

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.

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... B This return/report is: [ ] a single-employer plan [ ] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [ ] automatic extension... 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: NEW YORK STATE TEAMSTERS COUNCIL HEALTH & HOSPITAL FUND
1b Three-digit plan number (PN): 501
1c Effective date of plan: 06/09/1952
2a Plan sponsor's name (employer, if for a single-employer plan): TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH & HOSPITAL FUND
2b Employer Identification Number (EIN): 15-0551885
2c Plan Sponsor's telephone number: 315-455-9790
2d Business code (see instructions): 484120

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator/employer/DFE, Date, and Name of individual signing. Includes entries for JOHN A. BULGARO and MICHAEL S. SCALZO.

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

Form 5500 (2024) v. 240311

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN	
	<b>3c</b> Administrator's telephone number	
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN	
	<b>4d</b> PN	
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	10626
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ). <b>a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>a(2)</b> Total number of active participants at the end of the plan year ..... <b>b</b> Retired or separated participants receiving benefits..... <b>c</b> Other retired or separated participants entitled to future benefits ..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> ..... <b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) ..... <b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) ..... <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b>	10530
	<b>6a(2)</b>	10564
	<b>6b</b>	79
	<b>6c</b>	
	<b>6d</b>	10643
	<b>6e</b>	
	<b>6f</b>	
	<b>6g(1)</b>	
<b>6g(2)</b>		
<b>6h</b>		
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>	483

**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 4G

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

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

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

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

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

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

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

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

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

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**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**EXCELLUS BCBS MX SUPP PLAN F**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>15-0329043</b>	<b>55107</b>	<b>510018</b>	<b>172</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	413548
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**MOYER RUSSI AND RANDALL, PC**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>20-5838507</b>	<b>54111</b>	<b>NA</b>	<b>6871</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1650941
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**DAVIS VISION**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>11-3051991</b>	<b>93440</b>	<b>XA2</b>	<b>8528</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

<b>(a)</b> Total amount of commissions paid <b>128881</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
--	--

**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

**LILA MARKETING LLC**

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	
<b>128881</b>			

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	2577613
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**EXCELLUS BCBS MEDICARE**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>15-0329043</b>	<b>55107</b>	<b>00500011</b>	<b>215</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

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

**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

**LILA MARKETING LLC**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>	780641
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... Specify nature of costs.	<b>10b</b>	

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

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

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>13-1423090</b>	<b>69744</b>	<b>CP4474</b>	<b>6025</b>	<b>01/01/2024</b>	<b>12/31/2024</b>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	1661682
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>		<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier  
**STANDARD OF NEW YORK**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>13-4119477</b>	<b>89009</b>	<b>761932</b>	<b>8319</b>	<b>02/01/2024</b>	<b>01/31/2025</b>

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

<b>(a)</b> Total amount of commissions paid <b>58051</b>	<b>(b)</b> Total amount of fees paid <b>0</b>
---	--

**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 ARGIRO GROUP INC**  
**2105 W GENESEE ST #115**  
**SYRACUSE, NY 13219**

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	
<b>58051</b>			

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**6** Contracts With Allocated Funds:

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

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

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

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

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

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

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

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

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

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

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

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	829300
<b>b</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....	<b>10b</b>	

Specify nature of costs.

**Part IV Provision of Information**

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

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

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

<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>	

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

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

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

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

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

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

<b>VANGUARD</b>	<b>PO BOX 2900 VALLEY FORGE, PA 19482</b>
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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

<b>GQG PARTNERS LLC</b>	<b>350 EAST LAS OLAS BOULEVARD FORT LAUDERDALE, FL 33301</b>
<b>81-2109181</b>	

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

<b>DIMENSIONAL FUND ADVISORS</b>	<b>6300 BEE CAVE ROAD AUSTIN, TX 78746</b>
<b>30-0447847</b>	

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

<b>FIDUCIARY MANAGEMENT INC</b>	<b>100 EAST WISCONSIN AVE MILWAUKEE, WI 52020</b>
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**(b)** Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

ARTISAN PARTNERS, LP

SUITE 800, 875 WISCONSIN AVE  
MILWAUKEE, WI 53202

39-1807188

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

BRIGADE CAPITAL MANAGEMENT

399 PARK AVENUE, 16TH FLOOR  
NEW YORK, NY 10022

26-0240191

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

CBRE INVESTMENT MANAGEMENT

200 PARK AVENUE, SUITE 2001  
NEW YORK, NY 10166

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

IFM INVESTORS

114 WEST 47TH STREET, 19TH FLOOR  
NEW YORK, NY 10036

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

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

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

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

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

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

EXCELLUS BLUECROSS BLUESHIELD

333 BUTTERNUT DRIVE  
SYRACUSE, NY 13214

15-0329043

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50 12	NONE	4337775	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ONEGROUP, INC.

5232 WITZ DRIVE  
NORTH SYRACUSE, NY 13212

16-1593071

(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?
22 50	NONE	422444	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PARAVATI,KARL,GREEN & DEBELLA

520 SENECA STREET, SUITE 105  
UTICA, NY 13502

16-1284656

(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	313355	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

GALLAGHER BENEFIT SERVICES

85 CHESTNUT RIDGE ROAD SUITE 214  
MONTVALE, NJ 07645

20-2532319

(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	286601	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LOOMIS SAYLES & COMPANY

ONE FINANCIAL CENTER  
BOSTON, MA 02111

04-3200030

(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?
51 28	NONE	251245	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JESSICA HOYT

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	220291	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

KENNETH STILWELL

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	172654	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

COHEN, WEISS AND SIMON

909 THIRD AVENUE, 12TH FLOOR  
NEW YORK, NY 10022-4731

(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	NONE	170831	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MINDI HOUGHTALING

151 NORTHERN CONCOURSE  
BALDWINVILLE, NY 13221

15-0551885

(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?
30 50	NONE	113155	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

DEBORA LOIACANO

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	105735	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JOSEPH SALERNO

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	102829	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STATE STREET GLOBAL ADVISORS

200 NEWPORT AVENUE  
QUINCY, MA 02171

81-4017137

(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?
51 18 19	NONE	101583	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

AMANDA CARMICHAEL

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	99016	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BARTON CASE

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	96574	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AUSTIN BRUTCHER

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	88034	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

TIMOTHY RICH

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30	NONE	81610	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STEFFEN WHEELOCK

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	79720	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

STATE STREET BANK AND TRUST

200 NEWPORT AVENUE  
QUINCY, MA 02171

04-1867445

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 50	NONE	79448	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

THOMAS NANNA

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	78693	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CHRISTA BENNETT

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	77666	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MORGAN, LEWIS & BOCKIUS

PO BOX 8500 S-6050  
PHILADELPHIA, PA 19178

23-0891050

(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	77104	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MARK CHILDS

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

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30 50	NONE	75131	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ALEXANDER CONNOLLY

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	75095	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MA POLCE CONSULTING

401 PHOENIX DRIVE  
ROME, NY 13441

16-1597994

(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	74694	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

RUSSELL MORREALE

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

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30 50	NONE	71201	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JOHN TIERNEY

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

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30 50	NONE	71083	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KRISTIN ALLEN

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

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30 50	NONE	66994	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

PAULA CURRO

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

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30 50	NONE	63545	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

BARBARA ACEY

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	61204	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MICHELLE DEEMER

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	59972	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

DENISE GOMEZ

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	59834	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JENNIFER MAHONEY

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	59340	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

KIM CUNNINGHAM

151 NORTHERN CONCOURSE  
NORTH SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	56235	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

ROSEMARY INSALCO

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	56069	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

D'ARCANGELO & CO., LLP

120 LOMOND COURT  
UTICA, NY 13502

13-2550103

(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	55928	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

SIRIUS COMPUTER SOLUTIONS

PO BOX 2893  
SYRACUSE, NY 13220

74-2836721

(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	46510	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

AMY LEVEA

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	44401	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CHARLES MARTIN

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30 50	NONE	43295	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MEKETA INVESTMENT GROUP

100 LOWDER BROOK DRIVE  
WESTWOOD, MA 02090

04-2659023

(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	41452	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

WELLINGTON TRUST COMPANY, NA CTF EM

280 CONGRESS STREET  
BOSTON, MA 02210

04-2755549

(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?
51 28	NONE	37520	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

HONEYWELL

4705 CROSSROADS PARK DRIVE  
LIVERPOOL, NY 13088

22-6450650

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
99 50	NONE	30702	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CORPORATE MAINTENANCE SYSTEMS

7658 WINDSOR DR  
N SYRACUSE, NY 13212

16-1498422

(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?
50	NONE	30605	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SANDRA CARTER

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30	NONE	28813	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WILLIAM ARNAULT

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(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?
30	NONE	28533	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JUST THE RIGHT STUFF

103 TWIN OAKS DRIVE  
SYRACUSE, NY 13206

16-1407121

(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	25610	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

IRON MOUNTAIN

220 WAVEL ST  
SYRACUSE, NY 13206

04-3038590

(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	19284	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NORTHLAND COMMUNICATIONS

9560 MAIN STREET  
HOLLAND PATENT, NY 13354

16-1188181

(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	18970	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

WB MASON COMPANY

PO BOX 981101  
BOSTON, MA 02298

04-2455641

(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	12915	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

TOSHIBA FINANCIAL SERVICES

PO BOX 790448  
SAINT LOUIS, MO 63179

33-0865305

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	12630	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

FRESCHÉ SOLUTIONS INC

PO BOX 95000  
PHILADELPHIA, PA 19195

42-1770943

(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	12532	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CR FLETCHER TEMPS

126 NORTH SALINA STREET  
SYRACUSE, NY 13202

16-1504346

(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	11236	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

INSIGHT DIRECT USA, INC.

PO BOX 731069  
DALLAS, TX 75373-1069

36-3948996

(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	10309	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

LANPHEAR LANDSCAPES

2018 NEW BOSTON STREET  
CHITTENANGO, NY 13037

16-1390463

(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	NONE	9558	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

AMTRUST NORTH AMERICA

800 SUPERIOR AVE E  
CLEVELAND, OH 44114

04-3106389

(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?
50	NONE	8628	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

SHRED IT USA

4769 ROUTE 233  
WESTMORELAND, NY 13490

46-5506074

(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	6869	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	0	Yes <input type="checkbox"/> No <input type="checkbox"/>

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

GEORGE HARRIGAN

151 NORTHERN CONCOURSE  
SYRACUSE, NY 13221

15-0551885

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
20	NONE	5874	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

QUADIENT LEASING USA, INC

478 WHEELERS FARMS ROAD  
MILFORD, CT 06461

94-5984524

(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	5767	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

<b>A</b> Name of plan <u>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</u>	<b>B</b> Three-digit plan number (PN) ▶	<u>501</u>
<b>C</b> Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</u>	<b>D</b> Employer Identification Number (EIN) <u>15-0551885</u>	

<b>Part I</b>	<b>Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs)</b> (Complete as many entries as needed to report all interests in DFEs)
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<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EMERGING MARKETS FREE CTF</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>75-6661332-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>10010229</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>MSCI EAFE INDEX NL CTF</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>04-6832069-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>20580968</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>PASSIVE EM LOC CURR BD NL CTF ZVPD</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>27-6784056-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>15929996</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>RUSSELL 1000 NON LENDING CTF</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>04-6809841-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>9832289</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>US AGGREGATE BOND MKT IDK CTF</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>04-6928341-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>119305249</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>US HIGH YIELD BOND INDEX NL</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>81-7064772-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>21588891</u>
<b>a</b> Name of MTIA, CCT, PSA, or 103-12 IE: <u>US SHORT TERMGGOVT CREDIT</u>		
<b>b</b> Name of sponsor of entity listed in (a): <u>STATE STREET GLOBAL ADVISORS</u>		
<b>c</b> EIN-PN <u>27-6934633-001</u>	<b>d</b> Entity code <u>C</u>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>87851758</u>

**a** Name of MTIA, CCT, PSA, or 103-12 IE: **SSGA TIP INDEX CTF**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISORS**

<b>c</b> EIN-PN <b>02-6138231-001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>111713041</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **US TREASURY INFL PROTECTED SE MUTUA**

**b** Name of sponsor of entity listed in (a): **STATE STREET GLOBAL ADVISORS**

<b>c</b> EIN-PN <b>88-2478228-001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>89007565</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE: **CTF EMERGING LOCAL DEBT FUND**

**b** Name of sponsor of entity listed in (a): **WELLINGTON TRUST**

<b>c</b> EIN-PN <b>27-2594633-001</b>	<b>d</b> Entity code <b>C</b>	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <b>7348193</b>
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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**a** Name of MTIA, CCT, PSA, or 103-12 IE:

**b** Name of sponsor of entity listed in (a):

<b>c</b> EIN-PN	<b>d</b> Entity code	<b>e</b> Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
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<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>01/01/2024</b> and ending <b>12/31/2024</b>	
<b>A</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>501</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>D</b> Employer Identification Number (EIN) <b>15-0551885</b>

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

		(a) Beginning of Year	(b) End of Year
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>		
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>	14998307	13452392
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	13403194	12924944
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	13028731	19156021
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>	123714283	80768040
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>	85356965	90142260
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>	491687545	493168179
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>	78969462	144695110
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

<b>1d</b> Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	<b>1d(1)</b>		
(2) Employer real property.....	<b>1d(2)</b>		
<b>e</b> Buildings and other property used in plan operation.....	<b>1e</b>	894952	852274
<b>f</b> Total assets (add all amounts in lines 1a through 1e).....	<b>1f</b>	822053439	855159220
<b>Liabilities</b>			
<b>g</b> Benefit claims payable.....	<b>1g</b>		
<b>h</b> Operating payables.....	<b>1h</b>	622853	703758
<b>i</b> Acquisition indebtedness.....	<b>1i</b>		
<b>j</b> Other liabilities.....	<b>1j</b>	158377194	164085099
<b>k</b> Total liabilities (add all amounts in lines 1g through 1j).....	<b>1k</b>	159000047	164788857
<b>Net Assets</b>			
<b>l</b> Net assets (subtract line 1k from line 1f).....	<b>1l</b>	663053392	690370363

**Part II Income and Expense Statement**

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

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: <b>(A)</b> Employers.....	<b>2a(1)(A)</b>	202874777	
<b>(B)</b> Participants.....	<b>2a(1)(B)</b>	846449	
<b>(C)</b> Others (including rollovers).....	<b>2a(1)(C)</b>		
(2) Noncash contributions.....	<b>2a(2)</b>		
(3) Total contributions. Add lines <b>2a(1)(A)</b> , <b>(B)</b> , <b>(C)</b> , and line <b>2a(2)</b> .....	<b>2a(3)</b>		203721226
<b>b Earnings on investments:</b>			
<b>(1) Interest:</b>			
<b>(A)</b> Interest-bearing cash (including money market accounts and certificates of deposit).....	<b>2b(1)(A)</b>	314402	
<b>(B)</b> U.S. Government securities.....	<b>2b(1)(B)</b>		
<b>(C)</b> Corporate debt instruments.....	<b>2b(1)(C)</b>		
<b>(D)</b> Loans (other than to participants).....	<b>2b(1)(D)</b>		
<b>(E)</b> Participant loans.....	<b>2b(1)(E)</b>		
<b>(F)</b> Other.....	<b>2b(1)(F)</b>	922823	
<b>(G)</b> Total interest. Add lines <b>2b(1)(A)</b> through <b>(F)</b> .....	<b>2b(1)(G)</b>		1237225
<b>(2) Dividends:</b>			
<b>(A)</b> Preferred stock.....	<b>2b(2)(A)</b>		
<b>(B)</b> Common stock.....	<b>2b(2)(B)</b>	1981720	
<b>(C)</b> Registered investment company shares (e.g. mutual funds).....	<b>2b(2)(C)</b>	4185989	
<b>(D)</b> Total dividends. Add lines <b>2b(2)(A)</b> , <b>(B)</b> , and <b>(C)</b> .....	<b>2b(2)(D)</b>		6167709
<b>(3)</b> Rents.....	<b>2b(3)</b>		
<b>(4) Net gain (loss) on sale of assets:</b>			
<b>(A)</b> Aggregate proceeds.....	<b>2b(4)(A)</b>	36900327	
<b>(B)</b> Aggregate carrying amount (see instructions).....	<b>2b(4)(B)</b>	34888691	
<b>(C)</b> Subtract line <b>2b(4)(B)</b> from line <b>2b(4)(A)</b> and enter result.....	<b>2b(4)(C)</b>		2011636
<b>(5) Unrealized appreciation (depreciation) of assets:</b>			
<b>(A)</b> Real estate.....	<b>2b(5)(A)</b>	-5277	
<b>(B)</b> Other.....	<b>2b(5)(B)</b>	11341072	
<b>(C)</b> Total unrealized appreciation of assets. Add lines <b>2b(5)(A)</b> and <b>(B)</b> .....	<b>2b(5)(C)</b>		

	(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts .....	2b(6)	15387877
(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)	10028207
<b>c</b> Other income .....	2c	324133
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	2d	250213808

**Expenses**

<b>e</b> Benefit payment and payments to provide benefits:		
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	203464835
(2) To insurance carriers for the provision of benefits .....	2e(2)	5264813
(3) Other.....	2e(3)	
(4) Total benefit payments. Add lines 2e(1) through (3) .....	2e(4)	208729648
<b>f</b> Corrective distributions (see instructions) .....	2f	
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	2g	
<b>h</b> Interest expense.....	2h	
<b>i</b> Administrative expenses:		
(1) Salaries and allowances .....	2i(1)	2561917
(2) Contract administrator fees .....	2i(2)	8610009
(3) Recordkeeping fees .....	2i(3)	
(4) IQPA audit fees .....	2i(4)	55928
(5) Investment advisory and investment management fees .....	2i(5)	999665
(6) Bank or trust company trustee/custodial fees .....	2i(6)	
(7) Actuarial fees .....	2i(7)	276401
(8) Legal fees .....	2i(8)	535732
(9) Valuation/appraisal fees .....	2i(9)	
(10) Other trustee fees and expenses .....	2i(10)	
(11) Other expenses.....	2i(11)	1127537
(12) Total administrative expenses. Add lines 2i(1) through (11) .....	2i(12)	14167189
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	2j	222896837

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line 2j from line 2d.....	2k	27316971
<b>l</b> 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)  Unmodified (2)  Qualified (3)  Disclaimer (4)  Adverse

**b** Check the appropriate box(es) to indicate whether the IQPA performed an ERISA section 103(a)(3)(C) audit. Check both boxes (1) and (2) if the audit was performed pursuant to both 29 CFR 2520.103-8 and 29 CFR 2520.103-12(d). Check box (3) if pursuant to neither.

(1)  DOL Regulation 2520.103-8 (2)  DOL Regulation 2520.103-12(d) (3)  neither DOL Regulation 2520.103-8 nor DOL Regulation 2520.103-12(d).

**c** Enter the name and EIN of the accountant (or accounting firm) below:

(1) Name: **D'ARCANGELO & CO., LLP**

(2) EIN: **13-0255013**

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

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

**Part IV Compliance Questions**

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

During the plan year:

	Yes	No	Amount
<b>a</b> Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)		X	
<b>b</b> Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
<b>c</b> Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
<b>d</b> Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
<b>e</b> Was this plan covered by a fidelity bond?	X		500000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>h</b> Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
<b>n</b> If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

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

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

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

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

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

**D'Arcangelo & Co., LLP**  
**Certified Public Accountants & Consultants**

120 Lomond Court, Utica, N.Y. 13502-5950  
315-735-5216 Fax: 315-735-5210

**Independent Auditor's Report**

Trustees  
New York State Teamsters Council Health and Hospital Fund

**Opinion**

We have audited the accompanying financial statements of New York State Teamsters Council Health and Hospital Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of New York State Teamsters Council Health and Hospital Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

**Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 New York State Teamsters Council Health and Hospital Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

**Responsibilities of Management for the Financial Statements**

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

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

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

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

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 generally accepted auditing standards, 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 New York State Teamsters Council Health and Hospital Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about New York State Teamsters Council Health and Hospital Fund's ability to continue as a going concern for a reasonable period of time.

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

#### **Supplemental Schedule Required by ERISA**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule as listed in the table of contents, is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such 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 generally accepted auditing standards.

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

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

*D'Arcangelo + Co., LLP*

October 14, 2025

Utica, New York

NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
ATTACHMENT FOR SCHEDULE H, PART IV, LINE 4f

December 31, 2024

CATEGORY	SECURITY DESCRIPTION	REVALUED		MARKET VALUE	UNREALIZED REVALUED	
		COST	2		1	GAIN/LOSS
INTEREST BEARING CASH	BRAZILIAN REAL				(1)	
INTEREST BEARING CASH	EURO CURRENCY	4,363	-4,082			(486)
INTEREST BEARING CASH	EURO CURRENCY	43,247	42,921			(326)
INTEREST BEARING CASH	POUND STERLING	13,569	12,503			(1,066)
INTEREST BEARING CASH	POUND STERLING	28,184	27,759			(424)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN SALXX SS INST US GOV MM ADMIN CLASS	7,218	7,218			-
INTEREST BEARING CASH	SS INST US GOV MM ADMIN SALXX SS INST US GOV MM ADMIN CLASS	1,131,311	1,120,392			(919)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN SALXX SS INST US GOV MM ADMIN CLASS	3,247,648	3,241,332			(6,316)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN SALXX SS INST US GOV MM ADMIN CLASS	1,568,687	1,568,687			-
		6,034,419	6,030,896			(3,523)
CORPORATE STOCKS - COMMON	CIE FINANCIERE RICHEMO A REG COMMON STOCK CHF1 0	1,072,844	1,178,370			105,525
CORPORATE STOCKS - COMMON	UBS GROUP AG REG COMMON STOCK USD 1	1,382,193	1,364,362			(17,831)
CORPORATE STOCKS - COMMON	DAIMLER TRUCK HOLDING AG COMMON STOCK	528,885	538,183			9,297
CORPORATE STOCKS - COMMON	COMPASS GROUP PLC COMMON STOCK GBP 1105	1,730,444	2,106,451			376,007
CORPORATE STOCKS - COMMON	ALIBABA GROUP HOLDING LTD COMMON STOCK USD 000003125	1,113,567	1,211,780			98,213
CORPORATE STOCKS - COMMON	UNIVERSAL MUSIC GROUP NV COMMON STOCK EUR 10.0	835,583	819,122			(16,461)
CORPORATE STOCKS - COMMON	SHELL PLC COMMON STOCK EUR 07	1,730,500	1,641,360			(89,140)
CORPORATE STOCKS - COMMON	DANONE COMMON STOCK EUR 25	2,134,247	2,224,237			89,990
CORPORATE STOCKS - COMMON	TOTALENERGIES SE COMMON STOCK EUR2.5	923,219	751,654			(171,564)
CORPORATE STOCKS - COMMON	RECKITT BENCKISER GROUP PLC COMMON STOCK GBP 1	941,697	830,814			(110,883)
CORPORATE STOCKS - COMMON	ALLEGION PLC COMMON STOCK USD 01	660,084	646,082			(14,002)
CORPORATE STOCKS - COMMON	AON PLC CLASS A COMMON STOCK	590,639	717,961			127,322
CORPORATE STOCKS - COMMON	ALPHABET INC CL A COMMON STOCK USD 001	1,874,949	2,523,937			648,988
CORPORATE STOCKS - COMMON	ALPHABET INC CL A COMMON STOCK USD 001	1,069,187	1,448,902			379,715
CORPORATE STOCKS - COMMON	DIAGEO PLC COMMON STOCK GBP 2893318	892,494	790,074			(102,420)
CORPORATE STOCKS - COMMON	AMERICAN EXPRESS CO COMMON STOCK USD 2	1,527,510	2,414,387			886,837
CORPORATE STOCKS - COMMON	BAE SYSTEMS PLC COMMON STOCK GBP 025	947,865	960,896			13,031
CORPORATE STOCKS - COMMON	ELEVANCE HEALTH INC COMMON STOCK USD 01	2,447,472	1,838,570			(608,902)
CORPORATE STOCKS - COMMON	ARAMARK COMMON STOCK USD 01	1,241,841	1,410,766			168,925
CORPORATE STOCKS - COMMON	VERY DENNISON CORP COMMON STOCK USD1.0	1,486,131	1,364,365			(121,766)
CORPORATE STOCKS - COMMON	BANK OF NEW YORK MELLON CORP COMMON STOCK USD 01	1,525,522	2,248,891			723,369
CORPORATE STOCKS - COMMON	BERKSHIRE HATHAWAY INC CL B COMMON STOCK USD 0033	1,633,456	2,075,116			441,660
CORPORATE STOCKS - COMMON	BERKSHIRE HATHAWAY INC CL B COMMON STOCK USD 0033	1,323,565	1,684,122			360,557
CORPORATE STOCKS - COMMON	LLOYDS BANKING GROUP PLC COMMON STOCK GBP 1	719,983	811,879			91,896
CORPORATE STOCKS - COMMON	BLACKROCK INC COMMON STOCK USD 01	451,521	780,335			328,813
CORPORATE STOCKS - COMMON	BOOKING HOLDINGS INC COMMON STOCK USD 008	1,291,188	1,808,505			517,317
CORPORATE STOCKS - COMMON	CDW CORP/IDE COMMON STOCK USD 01	862,952	705,906			(157,046)
CORPORATE STOCKS - COMMON	CSX CORP COMMON STOCK USD 1.0	1,003,392	974,167			(29,225)
CORPORATE STOCKS - COMMON	CARLISLE COS INC COMMON STOCK USD1.0	508,324	600,103			91,779
CORPORATE STOCKS - COMMON	CARMAX INC COMMON STOCK USD 5	1,141,883	1,238,173			96,290
CORPORATE STOCKS - COMMON	CARRIER GLOBAL CORP COMMON STOCK USD 01	1,002,503	1,191,137			188,635
CORPORATE STOCKS - COMMON	CITIGROUP INC COMMON STOCK USD 01	1,063,241	1,453,976			390,735
CORPORATE STOCKS - COMMON	DOLLAR TREE INC COMMON STOCK USD 01	1,079,170	986,635			(92,535)
CORPORATE STOCKS - COMMON	META PLATFORMS INC CLASS A COMMON STOCK USD 000006	1,321,503	2,186,636			865,133
CORPORATE STOCKS - COMMON	FERGUSON ENTERPRISES INC COMMON STOCK USD 0001	1,020,511	1,423,183			402,672
CORPORATE STOCKS - COMMON	FRESenius MEDICAL CARE ADR ADR	715,649	780,718			65,068
CORPORATE STOCKS - COMMON	KONINKRIJKE PHILIPS NV NY REG SHRS	753,771	846,017			92,246
CORPORATE STOCKS - COMMON	HEIDELBERG MATERIALS AG COMMON STOCK	1,910,696	2,638,217			727,521
CORPORATE STOCKS - COMMON	LAM RESEARCH CORP COMMON STOCK USD 001	467,296	680,407			213,111
CORPORATE STOCKS - COMMON	MARSH + MCLENNAN COS COMMON STOCK USD 1.0	1,209,473	1,355,601			146,128
CORPORATE STOCKS - COMMON	MARSCO CORP COMMON STOCK USD 1.0	1,216,223	1,317,726			101,503
CORPORATE STOCKS - COMMON	MICROCHIP TECHNOLOGY INC COMMON STOCK USD 001	705,744	664,285			(41,459)
CORPORATE STOCKS - COMMON	MICRON TECHNOLOGY INC COMMON STOCK USD 1	664,214	652,072			(12,141)
CORPORATE STOCKS - COMMON	KONINKRIJKE PHILIPS NV COMMON STOCK EUR 2	1,771,650	1,931,121			159,471
CORPORATE STOCKS - COMMON	O'REILLY AUTOMOTIVE INC COMMON STOCK USD 01	639,696	787,371			147,675
CORPORATE STOCKS - COMMON	SAMSUNG ELECTRONICS CO LTD COMMON STOCK KRW 100.0	2,695,681	1,613,942			(1,081,739)
CORPORATE STOCKS - COMMON	PAYPAL HOLDINGS INC COMMON STOCK	553,759	553,239			(521)
CORPORATE STOCKS - COMMON	SODEXO SA COMMON STOCK EUR4.0	711,990	717,972			5,982
CORPORATE STOCKS - COMMON	GRUPE BRUXELLES LAMBERT NV COMMON STOCK CHF 19	556,795	484,098			(72,697)
CORPORATE STOCKS - COMMON	NOVARTIS AG REG COMMON STOCK USD 1.0	2,098,345	2,036,601			(61,744)
CORPORATE STOCKS - COMMON	PROGRESSIVE CORP COMMON STOCK USD 1.0	1,161,761	1,211,485			49,724
CORPORATE STOCKS - COMMON	PROGRESSIVE CORP COMMON STOCK USD 1.0	777,286	1,169,297			392,010
CORPORATE STOCKS - COMMON	QUEST DIAGNOSTICS INC COMMON STOCK USD 01	963,961	1,074,218			109,257
CORPORATE STOCKS - COMMON	HEINEKEN NV COMMON STOCK EUR1.6	1,260,111	889,591			(370,520)
CORPORATE STOCKS - COMMON	HENRY SCHEIN INC COMMON STOCK USD 01	851,567	797,876			(53,691)
CORPORATE STOCKS - COMMON	SCHLUMBERGER LTD COMMON STOCK USD 01	486,834	358,071			(128,764)
CORPORATE STOCKS - COMMON	SCHWAB (CHARLES) CORP COMMON STOCK USD 01	2,231,527	2,468,011			236,484
CORPORATE STOCKS - COMMON	SCHWAB (CHARLES) CORP COMMON STOCK USD 01	1,782,442	1,932,105			149,664
CORPORATE STOCKS - COMMON	SMITH + NEPHEW PLC SPON ADR ADR	604,443	544,619			(59,824)
CORPORATE STOCKS - COMMON	SONY GROUP CORP SP ADR ADR	1,046,333	1,188,980			142,648

NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
ATTACHMENT FOR SCHEDULE H, PART IV, LINE 4f

December 31, 2024

CATEGORY	SECURITY DESCRIPTION	REVALUED COST	MARKET VALUE	UNREALIZED REVALUED GAIN/LOSS
CORPORATE STOCKS - COMMON	SOUTHWEST AIRLINES CO COMMON STOCK USD1 0	573,385	667,892	94,507
CORPORATE STOCKS - COMMON	SYSCO CORP COMMON STOCK USD1 0	1,034,345	1,069,146	34,801
CORPORATE STOCKS - COMMON	TX COMPANIES INC COMMON STOCK USD1 0	382,763	467,172	84,409
CORPORATE STOCKS - COMMON	UNILEVER PLC SPONSORED ADR ADR	961,263	1,124,021	162,758
CORPORATE STOCKS - COMMON	UNITEDHEALTH GROUP INC COMMON STOCK USD 01	1,209,746	1,152,349	(57,397)
CORPORATE STOCKS - OTHER	HSBC BANK PLC WARRANTS	409,715	408,490	(1,225)
		<u>73,464,773</u>	<u>80,768,040</u>	<u>7,303,267</u>
PARTN /JOINT VENTURE INTERESTS	IFM GLOBAL INFRASTRUCTURE (US) LIMITED PARTNERSHIP	37,766,633	40,211,138	2,444,505
PARTN /JOINT VENTURE INTERESTS	CBRE US CORE PARTNERS, LP LIMITED PARTNERSHIP	29,314,010	28,092,970	(1,221,040)
PARTN /JOINT VENTURE INTERESTS	BRIGADE HIGH YIELD FUND LP	19,777,132	20,537,352	760,220
		<u>86,857,775</u>	<u>90,142,260</u>	<u>3,267,485</u>
* COMMON/COLLECTIVE TRUSTS	MSCI EMERGING MARKETS FREE CTF EMFUND	9,332,059	10,010,229	678,170
* COMMON/COLLECTIVE TRUSTS	US AGG BOND INDX NL CTF	117,655,186	119,805,249	1,650,064
* COMMON/COLLECTIVE TRUSTS	RUSSELL 1000 NON LENDING CTF	7,898,078	9,832,289	1,934,211
* COMMON/COLLECTIVE TRUSTS	SSGA TIP INDEX CTF (CMY5) COMINGLED FUND	109,565,846	111,713,041	2,147,195
* COMMON/COLLECTIVE TRUSTS	U S SHORT TERM GOVT CREDIT MUTUAL FUNDS	84,134,807	87,851,258	3,716,451
* COMMON/COLLECTIVE TRUSTS	PASSIVE E M LOC CURR BD NL CTF ZVPD	16,315,219	15,920,996	(394,223)
* COMMON/COLLECTIVE TRUSTS	MSCI EAFE INDEX NL CTF	19,842,543	20,380,968	538,425
* COMMON/COLLECTIVE TRUSTS	U S HIGH YIELD BOND INDEX NL U S HIGH YIELD BOND INDEX NL	19,911,208	21,584,891	1,673,683
* COMMON/COLLECTIVE TRUSTS	U S TREASURY INFL PROTECTED SE MUTUAL FUNDS	84,941,436	89,007,565	4,066,129
* COMMON/COLLECTIVE TRUSTS	CTF EMERGING LOCAL DEBT	8,163,831	7,318,193	(845,638)
		<u>477,780,302</u>	<u>493,168,179</u>	<u>15,387,877</u>
REGISTERED INVESTMENT COMPANY	QQQ PARTNERS EMERGING MARKETS GQG PARTNERS	6,792,935	10,164,955	672,020
REGISTERED INVESTMENT COMPANY	QQQ PARTNERS GLOBAL EQUITY - GLOBAL EQUITY FUND	27,654,793	33,424,749	5,769,956
REGISTERED INVESTMENT COMPANY	LOOMIS SAYLES SENIOR LOAN FUND	51,996,659	55,887,399	4,890,740
REGISTERED INVESTMENT COMPANY	DFA EMERGING MARKETS SMALL CAP DFA EMERGING MARKETS SML CAP	8,849,415	8,982,895	133,479
REGISTERED INVESTMENT COMPANY	VANGUARD DIVIDEND GROWTH FUND VANGUARD DIVIDEND GROWTH INV	36,873,440	35,935,112	(938,328)
		<u>134,666,903</u>	<u>144,695,110</u>	<u>10,028,207</u>
		<u>778,005,672</u>	<u>814,804,484</u>	<u>36,801,263</u>

\* DENOTES PARTY-IN-INTEREST

NEW YORK STATE  
TEAMSTERS COUNCIL  
HEALTH AND HOSPITAL  
FUND

For the Year Ended  
December 31, 2024

FINANCIAL STATEMENTS  
AND SUPPLEMENTAL  
SCHEDULES

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

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**D'Arcangelo & Co., LLP**  
**Certified Public Accountants & Consultants**

120 Lomond Court, Utica, N.Y. 13502-5950  
315-735-5216 Fax: 315-735-5210

**Independent Auditor's Report**

Trustees  
New York State Teamsters Council Health and Hospital Fund

**Opinion**

We have audited the accompanying financial statements of New York State Teamsters Council Health and Hospital Fund, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and benefit obligations of New York State Teamsters Council Health and Hospital Fund as of December 31, 2024 and 2023, and the changes in its net assets available for benefits and changes in benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

**Basis for Opinion**

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 New York State Teamsters Council Health and Hospital Fund and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

**Responsibilities of Management for the Financial Statements**

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

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

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

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

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards 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 generally accepted auditing standards, 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 New York State Teamsters Council Health and Hospital Fund's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about New York State Teamsters Council Health and Hospital Fund's ability to continue as a going concern for a reasonable period of time.

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

#### **Supplemental Schedule Required by ERISA**

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule as listed in the table of contents, is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. Such 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 generally accepted auditing standards.

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

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

*D'Arcangelo + Co., LLP*

October 14, 2025

Utica, New York

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS**

**December 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>Assets</b>		
<b>Investments at Fair Value</b>		
Short-Term Investments and Commingled Bank Trust	\$ 6,030,896	\$ 6,080,831
Corporate Equity Securities	80,768,040	72,217,624
Common and Collective Trusts and Commingled Funds	<u>728,005,548</u>	<u>707,510,631</u>
Total Investments at Fair Value	<u>814,804,484</u>	<u>785,809,086</u>
<b>Receivables</b>		
Employer Contributions, Net	13,452,392	15,909,073
Accrued Investment Income	61,932	109,070
Receivable for Securities Sold	<u>288,782</u>	<u>197,372</u>
Total Receivables	<u>13,803,106</u>	<u>16,215,515</u>
Operating Cash	7,312,887	2,608,965
HRA Cash	5,812,239	4,338,935
Property Used in Operations, Net	362,207	399,608
Other Assets	<u>12,574,230</u>	<u>13,096,752</u>
<b>Total Assets</b>	<u>854,669,153</u>	<u>822,468,861</u>
<b>Liabilities</b>		
Accounts Payable and Accrued Expenses	703,758	622,853
Due to Pension Fund	8,957	60,868
Due to UPS Retiree Fund	1,096,648	1,863,855
Payable for Securities Purchased	26,120	7,378
HRA Liability	89,926,739	92,453,435
Prepaid Contributions	<u>3,608,476</u>	<u>3,018,424</u>
<b>Total Liabilities</b>	<u>95,370,698</u>	<u>98,026,813</u>
<b>Net Assets Available for Benefits</b>	<u>\$ 759,298,455</u>	<u>\$ 724,442,048</u>

The Accompanying Notes are an Integral Part of These Financial Statements.

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**  
**STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS**

**For the Years Ended December 31, 2024 and 2023**

	2024	2023
<b>Additions</b>		
Investment Income		
Net Appreciation in Fair Value of Investments	\$ 38,768,792	\$ 72,037,248
Interest, Dividends and Other Investment Income	<u>7,404,934</u>	<u>5,040,003</u>
Investment Income	46,173,726	77,077,251
Less Investment Fees	<u>858,532</u>	<u>899,212</u>
Net Investment Income	45,315,194	76,178,039
Employer Contributions	202,874,777	204,165,903
COBRA and Retirees' Contributions	846,449	828,480
Payroll Audit and Collection Fees	75,190	112,329
Legal Settlements	158,252	378,407
Other Income	<u>90,691</u>	<u>94,170</u>
<b>Total Additions</b>	<u>249,360,553</u>	<u>281,757,328</u>
<b>Deductions</b>		
Benefits Paid for Plan Participants	195,930,676	183,463,018
Insurance Premiums	5,264,813	5,472,602
Administrative Expenses	<u>13,308,657</u>	<u>13,445,122</u>
<b>Total Deductions</b>	<u>214,504,146</u>	<u>202,380,742</u>
<b>Net Increase</b>	34,856,407	79,376,586
<b>Net Assets Available for Benefits, Beginning of Year</b>	<u>724,442,048</u>	<u>645,065,462</u>
<b>Net Assets Available for Benefits, End of Year</b>	<u>\$ 759,298,455</u>	<u>\$ 724,442,048</u>

The Accompanying Notes are an Integral Part of These Financial Statements.

NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

STATEMENTS OF BENEFIT OBLIGATIONS

December 31, 2024 and 2023

	<u>2024</u>	<u>2023</u>
<b>Amounts Currently Payable to or for Participants, Beneficiaries, and Dependents</b>		
Health Claims Payable	\$ 950,759	\$ 0
<b>Other Obligations for Current Benefit Coverage, at Present Value of Estimated Amounts</b>		
Claims Incurred and Pending	21,950,000	19,184,000
Accumulated Eligibility Credits	45,962,400	42,109,000
Frozen Disability Death Benefits	<u>555,000</u>	<u>591,000</u>
	<u>68,467,400</u>	<u>61,884,000</u>
<b>Total Benefit Obligations</b>	<u>\$ 69,418,159</u>	<u>\$ 61,884,000</u>

The Accompanying Notes are an Integral Part of These Financial Statements.

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS**

**For the Years Ended December 31, 2024 and 2023**

	<u>2024</u>	<u>2023</u>
<b>Amounts Currently Payable to or for</b>		
<b>Participants, Beneficiaries, and Dependents</b>		
Balance at Beginning of Year	\$ 0	\$ 0
Claims Reported and Approved for Payment	196,881,435	183,463,018
Claims Paid	<u>(195,930,676)</u>	<u>(183,463,018)</u>
Balance at End of Year	<u>950,759</u>	<u>0</u>
<b>Other Obligations for Current Benefit Coverage,</b>		
<b>at Present Value of Estimated Amounts</b>		
Balance at Beginning of Year	61,884,000	56,261,800
Net Change During Year:		
Claims Incurred and Pending	2,766,000	3,585,000
Accumulated Eligibility Credits	3,853,400	2,022,200
Frozen Disability Death Benefits	<u>(36,000)</u>	<u>15,000</u>
Balance at End of Year	<u>68,467,400</u>	<u>61,884,000</u>
<b>Total Benefit Obligations</b>	<u>\$ 69,418,159</u>	<u>\$ 61,884,000</u>

The Accompanying Notes are an Integral Part of These Financial Statements.

# NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

## NOTES TO FINANCIAL STATEMENTS

### NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

#### Operations

The New York State Teamsters Council Health and Hospital Fund (the Fund/Plan) is a multi-employer collectively bargained employee benefit plan. Its purpose is to provide health care benefits to members with union agreements requiring contributions to the Fund. The Fund is located in Syracuse, New York, and covers participants in the central, upstate, and western regions of New York State and the Baltimore, Maryland area.

#### Description of Plan

The following description of the Plan provides only general information. Participants should refer to the Plan agreement for a detailed description of the Plan provisions.

The New York State Teamsters Council Health and Hospital Fund is a multi-employer health benefit fund. The Fund provides hospital, medical, surgical, dental, vision, prescription, disability, death, legal, and other related health care benefits to eligible active participants including their spouses and dependents. In addition, certain members and their dependents may participate on a self-pay basis. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Eligibility for benefits is based on covered employment; bargaining unit employees who are employed by a contributing employer must be credited with paid contributions for a minimum of 36 working days in a qualifying quarter. Coverage is effective on the first day of the benefit quarter, which follows the qualifying quarter and will remain in effect for the 3 months indicated. The Fund also provides benefits to certain participants if they have accumulated in the current year or prior years credit amounts (bank hours) in excess of hours required for current coverage. At December 31, 2024 and 2023, there were approximately 10,700 and 10,600 active members eligible for benefits under the Plan, respectively.

Plan benefits are provided on a self-insured basis except for vision, disability, death, and legal benefits which are fully insured. For the years ended December 31, 2024 and 2023, the Fund provided, on a self-insured basis, medical, hospital, and dental benefits through Excellus BlueCross BlueShield of Central New York, Inc., and prescription benefits through Express Scripts. The Fund contracts with the following companies to provide benefits on a fully-insured basis: Davis Vision to administer its vision benefits, ULLICO to administer its disability benefits, UNUM to administer its death benefits, and Moyer, Russi & Randall to administer legal benefits. Under the terms of their contracts, each administrator is responsible for payment of certain benefits in accordance with Plan provisions. In addition to the above administrators, Fund employees process certain member benefits in-house.

The Fund has a Health Reimbursement Account Plan (HRA) that is funded through employer contributions and is administered with the assistance of Lifetime Benefit Solutions, Inc. The HRA Plan allows participants to be reimbursed tax free for qualified medical expenses up to the amount available in their individual account. Amounts remaining at the end of the year can be carried over to future plan years. If a participant leaves covered employment, they may continue to receive reimbursements from their individual account for so long as a balance is maintained in the account. Upon death, a participant's spouse and other dependents may continue to apply for reimbursement of health-related expenses under the Plan. If no contributions into or distributions from the account have occurred within the preceding twenty-four months and the account balance is less than \$500, a participant's account balance will be closed and the balance forfeited. Active participant HRA balances were \$86,404,285 and \$90,318,392 at December 31, 2024 and 2023, respectively.

The Plan agreement provides that contributing employers make monthly contributions to the Fund to provide benefits for members. Current employer contributions vary based on plan type weekly rates. Contributions are collected monthly based upon employment information reports submitted by employers. Employees contribute to the Fund for COBRA eligibility at monthly rates established annually by the Trustees.

In the event of plan termination, the net assets of the Fund will be allocated as prescribed by ERISA and regulations pursuant thereto.

# NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

## NOTES TO FINANCIAL STATEMENTS

### NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

The Fund also has a Health Reimbursement Account Benefits – Retirees and Former Employees Plan (Retiree HRA). When a participant of the New York State Teamsters Health & Hospital Fund Medical Benefits Plan loses eligibility as an active employee, they automatically become a participant of the Retiree HRA Plan, provided that there is a balance in their Health Reimbursement Account under the HRA Plan. The sole source of contributions to the Retiree HRA Plan is the amount transferred to the Retiree HRA Plan from the Active Plan. Participants remain in the Retiree HRA Plan until the earlier of (1) the exhaustion of their individual account balance, (2) they once again become covered as an eligible employee under the Active Plan, or (3) the Trustees terminate the Retiree HRA Plan. Upon death, a participant's spouse and other eligible dependents may continue to apply for reimbursement of health-related expenses under the Retiree HRA Plan and use the account for payment of health insurance premiums so long as the balance in the account is sufficient to cover the claims. If the participant does not have a spouse or any other eligible dependents, any balance remaining in their individual account will be forfeited. Retiree HRA balances were \$3,522,454 and \$2,135,043 at December 31, 2024 and 2023, respectively.

#### Basis of Accounting

The accompanying financial statements have been prepared on the accrual basis of accounting and follows Financial Accounting Standards Board authoritative guidance on Accounting and Reporting by Health and Welfare Benefit Plans for reporting purposes. These reporting standards require that the Fund include all claims related liabilities in a statement of benefit obligations at year end and changes in benefit obligations for the year then ended.

#### Contributions Receivable

Contributions receivable from participating employers are valued at cost and are accrued based upon contribution reports received subsequent to the year-end, which include contributions due in the current year.

#### Allowance for Credit Losses

A provision for losses on receivables is made in order to maintain an adequate reserve to cover anticipated uncollectible accounts. The allowance is determined by management based on review of receivable accounts. At December 31, 2024 and 2023, the reserve approximated \$2,861,908 and \$3,853,010, respectively.

The Plan determines allowances using the current expected credit loss (CECL) methodology, incorporating various estimates and relevant factors. The Plan continuously assess credit risk by considering forward-looking economic conditions and refining its loss estimation models. This approach ensures the timely recognition of potential credit losses.

#### Revenue Recognition

Employer contribution revenue is recognized in the period for which the employee benefits pertain.

#### Investment Valuation and Income Recognition

Investments are recorded 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. See Note 5 for discussion of 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 (depreciation) in the statements of changes in net assets available for benefits includes the Fund's gains and losses on investments bought and sold as well as held during the year.

#### Property Used in Operations

The Fund's equity in the office building and its interest in related furniture and equipment are valued at cost which approximates fair value. The capitalization policy requires any purchased property with a cost or fair market value exceeding \$500 to be recorded as a capital asset. Depreciation is recorded using the straight-line method over estimated useful lives as follows:

	<u>Estimated Life</u>
Building and Improvements	5-40 Years
Furniture, Fixtures, and Equipment	3-7 Years

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)**

The carrying value and accumulated depreciation of Fund property at December 31, 2024 and 2023, are as follows:

	<u>2024</u>	<u>2023</u>
Land, Building, and Improvements	\$ 1,618,671	\$ 1,618,671
Furniture, Fixtures, and Equipment	<u>288,656</u>	<u>247,618</u>
	1,907,327	1,866,289
Less: Accumulated Depreciation	<u>1,545,120</u>	<u>1,466,681</u>
Net Property and Equipment	\$ <u><u>362,207</u></u>	\$ <u><u>399,608</u></u>

The Fund recorded depreciation expense of \$78,439 and \$104,961 for the years ended December 31, 2024 and 2023, respectively.

**Reclassifications**

Certain amounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

**NOTE 2 CONCENTRATIONS OF CREDIT RISK**

Contributing employers primarily represent companies employing Teamster members in central, upstate, and western regions of New York State and the Baltimore, Maryland area. Contributions are pursuant to collective bargaining agreements and no collateral is required. One of the Plan's contributing employers comprises approximately 41% of total employer contributions.

The Fund invests in various types of investment securities. Investment securities are exposed to various risks, such as interest rate, market, and credit risk. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care 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 3 TAX STATUS**

The trust established under the Plan to hold the Fund's assets obtained an updated determination letter dated September 2, 2009, in which the Internal Revenue Service stated that the trust, as then designed, constituted a tax-exempt organization, and is, therefore, exempt from Federal income taxes under provisions of Section 501(c)(5) of the Internal Revenue Code.

The Plan has been amended since receiving the determination letter. However, the Fund's administrator and tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code. Therefore, no provision for income taxes has been included in the Fund's financial statements.

**NOTE 4 INVESTMENTS**

At December 31, 2024 and 2023, State Street Bank and Trust Company served as custodian for the Fund's securities in accordance with a custodial agreement. Investments are directed by various investment advisors in accordance with the terms of discretionary investment management agreements entered into by the Fund, subject to investment policy guidelines adopted by the Trustees.

**NOTE 5 FAIR VALUE MEASUREMENTS**

The Financial Accounting Standards Board authoritative guidance on fair value measurements establishes a framework for measuring fair value. That framework 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 are described as follows:

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 5 FAIR VALUE MEASUREMENTS (Continued)**

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

**Level 2:** Inputs to the valuation methodology include the following:

- 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.

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

Short-Term Investments and Commingled Bank Trusts: Valued at amortized cost which approximates fair value.

Corporate Equity Securities: Fair values of securities traded on a national securities exchange are based on the last reported sales price on the last business day of the year.

Common Collective Trusts and Commingled Funds: The fair value is determined by its sponsor.

Receivables/Payables for Securities Sold and Purchased: The fair value of receivables/payables for securities sold and purchased is determined based on the specific inputs at the end of the year. Changes in valuation are a result of timing from the point of purchase or sale and the actual delivery of the securities. Generally, the fair value is based on similar securities traded in an active market.

All assets have been valued using a market approach.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Fund believes its valuation methods are 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.

The following table sets forth by level, within the fair value hierarchy, the Fund's assets and liabilities measured at fair value on a recurring basis as of December 31, 2024 and 2023:

	Fair Value Measurements at December 31, 2024			
	Total	(Level 1)	(Level 2)	(Level 3)
<b>Assets:</b>				
Short-Term Investments and Commingled Bank Trusts	\$ 6,030,896	\$ 6,030,896	\$ 0	\$ 0
Corporate Equity Securities	80,768,040	80,768,040	0	0
Common Collective Trusts and Commingled Funds (a)	<u>728,005,548</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total Investments at Fair Value	814,804,484	86,798,936	0	0
Receivable for Securities Sold	<u>288,782</u>	<u>288,782</u>	<u>0</u>	<u>0</u>
Total Assets at Fair Value	<u>\$ 815,093,266</u>	<u>\$ 87,087,718</u>	<u>\$ 0</u>	<u>\$ 0</u>
<b>Liabilities:</b>				
Payable for Securities Purchased	\$ 26,120	\$ 26,120	\$ 0	\$ 0
Total Liabilities at Fair Value	<u>\$ 26,120</u>	<u>\$ 26,120</u>	<u>\$ 0</u>	<u>\$ 0</u>

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 5 FAIR VALUE MEASUREMENTS (Continued)**

	Fair Value Measurements at December 31, 2023			
	Total	(Level 1)	(Level 2)	(Level 3)
<b>Assets:</b>				
Short-Term Investments and Commingled Bank Trusts	\$ 6,080,831	\$ 6,080,831	\$ 0	\$ 0
Corporate Equity Securities	72,217,624	72,217,624	0	0
Common Collective Trusts and Commingled Funds (a)	707,510,631	0	0	0
Total Investments at Fair Value	785,809,086	78,298,455	0	0
Receivable for Securities Sold	197,372	197,372	0	0
Total Assets at Fair Value	\$ 786,006,458	\$ 78,495,827	\$ 0	\$ 0
<b>Liabilities:</b>				
Payable for Securities Purchased	\$ 7,378	\$ 7,378	\$ 0	\$ 0
Total Liabilities at Fair Value	\$ 7,378	\$ 7,378	\$ 0	\$ 0

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

The following sets forth additional disclosures of the Fund’s investments whose fair value is estimated using net asset value per share or its equivalent at December 31, 2024 and 2023:

**Common Collective Trusts and Commingled Funds**

**Domestic Equity Assets** - Invested assets in this category include replicating or exceeding returns of the S&P 500 and Russell 1000 indexes and seeking long-term capital appreciation by owning small capitalization stocks believed to have catalysts to drive growth over an intermediate time frame. These investments have no unfunded commitments and no redemption restrictions.

**Investment Grade Bond Assets** – Invested assets in this category seek to replicate the returns of the Barclays Aggregate and Barclays Universal indexes by investing in various fixed income instrument securities, both domestic and foreign, with varying maturities and an average quality of “BBB” or better. These investments have no unfunded commitments and no redemption restrictions.

**Treasury Inflation Protected Securities** – Invested assets in this category seek to match the return of the Barclays U.S. TIPS Index by investing in a portfolio of inflation-protected securities. These investments have no unfunded commitments and no redemption restrictions.

**High Yield Bond Assets** – Invested assets in this category seek to match the return of the Bloomberg High Yield Index by investing in a portfolio of primarily bank debt and corporate fixed income debt securities. These investments have no unfunded commitments and no redemption restrictions.

**Senior Loan Fund** – Invested assets in this category seek to provide access to higher quality senior secured floating rate notes of leveraged companies. The portfolios are structured to be broadly diversified by sector and industry, having exposure to over 200 loan issuers. These investments have no unfunded commitments and no redemption restrictions.

**International Developed Markets** – Funds in this category seek to outperform the MSCI EAFE index by actively managing both a bottom-up and top-down international equity portfolio. These investments have no unfunded commitments and no redemption restrictions.

**Emerging Markets** – The investment strategy of funds in this category include investing in large, medium, and small capitalization companies in developing nations. These investments have no unfunded commitments and no redemption restrictions.

**NOTE 6 DEPOSITS WITH THIRD-PARTY ADMINISTRATORS**

In accordance with the Fund’s contract with Excellus BlueCross BlueShield of Central New York, Inc., the Fund is required to maintain a deposit to fund the lag in billing for claims paid by the administrator. The Fund had a deposit of \$2,960,300 and \$2,921,800 for major medical claims for the years ended December 31, 2024 and 2023, respectively.

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 7 PENSION PLAN**

The Fund contributes to the New York State Teamsters Pension and Retirement Fund (a multiemployer defined benefit pension plan) under the terms of collective-bargaining agreements that cover its union-represented employees. The risks of participating in multiemployer plans are different from single-employer plans in the following aspects:

- a. Assets contributed to the multiemployer plan by one employer may be used to provide benefits to employees of other participating employers.
- b. If a participating employer stops contributing to the plan, the unfunded obligations of the plan may be borne by the remaining participating employers.
- c. If the Fund chooses to stop participating in its multiemployer plan, the Fund may be required to pay the plan an amount based on the underfunded status of the plan, referred to as a withdrawal liability.

The Fund’s participation in this multiemployer defined benefit pension plan for the years ended December 31, 2024 and 2023, is outlined in the table below. Unless otherwise noted, the most recent Pension Protection Act (PPA) zone status available in 2024 and 2023 is for the Fund’s year-end at December 31, 2023, and December 31, 2022, respectively. The zone status is based on information that the Fund received from the plan and is certified by the Fund’s actuary. Among other factors, plans in the critical zone are generally less than 65 percent funded, plans in the endangered zone are less than 80 percent funded, and plans in the green zone are at least 80 percent funded. The “FIP/RP Status Pending/Implemented” column indicates plans for which a financial improvement plan (FIP) or a rehabilitation plan (RP) is either pending or has been implemented.

<u>Pension Fund</u>	<u>EIN/Pension Plan Number</u>	<u>Protection Act Zone Status</u>		<u>FIP/RP Status Pending/Implemented</u>	<u>Contributions</u>		<u>Surcharge Imposed</u>	<u>Expiration Date of Collective Bargaining Agreement</u>
		<u>2024</u>	<u>2023</u>		<u>2024</u>	<u>2023</u>		
New York State Teamsters Pension & Retirement Fund	16-6063585/074	Critical	Critical	Yes	\$ 535,433	\$ 490,021	Yes	12/31/2025

**NOTE 8 PARTIES-IN-INTEREST AND RELATED-PARTY INFORMATION**

The Fund holds title to its principal operating office building located at 3 Northern Concourse, Syracuse, New York, jointly with New York State Teamsters Conference Pension and Retirement Fund (Pension Fund). Ownership and occupancy costs are shared equally by the two related benefit funds.

Substantially all common expenses of Fund operations (including supplies, utilities, repairs, maintenance, equipment maintenance, taxes, and security) are shared equally between the Pension and Health Funds. Salary and wage expenses and related employment costs are allocated based on the actual cost of employees working exclusively for each Fund. The costs of employees providing services to both Funds are shared equally. In addition, certain contributions were held in escrow by the Pension Fund. The Health Fund had amounts due to the Pension Fund of \$8,957 and \$60,868 at December 31, 2024 and 2023, respectively.

An administrative cost sharing agreement exists between the Pension and Health Funds and the New York State Teamsters Council – United Parcel Service (“UPS”) Retiree Health Fund (UPS Retiree Health Fund) for the costs of shared personnel as well as other shared office administrative expenses. For the years ended December 31, 2024 and 2023, the UPS Retiree Health Fund reimbursed the Health Fund \$44,273 and \$38,013, respectively for its share of administrative expenses.

In October 2023, UPS and the Union directed contribution allocations to the UPS Retiree Health Fund under the UPS National Master Agreement retroactive to August 1, 2022 and August 1, 2023. For hours worked beginning August 1, 2022 the rate is \$0.428 per hour worked for full time employees and \$0.561 per hour worked for part time employees. These amounts were previously remitted by UPS to the NYS Teamsters Health and Hospital Fund, pending formal allocation. For hours worked beginning August 1, 2023 the rate is \$0.928 per hour worked for full time employees and \$1.061 per hour worked for part time employees. For hours worked beginning August 1, 2024 the rate is \$1.428 per hour worked for full time employees and \$1.561 per hour worked for part time employees. At December 31, 2024 and 2023, the Health Fund owed the UPS Retiree Health Fund \$1,096,648 and \$1,863,855, respectively, related to this contribution allocation by the bargaining parties.

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 8 PARTIES-IN-INTEREST AND RELATED-PARTY INFORMATION (Continued)**

A party-in-interest is defined under the Department of Labor regulations as any fiduciary of the Fund, any party rendering services to the Fund or an employer whose employees are covered by the Fund. The Fund pays expenses related to Fund operations and investment activity to various service providers. Therefore, payments to such service providers by the Fund qualify as party-in-interest transactions.

Material party-in-interest transactions include investments managed by State Street Global Advisors (SSGA), which is a subsidiary of State Street Corporation Bank and Trust Company. State Street Bank and Trust Company also provides custody and accounting services for all of the Fund's investments. At December 31, 2024 and 2023, the fair value of the Fund's investments managed by SSGA was \$485,819,986 and \$484,020,912, respectively.

**NOTE 9 FIDELITY BOND COVERAGE**

The Fund presently carries Fidelity Bond Insurance in the amount of \$500,000, which is the maximum amount required.

**NOTE 10 PREMIUM ASSISTANCE PROGRAM**

The Trustees of the Fund have approved and implemented a Premium Assistance Program to individuals who retire and are under 65 years of age, and have a minimum of 60 quarters (or 40 quarters if disabled) of participation with the Health Fund. The program will subsidize the monthly premium payable for the HMO program or designated Retiree Medical Program at \$200 per month for members retiring after December 31, 1998 and \$75 per month for members retiring on or after January 1, 1995, but before or on December 31, 1998, for a maximum period of 120 months or when a member becomes eligible for Medicare.

Effective January 1, 2004, all new retirees who are eligible for premium assistance will be entitled to receive a higher amount if they work beyond their Unreduced Retirement Date. The additional amounts range from an additional \$50 per month to a maximum of \$300. In addition, members meeting the same eligibility requirements and 25 years of service with UPS, are provided dental and vision benefits in lieu of the \$200 monthly benefit. The program is subject to an annual review and approval of the Trustees. During both years ended December 31, 2024 and 2023, there was an average 1 retiree eligible for this benefit.

**NOTE 11 PRIORITIES ON TERMINATION OF PLAN**

In the event of termination of the Plan, the assets remaining will be used to pay necessary administrative costs and remaining benefits, until all assets are depleted. If all assets are expended, no further benefits would be provided by the Plan. Upon termination of this Plan, participants and beneficiaries will have no further rights or vested interests in the Plan.

**NOTE 12 PLAN AMENDMENTS**

The Fund's Board of Trustees adopted certain plan amendments to enhance certain benefits and to comply with recent legislation during the years ended December 31, 2024 and 2023.

**NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND**

**NOTES TO FINANCIAL STATEMENTS**

**NOTE 13 RECONCILIATIONS 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	\$ 759,298,455	\$ 724,442,048
Add:		
Fair Value Adjustment for Property Used in Operations	490,067	495,344
Less:		
Health Claims Payable	950,759	0
Estimated Claims Incurred and Pending	21,950,000	19,184,000
Estimated Liability for Accumulated Eligibility Credits	45,962,400	42,109,000
Estimated Liability for Disability Death Benefits	555,000	591,000
	69,418,159	61,884,000
Net Assets Available for Benefits Per the Form 5500	\$ 690,370,363	\$ 663,053,392

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

	2024	2023
Benefits Paid for Participants Per the Financial Statements	\$ 195,930,676	\$ 183,463,018
Increase (Decrease) in Benefits Payable	950,759	0
Increase (Decrease) in Estimated Benefit Obligations	6,583,400	5,622,200
Benefits Paid to Participants Per the Form 5500	\$ 203,464,835	\$ 189,085,218

**NOTE 14 SUBSEQUENT EVENTS**

Management has evaluated subsequent events through October 14, 2025, the date on which the financial statements were available to be issued.

NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
ATTACHMENT FOR SCHEDULE H, PART IV, LINE 4f

December 31, 2024

CATEGORY	SECURITY DESCRIPTION	REVALUED		MARKET VALUE	UNREALIZED	
		COST	VALUE		REVALUED	GAIN/LOSS
INTEREST BEARING CASH	BRAZILIAN REAL					(1)
INTEREST BEARING CASH	EURO CURRENCY	4,363	4,082			(480)
INTEREST BEARING CASH	POUND STERLING	43,247	42,921			(326)
INTEREST BEARING CASH	POUND STERLING	13,560	12,503			(1,058)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN SALXX	28,184	27,759			(424)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN CLASS	7,218	7,218			-
INTEREST BEARING CASH	SS INST US GOV MM ADMIN CLASS	1,121,311	1,120,392			(919)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN CLASS	3,247,648	3,247,332			(316)
INTEREST BEARING CASH	SS INST US GOV MM ADMIN CLASS	1,568,687	1,568,687			-
		6,034,419	6,030,896			(3,523)
CORPORATE STOCKS - COMMON	CIE FINANCIERE RICHEMO A REG	1,072,844	1,178,370			105,525
CORPORATE STOCKS - COMMON	UBS GROUP AG REG	1,382,193	1,364,362			(17,831)
CORPORATE STOCKS - COMMON	DAIMLER TRUCK HOLDING AG	528,985	538,183			9,207
CORPORATE STOCKS - COMMON	COMPASS GROUP PLC	1,730,444	2,106,451			376,007
CORPORATE STOCKS - COMMON	ALIBABA GROUP HOLDING LTD	1,113,567	1,211,780			98,213
CORPORATE STOCKS - COMMON	UNIVERSAL MUSIC GROUP NV	835,583	819,122			(6,464)
CORPORATE STOCKS - COMMON	SHELL PLC	1,730,300	1,641,360			(89,140)
CORPORATE STOCKS - COMMON	DANONE	2,134,247	2,224,237			89,990
CORPORATE STOCKS - COMMON	TOTALENERGIES SE	923,219	751,654			(171,565)
CORPORATE STOCKS - COMMON	RECKITT BENCKISER GROUP PLC	941,697	830,814			(110,883)
CORPORATE STOCKS - COMMON	ALLEGION PLC	660,084	646,082			(14,003)
CORPORATE STOCKS - COMMON	AON PLC CLASS A	590,639	717,961			127,322
CORPORATE STOCKS - COMMON	ALPHABET INC CL A	1,874,949	2,523,937			648,988
CORPORATE STOCKS - COMMON	ALPHABET INC CL A	1,069,187	1,448,902			379,715
CORPORATE STOCKS - COMMON	DIAGEO PLC	892,404	790,074			(102,420)
CORPORATE STOCKS - COMMON	AMERICAN EXPRESS CO	1,527,550	2,414,387			886,837
CORPORATE STOCKS - COMMON	BAE SYSTEMS PLC	947,865	960,896			13,031
CORPORATE STOCKS - COMMON	ELEVANCE HEALTH INC	2,447,472	1,938,570			(508,902)
CORPORATE STOCKS - COMMON	ARAMARK	1,241,841	1,410,766			168,925
CORPORATE STOCKS - COMMON	EVERY DENNISON CORP	1,886,131	1,364,365			(521,766)
CORPORATE STOCKS - COMMON	BANK OF NEW YORK MELLON CORP	1,525,522	2,248,891			723,369
CORPORATE STOCKS - COMMON	BERKSHIRE HATHAWAY INC CL B	1,633,456	2,075,116			441,660
CORPORATE STOCKS - COMMON	BERKSHIRE HATHAWAY INC CL B	1,323,565	1,682,122			358,557
CORPORATE STOCKS - COMMON	LYOYD BANKING GROUP PLC	719,983	811,879			91,896
CORPORATE STOCKS - COMMON	BLACKROCK INC	454,521	780,335			325,813
CORPORATE STOCKS - COMMON	BOOKING HOLDINGS INC	1,291,188	1,808,505			517,317
CORPORATE STOCKS - COMMON	CDW CORP/DE	862,952	705,906			(157,046)
CORPORATE STOCKS - COMMON	CSX CORP	1,003,392	974,167			(29,225)
CORPORATE STOCKS - COMMON	CARULUX COS INC	508,324	600,103			91,779
CORPORATE STOCKS - COMMON	CARRIER GLOBAL CORP	1,141,843	1,248,173			106,330
CORPORATE STOCKS - COMMON	CITIGROUP INC	1,062,503	1,191,137			128,634
CORPORATE STOCKS - COMMON	DOLLAR TREE INC	1,079,170	580,635			(498,535)
CORPORATE STOCKS - COMMON	META PLATFORMS INC CLASS A	1,321,503	2,186,636			865,133
CORPORATE STOCKS - COMMON	FERGUSON ENTERPRISES INC	1,020,511	1,425,183			404,672
CORPORATE STOCKS - COMMON	FRESENIUS MEDICAL CARE ADR	715,649	780,718			65,068
CORPORATE STOCKS - COMMON	KONINKLIJKE PHILIPS NV NY REG SHRS	753,771	846,017			92,246
CORPORATE STOCKS - COMMON	HEIDELBERG MATERIALS AG	1,910,696	2,638,217			727,521
CORPORATE STOCKS - COMMON	LAM RESEARCH CORP	467,296	680,407			213,111
CORPORATE STOCKS - COMMON	MARSH + MCLENNAN COS	1,209,473	1,355,601			146,128
CORPORATE STOCKS - COMMON	MASCO CORP	1,216,223	1,317,726			101,503
CORPORATE STOCKS - COMMON	MICROCHIP TECHNOLOGY INC	705,744	664,285			(41,459)
CORPORATE STOCKS - COMMON	MICRON TECHNOLOGY INC	661,214	652,072			(9,143)
CORPORATE STOCKS - COMMON	KONINKLIJKE PHILIPS NV	1,771,650	1,931,121			159,471
CORPORATE STOCKS - COMMON	O RIELLY AUTOMOTIVE INC	639,696	783,371			143,675
CORPORATE STOCKS - COMMON	SAMSUNG ELECTRONICS CO LTD	2,695,681	1,613,942			(1,081,739)
CORPORATE STOCKS - COMMON	PAYPAL HOLDINGS INC	553,759	553,239			(521)
CORPORATE STOCKS - COMMON	SOPEX SA	711,990	717,972			5,982
CORPORATE STOCKS - COMMON	GRUPE BRUXELLES LAMBERT NV	556,795	484,098			(72,697)
CORPORATE STOCKS - COMMON	NOVARTIS AG REG	2,098,345	2,036,601			(61,744)
CORPORATE STOCKS - COMMON	PROGRESSIVE CORP	1,161,761	1,741,485			579,724
CORPORATE STOCKS - COMMON	PROGRESSIVE CORP	777,286	1,169,297			392,010
CORPORATE STOCKS - COMMON	QUEST DIAGNOSTICS INC	963,961	1,073,218			109,257
CORPORATE STOCKS - COMMON	HEINIKEN NV	1,260,111	849,391			(410,720)
CORPORATE STOCKS - COMMON	HENRY SCHEIN INC	851,567	797,876			(53,691)
CORPORATE STOCKS - COMMON	SCHLUMBERGER LTD	486,834	358,671			(128,164)
CORPORATE STOCKS - COMMON	SCHWAB (CHARLES) CORP	2,231,527	2,468,011			236,484
CORPORATE STOCKS - COMMON	SCHWAB (CHARLES) CORP	1,782,442	1,932,105			149,664
CORPORATE STOCKS - COMMON	SMITH + NEPHEW PLC SPON ADR	604,443	544,619			(59,824)
CORPORATE STOCKS - COMMON	SONY GROUP CORP SP ADR	1,046,333	1,184,980			138,648

NEW YORK STATE TEAMSTERS COUNCIL HEALTH AND HOSPITAL FUND

SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
ATTACHMENT FOR SCHEDULE H, PART IV, LINE 4f

December 31, 2024

CATEGORY	SECURITY DESCRIPTION	REVALUED COST	MARKET VALUE	UNREALIZED REVALUED GAIN/LOSS
CORPORATE STOCKS - COMMON	SOUTHWEST AIRLINES CO COMMON STOCK USD1.0	573,385	667,592	94,207
CORPORATE STOCKS - COMMON	SYSCO CORP COMMON STOCK USD1.0	1,034,545	1,069,140	34,595
CORPORATE STOCKS - COMMON	TIX COMPANIES INC COMMON STOCK USD1.0	362,763	467,172	104,409
CORPORATE STOCKS - COMMON	UNILEVER PLC SPONSORED ADR ADR	961,263	1,124,021	162,758
CORPORATE STOCKS - COMMON	UNITEDHEALTH GROUP INC COMMON STOCK USD 01	1,209,746	1,152,349	(57,397)
CORPORATE STOCKS - OTHER	HSBC BANK PLC WARRANTS	409,715	408,490	(1,225)
		<u>73,464,773</u>	<u>80,766,040</u>	<u>7,301,267</u>
PARTN //JOINT VENTURE INTERESTS	IFM GLOBAL INFRASTRUCTURE (US) LIMITED PARTNERSHIP	37,766,633	40,211,738	2,445,105
PARTN //JOINT VENTURE INTERESTS	CBRE US CORE PARTNERS LP LIMITED PARTNERSHIP	20,314,910	28,992,970	8,678,060
PARTN //JOINT VENTURE INTERESTS	BRIGRADE HIGH YIELD FUND LP	19,977,332	20,937,352	1,959,821
		<u>86,695,275</u>	<u>90,142,260</u>	<u>4,082,285</u>
* COMMON/COLLECTIVE TRUSTS	MSCI EMERGING MARKETS FREE CTF EMFUNL	9,332,059	10,010,229	678,170
* COMMON/COLLECTIVE TRUSTS	US AGG BOND INDX NL CTF	117,635,186	119,305,249	1,650,064
* COMMON/COLLECTIVE TRUSTS	RUSSELL 1000 NON LENDING CTF	7,898,078	9,832,289	1,934,211
* COMMON/COLLECTIVE TRUSTS	SSGA TIP INDEX CTF (CMY3) - COMINGLED FUND	109,565,846	111,713,041	2,147,195
* COMMON/COLLECTIVE TRUSTS	US SHORT TERM GOVT CREDIT MUTUAL FUNDS	84,134,897	87,851,258	3,716,361
* COMMON/COLLECTIVE TRUSTS	PASSIVE E M LOC CURR BD NL CTF ZVPP	16,315,219	15,929,996	(385,223)
* COMMON/COLLECTIVE TRUSTS	MSCI EAFE INDEX NL CTF	19,842,543	20,580,568	738,025
* COMMON/COLLECTIVE TRUSTS	US HIGH YIELD BOND INDEX NL U.S. HIGH YIELD BOND INDEX NL	19,911,208	21,388,891	1,477,683
* COMMON/COLLECTIVE TRUSTS	US TREASURY INFL PROTECTED SE MUTUAL FUNDS	84,941,436	89,007,565	4,066,129
* COMMON/COLLECTIVE TRUSTS	CTF EMERGING LOCAL DEBT	8,163,831	7,318,193	(845,638)
		<u>477,780,302</u>	<u>493,168,179</u>	<u>15,387,877</u>
REGISTERED INVESTMENT COMPANY	GQG PARTNERS EMERGING MARKETS GQG PARTNERS	9,702,595	10,164,955	672,360
REGISTERED INVESTMENT COMPANY	GQG PARTNERS GLOBAL EQUITY - GLOBAL EQUITY FUND	27,654,793	33,424,749	5,769,956
REGISTERED INVESTMENT COMPANY	LOOMIS SAYLES SENIOR LOAN FUND	51,496,059	55,887,399	4,391,340
REGISTERED INVESTMENT COMPANY	DFA EMERGING MARKETS SMALL CAP DFA EMERGING MARKETS SML CAP	8,849,415	8,982,895	133,479
REGISTERED INVESTMENT COMPANY	VANGUARD DIVIDEND GROWTH FUND VANGUARD DIVIDEND GROWTH INV	36,873,440	35,935,112	(938,329)
		<u>134,666,903</u>	<u>144,695,110</u>	<u>10,028,207</u>
		<u>778,095,672</u>	<u>814,904,484</u>	<u>36,808,763</u>

\* DENOTES PARTY-IN-INTEREST

**Form 5500**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

**Annual Return/Report of Employee Benefit Plan**

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

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

OMB Nos. 1210 - 0110  
1210 - 0089

**2024**

**This Form is Open to Public Inspection**

**Part I Annual Report Identification Information**

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



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

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

<b>1a</b> Name of plan <b>NEW YORK STATE TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL FUND</b>	<b>1b</b> Three-digit plan number (PN) ▶ <b>501</b>
	<b>1c</b> Effective date of plan <b>06/09/1952</b>
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <b>TRUSTEES OF NYS TEAMSTERS COUNCIL HEALTH &amp; HOSPITAL</b>  <b>PO BOX 4928</b>  <b>SYRACUSE NY 13221-4928</b>	<b>2b</b> Employer Identification Number (EIN) <b>15-0551885</b>
	<b>2c</b> Plan Sponsor's telephone number <b>(315) 455-9790</b>
	<b>2d</b> Business code (see instructions) <b>484120</b>

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

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

<b>SIGN HERE</b>		10/13/25	<b>JOHN A. BULGARO, UNION TRUSTEE</b>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>		10/13/25	<b>MICHAEL S. SCALZO, EMPLOYER TRUSTEE</b>
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

**Form 5500 (2024)  
v. 240311**

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN
	<b>3c</b> Administrator's telephone number

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

<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b>	11404
<b>6</b> 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).		
<b>a (1)</b> Total number of active participants at the beginning of the plan year	<b>6a(1)</b>	10530
<b>a (2)</b> Total number of active participants at the end of the plan year	<b>6a(2)</b>	10564
<b>b</b> Retired or separated participants receiving benefits	<b>6b</b>	79
<b>c</b> Other retired or separated participants entitled to future benefits	<b>6c</b>	
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c	<b>6d</b>	10643
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	<b>6e</b>	
<b>f</b> Total. Add lines 6d and 6e	<b>6f</b>	
<b>g (1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	<b>6g(1)</b>	
<b>(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	<b>6g(2)</b>	
<b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	<b>6h</b>	
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<b>7</b>	483

**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 4G**

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

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

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

- b General Schedules**
- (1)  **H** (Financial Information)
  - (2)  **I** (Financial Information - Small Plan)
  - (3)  **A** (Insurance Information) - Number Attached 6
  - (4)  **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 \_\_\_\_\_