

Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

- A This return/report is for: [X] a multiemployer plan [] a multiple-employer plan... B This return/report is: [] a single-employer plan [] a DFE... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension... E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here... []

Part II Basic Plan Information—enter all requested information

1a Name of plan LOCAL 298 HEALTH BENEFIT FUND I 1b Three-digit plan number (PN) 501 1c Effective date of plan 01/01/1955 2a Plan sponsor's name (employer, if for a single-employer plan) BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1 2b Employer Identification Number (EIN) 11-1967404 2c Plan Sponsor's telephone number 516-872-6690 2d Business code (see instructions) 524290

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

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

Table with 4 columns: SIGN HERE, Signature of plan administrator, Date, Enter name of individual signing as plan administrator. Includes rows for employer/plan sponsor and DFE.

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

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	3177
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)	3177
	6a(2)	2172
	6b	
	6c	
	6d	2172
	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	110

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

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 checked="" 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>3</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 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 298 HEALTH BENEFIT FUND I		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1		D Employer Identification Number (EIN) 11-1967404

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
UNION LABOR LIFE INSURANCE CO.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-1423090	69744	C9711	2172	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. **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	2296547
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>
---	--	--

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

<p>A Name of plan LOCAL 298 HEALTH BENEFIT FUND I</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 BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1</p>	<p>D Employer Identification Number (EIN) 11-1967404</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
EMPOWER ANNUITY INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1050034	93629	069025		01/01/2024	12/31/2024

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

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

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

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

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

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

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

(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	1315789
5	Current value of plan's interest under this contract in separate accounts at year end.....	
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) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>	
7	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract: (1) <input checked="" type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶	
b	Balance at the end of the previous year	7b 2259321
c	(1) Contributions deposited during the year	7c(1)
	(2) Dividends and credits.....	7c(2)
	(3) Interest credited during the year.....	7c(3) 56468
	(4) Transferred from separate account	7c(4)
	(5) Other (specify below)..... ▶	7c(5)
	(6) Total additions	7c(6) 56468
d	Total of balance and additions (add lines 7b and 7c(6))	7d 2315789
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)
	(2) Administration charge made by carrier.....	7e(2)
	(3) Transferred to separate account	7e(3)
	(4) Other (specify below)..... ▶ OTHER DEDUCTIONS	7e(4) 1000000
(5) Total deductions	7e(5) 1000000	
f	Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f 1315789

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	
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>
---	--	--

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

<p>A Name of plan LOCAL 298 HEALTH BENEFIT FUND I</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 BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1</p>	<p>D Employer Identification Number (EIN) 11-1967404</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
DELAWARE 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
04-2461439		KA12608506		01/01/2024	12/31/2024

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

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

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

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

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

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

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

(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	29524
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)	
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
	(5) Total deductions	7e(5)
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	
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.
--	--	---

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

A Name of plan LOCAL 298 HEALTH BENEFIT FUND I	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1	D Employer Identification Number (EIN) 11-1967404	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

(b) 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

(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

(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

(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

(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

(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)

ANTHEM BLUE CROSS

23-7391136

(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	1115264	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)

DICKINSON GROUP

20-1241472

(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	952110	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)

EASTERN STATES JOINT BOARD

46-2849057

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	736316	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)

JOSEPH GIOVINCO

11-1967404

(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	176009	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)

VICTOR LAGRECA

11-1967404

(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	80631	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)

MCCARTHY & PREECE, PLLC

84-3667887

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
22	NONE	46480	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)

ANGELA DIGIOVANNI

11-1967404

(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	38233	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

JOSEPH MANZELLA

11-1967404

(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	37612	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

CHARLES CLEMENZA

11-1967404

(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	35367	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)

NICOLE JEAN-CHARLES

11-1967404

(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	34850	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)

ANTHONY RAINONE

11-1967404

(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	33366	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)

JAMES VOGT

11-1967404

(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	31219	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)

PRISCILLA FARDUCHI

11-1967404

(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	30794	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)

WEAVER AND TIDWELL LLP

75-0786316

(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	30000	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)

NORA ROA

11-1967404

(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	29339	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)

TPA COMPUTER CORP

13-3329882

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	NONE	22200	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)

INTERCONTINENTAL REAL ESTATE INVEST

04-3549299

(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	17720	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)

QUAN-VEST CONSULTANTS, INC.

11-2559669

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	13644	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)

ATLANTA SOSNOFF CAPITAL LLC

13-3098640

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
51	NONE	13159	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)

SUMMIT ACTUARIAL SERVICES

11-4385930

(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	10000	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)

LAWRENCE S. FISCHER, CPA

52-2326815

(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	7200	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)

D.D. SERVICES INC.

11-2705347

(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	6764	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: WEAVER AND TIDWELL, L.L.P.	b EIN: 75-0786316
c Position: ACCOUNTANT	
d Address: 1 PENNSYLVANIA PLAZA #2800 NEW YORK, NY 10119	e Telephone: 212-695-5003

Explanation: **ACCOUNTANT WAS TERMINATED THROUGH NORMAL BIDDING PROCESS.**

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <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
--	--	--

For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan LOCAL 298 HEALTH BENEFIT FUND I	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND 1	D Employer Identification Number (EIN) 11-1967404

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		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	646315	1315478
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	220054	132246
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	1086594	231049
(2) U.S. Government securities	1c(2)	2100168	2344565
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	2551487	2433687
(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)	1884131	1788808
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	12317065	13768081
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	2259321	1253257
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)	29440	29524
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	23094575	23296695
Liabilities			
g Benefit claims payable.....	1g	9872532	17197000
h Operating payables.....	1h	14910	16179
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	19769	1857560
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	9907211	19070739
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	13187364	4225956

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)	47912854	
(B) Participants.....	2a(1)(B)	362882	
(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)		48275736
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	3238	
(B) U.S. Government securities.....	2b(1)(B)	107298	
(C) Corporate debt instruments.....	2b(1)(C)	138071	
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	118283	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		366890
(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)	498359	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		498359
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	4216287	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	4344055	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		-127768
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)	-176791	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		1302713
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total.....	2d		50139139

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	55814279	
(2) To insurance carriers for the provision of benefits	2e(2)	2296547	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		58110826
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)	654516	
(2) Contract administrator fees	2i(2)		
(3) Recordkeeping fees	2i(3)	7200	
(4) IQPA audit fees	2i(4)	30000	
(5) Investment advisory and investment management fees	2i(5)	44523	
(6) Bank or trust company trustee/custodial fees	2i(6)	2351	
(7) Actuarial fees	2i(7)	10000	
(8) Legal fees	2i(8)	46480	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)	194651	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		989721
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		59100547

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-8961408
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		1788808
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 298 HEALTH BENEFIT FUND I

FINANCIAL STATEMENTS

DECEMBER 31, 2024

LOCAL 298 HEALTH BENEFIT FUND I

FINANCIAL STATEMENTS WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

CONTENTS

	PAGE
Independent Auditor's Report	1
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	6
Statements of Benefit Obligations	7
Statements of Changes in Benefit Obligations	8
Notes to Financial Statements	9
Supplemental Information	
Schedules of Cost of Benefits	19
Schedules of Administrative Expenses	20
Schedule of Assets Held at End of Year	21
Schedule of Reportable Transactions	24

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
Local 298 Health Benefit Fund I

Opinion on the 2024 Financial Statements

We have audited the financial statements of the Local 298 Health Benefit Fund I (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the year then ended, and the related notes to the financial statements.

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

Basis for Opinion on the 2024 Financial Statements

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the 2024 Financial Statements section of our report. We are required to be independent of the Plan and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the 2024 Financial Statements

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

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

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

Auditor's Responsibilities for the Audit of the 2024 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 2024 Supplemental Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The 2024 supplemental Schedule of Benefits Paid, Schedule 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 ERISA. The supplemental information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

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

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

2023 Financial Statements

The financial statements of Local 298 Health Benefit Fund I as of December 31, 2023, were audited by other auditors whose report dated March 3, 2025 expressed an unmodified opinion on those statements.

Novak Francella LLC

New York, New York
January 20, 2026

LOCAL 298 HEALTH BENEFIT FUND I

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

ASSETS	2024	2023
INVESTMENTS, at fair value		
United States Government and Government agency obligations	\$ 2,344,565	\$ 2,100,168
Corporate obligations	2,433,687	2,551,487
Mutual funds	13,768,081	12,317,065
Limited partnership	1,788,808	1,884,131
Investment contract with insurance co.	1,253,257	2,259,321
Short-term investment fund	231,049	1,047,068
Total investments, at fair value	21,819,447	22,159,240
INVESTMENTS, at contract value		
Variable annuity contract	29,524	29,440
Total investments	21,848,971	22,188,680
PREPAID EXPENSES	420	2,739
RECEIVABLES		
Employer contributions	1,315,478	646,315
Stop-loss reimbursements	-	153,747
Securities sold and not settled	41,960	22,155
Due from related parties	40,061	39,526
Accrued interest	49,805	41,413
Total receivables	1,447,304	903,156
Total assets	23,296,695	23,094,575

See accompanying notes to financial statements.

LIABILITIES AND NET ASSETS

LIABILITIES

Accounts payable	\$ 16,179	\$ 14,910
Cash overdraft	1,800,245	-
Due to related parties	17,093	-
Securities purchased and not settled	<u>40,222</u>	<u>19,769</u>
Total liabilities	<u>1,873,739</u>	<u>34,679</u>
NET ASSETS AVAILABLE FOR BENEFITS	<u>\$ 21,422,956</u>	<u>\$ 23,059,896</u>

See accompanying notes to financial statements.

LOCAL 298 HEALTH BENEFIT FUND I

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	\$ 998,154	\$ 1,004,031
Interest and dividends	865,249	760,274
	1,863,403	1,764,305
Less: investment expenses	(46,874)	(25,940)
Net investment income	1,816,529	1,738,365
Contributions		
Employer contributions	47,912,854	40,246,577
Participants (COBRA)	362,882	251,836
Total contributions	48,275,736	40,498,413
Total additions	50,092,265	42,236,778
DEDUCTIONS		
Cost of benefits	50,786,358	37,052,953
Administrative expenses	942,847	1,507,347
Total deductions	51,729,205	38,560,300
NET INCREASE (DECREASE)	(1,636,940)	3,676,478
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	23,059,896	19,383,418
End of year	\$ 21,422,956	\$ 23,059,896

LOCAL 298 HEALTH BENEFIT FUND I
STATEMENTS OF BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

	2024	2023
AMOUNT CURRENTLY PAYABLE TO OR FOR PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Health claims payable	\$ 14,844,000	\$ 8,408,522
Insurance premiums payable	-	144,010
OTHER OBLIGATIONS FOR CURRENT BENEFIT COVERAGE AT PRESENT VALUE OF ESTIMATED AMOUNTS		
Estimated health claims incurred but not yet reported	2,353,000	1,320,000
TOTAL BENEFIT OBLIGATIONS	\$ 17,197,000	\$ 9,872,532

See accompanying notes to financial statements.

LOCAL 298 HEALTH BENEFIT FUND I

STATEMENTS OF CHANGES IN PLAN BENEFIT OBLIGATIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
NET INCREASE IN BENEFIT OBLIGATIONS ATTRIBUTABLE TO		
Increase in amounts payable to or on behalf of		
participants, beneficiaries or dependents benefit claims payable		
payable	\$ 6,435,478	4,217,904
Insurance premiums payable	(144,010)	(63,953)
Increase (Decrease) in other obligations for current benefit coverage,		
at estimated amounts benefit claims incurred but not		
yet reported	<u>1,033,000</u>	<u>(1,230,000)</u>
Net increase in benefit obligations	7,324,468	2,923,951
BENEFIT OBLIGATION BALANCE AT BEGINNING OF YEAR	<u>9,872,532</u>	<u>6,948,581</u>
BENEFIT OBLIGATION BALANCE AT END OF YEAR	<u><u>\$ 17,197,000</u></u>	<u><u>\$ 9,872,532</u></u>

See accompanying notes to financial statements.

LOCAL 298 HEALTH BENEFIT FUND I

NOTES TO FINANCIAL STATEMENTS

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following brief description of the Local 298 Health Benefit Fund I (the Plan) provides only general information. Participants should refer to their Plan's applicable Summary Plan Description (SPD) for a more complete description of the Plan's provisions.

General

The Agreement and Declaration of Trust establishing the Sick and Welfare Fund – Local 139 was executed on January 1, 1960, pursuant to collective bargaining agreements between various employers under the jurisdiction of Amalgamated & Metal Workers Union Joint Board 1 (the “Board”). Effective October 1, 1996, subsequent to the merger of the Board with Amalgamated Local 298 (the “Union”), the Plan changed its name to Local 298 Health Benefit Fund I. The Plan is a multi-employer benefit plan. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended.

Additionally, pursuant to participation agreements, covered employees of the Amalgamated Transit Workers Local 854 Health Benefit Fund (the “Local 854 Plan”) and Local 426 Health Benefit Fund (the “Local 426 Plan”) are eligible to participate in the Plan.

Benefits

The Plan provides health benefits (medical, hospital, surgical, major medical, dental, prescription drugs, and optical), and death benefits to eligible participants and their eligible covered dependents. In addition, the Plan offers COBRA to members separated from employment.

All plan benefits are self-insured. The claims for self-insured benefits are processed by the Plan's third-party claims processors under administrative services only agreements. The Plan pays claims directly to or on behalf of participants and are then reimbursed by the Plan. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan.

Stop-Loss Coverage

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims). Stop-loss reimbursements totaling \$185,589 and \$422,909 have been netted with medical claims paid for the years ended December 31, 2024 and 2023, respectively.

NOTE 1. DESCRIPTION OF THE PLAN (continued)

Contributions

Contribution rates have been established under collective bargaining agreements between the Union and the various employers. Each employer is required to contribute to the Plan at the rate(s) specified in the collective bargaining agreement. Contributions are accounted for as exchange transactions. Contribution rates vary depending on the types of coverage negotiated.

The Plan is noncontributory for employees except for COBRA premiums as required by law and is funded mainly from contributions received from employers.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Investment Valuation and Income Recognition - Investments in U.S. Government and Government Agency obligations, corporate obligations, and mutual funds are carried at fair value which generally represents quoted market prices or net asset value of the fund as of the last business day of the fiscal year as provided by the custodian or investment manager or valued using pricing models maximizing the use of observable inputs for similar securities with similar credit ratings. The investment in the limited partnership is carried at estimated fair value as determined by the partnership. The investment contract with insurance company is stated at estimated fair value as reported by the insurance company. Short-term investments are valued at cost, which approximates fair value.

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

Cash and cash equivalents - The Plan considers all non-interest bearing cash deposits to be cash or cash equivalents.

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

Securities Purchased or Sold and Not Settled - This represents the amounts due to or from the custodial bank for the purchase or sale of securities with trade dates prior to year-end and settlement dates after year end.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Payment of Benefits - Plan obligations for health claims incurred but not reported as of December 31, 2024 and 2023 are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party claims administrators. The amounts are paid by the Plan only if claims are submitted and approved for payments. Benefits are recorded when paid.

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.

Reclassification - Certain reclassifications have been made to the 2023 financial statements to conform to the 2024 financial statement presentation. These reclassifications had no effect on changes in net assets available for benefits.

NOTE 3. PRIORITIES UPON TERMINATION

Although it has not expressed any intent to do so, the Plan has the right to modify the benefits provided to, and contributions required of, participants to discontinue its contributions at any time and to terminate the Plan subject to the provisions of ERISA. In the event of Plan termination, remaining assets will be applied in a uniform and nondiscriminatory manner toward the provision of benefits for or on account of the participants. No assets of the Plan may be used for purposes other than for the exclusive benefit of the Plan's participants.

NOTE 4. TAX STATUS

The Plan received an exemption letter from the Internal Revenue Service (IRS) stating that the Plan is tax exempt under the provisions of Section 501(c)(9) of the IRC. However, as a result of the Plan's funding policy, from time to time the trust may be subject to income taxes.

In addition, the Plan and related parties are required to operate in conformity with the IRC to maintain the tax-exempt status of the trust. Plan management believes that the Plan is being operated in compliance with the applicable requirements of the IRC and, therefore believes that the related trust is tax-exempt.

US GAAP requires Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

NOTE 5. 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.

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

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

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

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

NOTE 5. FAIR VALUE MEASUREMENTS (continued)

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
United States Government and				
Government agency obligations	\$ 2,344,565	\$ 937,519	\$ 1,407,046	\$ -
Corporate obligations	2,433,687	-	2,433,687	-
Mutual funds	13,768,081	13,768,081	-	-
Investment contract with insurance co.	1,253,257	-	-	1,253,257
Short-term investments	231,049	231,049	-	-
Total investments at fair value	\$ 20,030,639	\$ 14,936,649	\$ 3,840,733	\$ 1,253,257
Investments measured at NAV*	1,788,808			
	<u>\$ 21,819,447</u>			
	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
United States Government and				
Government agency obligations	\$ 2,100,168	\$ 871,782	\$ 1,228,386	\$ -
Corporate obligations	2,551,487	-	2,551,487	-
Mutual funds	12,317,065	12,317,065	-	-
Investment contract with insurance co.	2,259,321	-	-	2,259,321
Short-term investments	1,047,068	1,047,068	-	-
Total investments at fair value	\$ 20,275,109	\$ 14,235,915	\$ 3,779,873	\$ 2,259,321
Investments measured at NAV*	1,884,131			
	<u>\$ 22,159,240</u>			

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

NOTE 5. FAIR VALUE MEASUREMENTS (continued)

The following table set forth a summary of changes in the fair value of the Plan’s level 3 investment for the year ended December 31, 2024 and 2023:

	Level 3 Fair Value Measurements for 2024				
	Beginning balance	Purchases	Sales	Unrealized Gain/(Loss)	Ending balance
Investment contract with insurance company: Prudential Fixed Rate Fund	\$ 2,259,321	\$ 56,468	\$ (1,000,000)	\$ (62,532)	\$ 1,253,257

	Level 3 Fair Value Measurements for 2023				
	Beginning balance	Purchases	Sales	Unrealized Gain/(Loss)	Ending balance
Investment contract with insurance company: Prudential Fixed Rate Fund	\$ 3,249,721	\$ 72,655	\$ (1,250,000)	\$ 186,945	\$ 2,259,321

Quantitative Information about Significant Unobservable Inputs Used in Level 3 Fair Value Measurements

The following table represents the Plan’s Level 3 financial instruments, the valuation techniques used to measure the fair value of those financial instruments, and the significant unobservable inputs and the ranges of values for those inputs at December 31, 2024 and 2023:

Instrument	2024 Fair Value	Principal Valuation Technique	Unobservable Inputs	Range of Significant Input Values	Weighted Average
Investment contract with insurance company: Prudential Fixed Rate Fund	\$ 1,253,257	Discounted cash flows	Composite market value factor	0.945272 - 1.018345	0.952476
			Earnings at Guaranteed Crediting Rate	Guaranteed Crediting Rate must be greater than or equal to contractual minimum crediting rate	N/A

NOTE 5. FAIR VALUE MEASUREMENTS (continued)

Instrument	2023 Fair Value	Principal Valuation Technique	Unobservable Inputs	Range of Significant Input Values	Weighted Average
Investment contract with insurance company:					
Prudential Fixed Rate Fund	\$ 2,259,321	Discounted cash flows	Composite market value factor	0.904550 - 1.057704	0.924241
			Earnings at Guaranteed Crediting Rate	Guaranteed Crediting Rate must be greater than or equal to contractual minimum crediting rate	N/A

The insurance contract with Empower Annuity Insurance Company of America (Empower) deposits all contributions from the Prudential Fixed Rate Fund into the general assets of Empower. Empower invests those general assets predominantly in privately placed securities and mortgages. The remaining portion of assets is invested in publicly traded bonds, real estate, common and preferred stock, and other types of equity investments, as well as short-term investments. Its market value represents contributions to the Fixed Rate Fund plus accumulated interest, less withdrawals adjusted to reflect market conditions as determined by Empower. Empower provides that the Plan can withdraw from the Fixed Rate Fund its contract's share of the amount necessary to pay participants benefits under the Plan up to the value of amounts held in the Fixed Rate Fund. Withdrawals will be made following the date of the withdrawal request or on the date specified in the withdrawal request.

The unfunded commitments and redemption information and redemption period are as follows at December 31, 2024 and 2023:

December 31, 2024	Fair Value	Commitments	Frequency	Notice Period
Limited partnership:				
U.S. Real Estate Investment Fund, LLC	<u>\$ 1,788,808</u>	<u>\$ -</u>	(a)	(a)
December 31, 2023	Fair Value	Commitments	Frequency	Notice Period
Limited partnership:				
U.S. Real Estate Investment Fund, LLC	<u>\$ 1,884,131</u>	<u>\$ -</u>	(a)	(a)

- (a) U.S. Real Estate Investment Fund, LLC - The Fund's investment objectives are to invest in a pool of real estate assets that are diversified by geography and property type, with a focus on yield-driven investments and, to a lesser extent, on value-added investments. Each Member may request redemption of its interests quarterly, provided that the Member has no unfunded commitment outstanding.

NOTE 6. VARIABLE ANNUITY CONTRACT WITH INSURANCE COMPANY

Investment in the variable annuity contract consists of an insurance contract that if held for the required contractual terms can be redeemed for an amount not less than the original investment made by the Plan. Redemption requests made prior to the contractual term date will be made based upon the then existing contract value. The variable annuity contract includes a death benefit payable to the Plan upon the death of the Plan officer named in the contract. The value of the variable annuity contract is \$29,524 and \$29,440 as of December 31, 2024 and 2023, respectively.

NOTE 7. RELATED PARTY TRANSACTIONS

Administrative Expenses

The Plan shares office space with the Eastern States Joint Board (ESJB) and reimburses ESJB for their share of shared administrative expenses. Shared administrative expenses are allocated based on cost sharing agreements between the Plan and ESJB. The Plan reimbursed ESJB for payroll and administrative expenses in the amounts of \$736,316 and \$1,155,719 for the years ended December 31, 2024 and 2023, respectively. At December 31, 2024, the Fund had a payable amount due to ESJB for shared expenses in the amount of \$13,539.

At December 31, 2024, the Plan had a payable amount due to Local 298 Union in the amount of \$3,554 for employer dues deposited by the Plan.

At December 31, 2024, the Fund has a receivable in the amount of \$40,061 and \$39,526 at December 31, 2023 due from ESJB.

Benefits

Employees of the Plan and related organizations participate in the Plan. Contributions made to the Plan by Local 298 are \$5,100 for the year ended December 31, 2024.

Members of the Amalgamated Transit Workers Local 854 Health Benefit Fund (Local 854) and Local 426 Health Benefit Fund (Local 426) also participated in the Plan. Contributions made to Local 854 and Local 426 by the employers are then transferred out to the Local 298 Health Benefit Fund I as premiums paid for insurance coverage. The premiums paid by Local 854 were \$6,559,645 for the year ended December 31, 2024. The premiums paid by Local 426 were \$19,326,962 for the year ended December 31, 2024.

NOTE 8. PENSION PLAN

The Plan is the sole sponsor of the Production Workers Union Local 148 and Welfare Fund Salaried Employee's Pension Plan, a single-employer defined benefit plan. Financial information for the Production Workers Union Local 148 and Welfare Fund Salaried Employee's Pension Plan as of, and for the years ended, February 29, 2024 and February 28, 2023 is as follows:

	February 29, 2024	February 28, 2023
Revenue	\$ 36,305	\$ 27,884
Expenses	35,491	33,301
Net plan assets, end of year	361,550	360,736

The funding target, as determined by the actuary, was approximately \$380,000 and \$385,000 for the years ending February 29, 2024 and February 28, 2023.

NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	<u>2024</u>	<u>2023</u>
Net assets available for benefits as reported on the financial statements	\$ 21,422,956	\$ 23,059,896
Claims incurred but not reported and health claims payable	<u>(17,197,000)</u>	<u>(9,872,532)</u>
Net assets available for benefits as reported on Form 5500	<u>\$ 4,225,956</u>	<u>\$ 13,187,364</u>

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

	<u>2024</u>
Benefits paid to or for participants per the financial statements	\$ 50,786,358
Add - amounts payable at end of year	17,197,000
Less - amounts payable at beginning of year	<u>(9,872,532)</u>
Benefits paid to or for participants per Form 5500	<u>\$ 58,110,826</u>

Amounts currently payable to or for participants, dependents, and beneficiaries for benefit claims that have been processed and approved for payment prior to the years ended December 31, 2024 and 2023, but not yet paid as of that date, as well as claims incurred but not reported, are reported on the Form 5500.

NOTE 10. RISKS AND UNCERTAINTIES

Financial instruments that potentially expose the Plan to concentrations of credit risk include cash and investments. The Plan maintains accounts at high quality financial institutions. While the Plan attempts to limit its financial exposure, deposit balances may, at times, exceed federally insured limits. The Plan has not experienced any losses on such accounts.

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

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

NOTE 11. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through January 20, 2026, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

LOCAL 298 HEALTH BENEFIT FUND I

SCHEDULES OF COST OF BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
SELF-INSURED BENEFITS - CLAIMS		
Medical, net of stop loss reimbursements	\$ 36,541,495	\$ 26,366,522
Prescriptions	9,367,400	7,198,355
Dental	70,471	25,131
Optical	4,830	-
Public goods pool	324,814	-
Total self-insured benefits - claims	<u>46,309,010</u>	<u>33,590,008</u>
STOP-LOSS INSURANCE PREMIUMS	<u>2,296,547</u>	<u>1,627,575</u>
VACATION BENEFITS	<u>64,701</u>	<u>55,012</u>
ADMINISTRATIVE FEES TO PROVIDE BENEFITS	<u>2,116,100</u>	<u>1,780,358</u>
Total cost of benefits	<u><u>\$ 50,786,358</u></u>	<u><u>\$ 37,052,953</u></u>

See accompanying notes to financial statements.

LOCAL 298 HEALTH BENEFIT FUND I

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	<u>2024</u>	<u>2023</u>
Salaries and payroll taxes	\$ 467,099	\$ 493,221
Employee benefits	187,417	512,257
Shared administrative expenses	111,800	150,241
Legal fees	46,480	45,000
Auditing fees	37,200	51,000
Rent	29,252	29,922
Computer consultant	22,200	19,576
Miscellaneous	18,555	12,893
Actuarial fees	10,000	10,000
Insurance	7,200	38,735
Office expense	5,644	565
Legal settlement fees	-	143,937
Total administrative expenses	<u>\$ 942,847</u>	<u>\$ 1,507,347</u>

LOCAL 298 HEALTH BENEFIT FUND I

SCHEDULE OF ASSETS HELD FOR INVESTMENT PURPOSES

DECEMBER 31, 2024

Form 5500, Schedule H, Item 4i

EIN: 11-1967404
Plan No. 501

(a)	(b)	(c)				(d)	(e)
		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value					
Identity of Issuer, Borrower,	Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value	
<u>1c(1) Interest bearing cash:</u>							
*	Dreyfus Treasury & Agency Cash Management	MMA	Demand	Var %	15,445	\$ 15,445	\$ 15,445
	Lending Club Business Interest Checking	MMA	Demand	Var	215,604	215,604	215,604
	Total interest bearing cash					231,049	231,049
<u>1c(2) United States Government securities:</u>							
	Federal Farm Credit Bank	Bond	02/13/34	5.250	40,000	40,000	40,161
	Federal Farm Credit Bank	Bond	08/14/34	5.650	55,000	55,000	54,831
	Federal Farm Credit Bank	Bond	04/25/39	6.220	50,000	50,080	50,082
	Federal Farm Credit Bank	Bond	05/06/39	6.250	75,000	75,135	75,128
	Federal Farm Credit Bank	Bond	06/10/39	6.070	80,000	80,080	80,023
	Federal Farm Credit Bank	Bond	10/28/44	5.720	75,000	75,000	75,028
	Federal Farm Credit Bank	Bond	11/14/44	5.950	70,000	70,000	69,917
	Federal Home Loan Bank	Bond	05/23/34	5.920	80,000	80,040	80,168
	Federal Home Loan Bank	Bond	12/27/35	5.750	100,000	100,000	100,000
	Federal Home Loan Bank	Bond	11/22/39	5.750	60,000	60,000	59,869
	Federal Home Loan Bank	Bond	12/06/40	5.900	100,000	100,100	99,768
	Federal Home Loan Mortgage Association Gold	Pool	06/01/31	7.000	207	120	214
	Federal Home Loan Mortgage Association Gold	Pool	11/01/33	7.000	172	17	178
	Federal Home Loan Mortgage Association Gold	Pool	09/01/35	5.000	8,077	8,547	8,021
	Federal Home Loan Mortgage Association Gold	Pool	09/01/40	4.000	20,456	701	1,933
	Federal Home Loan Mortgage Association Gold	Pool	12/01/40	4.000	4,890	3,042	4,619
	Federal Home Loan Mortgage Association Gold	Pool	01/01/41	4.000	3,223	2,074	3,045
	Federal Home Loan Mortgage Association Gold	Pool	01/01/41	4.000	6,287	4,969	5,939
	Federal Home Loan Mortgage Association Gold	Pool	02/01/41	4.000	5,161	3,031	4,875
	Federal Home Loan Mortgage Association Gold	Pool	03/01/41	4.000	587	218	555
	Federal Home Loan Mortgage Association Gold	Pool	03/01/41	4.000	2,539	1,559	2,399
	Federal Home Loan Mortgage Association Gold	Pool	05/01/41	4.000	996	842	941
	Federal Home Loan Mortgage Association Gold	Pool	12/01/41	3.500	3,056	2,921	2,788
	Federal Home Loan Mortgage Association Gold	Pool	01/01/42	3.500	458	393	418
	Federal Home Loan Mortgage Association Gold	Pool	04/01/42	3.500	1,516	1,477	1,383
	Federal Home Loan Mortgage Association Gold	Pool	06/01/42	3.500	2,225	2,113	2,030
	Federal Home Loan Mortgage Association Gold	Pool	01/01/43	3.000	1,822	1,749	1,610
	Federal Home Loan Mortgage Association Gold	Pool	07/01/44	4.000	9,340	8,842	8,636
	Federal Home Loan Mortgage Corporation	Pool	01/01/53	6.000	48,905	50,020	49,913
	Federal Home Loan Mortgage Corporation	Pool	04/01/53	5.500	37,172	37,904	37,190
	Federal Home Loan Mortgage Corporation	Pool	09/01/53	5.000	78,634	78,339	76,730
	Federal Home Loan Mortgage Corporation	Pool	03/01/54	6.000	69,293	70,636	70,506
	Federal National Mortgage Association	Pool	06/01/40	4.500	4,654	720	4,512
	Federal National Mortgage Association	MBS	11/25/40	4.500	4,165	4,385	4,145
	Federal National Mortgage Association	Pool	01/01/41	4.500	5,042	4,241	4,888
	Federal National Mortgage Association	Pool	03/01/41	4.000	4,397	3,334	4,149
	Federal National Mortgage Association	Pool	12/01/41	4.000	264	246	247
	Federal National Mortgage Association	Pool	01/01/42	3.500	63	16	63
	Federal National Mortgage Association	Pool	12/01/43	4.500	5,259	4,936	5,053
	Federal National Mortgage Association	Pool	05/01/44	4.500	10,775	9,671	10,352

(a)	(b)	(c)			(d)	(e)
		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value				
Identity of Issuer, Borrower,	Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value
<u>1c(2) United States Government securities (continued):</u>						
Federal National Mortgage Association	Pool	08/01/44	4.000 %	1,878	\$ 1,743	\$ 1,755
Federal National Mortgage Association	Pool	09/01/44	4.000	2,931	3,010	2,751
Federal National Mortgage Association	Pool	09/01/44	4.000	6,411	6,251	5,973
Federal National Mortgage Association	Pool	12/01/44	4.000	26,380	27,041	24,525
Federal National Mortgage Association	Pool	06/01/53	6.000	31,512	32,123	31,882
Federal National Mortgage Association	Pool	09/01/53	6.000	115,131	115,923	116,265
Federal National Mortgage Association	MBS	10/01/53	6.000	37,521	38,154	37,721
Federal National Mortgage Association	Pool	04/01/54	6.500	37,534	39,153	38,953
Government National Mortgage Association Remic	MBS	12/20/53	6.000	45,000	45,731	44,914
United States Treasury	Note	04/30/25	3.875	40,000	39,948	39,940
United States Treasury	Note	11/30/28	4.375	50,000	50,438	50,021
United States Treasury	Note	08/31/30	4.125	70,000	70,301	68,923
United States Treasury	Note	05/15/32	2.875	100,000	100,813	89,810
United States Treasury	Note	08/15/32	2.750	32,000	31,175	28,379
United States Treasury	Note	11/15/32	4.125	305,000	308,905	297,473
United States Treasury	Note	08/15/33	3.875	35,000	34,721	33,310
United States Treasury	Note	11/15/34	4.250	75,000	73,887	73,046
United States Treasury	Bond	05/15/42	3.250	50,000	45,937	40,670
United States Treasury	Bond	11/15/42	4.000	240,000	235,385	215,947
Total United States Government securities					2,393,137	2,344,565
<u>1c(3) Corporate debt instruments:</u>						
AbbVie Inc.	Bond	03/15/44	5.350	45,000	44,938	43,866
Allstate Corp.	Bond	08/15/53	Var	100,000	106,218	100,014
American Express Co.	Bond	05/26/33	Var	100,000	99,117	97,507
Anheuser Busch Co.	Bond	01/15/33	5.950	50,000	55,007	52,150
Anheuser Busch Co.	Bond	04/01/36	5.750	40,000	41,940	40,799
Archer Daniels Midland	Bond	10/01/32	5.935	25,000	28,628	26,344
AutoZone Inc.	Bond	02/01/33	4.750	25,000	24,984	23,986
Avent Inc.	Bond	05/15/31	3.000	58,000	57,971	49,350
Brighthouse Financial Inc.	Bond	12/22/51	3.850	45,000	44,993	29,255
Bristol Myers Squibb	Bond	11/15/33	5.900	30,000	29,954	31,477
Dominion Resources Inc.	Bond	06/15/38	7.000	38,000	58,297	42,297
Duke Energy Carolinas	Bond	06/01/37	6.100	80,000	113,128	83,291
First Union Corp.	Bond	08/01/26	7.574	32,000	40,319	33,215
Goldman Sachs Group	Bond	07/23/35	Var	75,000	75,000	73,600
Harris Corporations	Bond	04/27/35	4.854	45,000	57,285	42,794
HCA Inc.	Bond	11/06/33	7.500	45,000	50,531	49,886
Kinder Morgan	Bond	03/15/35	5.800	60,000	78,853	60,359
Kinross Gold Corp.	Bond	09/01/41	6.875	39,000	54,261	41,107
Lowe's Cos Inc.	Bond	09/15/44	4.250	90,000	79,672	69,715
MetLife Inc	Bond	12/15/34	5.300	75,000	74,688	74,711
National Rural Utilities	Bond	04/30/43	Var	43,000	44,398	43,088
Nationwide Mutual Insurance	Bond	04/01/33	7.875	50,000	70,770	55,336
New York Life Insurance	Bond	05/15/33	5.875	50,000	60,499	51,770
Nextera Energy Capital Holdings	Bond	09/01/54	Var	40,000	40,000	40,712
Northwest Pipeline	Bond	12/01/25	7.125	35,000	42,578	35,532
Occidental Petroleum Corp.	Bond	09/15/36	6.450	62,000	75,553	63,471
Oglethorpe Power Corp.	Bond	12/01/42	4.200	68,000	73,117	53,891
Pfizer Investment Enterprises	Bond	05/19/43	5.110	35,000	34,300	32,855
Puget Energy Inc.	Bond	09/15/51	2.893	80,000	80,000	48,854
Quest Diagnostic	Bond	01/30/40	5.750	55,000	57,704	52,846
Raytheon Technologies	Bond	02/27/33	5.150	65,000	64,809	64,454
RTX Corporation	Bond	03/15/34	6.100	25,000	24,953	26,325

(a)	(b)	(c)			(d)	(e)	
		Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value					
Identity of Issuer, Borrower,		Type	Maturity Date	Rate of Interest	Par / Maturity Value or Shares	Cost	Current Value
<u>1c(3) Corporate debt instruments (continued):</u>							
	Schwab Charles Corp.	Bond	08/24/34	Var %	75,000	\$ 74,814	\$ 78,744
	Sierra Pacific Power Co.	Bond	07/01/27	6.750	40,000	44,872	43,634
	Simon Property Group LP	Bond	03/08/53	5.850	65,000	64,419	65,449
	Tosco Corp.	Bond	01/01/47	7.900	35,000	43,632	40,837
	Tri-State Generation & Transmission Association	Bond	11/01/44	4.700	55,000	49,940	42,923
	Truist Financial Corp.	Bond	10/28/33	Var	100,000	102,196	104,124
	Union Electric Co.	Bond	03/15/53	5.450	75,000	74,920	71,814
	Union Pacific Corp.	Bond	02/01/44	4.821	75,000	69,720	65,142
	United Parcel Service	Bond	04/01/40	5.200	115,000	117,567	112,008
	United Technologies Corp.	Bond	11/16/28	4.121	60,000	67,932	58,399
	Voya Financial Inc.	Bond	01/23/48	Var	50,000	52,937	47,086
	Weyerhaeuser Co.	Bond	03/15/32	7.375	8,000	11,187	8,905
	Xcel Energy Inc.	Bond	03/15/34	5.500	60,000	59,792	59,765
	Total Corporate debt instruments					<u>2,718,393</u>	<u>2,433,687</u>
<u>1c(5) Partnership/joint ventures:</u>							
	U.S. Real Estate Investment Fund LLC					<u>1,752,914</u>	<u>1,788,808</u>
<u>1c(6) Mutual funds:</u>							
*	Vanguard Institutional Index Fund Institutional				227,157	3,918,198	2,341,992
*	Vanguard Short-Term Investment Grade Admiral				15,086	2,410,057	6,901,840
*	Vanguard Treasury Money Market Fund				4,524,249	4,524,249	4,524,249
	Total mutual funds					<u>10,852,504</u>	<u>13,768,081</u>
<u>1c(14) Funds held in Insurance Co. general account:</u>							
	Delaware Life Insurance Annuity					<u>29,524</u>	<u>29,524</u>
<u>1c(15) Investment contract with insurance company:</u>							
*	Prudential Fixed Rate Fund					<u>1,315,789</u>	<u>1,253,257</u>
	Total investments					<u>\$ 19,293,310</u>	<u>\$ 21,848,971</u>

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

LOCAL 298 HEALTH BENEFIT FUND I

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Line 4j

EIN: 11-1967404
Plan No. 501

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Description of Asset	Purchase Price	Selling Price	Cost of Asset	Current Value of Asset	Net Gain or (Loss)	
* Dreyfus Treasury & Agency Cash Management	\$ 1,754,453 N/A	N/A \$ 1,751,658	\$ 1,754,453 1,751,658	\$ 1,754,453 1,751,658	N/A \$ -	
Lending Club Business Interest Checking	5,780,140 N/A	N/A 5,983,661	5,780,140 5,983,661	5,780,140 5,983,661	N/A -	

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

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

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF ASSETS HELD

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210 - 0110
1210 - 0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

Part II Basic Plan Information - enter all requested information

1a Name of plan LOCAL 298 HEALTH BENEFIT FUND I	1b Three-digit plan number (PN) ▶	501
	1c Effective date of plan	01/01/1955
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BOARD OF TRUSTEES OF LOCAL 298 HEALTH BENEFIT FUND	2b Employer Identification Number (EIN)	11-1967404
201 WEST VALLEY STREAM BLVD	2c Plan Sponsor's telephone number	516-872-6690
VALLEY STREAM NY 11580-5538	2d Business code (see instructions)	524290

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		1/14/24	JOSEPH GIOVINCO
	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

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

Form 5500 (2024)
v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
--	--

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	3,177
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).		
a (1) Total number of active participants at the beginning of the plan year	6a(1)	3,177
a (2) Total number of active participants at the end of the plan year	6a(2)	2,172
b Retired or separated participants receiving benefits	6b	
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d	2,172
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f Total. Add lines 6d and 6e	6f	
g (1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	110

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

9a Plan funding arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input checked="" type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input checked="" type="checkbox"/> Trust (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 (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) - Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> A (Insurance Information) - Number Attached <u> 3 </u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input 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 _____

SEE ACCOUNTANT'S OPINION FOR SCHEDULE
OF FIVE PERCENT TRANSACTIONS