 50	EMPLOYEE	248367	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

IOMM&P

13-6020335

(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?
14 50	SPONSORING UNION	227188	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)

KENNETH RYAN

13-6696938

(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?
35 50	EMPLOYEE	200151	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DELTA DENTAL

23-1667011

(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	159108	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MICHAEL MCCULLOUGH

13-6696938

(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?
35 50	EMPLOYEE	151191	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)

ROFFE ENTERPRISES

52-1650540

(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	132130	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JOSEPH GIUSTO

13-6696938

(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?
35 50	EMPLOYEE	125119	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

DAVID ROMANO

13-6696938

(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?
35 50	EMPLOYEE	120638	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)

PAULA PHILLIPS

13-6696938

(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?
35 50	EMPLOYEE	117214	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

SHAWNA THORNTON

13-6696938

(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?
35 50	EMPLOYEE	113117	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ANN MCCULLOUGH

13-6696938

(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?
35 50	EMPLOYEE	104658	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)

DEBRA CAVEY

13-6696938

(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?
35 50	EMPLOYEE	92971	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MARCIA FAWTHROP

13-6696938

(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?
35 50	EMPLOYEE	90265	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ALFRED MANZO

13-6696938

(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?
35 50	EMPLOYEE	86046	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)

JESSICA CHADWELL

13-6696938

(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?
35 50	EMPLOYEE	80450	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ALICE ANDRZEJEWSKI

13-6696938

(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?
35 50	EMPLOYEE	75937	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

RX SAVINGS LLC

26-3642434

(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	75567	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)

DENISE ROMANO

13-6696938

(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?
35 50	EMPLOYEE	73036	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MARY JURNEY

13-6696938

(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?
35 50	EMPLOYEE	65063	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DIANE FITZBERGER

13-6696938

(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?
35 50	EMPLOYEE	64499	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)

ROMNEY PATTISON

13-6696938

(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?
35 50	EMPLOYEE	63797	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

SYDNIE BOSSOM

13-6696938

(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?
35 50	EMPLOYEE	63464	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CYNTHIA LAMARTINA

13-6696938

(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?
35 50	EMPLOYEE	60836	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)

RUSS BALZARINI

13-6696938

(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?
35 50	EMPLOYEE	60750	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MAYRA ROBLES

13-6696938

(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?
35 50	EMPLOYEE	59360	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

KATHRYNE MCGEE

13-6696938

(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?
35 50	EMPLOYEE	59276	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)

AMERICAN HEALTH HOLDINGS LLC

31-1368946

(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	58170	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JEAN ADAMS-MENCIK

13-6696938

(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?
35 50	EMPLOYEE	58163	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

SEAN MEAD

13-6696938

(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?
35 50	EMPLOYEE	56847	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)

VERA BRENNAN

13-6696938

(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?
35 50	EMPLOYEE	56563	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

LISA LINDAUER

13-6696938

(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?
35 50	EMPLOYEE	52053	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MADELINE PETRELLI

13-6696938

(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?
35 50	EMPLOYEE	51506	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)

JENNIFER KELLNER

13-6696938

(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?
35 50	EMPLOYEE	51220	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

GORFINE SCHILLER & GARDYN PA

52-1231901

(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	48887	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CATHERINE GEOGHEGAN

13-6696938

(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?
35 50	EMPLOYEE	46784	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)

TERRENCE SHOWERS

13-6696938

(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?
35 50	EMPLOYEE	46444	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

ELIZABETH GARY

13-6696938

(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?
35 50	EMPLOYEE	45730	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

MASHA JURNEY

13-6696938

(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?
35 50	EMPLOYEE	42584	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)

B.I.C.C

36-2852073

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	41180	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

LAURY JACKSON

13-6696938

(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?
35 50	EMPLOYEE	39953	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

JESSICA PERKINS

13-6696938

(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?
35 50	EMPLOYEE	35514	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)

K.P. LAW, P.C.

04-2746356

(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	33497	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

CATHLEEN BRADLEY

13-6696938

(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?
35 50	EMPLOYEE	32455	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

KELSEY JOHNSON

13-6696938

(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?
35 50	EMPLOYEE	31952	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)

TELUS HEALTH

52-1883918

(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	29494	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DANIELLE RAU

13-6696938

(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?
35 50	EMPLOYEE	28481	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

GREEN LIGHT COST MANAGEMENT

45-5248276

(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	25621	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)

STACEY SULLIVAN

13-6696938

(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?
35 50	EMPLOYEE	23983	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

CHARLENE ROGERS

13-6696938

(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?
35 50	EMPLOYEE	23019	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE NORTHERN TRUST COMPANY

36-1561860

(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 50	NONE	19020	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)

EYEMED VISION CARE LLC

31-1656473

(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 14 16 50	NONE	16032	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MARINER INSTITUTIONAL LLC (AND CO)

59-3676225

(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?
27 50	NONE	15000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

KIMBERLY GABLE

13-6696938

(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?
35 50	EMPLOYEE	14878	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)

TERRASA & STAIR, P.A.

27-1399538

(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	14454	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

JACK FINZ

7055 SOUTHPORT DR.
BOYNTON BEACH, FL 33472

(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	11898	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

MARY FRANCES RIDGELY

13-6696938

(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?
35 50	EMPLOYEE	11874	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)

GEORGE AIKINS

13-6696938

(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?
35 50	EMPLOYEE	9360	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

DAVID MICHELS

13-6696938

(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?
35 50	EMPLOYEE	9053	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

AVAILITY, LLC.

59-3715944

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	9000	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)

ADP

13-3036745

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	7643	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

JUSTIN JONES

13-6696938

(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?
35 50	EMPLOYEE	5143	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

INTERNATIONAL SCHOLARSHIP AND TUITI

62-1247492

(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 70 50	NONE	5000	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
CIGNA		0

(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.
CIGNA 06-0303370	SEE ATTACHED

(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:	**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:

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
MM&P HEALTH AND BENEFIT PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

D Employer Identification Number (EIN)
13-6696938

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)	4258282	4476458
(2) Participant contributions	1b(2)	109792	184889
(3) Other	1b(3)	7483144	3207456
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	6525865	12760505
(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)		
(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)	38638001	42044565
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

		(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		
f Total assets (add all amounts in lines 1a through 1e)	1f	57015084	62673873
Liabilities			
g Benefit claims payable	1g	11915300	12294200
h Operating payables	1h	348711	429319
i Acquisition indebtedness	1i		
j Other liabilities	1j	1449141	2233849
k Total liabilities (add all amounts in lines 1g through1j)	1k	13713152	14957368
Net Assets			
l Net assets (subtract line 1k from line 1f)	1l	43301932	47716505

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)	80118952	
(B) Participants	2a(1)(B)	6010907	
(C) Others (including rollovers)	2a(1)(C)	12065	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		86141924
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	544496	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		544496
(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)	1695049	
(D) Total dividends. Add lines **2b(2)(A)**, **(B)**, and **(C)**	2b(2)(D)		1695049
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)	70617809	
(B) Aggregate carrying amount (see instructions)	2b(4)(B)	70617809	
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	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)		1715876
c Other income	2c		
d Total income. Add all **income** amounts in column (b) and enter total	2d		90097345
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	74851204	
(2) To insurance carriers for the provision of benefits	2e(2)	3813018	
(3) Other	2e(3)	1685685	
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		80349907
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)		
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	48887	
(5) Investment advisory and investment management fees	2i(5)	34020	
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	210974	
(8) Legal fees	2i(8)	424230	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	4614754	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		5332865
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		85682772
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		4414573
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: GORFINE, SCHILLER & GARDYN, P.A. **(2)** EIN: 52-1231901

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		3000000
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	
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**		X	
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**		X	

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 _____.

GSG Gorfine Schiller Gardyn
Certified Public Accountants and Consultants

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Masters, Mates and Pilots Health and Benefit Plan
Linthicum Heights, Maryland

Opinion

We have audited the accompanying financial statements of Masters, Mates and Pilots Health and Benefit Plan, an employee benefit plan subject to the Employee Income Security Act of 1974, which comprise the statements of net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years ended December 31, 2024 and 2023, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial status of Masters, Mates and Pilots Health and Benefit Plan as of December 31, 2024 and 2023, and the changes in its financial status for the years ended December 31, 2024 and 2023 in accordance with account principles generally accepted in the United States of America (GAAP).

Basis for Opinion

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

Management's Responsibility for the Financial Statements

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

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

Auditors' Responsibility 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 auditors' 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 Masters, Mates and Pilots Health and Benefit 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 Masters, Mates and Pilots Health and Benefit 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—Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of the schedule of assets (held at end of year) as of December 31, 2024 and schedule of reportable (5%) transactions for the year ended December 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Horkins, Schiller & Gardyn, P.A.

October 9, 2025
Owings Mills, Maryland

MASTERS, MATES AND PILOTS
HEALTH AND BENEFIT PLAN
E.I.N. 13-6696938, PLAN 501
FORM 5500, SCHEDULE H, ITEM 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2024

(a)	(b) Identity of issuer, borrower, or similar party	(c) Description of investment including collateral, maturity date, rate of interest, par/maturity value or shares: Description	Collateral	Maturity Date	Rate of Interest	Par/Maturity value or shares	(d) Cost	(e) Current value
	Registered investment companies							
	MFO AMERICAN EUROPACIFIC GRTH-R6	Mutual Fund	NA	NA	NA	51,995	$ 2,715,359	$ 2,987,566
	MFO AIM COUNSELOR SER TR INVESCO COUNSELOR SER TR INVESCO CORE PLUS BD	Mutual Fund	NA	NA	NA	1,861,565	20,135,220	17,842,731
	MFO BLACKROCK FDS II MULTI-ASSET INCOME PORT CL K	Mutual Fund	NA	NA	NA	235,541	2,690,433	2,525,623
	MFO PIMCO FDS PAC INVT MGMT SER ALL AST FD INSTL CL	Mutual Fund	NA	NA	NA	217,510	2,672,238	2,493,514
	MFO PIMCO FDS PAC INVT MGMT SER TOTAL RETURN FD INSTL CL	Mutual Fund	NA	NA	NA	489,502	5,509,965	4,344,562
	MFO VANGUARD INDEX FUNDS STK MKT INST	Mutual Fund	NA	NA	NA	82,903	2,359,340	11,850,569
	Total registered investment companies						36,082,555	42,044,565
	Short-Term Investment Fund							
	MFB NORTHERN INSTL FDS GOVT PORTFOLIO CLA	STIF	NA	NA	NA	6,392,456	12,760,505	12,760,505
	Total investments						$ 48,843,060	$ 54,805,070

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN

FINANCIAL STATEMENTS
DECEMBER 31, 2024 AND 2023

GSG Gorfine Schiller Gardyn
Certified Public Accountants and Consultants

INDEPENDENT AUDITORS' REPORT

The Board of Trustees
Masters, Mates and Pilots Health and Benefit Plan
Linthicum Heights, Maryland

Opinion

We have audited the accompanying financial statements of Masters, Mates and Pilots Health and Benefit Plan, an employee benefit plan subject to the Employee Income Security Act of 1974, which comprise the statements of net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years ended December 31, 2024 and 2023, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial status of Masters, Mates and Pilots Health and Benefit Plan as of December 31, 2024 and 2023, and the changes in its financial status for the years ended December 31, 2024 and 2023 in accordance with account principles generally accepted in the United States of America (GAAP).

Basis for Opinion

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

Management's Responsibility for the Financial Statements

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

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

Auditors' Responsibility 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 auditors' 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 Masters, Mates and Pilots Health and Benefit 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 Masters, Mates and Pilots Health and Benefit 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—Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of the schedule of assets (held at end of year) as of December 31, 2024 and schedule of reportable (5%) transactions for the year ended December 31, 2024 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

Gorfine, Schiller & Gardyn, P.A.

October 9, 2025
Owings Mills, Maryland

FINANCIAL STATEMENTS

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
December 31, 2024 and 2023

	2024	2023
ASSETS		
INVESTMENTS		
Investments	$ 54,805,070	$ 45,163,866
RECEIVABLES		
Employer contributions	4,476,458	4,258,282
Participants' contributions	184,889	109,792
Due from other Masters, Mates and Pilots Plans & IOMMP	406,430	306,772
Interest and dividends receivable	45,919	29,310
Other	2,755,107	7,147,062
Total receivables	7,868,803	11,851,218
TOTAL ASSETS	62,673,873	57,015,084
LIABILITIES		
Bank overdraft	1,587,928	661,453
Accounts payable	429,319	348,711
Due to other Masters, Mates and Pilots Plans & IOMMP	645,921	787,688
TOTAL LIABILITIES	2,663,168	1,797,852
NET ASSETS AVAILABLE FOR BENEFITS	$ 60,010,705	$ 55,217,232

The accompanying notes are an integral part of these financial statements.

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
Years Ended December 31, 2024 and 2023

	2024	2023
ADDITIONS		
INVESTMENT INCOME		
Net appreciation in fair value of investments	$ 1,715,876	$ 2,834,067
Dividends and interest	2,239,545	1,809,049
	3,955,421	4,643,116
Less investment expenses	(34,020)	(35,143)
Net investment income	3,921,401	4,607,973
CONTRIBUTIONS		
Employers	80,118,952	76,408,678
Participants	6,010,907	4,670,704
Other voluntary	12,065	11,877
Total contributions	86,141,924	81,091,259
TOTAL ADDITIONS	90,063,325	85,699,232
DEDUCTIONS		
BENEFITS		
Participants and beneficiaries	74,472,304	71,039,483
Payments to insurance carriers	3,813,018	3,578,193
Other	1,685,685	2,063,953
Total benefits	79,971,007	76,681,629
ADMINISTRATIVE AND OTHER EXPENSES		
Administrative office	3,885,400	3,615,076
Allocated expenses	202,659	201,162
Professional fees - administrative	809,062	974,963
Other	401,724	378,424
Total administrative and other expenses	5,298,845	5,169,625
TOTAL DEDUCTIONS	85,269,852	81,851,254
Changes in net assets available for benefits	4,793,473	3,847,978
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	55,217,232	51,369,254
End of year	$ 60,010,705	$ 55,217,232

The accompanying notes are an integral part of these financial statements.

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
STATEMENTS OF BENEFIT OBLIGATIONS
December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries, dependents, and other obligations for current benefit coverage:		
At present value of estimated amounts:		
Estimated liability for pending and unrevealed claims	$ 12,294,200	$ 11,915,300
Net appreciation in fair value of investments		
Total current benefit obligations	12,294,200	11,915,300
Other obligations for current benefit coverage at estimated amounts:		
Continuing eligibility	12,751,699	12,883,267
Postretirement benefit obligations:		
Current retirees and dependents	113,156,661	124,973,784
Active participants fully eligible for benefits	40,559,073	36,192,876
Other participants not yet fully eligible for benefits	36,881,959	41,292,260
Total postretirement benefit obligations	190,597,693	202,458,920
Total benefit obligations	$ 215,643,592	$ 227,257,487

The accompanying notes are an integral part of these financial statements.

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS
Years Ended December 31, 2024 and 2023

	2024	2023
Amounts currently payable to or for participants, beneficiaries, dependents, and other obligations for current benefit coverage:		
At present value of estimated amounts:		
Balance at beginning of year	$ 11,915,300	$ 11,498,600
Net increase	378,900	416,700
Balance at end of year	12,294,200	11,915,300
Other obligations for current benefit coverage at estimated amounts:		
Balance at beginning of year	12,883,267	11,402,106
Net (decrease) increase	(131,568)	1,481,161
Balance at end of year	12,751,699	12,883,267
Postretirement benefit obligations:		
Balance at beginning of year	202,458,920	217,924,120
Increase (decrease) during the year attributable to:		
Benefits earned:		
Service cost	5,262,409	4,797,436
Interest cost	9,851,022	11,112,934
Benefits paid	(11,011,340)	(12,660,316)
Plan amendments	(2,970,031)	(9,059,099)
Actuarial experience loss	-	3,075,879
Changes in actuarial assumptions	(12,993,287)	(12,732,034)
Balance at end of year	190,597,693	202,458,920
Total benefit obligations	$ 215,643,592	$ 227,257,487

The accompanying notes are an integral part of these financial statements.

NOTE A – PLAN DESCRIPTION

The following brief description of the Masters, Mates, and Pilots (MM&P) Health and Benefit Plan (the Plan) and Agreement and Declaration of Trust is provided for general information purposes only. Participants should refer to the Plan's Summary Plan Description, Plan Regulations and Trust documents for more complete information.

General

The Plan is a multiemployer plan, which was established August 1, 1950, under the provisions of an Agreement and Declaration of Trust (the Trust), as amended, made by and between the International Organization of Masters, Mates, and Pilots, AFL-CIO (IOMM&P) and various signatory employers. The Plan was established to provide health and other benefits to eligible employees and their dependents as specified in the Plan Regulations. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan continues through September 30, 2028 and may be extended thereafter by agreement of the collective bargaining parties.

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The following are the significant accounting policies followed by the Plan:

1. **Method of Accounting**

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

2. **Use of Estimates**

   The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, benefit obligations and changes therein, and the disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

3. **Investments Valuation and Income Recognition**

   Investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Board of Trustees determines the Plan's valuation policies utilizing information provided by the investment advisors and custodian. See Note D for discussion of the fair value measurements.

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

4. **Estimated Benefit Obligations**

   Estimated liabilities for pensioners' benefits, pending and unrevealed claims, death benefits, and future payment of benefits based on participants' extended eligibility as of December 31, 2024 and 2023, are calculated by the Plan's independent actuarial and consulting firm. These calculations are based upon accepted actuarial principles and information provided by the Plan office.

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – Continued

4. Estimated Benefit Obligations - Continued

The Board of Trustees receives the independent actuarial and consulting firm's report and implements the recording of these obligations. The statements of benefit obligations include an actuarial estimate of all benefit obligations, including postretirement benefit obligations, which are expected to be funded by future contributions and earnings on investments.

5. Participants Continuing Eligibility

Participants who meet the initial eligibility requirements will continue to receive coverage, provided they complete at least thirty days of covered employment with one or more contributing employers during any period of six consecutive calendar months, and the participant continues to make their co-pay contributions.

Covered employment for continued eligibility includes shipboard employment and days of vacation.

6. Contributions

The benefits available under the Plan are funded by employer contributions and participant contributions required to be paid pursuant to collective bargaining agreements, participation agreements between the IOMM&P and signatory employers, or as agreed to by the Board of Trustees and required to be paid pursuant to the Plan Regulations.

7. Benefits

Benefits provided by the Plan in accordance with the terms of collective bargaining agreements and/or participation agreements include: major medical, prescription drug, death, accidental death and dismemberment, disability, dental, vision care, hearing, scholarship program, Coast Guard legal aid, wage insurance, and license insurance. The Plan also provides additional death and accidental death and dismemberment benefits for active members on a voluntary basis to be paid for by those covered participants. Additionally, long-term care insurance for both active and retired participants is available on a voluntary basis. Under the terms of the Plan, the Board of Trustees and/or the collective bargaining parties reserve the right to amend, modify, or terminate the Plan and the benefits provided thereunder in whole or in part, at any time.

8. Employer Contribution Receivables

Contributions receivable are stated at unpaid balances, less an allowance for doubtful accounts. The Plan provides for losses on contributions receivable using the allowance method. The allowance is based on experience and other circumstances, which may affect the ability of Employers to meet their obligations. At December 31, 2024 and 2023, the Plan considered all accounts receivables collectible and an allowance was not deemed necessary.

If full contribution payments are not received in accordance with the contractual terms, the Plan charges interest on the unpaid principal balance. It is the Plan's policy to charge off uncollectible accounts receivable when management determines the receivable will not be collected.

9. Other Receivables

Other receivables consist of amounts owed to the Plan that are not classified as employer contributions. These receivables may arise from various transactions, including stop-loss coverage, prescription drug rebates, and other non-operating activities. Other receivables were $2,755,107 and $7,147,062, respectively as of December 31, 2024 and 2023.

NOTE B – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES – Continued

10. Subsequent Events

The Plan has evaluated events and transactions for potential recognition or disclosure through October 9, 2025, the date the financial statements were available to be issued. During this period, the Plan did not have any material recognizable subsequent events.

NOTE C – FUNDING POLICY

1. Postretirement Benefit Obligation

The Plan follows Financial Accounting Standards Board (FASB), Accounting Standards Codification 965, *Plan Accounting – Health and Welfare Benefit Plans* (ASC 965) which requires that the postretirement benefit obligations be computed as the net cost to the Plan and should consider future contributions to be received from current participants during their remaining active service and postretirement periods. As of December 31, 2024 and 2023, $12,365,341 and $10,120,910 of projected retiree contributions were used to reduce the postretirement benefit obligation, respectively.

2. Employers' Contributions

Employer contributions to the Plan consist of sums required to be paid pursuant to collective bargaining agreements between the signatory employers and the IOMM&P. Contributions for employees not covered by the collective bargaining agreements are based upon a contribution rate determined by the actuaries each year and approved by the Board of Trustees of the Plan. The extent of future contributions is dependent upon the continuation of existing collective bargaining agreements or the periodic negotiation of new agreements.

3. Participants' Contributions

Participants' contributions to the Plan consist of sums required to be paid by eligible employees and pensioners pursuant to the Plan Regulations. Participants working in Covered Employment as defined by Plan documents are required to contribute the sum of 1-1/2% of all their earnings and vacation benefits with no maximum. Effective April 1, 2002, a pensioner and their dependents were not eligible for continued benefits under this Plan unless they agreed to pay or authorize the deductions from their pension benefits under the MM&P Pension Plan or MM&P Adjustable Pension Plan, in accordance with procedures established by the MM&P Pension Plan and MM&P Adjustable Pension Plan, a monthly contribution as determined by the Board of Trustees. As of December 31, 2024, the amount of contribution us 4% of the pension benefit, with a minimum of $50 per month and a maximum of $300 per month.

Coverage for certain classes of pensioners and survivors and their eligible dependents is available to these individuals on a self-pay basis at rates calculated by the Plan's independent actuarial firm and approved by the Board of Trustees.

4. Designated Investments

At the September 1990 Board of Trustees meeting, the parties to the collective bargaining agreements agreed to fund the cost of providing health benefits to pensioners, including future pensioners, over a seven year period, which was subsequently extended. A separate designated investment account has been established to accumulate a fund for the payment of health benefits to pensioners and future pensioners. The balance of this account is $42,049,380 and $38,638,001 at December 31, 2024 and 2023, respectively. This amount is funded at the current rate of $3 per man day, with some exceptions, as agreed to by the collective bargaining representatives.

NOTE D – 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 measurements) and the lowest priority to unobservable inputs (level 3 measurements). The three levels of the fair value hierarchy under FASB 820 are described below:

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.

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 used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

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

Registered investment companies: Valued at the daily closing price as reported by the fund. The registered investment companies are deemed to be actively traded.

Short-term investment funds: Valued at the net asset value (NAV) of units of the common trust fund. The NAV is based on the fair value of the underlying investments held by the fund less its liabilities

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while the Plan believes its valuation method is appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

NOTE D – FAIR VALUE MEASUREMENTS – Continued

The following table is set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2024 and 2023:

Assets at Fair Value as of December 31, 2024

	Level 1	Level 2	Level 3	Total
Registered investment companies	$ 42,044,565	$ -	$ -	$ 42,044,565
Total investments in the fair value hierarchy	42,044,565	-	-	42,044,565
Investments at net asset value	-	-	-	12,760,505
Total assets at fair value	$ 42,044,565	$ -	$ -	54,805,070

Assets at Fair Value as of December 31, 2023

	Level 1	Level 2	Level 3	Total
Registered investment companies	$ 38,638,001	$ -	$ -	$ 38,638,001
Total investments in the fair value hierarchy	38,638,001	-	-	38,638,001
Investments at net asset value	-	-	-	6,525,865
Total assets at fair value	$ 38,638,001	$ -	$ -	$ 45,163,866

FAIR VALUE OF INVESTMENTS IN ENTITIES THAT USE NAV

The short-term investment funds objectives are to preserve invested principal, while providing a competitive current rate of return. There are no restrictions on redemption and there were no unfunded commitments as of December 31, 2024 and 2023, respectively. Assets valued at NAV do not fall under any level of the fair value hierarchy.

NOTE E – POSTRETIREMENT BENEFITS

The postretirement benefit obligations represent the total actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31, 2024 and 2023 reduced by the actuarial present value of contributions expected to be received in the future from current plan participants. Postretirement benefits include future benefits for (1) currently eligible retired employees and their eligible dependents and (2) active employees and their dependents who at time of retirement from service with a participating employer meet health and benefit eligibility requirements. Prior to an active employee's full eligibility date, the postretirement benefit is the portion of the expected postretirement benefit that is attributed to that employee's service in the industry rendered to the valuation date. However, under the terms of the Plan, the Board of Trustees and/or the collective bargaining parties reserve the right to amend, modify, or terminate the Plan and the benefits provided thereunder, in whole or in part, at any time.

The actuarial present value of the expected benefit obligations is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims cost per participant 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.

NOTE E – POSTRETIREMENT BENEFITS – Continued

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

Assumption	2024	2023
Discount rate	5.50%	5.00%
Mortality rates	Healthy: Headcount-weighted Pri-2012 Blue Collar Employee/Healthy Retiree Mortality Tables with generational projection using the 2024 adjusted scale MP-2021 from 2012	Healthy: 110% of the Headcount-weighted RP-2014 Blue Collar Healthy Employee/ Annuitant Mortality Tables adjusted backwards to 2006 using Scale MP-2014 with generational projection from 2006 using Scale MP-2018
	Disabled: Headcount-weighted Pri-2012 Disabled Retiree Mortality Table with generational projection using the 2024 adjusted scale MP-2021 from 2012.	Disabled: 110% of the Headcount-weighted RP-2014 Disabled Retiree Mortality Table adjusted backwards to 2006 using Scale MP-2014 with generational projection from 2006 using Scale MP-2018
Medical healthcare cost trend rate	Healthcare cost trend rate of 5.75% for 2024, graded to 4.5% over 5 years	Healthcare cost trend rate of 6.0% for 2024, graded to 4.5% over 6 years

A 1% increase in the assumed medical trend rates would increase the benefit obligations as of December 31, 2024 and 2023 by $27,216,536 or 14.28% and $27,801,939 or 13.73%, respectively.

For the years ended December 31, 2024 and 2023, a change in valuation assumptions decreased the net benefit obligations $12,993,287 and $12,732,034, respectively. For 2024, the overall decrease was as a result of revising the valuation-year per capita health costs, revising mortality rates assumption, raising the discount rate from 5.00% to 5.50%, increase in retiree contribution requirement for the Co-pay program to 4% of the monthly pension amount, increase in dental orthodontia lifetime, and started covering infertility and family building benefits through Progyny at 70% coinsurance, with no deductible or out-of-pocket maximum. For 2023, the overall decrease was as a result of the increase in grading years from 4 to 6 years and transition to an EGWP plan for retirees effective January 1, 2024, partially offset by a decrease in the discount rate from 5.25% to 5.00%..

The foregoing assumptions are based on the assumption that the Plan will continue. Were the Plan to terminate, or the benefits provided thereunder modified, amended, or terminated, in whole or in part, different actuarial assumptions and other factors might be applicable in determining the actuarial value of the postretirement benefit obligations.

NOTE F – RELATED-PARTY TRANSACTIONS AND PARTY-IN-INTEREST TRANSACTIONS

1. Administrative Office Expenses

Expenditures for administrative services provided to all MM&P Plans are made through the MM&P Health and Benefit Plan administrator's accounts. The other Plans are then charged for their direct expenses and a pro rata allocation of other administrative expenses. These expenses are included in the due to and due from other Masters, Mates and Pilots Plans. At December 31, 2024 and 2023, the Plan owed $644,423 and $784,074, respectively, to the other Masters, Mates and Pilots Plans, and was due 406,430 and $306,479 respectively, from the other Masters, Mates and Pilots Plans and entities**.** Total administrative expenses were $3,885,400 and $3,615,076 for the years ended December 31, 2024 and 2023, respectively.

2. Other Allocated Expenses

Allocated expenses represent a reimbursement to the IOMM&P of the expenses incurred by the IOMM&P for the Plan's activities handled at the port offices. The IOMM&P pays port office expenses based upon various allocation methodologies that include space utilized and time spent on the Plan's activities. The Plan reimbursed the IOMM&P $202,659 and $201,162 for the years ended December 31, 2024 and 2023, respectively. For the year ended December 31, 2024 and 2023, the Plan owed $1,498 and $3,614 to the IOMM&P, respectively.

3. Employee Postretirement Benefits

The Plan's employees are covered for health benefits by the Plan and may be eligible for health benefits upon retirement, provided requirements specified in the Plan Regulations are met. Contributions allocated to the Plan for employee health benefits were $410,306 and $350,406 in 2024 and 2023, respectively.

4. Pension Plan

Under the Collective Bargaining Agreement, some of the Plan's employees are covered under the Masters, Mates & Pilots Pension Plan (Pension). It is a multiemployer defined benefit plan. The contribution rate was 18% for the years ended December 31, 2024 and 2023. Contributions to the Pension totaled $153,226 and $201,859 for the years ended December 31, 2024 and 2023, respectively. As of March 1, 2013, the Pension was frozen, see Adjustable Pension Plan note below.

5. Adjustable Pension Plan

As of March 1, 2013, the Plan's employees stopped earning pension benefits under the Masters, Mates and Pilots Pension Plan and began earning pension benefits under the Masters, Mates & Pilots Adjustable Pension Plan (APP) for employment performed on and after January 1, 2013. APP is a multiemployer defined benefit plan. The contribution rate was 10% for the years ended December 31, 2024 and 2023. Contributions to the APP totaled $245,804 and $237,023 for the years ended December 31, 2024 and 2023, respectively.

6. Individual Retirement Account Plan

The Plan makes contributions to the Masters, Mates & Pilots Individual Retirement Account Plan (IRAP), a multiemployer defined contribution pension plan, for its employees. Contributions to the IRAP totaled $102,691 and $100,735 for the years ended December 31, 2024 and 2023, respectively.

7. Covered Employees

Certain employees of other MM&P Plans are participants in this Plan. Accordingly, the Plan receives contributions and pays benefits on their behalf in accordance with the Plan Regulations.

NOTE F – RELATED-PARTY TRANSACTIONS AND PARTY-IN-INTEREST TRANSACTIONS – Continued

8. Party-In-Interest Transactions

Some fees incurred by the Plan for the investment management services are included in net appreciation in fair value of investments, as they are paid through revenue sharing arrangement, rather than direct payment. Certain investments are held or managed by investment managers who receive fees paid by the Plan for investment management and custodial services; therefore these transactions qualify as party-in-interest transactions, although not considered to be prohibited transactions. Total fees paid directly to these service providers were $34,020 and $35,143 for the years ended December 31, 2024 and 2023, respectively. The service providers are And Co Consulting and the Northern Trust Company.

9. Lease from the IOMM&P

The Plan leases office space from the International Organization of Masters, Mates & Pilots (IOMM&P), an affiliated entity through December 31, 2024. The lease was extended as of January, 2022 for five years. The Plan pays the monthly rent directly to the MAMAPI Trust, a company wholly-owned by IOMM&P, through the administrator's accounts and then allocates a portion of the monthly rent to the other MM&P Plans in proportion with other administrative expenses. During 2024 and 2023, the Plan paid the IOMM&P $407,107 and $395,250 under the lease, respectively. The lease requires that for each successive year, the monthly rent shall increase by 3%.

NOTE G – INCOME TAXES

The Internal Revenue Service has issued a determination letter to the Plan that concluded that the Trust was exempt from federal taxes under Section 501(c)(9) of the Internal Revenue Code. The Internal Revenue Service reaffirmed this determination by letter dated July 15, 1988. The Plan and its underlying trust have since been amended to conform to changes in the applicable collective bargaining agreements and to reflect benefit changes approved by the Board of Trustees. In the opinion of the Plan's management and Board of Trustees, the Plan and underlying trust have operated within the terms of the Plan and remain tax-exempt under the applicable provisions 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 IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE H – PRIORITIES UPON TERMINATION

Although they have not expressed any intention to do so, the Board of Trustees and/or the parties to the collective bargaining agreements have the right to discontinue or terminate the Plan in whole or in part on or after June 15, 2028, or to extend the Plan by agreement. It is the intent of the Board of Trustees and the parties to the collective bargaining agreements to continue the Plan in full force and effect; however, to safeguard against unforeseen circumstance, the right to discontinue the Plan is reserved to the Board of Trustees and/or the parties of the collective bargaining agreements. In the event of termination, the Board of Trustees shall first satisfy or make provisions to satisfy the obligations of the Plan. Any remaining assets of the Plan will be distributed in such manner as will, in the opinion of the Board of Trustees, bring about the purpose of the Plan. Termination shall not permit any part of Plan assets to be used for or directed to purposes other than the exclusive benefit of the participants and beneficiaries.

NOTE I – LEASE COMMITMENTS

The Plan leases office equipment and office space under various operating lease agreements. The minimum lease payments for the years ending December 31:

2025	$ 465,949
2026	479,338
Thereafter	23,374
	$ 968,661

Rental expense for office space and equipment leases is apportioned to each of the related Masters, Mates, and Pilot Plans.

NOTE J – SIGNIFICANT PLAN AMENDMENTS

During 2024 and 2023, amendments to the Plan were adopted. Significant new amendments are summarized below:

1. **Offshore coverage**

   The Board of Trustees approved to adopt Amendment No. 162 to provide coverage for Offshore employees who are pregnant, and their dependents, shall not terminate until 12 consecutive months after the date on which employee's eligibility would otherwise terminate.

2. **Increased co-pay**

   The Board of Trustees approved to amend Rules and Regulations, regarding the increased co-pay requirements, effective January 1, 2024 and January 1, 2025

3. **Employer Group Waiver Plan (EGWP)**

   As of January 1, 2024, the plan transitioned to an Employer Group Waiver Plan under the Medicare Part D. The Board of Trustees approved to add EGWP with SilverScript and reflets that (i) for retirees (and their dependents) who have opted out of the EGWP because they have Medicare Part D coverage under another plan, the Plan acts as a secondary payer, and (ii) the Plan will pay 80% of the cost of prescription drugs submitted by retirees (and their dependents) living outside of the US (including the territories).

4. **Out-of-network costs**

   The Board of Trustees approved to adopt Plan amendment No. 165, regarding the eligibility of domestic partners and clarifying out-of-network costs under the Plan.

5. **Orthopedic Maximum Benefit**

   The Board of Trustees approved to increase the maximum benefit from $2,000 to $3,000.

6. **No Surprise Services**

   The Board of Trustees approved to adopt amendments regarding (i) notice and consent language concerning No Surprise Services when a non-emergency service is performed by a non-contracted provider at a contracted health care facility, and (ii) Covered changes from telehealth services to December 31, 2024, unless otherwise extended by the trustees.

NOTE K – RISKS AND UNCERTAINTIES

The Plan invests in investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investments securities 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.

Plan contributions are made, and the actuarial present value of accumulated plan benefits are reported based on certain assumptions pertaining to interest rates, inflation rates, and employee 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 L – RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	December 31,	
	2024	2023
Net assets available for benefits per the financial statements	$ 60,010,705	$ 55,217,232
Benefit obligations currently payable	12,294,200	11,915,300
Net assets available for benefits per the Form 5500	$ 47,716,505	$ 43,301,932

The following is a reconciliation of benefits paid to or for participants per the financial statements to the Form 5500 for the years ended December 31:

	December 31,	
	2024	2023
Benefits paid to or for participants per the financial statements	$ 74,472,304	$ 71,039,483
Add amounts for pending and unrevealed claims - current year	12,294,200	11,915,300
Less amounts for pending and unrevealed claims - prior year	(11,915,300)	(11,498,600)
Benefits paid to or for participants per the Form 5500	$ 74,851,204	$ 71,456,183

SUPPLEMENTAL INFORMATION

MASTERS, MATES AND PILOTS
HEALTH AND BENEFIT PLAN
E.I.N. 13-6696938, PLAN 501
FORM 5500, SCHEDULE H, ITEM 4I - SCHEDULE OF ASSETS (HELD AT END OF YEAR)
December 31, 2024

(a)	(b) Identity of issuer, borrower, or similar party	(c) Description of investment including collateral, maturity date, rate of interest, par/maturity value or shares: Description	Collateral	Maturity Date	Rate of Interest	Par/Maturity value or shares	(d) Cost	(e) Current value
	Registered investment companies							
	MFO AMERICAN EUROPACIFIC GRTH-R6	Mutual Fund	NA	NA	NA	51,995	$ 2,715,359	$ 2,987,566
	MFO AIM COUNSELOR SER TR INVESCO COUNSELOR SER TR INVESCO CORE PLUS BD	Mutual Fund	NA	NA	NA	1,861,565	20,135,220	17,842,731
	MFO BLACKROCK FDS II MULTI-ASSET INCOME PORT CL K	Mutual Fund	NA	NA	NA	235,541	2,690,433	2,525,623
	MFO PIMCO FDS PAC INVT MGMT SER ALL AST FD INSTL CL	Mutual Fund	NA	NA	NA	217,510	2,672,238	2,493,514
	MFO PIMCO FDS PAC INVT MGMT SER TOTAL RETURN FD INSTL CL	Mutual Fund	NA	NA	NA	489,502	5,509,965	4,344,562
	MFO VANGUARD INDEX FUNDS STK MKT INST	Mutual Fund	NA	NA	NA	82,903	2,359,340	11,850,569
	Total registered investment companies						36,082,555	42,044,565
	Short-Term Investment Fund							
	MFB NORTHERN INSTL FDS GOVT PORTFOLIO CLA	STIF	NA	NA	NA	6,392,456	12,760,505	12,760,505
	Total investments						$ 48,843,060	$ 54,805,070

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
E.I.N. 13-6696938, PLAN 501
FORM 5500, SCHEDULE H, ITEM 4j - SCHEDULE of REPORTABLE (5%) TRANSACTIONS
Year Ended December 31, 2024

(a) Identity of party involved	(b) Description of assets (included interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expenses incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Northern Trust	MFB NORTHERN INSTL FDS GOVT PORTFOLIO CL A CUSIP: 665278404							
	432 Purchases	$ 256,145,961	N/A	N/A	$ -	$ 256,145,961	$ 256,145,961	N/A
	648 Sales	N/A	$ 250,230,522	N/A	$ -	$ 250,230,522	$ 250,230,522	$ -

SERVICE PROVIDER INFORMATION APPLICABLE TO:
Cigna Health and Life Insurance Company ("Cigna")

MASTERS, MATES & PILOTS BENEFIT PLAN
700 MARITIME BLVD
SUITE A
LINTHICUM HEIGHTS , MD 21090 -1996

Account Number : 3333590

For plan year beginning 01/01/2024 and ending 12/31/2024

Part I Service Provider Information

1. Information on Persons receiving Only Eligible Indirect Compensation:

(a) Check "No"
(b) Not applicable

2. Information on Other Service Providers Receiving Direct or Indirect Compensation:

(a) Cigna Health and Life Insurance Company ("Cigna")
Contract Identification Number: 59-1031071
NAIC Code: 67369

(b) Service Code(s):

12 Claims Processing	38 Participant communications	50 Direct payments from the Plan
13 Contract Administrator	49 Other Services	56 Non-monetary compensation
31 Named fiduciary - (if indicated in ASO Agreement)		62 Float Revenue

(c) Cigna provides claim administration and related Services Pursuant to an Administrative Services Agreement.

(d) Direct compensation paid by the plan:

	Amount Paid
Medical Fees	$948,596
Dental Fees	See attached Dental Sch C, if applicable

(e) Check "Yes." Cigna received Indirect compensation.

(f) Check "Yes", see appendix for eligible indirect compensation calculation.

(g) See Appendix for indirect compensation calculation.

(h) Check "Yes." See Appendix included with this reporting.

3. For information regarding each source of indirect compensation (a) of $1,000 or more and (b) each source of indirect compensation for which Cigna provided a formula refer to:

(a) Reference Appendix for information on eligible indirect compensation including formulas
(b) Reference Appendix for information on indirect compensation including formulas

Part II Service Providers Who Fail or Refuse to Provide Information

4. Do not identify Cigna in this section as information for completion of Schedule C as provided in this documentation.

THE INFORMATION REFLECTED IN THIS REPORT IS ACCURATE AND COMPLETE BASED UPON INFORMATION AVAILABLE TO CIGNA COMPANIES AT THE TIME THIS REPORT IS PREPARED AND IS CERTIFIED AS BEING COMPLETE AND ACCURATE.

NOTE TO POLICYHOLDERS: If you have elected not to receive identifiable health information, this report complies with your election. Nevertheless, please note that you may have responsibilities under law to determine whether the information contained in this report could be used to identify individuals either when combined with other information that you have or in any other manner and, if so, to take appropriate protective steps.

SERVICE PROVIDER INFORMATION APPLICABLE TO:
Cigna Health and Life Insurance Company ("Cigna")
FOOTNOTE DOCUMENT

MASTERS, MATES & PILOTS BENEFIT PLAN
700 MARITIME BLVD
SUITE A
LINTHICUM HEIGHTS , MD 21090 -1996

Account Number : 3333590

For plan year beginning 01/01/2024 and ending 12/31/2024

Part 1, line 2d: Amount reflects payments at the time this report is prepared. Other direct compensation may be due, but not yet paid.

Part 1, line 2d: May include prior year commissions not previously reported.

The following amounts were paid to your broker(s) /consultant(s) during the contract year:
Commissions: $0

Service/General Agent Fees: $0

Contact your broker/consultant for further details.

• Appendix refers to subscriber and membership information for your plan that is available at the Cigna Access Employer Portal at www.cignaaccess.com. Go to the report titled, Subscriber and Membership Reporting.

• In addition, Cigna enters into compensation programs under which certain brokers/ consultants provide us market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific plans, is funded from our general overhead, and is not required to be reported on Schedule C. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent/ broker for specific information about their participation.

• If you have a Cigna administered HRA and/or HSA, the Administrative Service Fees include fees charged by bank vendor.

Direct compensation amount does not include the following compensation received, if any, by affiliated companies:
• Plan benefit payments, if any, made to eviCore
• Utilization management fees paid to eviCore
• Plan benefit payment made to Evernorth Care Solutions, Inc. or Evernorth Behavioral Health, Inc.
• Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)
The amount of such compensation, if any, with respect to your plan is available upon request.

Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:
• eviCore
• Evernorth Care Solutions, Inc.
• Evernorth Behavioral Health, Inc.
• Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

APPENDIX FOR SERVICE PROVIDER INFORMATION REGARDING SOURCES OF INDIRECT COMPENSATION EXCLUDING ELIGIBLE INDIRECT COMPENSATION TO BE REPORTED ON SCHEDULE C PART I, LINE 3

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Castlight Health, 121 Spear St 3rd floor, San Francisco, CA 94105 EIN - 261989091

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Indirect compensation received by Cigna from this vendor (i) to defray Cigna's cost for the infrastructure changes required to facilitate implementation of this vendor's customer transparency and engagement services; (ii) as reimbursement for annually providing the vendor Cigna derived Center of Excellence (COE) and Cigna Designation (CCD) Information; (iii) as reimbursement for making available customer access to cost estimate information, and (iv) as reimbursed for access to client paid claim files.

Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from this vendor of approximately $3.24 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor. (excluding Shared Administration Repricing "SAR")

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Omada Health, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Digital Diabetes Preventive Care Services Provider - Indirect compensation received by Cigna from this provider for services including:
(i) explaining the Omada services to existing and prospective clients; (ii) encouraging at-risk individuals who may benefit from the Omada services to utilize Omada's preventive care services, and (iii) facilitating the enrollment of at-risk individuals in the Omada program.

Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from this vendor of approximately $1.23 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR"))

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Vision Service Plan "VSP", 333 Quality Drive, Rancho Cordova, CA 96670, EIN - 061227840

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
NOTE: The following is not applicable to your plan if your Cigna administered plan did not include benefits for vision services through VSP.

Vendor for Vision Services - Indirect compensation received by Cigna from this vendor for Cigna's expenses associated with administering plans with vision benefits.

Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from this vendor of approximately $0.67 per participant. (Determined by dividing total compensation received by the number of Vision Service Plan participants in participating plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid.) (excluding Shared Administration Repricing plans)

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Refer to Sagamore Network Hospital listing below *

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Network hospitals listed below have contracted with Sagamore Health Network (an affiliate of Cigna) to pay network administration fees.

Indirect Compensation Formula/Estimate:
For calendar year 2024, Cigna received indirect compensation from these hospitals of approximately $0.06 per participant. (Determined by dividing total indirect compensation received by the number of participants in all plans, including Shared Administration Repricing plans insured/administered by Cigna. The amount attributable specifically to your plan depends upon the amount of plan benefits paid to these hospitals.)

Hospital name
*** Bloomington Hospital, P. O. Box 1149, Bloomington, IN 47402, TIN = 351720796**
Bloomington Hospital of Orange County, 642 W. Hospital Road, Paoli, IN 47454, TIN = 352090919
Clark Memorial Hospital, 1220 Missouri Avenue, Jeffersonville, IN 47130, TIN = 350944638
Daviess Community Hospital, P. O. Box 32, Washington, IN 47501, TIN = 356001322
Deaconess Gibson Hospital, 1808 Sherman Drive, Princeton, IN 47670, TIN = 350877575
Good Samaritan Hospital, 520 S. Seventh Street, Vincennes, IN 47591-1098, TIN = 356001532
Goshen General Hospital, P. O. Box 139, Goshen, IN 46527-0139, TIN = 356001540

Greene County General Hospital, RR#1, Box 1000, Linton, IN 47441-9457, TIN = 356001492
Franciscan Health Lafayette, P. O. Box 310, Mishawaka, IN 46546-0310, TIN = 352056396
Franciscan Healthcare Rensselaer (Jasper County Hospital), 1104 E. Grace Street, Rennselaer, IN 47978, TIN = 351404051
Margaret Mary Community Hospital, P. O. Box 226, Batesville, IN 47006-8953, TIN = 356067049
Meadows Hospital, 3600 N. Prow Road, Bloomington, IN 47404, TIN = 351858510
Monroe Hospital, 4011 S. Monroe Medical Park Blvd., Bloomington, IN 47403, TIN = 202069733
Oaklawn Psychiatric Center, P. O. Box 809, Goshen, IN 46527, TIN 351070041
Starke Memorial Hospital (Principal Knox LLC), P. O. Box 339, Knox, IN 46534-0339, TIN = 621763056
Pulaski Memorial Hospital, P. O. Box 279, Winamac, IN 46996, TIN = 351097674
St. Joseph Regional Medical Center -Plymouth, P. O. Box 1935, South Bend, IN 46634, TIN = 351142669
St. Joseph Regional Medical Center -South Bend, P. O. Box 1935, South Bend, IN 46634, TIN = 350868157
St. Mary's Medical Center, 3700 Washington Ave, Evansville, IN 47750, TIN = 350869065
St. Mary's Warrick Hospital, P.O. Box 2408, Indianapolis, IN 46206, TIN = 351343019
White County Memorial Hospital, 720 South 6th St., Monticello, IN 47960, TIN = 351140233
Woodlawn Hospital, 1400 E. 9th St., Rochester, IN 46975, TIN = 351171815

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Bank of America (Lockbox), 540 West Madison Street, Chicago, IL 60661 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of claim overpayment recoveries. Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $0.37 per participant with the average annual rate of the earnings credit at 4.00%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Citibank NA, One Penns Way, New Castle, DE 19720 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna. Applicable to all self-funded plans utilizing Citibank services.

Eligible Indirect Compensation Formula/Estimate:

For calendar year 2024, $1.97 per participant with the average annual rate of the earnings credit at 3.66%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Citibank NA (Omnibus), One Penns Way, New Castle, DE 19720 EIN # 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits on daily fund balances associated with bank accounts utilized in the claim administration by Cigna. Applicable to all self-funded plans for Evernorth Behavioral Health, Inc. or Evernorth Care Solutions, Inc.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $0.01 per participant with the average annual rate of the earnings credit at 3.66%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Deutsche Bank, 60 Wall St., New York, NY 10005-2836 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of disbursing claim refunds. Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $0.00 per participant with the average annual rate of the earnings credit at 0.50%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
JPMorgan Chase, 3 Chase Metro Tech Center, 5th Floor, Brooklyn, NY 11245 EIN# 59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits on daily fund balances associated with bank accounts utilized in claim administration by Cigna.
Applicable to all self-funded plans utilizing JPMorgan Chase services.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $4.38 per participant with the average annual rate of the earnings credit at 3.54%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Cigna Healthy Rewards Vendors
Amplifon Hearing Healthcare Fifth Street Towers 150 South 5th St., Suite 2300 Minneapolis, MN 55402 EIN# 85-0437037
Fitbit 199 Fremont Street San Francisco, CA 94105 EIN# 20-8920744
LCA-Vision Inc. 7840 Montgomery Road, Cincinnati, OH 45236 EIN# 11-2882328
American Specialty Health Incorporated 10221 Wateridge Circle, San Diego, CA 92121 EIN# 330883241

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Volume based marketing fees paid by vendors participating in the Cigna Healthy Rewards program which offers plan participants discounts on various services. Applicable to your plan if your plan participants have a Cigna ID card and access to myCigna.com or other authorized portals.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $0.00 PMPY (this formula is based upon total compensation received from Healthy Reward Vendors across Cigna companies' entire insured and self-insured book of business.)

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing	**38 Participant communications**	**50 Direct payments from the plan**
13 Contract Administrator	**49 Other Services**	**56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement)		**62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
CHLIC - COR Deposits, PNC Bank, 1600 Market St., 19th Fl, Philadelphia, PA 1910 EIN #59-1031071

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Earnings credits associated with bank accounts utilized by Cigna in the administration of disbursing claim refunds.
Applicable to all self-funded plans administered by Cigna.

Eligible Indirect Compensation Formula/Estimate:
For calendar year 2024, $1.02 per participant with the average annual

rate of the earnings credit at 3.25%.

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

(a) Service provider name: **Cigna**

(b) Service codes:

12 Claims Processing **38 Participant communications** **50 Direct payments from the plan**
13 Contract Administrator **49 Other Services** **56 Non-monetary compensation**
31 Named fiduciary - (if indicated in ASO agreement) **62 Float Revenue**

(c) Amount of indirect compensation:
$0 (see formula/estimate provided below)

(d) Name and EIN (address) of source of indirect compensation:
Omada Complete, 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015

(e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Omada Diabetes and Hypertension Cigna □ Indirect compensation received by Cigna from this provider for services including: Services, and facilitate enrollment of Screened Participants in the Omada Covered Servies.

For calendar year 2024, Cigna received indirect

Eligible Indirect Compensation Formula/Estimate:
compensation from this vendor of approximately $0.17 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2024 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")
(i) explain the availability of Omada Covered Services to CHLIC existing clients and CHLIC prospective clients; and (ii) encourage the use of Omada Covered Services by Screened Participants that CHLIC has identified as potentially benefitting from the Omada Covered

Effective Date: **01/01/2024** Cancel Date:**01/01/9999**

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
MM&P HEALTH AND BENEFIT PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 08/01/1950

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)
MM&P HEALTH & BENEFIT FUND HEALTH AND BENEFIT PLAN

700 MARITIME BLVD.

LINTHICUM HEIGHTS MD 21090

2b Employer Identification Number (EIN) 13-6696938

2c Plan Sponsor's telephone number 410-850-8500

2d Business code (see instructions) 483000

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	[signature]	10/7/25	DONALD JOSBERGER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	[signature]	10/7/25	DANNY DEFANTI
	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**	5,343
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)**	3,783
a (2) Total number of active participants at the end of the plan year	**6a(2)**	3,874
b Retired or separated participants receiving benefits	**6b**	1,526
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2), 6b,** and **6c**	**6d**	5,400
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**	71

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

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

9a Plan funding 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

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 6
(4) [X] **C** (Service Provider Information)
(5) [ ] **D** (DFE/Participating Plan Information)
(6) [ ] **G** (Financial Transaction Schedules)

MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
E.I.N. 13-6696938, PLAN 501
FORM 5500, SCHEDULE H, ITEM 4j - SCHEDULE of REPORTABLE (5%) TRANSACTIONS
Year Ended December 31, 2024

(a) Identity of party involved	(b) Description of assets (included interest rate and maturity in case of a loan)	(c) Purchase price	(d) Selling price	(e) Lease rental	(f) Expenses incurred with transaction	(g) Cost of asset	(h) Current value of asset on transaction date	(i) Net gain or (loss)
Northern Trust	MFB NORTHERN INSTL FDS GOVT PORTFOLIO CL A CUSIP: 665278404							
	432 Purchases	$ 256,145,961	N/A	N/A	$ -	$ 256,145,961	$ 256,145,961	N/A
	648 Sales	N/A	$ 250,230,522	N/A	$ -	$ 250,230,522	$ 250,230,522	$ -