

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 <h1 style="text-align: center;">2024</h1> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

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

a single-employer plan a DFE (specify) _____

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

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

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

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

special extension (enter description) _____

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

Part II	Basic Plan Information—enter all requested information
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1a Name of plan <u>LOCAL 274 HEALTH AND WELFARE FUND</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>LOCAL 274 HEALTH AND WELFARE FUND</u> <u>C/O BENEFIT PROCESSING</u> <u>20 BRACE RD, SUITE 114</u> <u>CHERRY HILL, NJ 08034</u>	1c Effective date of plan <u>01/01/1950</u> 2b Employer Identification Number (EIN) <u>23-1489866</u> 2c Plan Sponsor's telephone number <u>856-616-2090</u> 2d Business code (see instructions) <u>721110</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/15/2025	RICHARD MINTER
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN	
	4d PN	
5 Total number of participants at the beginning of the plan year	5	1056
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6a(1)	1054
	6a(2)	1284
	6b	3
	6c	
	6d	1287
	6e	
	6f	
	6g(1)	
6g(2)		
6h		
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	35

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

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

9a Plan funding arrangement (check all that apply)	9b 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)

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

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

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

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

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

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

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan LOCAL 274 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 23-1489866

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

DOMINION NATIONAL

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
54-1808292	95657	27471	543	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	103724
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

<p>A Name of plan LOCAL 274 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 23-1489866</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
GRANULAR INSURANCE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
95-3670351	93521	ESL-1003	655	11/01/2023	10/31/2024

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

<p>(a) Total amount of commissions paid</p> <p style="text-align: center;">0</p>	<p>(b) Total amount of fees paid</p> <p style="text-align: center;">7875</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

BOLTON PARTNERS **325 SENTRY PARKWAY BLDG. 5 W. #200**
BLUE BELL, PA 19422

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	7875	SERVICE FEES	4

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	262485
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

<p>A Name of plan LOCAL 274 HEALTH AND WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 23-1489866</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
AMALGAMATED LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5501223	60216	26AP32	1040	01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	37833
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan LOCAL 274 HEALTH AND WELFARE FUND		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND		D Employer Identification Number (EIN) 23-1489866

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
DELTA DENTAL OF PENNSYLVANIA

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
23-1667011	54798	16899		01/01/2024	12/31/2024

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

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

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

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	30393
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider 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.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan LOCAL 274 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 23-1489866	

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

PGIM INVESTMENTS

22-3468527

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

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

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

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

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

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

INDEPENDENCE BLUE CROSS

23-0370270

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	363698	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)

BENEFIT PROCESSING INC

23-2204388

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
13 50	NONE	288497	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)

INDEPENDENCE ADMINISTRATORS

23-2184623

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	220823	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)

PHILADELPHIA JOINT BOARD WORKERS UN

23-0971735

(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	RELATED LABOR ORG	153141	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)

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	121026	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)

NOVAK FRANCELLA LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	100000	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)

KATHLEEN LYNCH

23-1489866

(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	EMPLOYEE	65593	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)

BOLTON PARTNERS INC

52-1231144

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11 50	NONE	58742	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)

PAYER MATRIX, LLC

81-3946362

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 16 50	NONE	58035	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)

HELEN KRZYWICKI

23-1489866

(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	EMPLOYEE	39821	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)

MERANZE, KATZ, GAUDIOSO & NEWLIN, P

23-2419899

(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	36613	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)

CHARTWELL INVESTMENT PARTNERS

23-2891243

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
28 51	NONE	24333	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)

AMALGAMATED BANK

13-4920330

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
19 28 50 51	NONE	10005	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)

PAYCHEX INC.

16-1124166

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	7295	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)

ELMCRX SOLUTIONS, LLC

37-1853309

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 50	NONE	6358	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)

RBC WEALTH MANAGEMENT

41-1416330

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
27 51	NONE	5000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan 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.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>LOCAL 274 HEALTH AND WELFARE FUND</u>	B Three-digit plan number (PN)	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>LOCAL 274 HEALTH AND WELFARE FUND</u>	D Employer Identification Number (EIN) <u>23-1489866</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
---------------	--

a Name of MTIA, CCT, PSA, or 103-12 IE: <u>LONGVIEW LARGE CAP 500 INDEX FD</u>		
b Name of sponsor of entity listed in (a): <u>AMALGAMATED BANK</u>		
c EIN-PN <u>13-4015803-009</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>2429047</u>
a Name of MTIA, CCT, PSA, or 103-12 IE: <u>LONGVIEW LARGE CAP 500 INDEX VEBA FD</u>		
b Name of sponsor of entity listed in (a): <u>AMALGAMATED BANK</u>		
c EIN-PN <u>13-4015803-008</u>	d Entity code <u>C</u>	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions) <u>663018</u>
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

a Name of MTIA, CCT, PSA, or 103-12 IE:

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

c EIN-PN

d Entity code

e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan LOCAL 274 HEALTH AND WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LOCAL 274 HEALTH AND WELFARE FUND	D Employer Identification Number (EIN) 23-1489866

Part I	Asset and Liability Statement
---------------	--------------------------------------

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	1060	123026
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	786808	823373
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	1011482	589051
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	3689424	4452509
(2) U.S. Government securities	1c(2)	3853960	4404396
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	3660397	3489415
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)	2653026	3092065
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	1978505	2116854
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	10218	6077
f Total assets (add all amounts in lines 1a through 1e).....	1f	17644880	19096766
Liabilities			
g Benefit claims payable.....	1g	690748	1468538
h Operating payables.....	1h	124885	179387
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	27852	
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	843485	1647925
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	16801395	17448841

Part II Income and Expense Statement

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

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	8702499	
(B) Participants.....	2a(1)(B)	334178	
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		9036677
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	151032	
(B) U.S. Government securities.....	2b(1)(B)	92239	
(C) Corporate debt instruments.....	2b(1)(C)	147846	
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		391117
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)	138300	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		138300
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	1735186	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	1713313	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		21873
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	13512	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		646254
(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)		50
c Other income	2c		18015
d Total income. Add all income amounts in column (b) and enter total	2d		10265798

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	8140042	
(2) To insurance carriers for the provision of benefits	2e(2)	464077	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		8604119
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)	158216	
(2) Contract administrator fees	2i(2)	405215	
(3) Recordkeeping fees	2i(3)	55000	
(4) IQPA audit fees	2i(4)	45000	
(5) Investment advisory and investment management fees	2i(5)	34114	
(6) Bank or trust company trustee/custodial fees	2i(6)	10005	
(7) Actuarial fees	2i(7)	58742	
(8) Legal fees	2i(8)	36613	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)	5853	
(11) Other expenses	2i(11)	205475	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1014233
j Total expenses. Add all expense amounts in column (b) and enter total	2j		9618352

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		647446
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

(1) Unmodified (2) Qualified (3) Disclaimer (4) Adverse

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

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

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

(1) Name: **NOVAK FRANCELLA, LLC**

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

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

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

Part IV Compliance Questions

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

During the plan year:

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

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

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

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

LOCAL 274 HEALTH AND WELFARE FUND

FINANCIAL STATEMENTS

DECEMBER 31, 2024

LOCAL 274 HEALTH AND WELFARE FUND

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

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INDEPENDENT AUDITOR'S REPORT

To the Participants and Trustees of
Local 274 Health and Welfare Fund

Opinion

We have audited the financial statements of the Local 274 Health and Welfare Fund (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024 and 2023, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedules of Administrative Expenses, Schedule of Assets Held at End of Year, and Schedule of Reportable Transactions, together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represent supplemental information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, as amended. Supplemental information is the responsibility of the Plan’s management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America.

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

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

Novak Francella LLC

Bala Cynwyd, Pennsylvania
September 9, 2025

LOCAL 274 HEALTH AND WELFARE FUND

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

ASSETS	2024	2023
INVESTMENTS - at fair value		
Corporate obligations	\$ 3,279,241	\$ 3,449,458
Foreign corporate obligations	59,580	84,590
United States Government and Government Agency obligations	4,404,396	3,853,960
Asset-backed securities	94,415	72,007
Collateralized mortgage-backed obligations	56,179	54,342
Equity indexed mutual funds	2,116,854	1,978,505
Common collective trust	3,092,065	2,653,026
Short-term investments	4,314,360	3,400,046
Total investments	17,417,090	15,545,934
RECEIVABLES		
Employer contributions	823,373	786,808
Accrued investment income	66,163	59,663
Stop loss reimbursement	20,343	-
Rebate and claim refund	176,369	154,964
Due from bank	-	7,130
Due from related party	2,342	2,342
Total receivables	1,088,590	1,010,907
DEPOSIT WITH INDEPENDENCE BLUE CROSS	292,100	747,100
PROPERTY AND EQUIPMENT - net	6,077	10,218
OTHER ASSETS		
Cash	261,175	290,438
Prepaid expenses	31,734	40,283
Total other assets	292,909	330,721
Total assets	19,096,766	17,644,880
LIABILITIES AND NET ASSETS		
LIABILITIES		
Accrued administrative expenses	179,387	124,885
Due to related party	-	27,852
Total liabilities	179,387	152,737
NET ASSETS AVAILABLE FOR BENEFITS	\$ 18,917,379	\$ 17,492,143

See accompanying notes to financial statements.

LOCAL 274 HEALTH AND WELFARE FUND

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
ADDITIONS		
Investment income		
Net appreciation		
in fair value of investments	\$ 681,689	\$ 774,192
Interest and dividends	529,417	408,588
	1,211,106	1,182,780
Less investment expenses	(44,119)	(35,230)
Investment income - net	1,166,987	1,147,550
 Contributions		
Employer contributions	8,702,499	7,594,116
Participants' dependent coverage and COBRA contributions	334,178	325,238
Total contributions	9,036,677	7,919,354
 Other income	18,015	18,843
Total additions	10,221,679	9,085,747
 DEDUCTIONS		
Benefits paid to or for participants		
Insured benefits		
Dental	134,117	127,371
Life insurance	45,476	37,643
Telemedicine	2,579	2,123
Self-funded benefits		
Independence Blue Cross	4,826,717	4,208,144
Independence Administrators	1,649,672	581,791
Prescription	863,539	510,337
Disability	77,853	92,329
Orthotics	33,600	12,200
Stop loss premiums	288,984	247,872
Stop loss reimbursements	(96,208)	(8,152)
Total benefits	7,826,329	5,811,658
Regulatory fees and taxes	2,201	1,887
Administrative expenses	967,913	833,108
Total deductions	8,796,443	6,646,653
 NET INCREASE	1,425,236	2,439,094
Merger of Local 10 Health and Welfare Fund	-	2,762,910
 NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	17,492,143	12,290,139
End of year	\$ 18,917,379	\$ 17,492,143

See accompanying notes to financial statements.

LOCAL 274 HEALTH AND WELFARE FUND

STATEMENTS OF BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Claims payable and claims incurred but not reported	\$ 1,468,538	\$ 690,748
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT ESTIMATED AMOUNTS		
Active participants' continuing eligibility	<u>592,872</u>	<u>480,667</u>
TOTAL BENEFIT OBLIGATIONS	<u>\$ 2,061,410</u>	<u>\$ 1,171,415</u>

See accompanying notes to financial statements.

LOCAL 274 HEALTH AND WELFARE FUND
STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS
YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
AMOUNTS CURRENTLY PAYABLE TO OR FOR		
PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Balance at beginning of year	\$ 690,748	\$ 421,091
Increase during the year attributable to changes in insurance premiums payable, claims payable and claims incurred but not reported	777,790	190,201
Merger of Local 10 Obligation	<u>-</u>	<u>79,456</u>
Balance at end of year	<u>1,468,538</u>	<u>690,748</u>
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE		
AT ESTIMATED AMOUNTS		
Balance at beginning of year	480,667	506,931
Decrease during the year attributable to changes in active participants' continuing eligibility	<u>112,205</u>	<u>(26,264)</u>
Balance at end of year	<u>592,872</u>	<u>480,667</u>
TOTAL BENEFIT OBLIGATIONS AT END OF YEAR	<u><u>\$ 2,061,410</u></u>	<u><u>\$ 1,171,415</u></u>

See accompanying notes to financial statements.

LOCAL 274 HEALTH AND WELFARE FUND

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF PLAN

The following brief description of the Local 274 Health and Welfare Fund (the Plan) is provided for general information purposes only. Participants should refer to the summary plan description for more complete information.

The Plan provides health and other benefits to eligible members of Locals 274 and 10 of the Philadelphia Joint Board which represents members in southeastern Pennsylvania, southern New Jersey and northern Delaware.

The Plan is a multiemployer welfare benefit plan and is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended. The administrator of the Plan is its labor management Board of Trustees. The Plan was established pursuant to various collective bargaining agreements covering employees in the hotel and restaurant industries.

Benefits are funded through employer, participant and COBRA contributions. Employer contributions are determined by the individual collective bargaining agreements. Employer contributions are accounted for as exchange transactions. The amount of required contributions for the different benefit levels are established by the Board of Trustees and may be changed from time to time.

The Plan provides medical, surgical, hospitalization, death, disability, dental, prescription, vision and orthotic benefits. The type and amount of benefits are dependent upon the employee's designated plan and status.

Participants are covered for medical/surgical and hospitalization benefits through a self-funded arrangement with Independence Blue Cross. Prescription benefits are provided through a self-funded arrangement with AEBRx. Dental benefits are provided through an insured arrangement with Dominion Dental.

The Board of Trustees has the right under the Agreement and Declaration of Trust to modify the benefits provided. The Plan may be modified by agreement between the labor and management Trustees subject to the provisions set forth in ERISA.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Investments - Investments in corporate obligations, foreign corporate obligations, and United States Government and Government Agency obligations are carried at fair value as provided by the investment custodian, which generally represents quoted market prices as of the last business day of the year. The asset-backed securities and collateralized mortgage-backed obligations are carried at estimated fair value as reported by the investment custodian as of the last business day of the year. The money market mutual fund is carried at cost which approximates fair value. The mutual funds are carried at net asset value as provided by the investment manager. The common collective trust is carried at its net asset value as provided by the trust.

Employer Contributions Receivables - Employer contributions due but not paid at year end are recorded as contributions receivable. Allowance for uncollectible accounts is considered unnecessary and is not provided.

Property and Equipment - Property and equipment are carried at cost. Major additions are capitalized, while replacements, maintenance and repairs which do not improve or extend the lives of the respective assets are expensed currently. Depreciation and amortization are computed using the straight line method over the estimated useful lives of the assets, which generally range from five to ten years. Depreciation and amortization expense totaled \$4,141 and \$2,071 for the years ended December 31, 2024 and 2023, respectively.

Payment of Benefits - Benefit payments are recorded when paid.

Benefit Obligations - Claims payable and claims incurred but not reported and active participants' continuity eligibility were estimated based on claims experience.

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

Stop-Loss Coverage - The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits. Premiums for stop-loss insurance and reimbursements for stop-loss claims are included in the accompanying statements of changes in net assets available for benefits.

NOTE 3. PLAN MERGER WITH LOCAL 10 HEALTH AND WELFARE FUND

The Local 10 of the Philadelphia Joint Board, Workers United and the Textile Maintenance Industry of Philadelphia & Vicinity Welfare & Security Fund (Local 10 Health & Welfare) merged into the Plan effective June 30, 2023. The Local 10 Health & Welfare Fund provides health and other benefits to eligible members of the former UNITE Local 10 Union which represented laundry workers in southeastern Pennsylvania and southern New Jersey. As a result of the merger the Plan will have more resources and increased member count to provide benefits to membership.

NOTE 3. PLAN MERGER WITH LOCAL 10 HEALTH AND WELFARE FUND (continued)

Net assets available for benefits and benefit obligations transferred to the Plan consisted of the following:

Net Assets Available for Benefits	
Investments - at fair value	\$ 2,398,362
Receivables	183,157
Deposit with Insurance Administrators	135,100
Cash	139,507
Prepaid expenses	40,083
Furniture and equipment - net	4,208
Accrued administrative expenses	<u>(137,507)</u>
Net Assets Available for Benefits transferred	<u>\$ 2,762,910</u>
Benefit Obligations	
Claims payable and claims incurred but not reported	<u>\$ 79,456</u>
Benefit Obligations transferred	<u>\$ 79,456</u>

NOTE 4. FAIR VALUE MEASUREMENTS

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

Basis of Fair Value Measurement:

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

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

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

NOTE 4. FAIR VALUE MEASUREMENTS (continued)

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

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

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

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
Corporate obligations	\$ 3,279,241	\$ 3,279,241	\$ -	\$ -
Foreign corporate obligations	59,580	59,580	-	-
U.S. Government and Government Agency obligations	4,404,396	4,404,396	-	-
Asset-backed security	94,415	-	94,415	-
Collateralized mortgage-backed obligations	56,179	-	56,179	-
Equity indexed mutual funds	2,116,854	2,116,854	-	-
Common collective trust	3,092,065	3,092,065	-	-
Short-term investments	4,314,360	4,314,360	-	-
	<u>\$ 17,417,090</u>	<u>\$ 17,266,496</u>	<u>\$ 150,594</u>	<u>\$ -</u>

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
Corporate obligations	\$ 3,449,458	\$ 3,449,458	\$ -	\$ -
Foreign corporate obligations	84,590	84,590	-	-
U.S. Government and Government Agency obligations	3,853,960	3,853,960	-	-
Asset-backed security	72,007	-	72,007	-
Collateralized mortgage-backed obligations	54,342	-	54,342	-
Equity indexed mutual funds	1,978,505	1,978,505	-	-
Common collective trust	2,653,026	2,653,026	-	-
Short-term investments	3,400,046	3,400,046	-	-
	<u>\$ 15,545,934</u>	<u>\$ 15,419,585</u>	<u>\$ 126,349</u>	<u>\$ -</u>

NOTE 5. CASH IN EXCESS OF FEDERALLY INSURED LIMITS

The Plan maintains cash balances at one financial institution. The cash balance is insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000. At December 31, 2024, the balance at PNC Bank exceeded the balance insured by the FDIC by \$2,060,714.

NOTE 6. PROPERTY AND EQUIPMENT

At December 31, 2024 and 2023, property and equipment consisted of the following:

Category	2024	2023
Office equipment	\$ 231,046	\$ 231,046
Furniture and fixtures	8,134	8,134
Leasehold improvements	44,615	44,615
	283,795	283,795
Less: Accumulated depreciation and amortization	(277,718)	(273,577)
Net property and equipment	\$ 6,077	\$ 10,218

NOTE 7. RELATED PARTY TRANSACTIONS

The Plan shares office facilities, office personnel, equipment and certain other expenses with the Philadelphia Joint Board Legal Services Trust Fund and the John Fox Scholarship Fund. These funds are related by common Trustees. The Health and Welfare Fund was charged 96.7% of common allocable expenses in the amount of \$478,874 for the year ended December 31, 2024 and \$460,008 for the year ended December 31, 2023. These allocated amounts are included in the administrative expenses shown on page 5.

The Plan pays rent to Philadelphia Joint Board, Workers United, some of whose officers are Trustees of the Plan, for office space under terms of a month-to-month operating lease. The rent has been determined based upon the approximate fair market value of the square footage used by the Plan. Rent totaled \$2,688 for each of the years ended December 31, 2024 and 2023, respectively.

The Plan is related to Philadelphia Joint Board, Workers United (the Union) because certain Trustees of the Plan are officers of the Union. The Plan reimburses the Union for the cost of personnel expenses, including salaries and benefits, of the Union's employees that perform administrative services for the Plan. The Plan reimbursed the Union \$45,612 for these expenses during the year ended December 31, 2024 and \$55,848 for these expenses during the year ended December 31, 2023. These amounts are included within the administrative expenses shown on page 5. At December 31, 2024 and 2023, \$2,342 was due from the Union.

NOTE 7. RELATED PARTY TRANSACTIONS (continued)

The Plan is related to Philadelphia Joint Board, Workers United (Welfare Fund) because certain Trustees of the Plan are officers of the Welfare Fund. During the year ended December 31, 2024, the Plan sent over \$33,548 to the Welfare Fund for contributions received from two employers on behalf of the Welfare Fund. At December 31, 2023, the Plan owed the Welfare Fund \$27,852, related to these erroneous contributions.

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

NOTE 8. TAX STATUS

The Plan obtained its latest determination letter on March 29, 1999, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements under section 501(c)(9) of the Internal Revenue Code. The Plan has been amended since receiving the determination letter. The Plan's administrator and the Plan's counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

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

NOTE 9. PRIORITIES UPON TERMINATION

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

NOTE 10. CLAIMS PAYABLE AND CLAIMS INCURRED BUT NOT REPORTED

The Plan's estimated obligation for health claims reported but not paid and estimated claims incurred but not reported at year end were as follows:

Type of Benefit	2024	2023
Major medical and diagnostic services	\$ 438,085	\$ 462,240
Prescription claims	107,557	98,576
Dental and medical claims	79,748	93,785
Claims incurred but not reported	843,148	36,147
	\$ 1,468,538	\$ 690,748

Claims incurred but not reported at December 31, 2024 and 2023 have been calculated by the Plan's management based on a claims lag study.

NOTE 11. ACTIVE PARTICIPANTS' CONTINUING ELIGIBILITY

A participant's eligibility ceases up to three months after separation from covered employment based on the terms of the collective bargaining agreement with each employer.

The estimated obligation for active participants' continuing eligibility at December 31, 2024 and 2023 is \$592,872 and \$480,667, respectively, based on employer contributions received for hours worked prior to December 31, 2024 and 2023, respectively.

NOTE 12. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	2024	2023
Net assets available for benefits as reported on the financial statements	\$ 18,917,379	\$ 17,492,143
Benefit obligations currently payable	(1,468,538)	(690,748)
Net assets available for benefits as reported on Form 5500	\$ 17,448,841	\$ 16,801,395

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

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

	<u>2024</u>
Total benefits as reported on the financial statements	\$ 7,826,329
Add: amounts currently payable at end of year	1,468,538
Less: amounts currently payable at beginning of year	<u>(690,748)</u>
Total benefits as reported on Form 5500	<u>\$ 8,604,119</u>

Claims payable and claims incurred but not reported are included on the Statements of Benefit Obligations on the financial statement but are included as liabilities on Form 5500.

NOTE 13. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN

Employees of the Local 274 Health and Welfare Fund (the Welfare Fund), the John Fox Scholarship Fund (the Scholarship Fund), and the Philadelphia Joint Board Legal Services Trust Fund (the Legal Services Plan), together referred to as the Benefit Plans, participate in a multiemployer defined benefit pension plan under the terms of a participation agreement that covers its full-time salaried employees and those employees covered under an existing Collective Bargaining Agreement. The shared expenses of the Benefit Plans are paid from a common operating account (the Operating Account). The Operating Account remits the contributions to this multiemployer defined benefit pension plan for the shared employees on behalf of the Benefit Plans. The Benefit Plans are allocated their share of the contributions based on a cost allocation study. The risks of participating in a multiemployer defined benefit pension plan are different from single-employer plans in the following aspects:

- a. Assets contributed to the multiemployer defined benefit pension 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 multiemployer defined benefit pension plan, the unfunded obligations of the multiemployer defined benefit pension plan may be borne by the remaining participating employers.
- c. If the Benefit Plans choose to stop participating in the multiemployer defined benefit pension plan, the Benefit Plans may be required to pay the multiemployer defined benefit pension plan an amount based on the underfunded status of the multiemployer defined benefit pension plan, referred to as a withdrawal liability.

NOTE 13. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN (continued)

The Benefit Plans’ participation in the multiemployer defined benefit pension plan for the annual periods ended December 31, 2024 and 2023 are outlined in the table below. The zone status is based on information that the Benefit Plans received from the multiemployer defined benefit pension plan and is certified by the multiemployer defined benefit pension plan's actuary. Among other factors, pension plans in the red zone are generally less than 65 percent funded, pension plans in the yellow zone are less than 80 percent funded, and pension plans in the green zone are at least 80 percent funded.

Legal Name of Pension Plan	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Pension Protection Act Zone Status				Expiration Date of Collective Bargaining Agreement
			Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	
National Retirement Fund	13-6130178	001	Red as of 01/01/24	No	Red as of 01/01/23	No	*

* The employees of the Benefit Plans participate in the National Retirement Fund through a participation agreement between the Benefit Plans and the National Retirement Fund. The participation agreement renews annually on October 1.

Legal Name of Pension Plan	Contributions paid by the Welfare Fund directly to the Pension Plan		Contributions to the Pension Plan greater than 5% of total Pension Plan Contributions (Plan year ending)		Employer Contribution Rates		Number of Employees Covered by the Pension Plan for which the Welfare Fund contributes directly to the Pension Plan	
	12/31/2024	12/31/2023	No, Plan year ending 12/31/24.	No, Plan year ending 12/31/23.	12/31/2024	12/31/2023	12/31/2024	12/31/2023
National Retirement Fund	\$ -	\$ -	No, Plan year ending 12/31/24.	No, Plan year ending 12/31/23.	\$639.12 per month worked	\$610.66 per month worked	-	-

The Welfare Fund reimbursed the Operating Account \$7,224 and \$8,595 during the years ended December 31, 2024 and 2023, respectively, for the Welfare Fund’s allocated share of the pension contributions for shared employees participating in the National Retirement Fund. During each of the years ended December 31, 2024 and 2023, the Operating Account remitted contributions to the National Retirement Fund for two shared employees.

Legal Name of Pension Plan	Funding Improvement Plan or Rehabilitation Plan Implemented or Pending?	Surcharge paid to Pension Plan by Benefit Plans?	Minimum contributions required in future by CBA, statutory requirements, or other contractual requirements.	
			No?	If yes, description
National Retirement Fund	Rehabilitation Plan Implemented	Yes	No	N/A

NOTE 14. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market and sector risks. Due to the level of risk associated with certain investments, it is at least reasonably possible that changes in the values of investments will occur in the near term and that such changes could materially affect the amounts reported in the statement of net assets available for benefits.

Claims payable have been estimated based on certain assumptions and claims reports. Due to uncertainties inherent in the estimations and assumptions processes, 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 15. DEPOSIT WITH INSURANCE CARRIERS

At December 31, 2024 and 2023, Independence Blue Cross held a deposit from the Plan totaling \$157,000 and \$612,000, respectively. This deposit is required by Independence Blue Cross as part of the arrangement between Independence Blue Cross and Local 274 Health and Welfare Fund. Under the terms of this arrangement, the deposit is used to fund claims that are paid by Independence Blue Cross on behalf of the Plan that have not yet been invoiced.

At December 31, 2024 and 2023, Independence Administrators (IA) held a deposit from the Plan totaling \$135,100. This deposit is required by IA as part of the arrangement between IA and the Plan. Under the terms of the arrangement, the deposit is used to fund claims that are paid by IA on behalf of the Plan that have not yet been invoiced.

NOTE 16. FEES MANDATED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Fees payable to the Patient-Centered Outcomes Research Institute (PCORI) are effective for seven years, through 2018. For the years ended December 31, 2024 and 2023, the Plan paid \$2,201 and \$1,887, respectively, in PCORI fees.

NOTE 17. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through September 9, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

LOCAL 274 HEALTH AND WELFARE FUND

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
PERSONNEL		
Salaries	\$ 142,575	\$ 149,252
Employee benefits	15,641	20,226
Payroll taxes	8,034	7,679
PROFESSIONAL FEES		
Administrative	405,215	325,587
Accounting, audit, payroll compliance reviews and government filings	100,000	105,000
Actuarial consultant	58,742	62,245
Legal	36,613	25,365
OFFICE AND DATA PROCESSING		
Rent	2,531	2,688
Office supplies and expenses	26,377	16,466
Depreciation of furniture and equipment	4,141	2,071
Postage	7,046	5,621
Printing	6,292	9,614
Computer services	129,522	83,007
EDUCATION		
Conference expenses	5,853	1,815
OTHER		
Insurance	16,901	15,294
Bank charges	2,430	1,178
	<u> </u>	<u> </u>
Total administrative expenses	<u>\$ 967,913</u>	<u>\$ 833,108</u>

LOCAL 274 HEALTH AND WELFARE FUND

SCHEDULE OF ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

Schedule H, Line 4i

EIN: 23-1489866

Plan No.: 501

(a) Issuer, Borrower	(b) Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value	(c)			(d) Cost	(e) Current Value
		Shares/ Type	Interest Principal	Maturity Rate		
				Date		
<u>Corporate obligations:</u>						
Accenture Capital	Bond	25,000	3.900 %	10/04/27	\$ 24,968	\$ 24,632
Amgen Inc Sr Nt	Bond	85,000	5.250	03/02/33	84,661	84,373
Anheuser-Busch InBev Wor	Bond	30,000	3.500	06/01/30	29,925	28,127
Anthem Inc	Bond	85,000	3.650	12/01/27	81,590	82,691
Ares Capital Corp	Bond	80,000	3.250	07/15/25	81,659	79,223
Ares Capital Corp	Bond	75,000	3.875	01/15/26	74,514	74,142
Bank of America	Bond	62,000	FLTG	02/05/26	62,128	62,053
Bank Of America Corp Fr	Bond	55,000	VAR	11/10/28	58,094	56,942
Blackrock Funding	Bond	15,000	4.600	07/26/27	15,000	15,034
Blackrock Funding	Bond	55,000	4.700	03/14/24	54,984	55,041
Comcast Corp	Bond	130,000	4.150	10/15/28	128,874	126,780
Comcast Corp	Bond	85,000	4.250	10/15/30	93,055	81,966
CVS Health Corp	Bond	95,000	3.250	08/15/29	93,501	86,488
CVS Health Corp	Bond	14,000	4.300	03/25/28	13,647	13,565
Duke Energy Carolinas	Bond	110,000	4.850	01/15/34	107,795	106,614
Extra Space Storage	Bond	70,000	2.200	10/15/30	65,855	59,560
FMC Corp	Bond	45,000	3.450	10/01/29	44,295	41,214
FMC Corp Sr Nt	Bond	45,000	5.150	05/18/26	44,968	45,049
General Motors Finl	Bond	40,000	5.650	01/17/29	40,499	40,594
Georgia Pwr Co Sr Glbl	Bond	50,000	5.004	02/23/27	49,884	50,385
Goldman Sachs Grp Inc	Bond	140,000	3.691	06/05/28	133,970	135,976
GSMBS	Bond	74,239	VAR	01/25/54	74,073	75,044
Healthpeak Properties	Bond	45,000	2.875	01/15/31	43,232	39,626
Hewlett Packard	Bond	55,000	5.000	10/15/34	54,493	52,864
Intercontinental Corporation	Bond	35,000	4.600	03/15/33	34,549	33,553
Jefferies Financial	Bond	35,000	5.875	07/21/28	34,815	35,790
Jefferies Financial	Bond	45,000	6.200	04/14/34	44,955	46,376
JP Morgan Chase & Co	Bond	85,000	FLTG	12/05/29	91,323	83,299
JP Morgan Chase & Co	Bond	100,000	VAR	02/24/26	98,652	99,657
JP Morgan Mortgage Trust	Bond	81,199	VAR	04/25/54	79,386	81,423
Lincoln National Corp	Bond	40,000	3.400	01/15/31	38,515	35,964
Merrill Lynch & Co	Bond	40,000	FLTG	09/15/26	37,558	40,056
Morgan Stanley	Bond	90,000	FLTG	04/28/26	88,698	89,197
Morgan Stanley	Bond	60,000	VAR	04/18/30	62,638	61,078
Morgan Stanley	Bond	60,000	VAR	04/20/28	58,278	59,141
Oracle Corp Sr Glbl Nt	Bond	55,000	6.250	11/09/32	55,901	58,287

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
<u>Corporate obligations: (continued):</u>						
Owl Rock Capital Corp	Bond	80,000	3.400 %	07/15/26	\$ 78,126	\$ 77,511
Philip Morris Intl	Bond	50,000	5.625	09/07/33	48,896	50,797
Philip Morris Intl Inc	Bond	90,000	5.250	02/13/34	88,030	88,950
PNC Fiml Svcs Group	Bond	60,000	VAR	01/21/28	60,035	60,515
Precision Castparts Corp	Bond	25,000	3.250	06/15/25	27,069	24,856
Rockwell Automation	Bond	60,000	3.500	03/01/29	66,775	56,989
Safehold Oper	Bond	65,000	2.850	01/15/32	62,100	54,612
Safehold Oper Partnership	Bond	70,000	2.800	06/15/31	69,221	59,767
Simon Property Group Lp	Bond	130,000	2.450	09/13/29	121,768	116,897
Simon Property Group Lp	Bond	35,000	3.500	09/01/25	36,566	34,753
Tractor Supply Co Sr	Bond	40,000	5.250	05/15/33	39,721	39,976
Truist Bank	Bond	110,000	2.250	03/11/30	102,994	94,460
Verizon Communications Inc	Bond	85,000	2.550	03/21/31	80,479	73,199
Virginia Elec & Power	Bond	55,000	3.500	03/15/27	54,182	53,600
Virginia Elec & Power	Bond	20,000	5.050	08/15/34	19,949	19,502
Walt Disney Company	Bond	65,000	3.375	11/15/26	68,144	63,613
Warnermedia Hldgs	Bond	70,000	3.755	03/15/27	70,065	67,440
Total corporate obligations					<u>3,375,052</u>	<u>3,279,241</u>
<u>Foreign corporate obligations:</u>						
JBS USA LUX S A / JBS	Bond	60,000	5.125	02/01/28	58,911	59,580
<u>United States Government and Government Agency obligations:</u>						
Fannie Mae	Note	45,000	4.125	08/28/25	45,000	44,898
Federal Farm Credit Bank	Note	50,000	3.300	03/23/32	50,000	45,444
Federal Farm Credit Bank	Note	35,000	4.300	05/17/32	35,000	33,770
Federal Farm Credit Bank	Note	45,000	4.980	07/20/32	45,000	44,764
Federal Home Loan Bank	Note	55,000	1.150	10/26/26	55,000	51,926
Federal Home Loan Bank	Note	65,000	1.500	11/23/26	65,000	61,667
Federal Home Loan Bank	Note	100,000	1.150	02/26/31	100,000	86,081
Federal Home Loan Bank	Note	100,000	1.250	03/17/31	100,000	89,369
FHLMC Pool #SB-8229	Note	41,410	4.500	05/01/38	41,060	40,510
FHLMC Pool #SD-3857	Note	69,025	6.000	09/01/53	68,400	69,370
FHLMC Remic Trust	Note	45,979	6.000	07/25/48	45,979	46,420
FHLMC Remic Trust	Note	33,945	5.000	09/25/50	33,648	33,483
FHLMC Umbs Pool #RB-5318	Note	89,242	4.500	11/01/44	85,965	85,156
FNMA UMBS Pool #CB5384	Note	95,621	4.500	12/01/52	91,250	90,137
FNMA UMBS Pool #MA5099	Note	50,145	4.000	07/01/38	47,990	48,147
United States NTS	Note	430,000	1.375	11/15/31	364,928	351,379
United States Treasury	Note	225,000	0.375	09/15/24	215,851	217,274
United States Treasury	Note	390,000	2.625	03/31/25	403,933	403,404
United States Treasury	Note	450,000	1.625	09/30/26	436,025	430,340
United States Treasury	Note	240,000	2.375	05/15/27	224,234	229,841
United States Treasury	Note	25,000	4.125	09/30/27	25,410	24,901
United States Treasury	Note	380,000	1.125	08/31/28	332,493	338,930

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
<u>United States Government and Government Agency obligations (continued):</u>						
United States Treasury	Note	260,000	3.250 %	06/30/29	\$ 251,361	\$ 248,100
United States Treasury	Note	95,000	0.625	05/15/30	74,473	77,951
United States Treasury	Note	280,000	1.125	02/15/31	248,586	231,070
United States Treasury	Note	295,000	2.750	08/15/32	266,791	261,615
United States Treasury	Note	310,000	4.500	11/15/33	320,429	308,596
United States Treasury	Note	30,000	4.375	05/15/34	29,808	29,538
U.S Treasury Tips	Note	196,041	1.125	01/15/33	178,621	180,301
United States Treasury Bond Tips	Note	73,432	1.750	01/15/28	115,195	119,650
United States Treasury BOD Tips	Note	81,728	0.125	04/15/27	74,994	80,364
Total United States Government and Government Agency obligations					<u>4,472,424</u>	<u>4,404,396</u>
<u>Asset-backed securities:</u>						
FYBR	Note	70,000	6.600	08/20/53	68,997	71,244
Small Business Admin	Note	16,108	1.930	12/01/32	15,512	14,562
Small Business Admin	Note	9,541	2.880	05/01/37	9,185	8,609
Total asset-backer securities					<u>93,694</u>	<u>94,415</u>
<u>Collateralized mortgage backed obligations:</u>						
FFCB	Note	58,500	1.000	03/23/26	58,500	56,179
<u>Equity indexed mutual funds:</u>						
Prudential High Yield Fund		252,910			2,231,594	2,116,854
<u>Common collective trust:</u>						
Longview Large Cap 500 Veba Index Fnd		696			72,547	663,018
Longview Large Cap 500 Index Fund		2,549			797,080	2,429,047
Total common collective trusts					<u>869,627</u>	<u>3,092,065</u>
<u>Short-term investments:</u>						
Interest-bearing cash, PNC		2,242,867			2,242,867	2,242,867
Dreyfus Treasury & Agency Cash Mgmt		249,861			249,861	249,861
Dreyfus Government Cash Mgmt		1,821,632			1,821,632	1,821,632
Total short-term investments					<u>4,314,360</u>	<u>4,314,360</u>
Total investments					<u>\$ 15,474,162</u>	<u>\$ 17,417,090</u>

LOCAL 274 HEALTH AND WELFARE FUND

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

EIN: 23-1489866
Plan No.: 501

Schedule H, Line 4j

(a)	(b)	(c)	(d)	(g)	(h)	(i)
	Description	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net (Loss) Gain on Transaction
	Dreyfus Treasury Cash Management	\$ 1,870,874	N/A	\$ 1,870,874	\$ 1,870,874	N/A
	Dreyfus Treasury Cash Management	N/A	\$ 1,877,943	1,877,943	1,877,943	\$ -

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS