

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.)
 - a single-employer plan
 - a DFE (specify) _____
- B** This return/report is:
 - the first return/report
 - the final return/report
 - an amended return/report
 - a short plan year return/report (less than 12 months)
- C** If the plan is a collectively-bargained plan, check here. ▶
- D** Check box if filing under:
 - Form 5558
 - automatic extension
 - the DFVC program
 - special extension (enter description)
- E** If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. ▶

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</u>	1b Three-digit plan number (PN) ▶ <u>502</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</u> <u>290 POST ROAD WEST, P.O. BOX 5160</u> <u>WESTPORT, CT 06880-9917</u>	1c Effective date of plan <u>01/01/2021</u> 2b Employer Identification Number (EIN) <u>06-6069081</u> 2c Plan Sponsor's telephone number <u>860-470-8551</u> 2d Business code (see instructions) <u>493100</u>

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

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

SIGN HERE	Filed with authorized/valid electronic signature.	10/02/2025	TIM MELIA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	10/07/2025	JASON PARADIS
	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	
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	24720
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)	24093
	6a(2)	24247
	6b	623
	6c	
	6d	24870
	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	46

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 4K

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

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

a Pension Schedules	b General Schedules
(1) <input type="checkbox"/> R (Retirement Plan Information)	(1) <input checked="" type="checkbox"/> H (Financial Information)
(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary	(2) <input type="checkbox"/> I (Financial Information – Small Plan)
(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>5</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 _____

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

<p>A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</p>	<p>D Employer Identification Number (EIN) 06-6069081</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
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC.

(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
04-1045815	53228	4955229	399	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

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(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	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) ▶ **SENIOR PLAN**

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	910505
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	D Employer Identification Number (EIN) 06-6069081

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
BLUE CROSS BLUE SHIELD OF RHODE ISLAND

(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
05-0158952	53473	MCA/1A307	100	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	

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	(c) Amount	(d) Purpose	

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	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) ▶ SENIOR PLAN

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	368145
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

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

A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND		B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND		D Employer Identification Number (EIN) 06-6069081	

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

BLUE MEDICARE RX

(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
05-0158952	53473	K7039268/702321		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	

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 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	820261
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.		10b	

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	D Employer Identification Number (EIN) 06-6069081

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

1 Coverage Information:

(a) Name of insurance carrier
DEARBORN LIFE INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-2598882	71129	VMLN00694	24827	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) ▶ **A, D & D**

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	682166
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	

Specify nature of costs.

Part IV Provision of Information

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

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

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

<p>A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>502</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND</p>	<p>D Employer Identification Number (EIN) 06-6069081</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
DELTA DENTAL OF CONNECTICUT, INC.

(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
81-2414649	15987	04414	33006	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	
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)	7283492
(2) Increase (decrease) in amount due but unpaid		9a(2)	-105
(3) Increase (decrease) in unearned premium reserve		9a(3)	
(4) Earned ((1) + (2) - (3))		9a(4)	7283387
b Benefit charges (1) Claims paid		9b(1)	6447581
(2) Increase (decrease) in claim reserves		9b(2)	13513
(3) Incurred claims (add (1) and (2))		9b(3)	6461094
(4) Claims charged		9b(4)	6461093
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)	634996	
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)	160235	
(F) Charges for risks or other contingencies	9c(1)(F)	72834	
(G) Other retention charges	9c(1)(G)		
(H) Total retention	9c(1)(H)		868065
(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)	510433
(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.
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For calendar plan year 2024 or fiscal plan year beginning **01/01/2024** and ending **12/31/2024**

A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	B Three-digit plan number (PN) ▶	502
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	D Employer Identification Number (EIN) 06-6069081	

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

THE VANGUARD GROUP INC.

23-1945930

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

NUVEEN FUND ADVISORS LLC

31-0942504

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

PIMCO

33-0629048

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

FRANKLIN ADVISERS INC

94-2990534

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

INVESCO TRUST COMPANY

46-3793325

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

J.P. MORGAN INVESTMENT MANAGEMENT

13-3200244

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

DUFF & PHELPS INVESTMENT MANAGEMENT 200 S WACKER DR STE 500
CHICAGO, IL 60606

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

VIRTUS INVESTMENT PARTNERS

26-3962811

(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 HEALTH PLANS INC.

06-1475928

(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	2731069	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)

UFCW UNION LOCAL 919 PENSION

06-1065206

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49 50	RELATED ORG	382289	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)

THE SEGAL COMPANY

13-1835864

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	280376	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)

OPTUMRX ADMINISTRATIVE SERVICES, LL

75-2578509

(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	182240	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)

EMPLOYEE 4

06-6069081

(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	171954	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)

VIRTA MEDICAL PC

36-4841662

(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	154033	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)

HINGE HEALTH, INC.

81-1884841

(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	146844	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)

UNION PRINTING, INC.

45 WESTBRIDGE DR.
WATERBURY, CT 06708

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
36 50	NONE	135439	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

NOVAK FRANCELLA, LLC

61-1436956

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
10 50	NONE	120524	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)

BRIDGEWAY BENEFIT TECHNOLOGIES

52-1796473

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	114050	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)

EMPLOYEE 8

06-6069081

(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	97488	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)

SEMO LAW GROUP

1710 CONNECTICUT AVE NW STE 300
WASHINGTON, DC 20009

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29 50	NONE	91614	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)

EMPLOYEE 7

06-6069081

(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	79152	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)

EMPLOYEE 5

06-6069081

(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	77770	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)

LIVONGO HEALTH, INC.

26-3542036

(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	77073	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)

FIRST AMERICAN ADMINISTRATORS

86-0773195

(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	75564	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)

EMPLOYEE 1

06-6069081

(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	72381	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)

EMPLOYEE 2

06-6069081

(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	69904	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)

EMPLOYEE 3

06-6069081

(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	57757	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)

PREMIER TECHNOLOGY SOLUTIONS, INC.

13-3933805

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	56591	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)

EMPLOYEE 6

06-6069081

(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	46479	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)

INTERCONTINENTAL REAL ESTATE CORP

04-2895544

(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	20236	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)

ADP

22-1467904

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15 50	NONE	12936	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

MORGAN STANLEY

20-8764829

(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	11294	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	0	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

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

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

BOYD WATTERSON ASSET MGMT.

34-1922005

(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 50	NONE	7509	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)
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a Name:	b EIN:
c Position:	
d Address:	e Telephone:

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	B Three-digit plan number (PN) ▶ 502
C Plan sponsor's name as shown on line 2a of Form 5500 TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	D Employer Identification Number (EIN) 06-6069081

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a		
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	1334742	1415720
(2) Participant contributions	1b(2)	489601	478702
(3) Other	1b(3)	3154899	4340005
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	23827808	27441810
(2) U.S. Government securities	1c(2)	6065805	5057098
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)	5282036	5362871
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)	44584	
(5) Partnership/joint venture interests	1c(5)	3188612	2988180
(6) Real estate (other than employer real property)	1c(6)	8740043	8482225
(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)	37981155	32124466
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)	100000	100000

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	25567	17057
f Total assets (add all amounts in lines 1a through 1e).....	1f	90234852	87808134
Liabilities			
g Benefit claims payable.....	1g	11630040	14599592
h Operating payables.....	1h	236808	261707
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	206053	200000
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	12072901	15061299
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	78161951	72746835

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)	119755441	
(B) Participants.....	2a(1)(B)	12137561	
(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)		131893002
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	101237	
(B) U.S. Government securities.....	2b(1)(B)	168445	
(C) Corporate debt instruments.....	2b(1)(C)	160205	
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	120357	
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		550244
(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)	1975356	
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		1975356
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	15380347	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	15008834	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		371513
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)	-257818	
(B) Other.....	2b(5)(B)	1293054	
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		1035236

		(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)		1295226
c Other income	2c		16419232
d Total income. Add all income amounts in column (b) and enter total.....	2d		153539809

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)	142750273	
(2) To insurance carriers for the provision of benefits	2e(2)	10450765	
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		153201038
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)	1030248	
(2) Contract administrator fees	2i(2)	3366823	
(3) Recordkeeping fees	2i(3)	70460	
(4) IQPA audit fees	2i(4)	63000	
(5) Investment advisory and investment management fees	2i(5)	51697	
(6) Bank or trust company trustee/custodial fees	2i(6)	175	
(7) Actuarial fees	2i(7)	280376	
(8) Legal fees	2i(8)	91614	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)	799494	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		5753887
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		158954925

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-5415116
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		1000000
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		11470405
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.)			
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.			

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 _____.

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

FINANCIAL STATEMENTS

DECEMBER 31, 2024

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

FINANCIAL STATEMENT WITH SUPPLEMENTAL INFORMATION

DECEMBER 31, 2024 AND 2023

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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of the
UFCW and Participating Employers
New England Health Fund

Opinion

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

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

Basis for Opinion

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

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with GAAS, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with GAAS, we:

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

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

Report on Supplemental Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental Schedule of Assets Held at End of Year, Schedule of Reportable Transactions, Schedules of Benefits, Insurance Premiums and Administrative Service Fees, and Schedules of Administrative Expenses together referred to as “supplemental information,” are presented for the purpose of additional analysis and are not a required part of the financial statements. The supplemental Schedule of Assets Held at End of Year and Schedule of Reportable Transactions represent supplemental information required by the Department of Labor’s Rules and Regulations for Reporting and Disclosure under ERISA. The supplemental information is the responsibility of the Plan’s management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the financial statements as a whole.

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

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

Novak Francella LLC

Killingworth, Connecticut
October 13, 2025

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS

DECEMBER 31, 2024 AND 2023

ASSETS	2024	2023
INVESTMENTS - at fair value		
Exchange traded funds	\$ 21,836,441	\$ 25,177,117
Corporate bonds	5,362,871	5,282,036
U.S. Government & Agency securities	5,057,098	6,065,805
Wholly-owned subsidiary - real estate property	8,482,225	8,740,043
Mutual funds	10,288,025	12,804,038
Common stocks	-	44,584
Real estate investment funds	2,988,180	3,188,612
Savings accounts, certificates of deposit, and money market accounts	27,441,810	23,827,808
Other foreign bonds	100,000	100,000
Total investments	81,556,650	85,230,043
RECEIVABLES		
Employer contributions	1,415,720	1,334,742
Employee co-pays	478,702	489,601
Prescription rebate receivable	3,590,988	2,472,752
Accounts receivable	51,190	7,081
Accrued interest	76,562	67,720
Prepaid expenses	621,265	607,346
Total receivables	6,234,427	4,979,242
PROPERTY AND EQUIPMENT		
Office furniture and equipment	230,010	230,010
Accumulated depreciation and amortization	(212,953)	(204,443)
Property and equipment - net	17,057	25,567
Total assets	87,808,134	90,234,852
LIABILITIES AND NET ASSETS		
LIABILITIES		
Deposit from Stop and Shop	200,000	200,000
Deferred revenue	-	6,053
Accounts payable	261,707	236,808
Total liabilities	461,707	442,861
NET ASSETS AVAILABLE FOR BENEFITS	\$ 87,346,427	\$ 89,791,991

See accompanying notes to financial statements.

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
ADDITIONS		
Investment income		
Net appreciation in fair value of investments	\$ 2,701,975	\$ 3,044,806
Interest and dividends	2,525,600	2,729,883
	5,227,575	5,774,689
Less: investments fees	(51,697)	(67,989)
Net investment income	5,175,878	5,706,700
Contributions		
Employer	119,755,441	116,382,167
Participant and retiree contributions	12,137,561	11,770,919
Total contributions	131,893,002	128,153,086
Other income		
Prescription rebates	15,784,433	8,156,155
Claims subrogation recovery	627,444	272,277
Dental rebates	105	-
Miscellaneous	7,250	72,670
Total other income	16,419,232	8,501,102
Total additions	153,488,112	142,360,888
DEDUCTIONS		
Benefits	147,164,804	145,799,513
Insurance premiums and administrative service fees	6,433,505	6,549,607
Administrative expenses	2,335,367	2,504,384
Total deductions	155,933,676	154,853,504
NET DECREASE	(2,445,564)	(12,492,616)
TRANSFER OF NET ASSETS AVAILABLE FOR BENEFITS FROM:		
UFCW 919 Health and Welfare Plan	-	199,434
UFCW Interstate Health and Welfare Plan	-	1,205
Total transferred	-	200,639
NET ASSETS AVAILABLE FOR BENEFITS		
Beginning of year	89,791,991	102,083,968
End of year	\$ 87,346,427	\$ 89,791,991

See accompanying notes to financial statements.

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

STATEMENTS OF BENEFIT OBLIGATIONS

DECEMBER 31, 2024 AND 2023

	2024	2023
AMOUNTS CURRENTLY PAYABLE TO OR FOR		
PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Health claims payable and incurred but not reported	\$ 14,453,824	\$ 11,630,040
Insurance premiums payable	145,768	-
Total amounts currently payable	14,599,592	11,630,040
POSTRETIREMENT BENEFIT OBLIGATIONS -		
NET OF AMOUNTS CURRENTLY PAYABLE		
Current retirees	24,699,549	26,851,137
Other participants fully eligible for benefits	5,116,679	4,091,757
Other participants not yet fully eligible for benefits	7,266,746	8,489,311
Total other obligations	37,082,974	39,432,205
TOTAL BENEFIT OBLIGATIONS	\$ 51,682,566	\$ 51,062,245

See accompanying note to financial statements.

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

STATEMENTS OF CHANGES IN BENEFIT OBLIGATIONS

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
AMOUNTS CURRENTLY PAYABLE TO OR FOR		
PARTICIPANTS, BENEFICIARIES AND DEPENDENTS		
Balance at beginning of year	\$ 11,630,040	\$ 12,106,411
Claims reported and approved for payment	153,201,038	148,493,892
Claims paid	(150,231,486)	(148,970,263)
Balance at end of year	14,599,592	11,630,040
POSTRETIREMENT BENEFIT OBLIGATIONS -		
NET OF AMOUNTS CURRENTLY PAYABLE		
Balance at beginning of year	39,432,205	35,172,044
Increase (decrease) during the year attributable to:		
Service cost	268,480	215,958
Interest cost	1,919,539	1,789,622
Expected benefits paid net of retiree contributions	(2,652,103)	(2,633,629)
Actuarial experience loss	-	1,290,945
Change in actuarial assumptions	(1,829,182)	3,597,265
Plan amendments	(55,965)	-
Balance at end of year	37,082,974	39,432,205
TOTAL BENEFIT OBLIGATIONS	\$ 51,682,566	\$ 51,062,245

See accompanying notes to financial statements.

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

NOTES TO FINANCIAL STATEMENT

DECEMBER 31, 2024 AND 2023

NOTE 1. DESCRIPTION OF THE PLAN

The following description of the UFCW and Participating Employers New England Health Fund (the Plan) is provided for general information only. Participants should refer to the Plan Trust Agreement and benefit Plan booklet for more complete information.

General - The Plan provides health and other benefits to all active participants. The Plan and related trust were established on January 1, 2021 as a result of the merger of the Amalgamated Welfare Trust Fund Local 371, the United Food and Commercial Workers and Participating Employers Interstate Health and Welfare Fund, the United Food and Commercial Workers' Union Local 919 and Contributing Employers' Health and Welfare Fund, and the UFCW Local 1459 and Contributing Employers Health and Welfare Fund. The Plan is maintained pursuant to collective bargaining agreements which provide for the rate of employer contributions, the type of work and areas of work for which contributions are payable and certain other terms governing contributions. The Plan is a defined benefit welfare plan subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Merger - On January 1, 2021, the Amalgamated Welfare Trust Fund Local 371, the United Food and Commercial Workers and Participating Employers Interstate Health and Welfare Fund, the United Food and Commercial Workers' Union Local 919 and Contributing Employers' Health and Welfare Fund, and the UFCW Local 1459 and Contributing Employers Health and Welfare Fund agreed to merge into the UFCW and Participating Employers New England Health Fund (EIN 06-6069081 PN 502). The transferred net assets have been recognized in the accounts of the UFCW and Participating Employers New England Health Fund. The changes in net assets of the combined Plans are included in the statements of changes in net assets available for benefits of the UFCW and Participating Employers New England Health Fund for the years ended December 31, 2024 and 2023.

Benefits - The purpose of the Plan is to provide for prescription drugs, surgical, hospital, and major benefits for all current participants and their dependents on a self-insured basis. Participants are also covered for disability. Dental, Life and accidental death and dismemberment are covered through insurance paid for by the Plan. The Plan also contributes to a scholarship fund. Benefits are recorded when paid.

Other - The Plan's Board of Trustees, as Sponsor, has the right under the Plan to modify the benefits provided to active employees. The Plan may be terminated only by joint agreement between industry and union, subject to the provisions set forth in ERISA.

NOTE 1. DESCRIPTION OF THE PLAN (continued)

Contributions - Employer contributions are received on a monthly basis from individual participating employers pursuant to the current collective bargaining agreement between employers and the union. In 2024, contributions for full-time employees ranged from \$445 to \$2,201 per month, per employee, and for part-time employees ranged from \$22 to \$615 per month, per employee. In 2023, contributions for full-time employees ranged from \$420 to \$1,948 per month, per employee, and for part-time employees ranged from \$13 to \$72 per month, per employee. Employer contributions are accounted for as exchange transactions.

Approximately 86% of employer contributions received were from 2 employers for the year ended December 31, 2024.

Employee Contributions (COBRA) - Contributions are received on a monthly basis from individual members who are no longer employed by contributing employers and who wish to continue medical coverage for the appropriate period of time as permitted by law.

Employee Contributions (Co-pay) - The Plan and some employers have entered into an agreement under which all participants enrolled in the medical, prescription, dental, and vision programs will pay weekly, pre-tax, payroll contribution/deductions for these benefits, according to the following schedule:

	<u>Range</u> <u>2024</u>	<u>Range</u> <u>2023</u>
Full-time employee only	\$ 8.00 - \$ 42.00	\$ 5.00 - \$ 25.00
Full-time employee and spouse	10.00 - 85.00	10.00 - 60.50
Full-time employee and child(ren)	10.00 - 64.00	10.00 - 57.00
Full-time family	15.00 - 110.00	10.00 - 99.00

Participant contributions are remitted to the Plan each month and are in addition to employer contributions.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Cash and Cash Equivalents - The Plan considers all highly liquid debt instruments purchased with maturities of three months or less to be cash equivalents.

Investments Valuation and Income Recognition - The Plan's investments are stated at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See Note 4 for disclosure of fair value measurements.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

The 290 Post Road West Corp. (the Corporation) is a wholly-owned subsidiary of the Plan and is valued at fair value. The Corporation owns the building at 290 Post Road West, Westport, Connecticut, which is leased to the Plan and its related entities. The building was purchased in 1991. An independent appraisal was performed on the property and building for the year ended December 31, 2024 valued using the comparable sales method.

The sales and purchase of investment securities, and gains and losses on the sale of investments, are recognized at the trade date. Interest income is recorded on the accrual basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) includes the Plan's gains and losses on investments bought and sold as well as held during the year.

Employers Contributions Receivable - Contributions due and not paid prior to year-end are recorded as contributions receivable. The Plan believes that the receivables are fully collectible; therefore, no allowance for credit losses is recorded.

Property and Equipment - Fixed assets are stated at cost less accumulated depreciation and amortization. Depreciation is calculated using the straight-line method based on estimated useful lives of the assets ranging from 5 to 7 years. Amortization of computer software is calculated using the straight-line method, based on a five-year estimated useful life. When assets are retired, the costs and accumulated depreciation are removed from the respective accounts, and any gain or loss on disposition is credited or charged to change in net assets.

Depreciation expense totaled \$8,510 for each of the years ended December 31, 2024 and 2023.

Use of Estimates - The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, claims incurred but not reported, claims payable, and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Plan obligations at December 31, 2024, for health claims incurred by active participants but not reported at that date are estimated by the Plan's actuary in accordance with accepted actuarial principles. Such estimated amounts are reported in the accompanying statements of benefit obligations.

Refunds - The Plan utilizes a pharmacy benefit manager (PBM) which periodically makes refunds to the Plan based on the Plan's actual utilization pattern of specific drugs. Refunds due from the Plan's PBM are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable. Pharmacy rebates totaled \$15,784,433 and \$8,156,155 for the years ended December 31, 2024 and 2023, respectively.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

Credit Risk - The Plan maintains its cash with a financial institution deemed to be credit worthy. Cash balances are insured by the Federal Deposit Insurance Corporation (FDIC) up to \$250,000 in a single bank. During the year, the Plan may have cash at banks in excess of FDIC-insured limits and is exposed to the credit risk resulting from this concentration of cash.

NOTE 3. BENEFIT OBLIGATIONS

(In Part): Summary of Significant Accounting Policies

Postretirement Benefit Obligations: The Plan has adopted the provisions of FASB ASC 965, “Plan Accounting Health and Welfare Benefit Plans”. The amount reported as the postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributed by the terms of the Plan to employees’ service rendered to the date of the financial statements, reduced by the actuarial present value of contributions expected to be received in the future from current Plan participants. Postretirement benefits include future benefits expected to be paid to or for 1) currently retired or terminated employees and their beneficiaries and dependents and 2) active employees and their beneficiaries and dependents after retirement from service with participating employers. The postretirement benefit obligation represents the amount that is to be funded by contributions from the Plan’s participating employers and from existing Plan assets. Prior to an active employee’s full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee’s service rendered to the valuation date.

The actuarial present value of the expected postretirement benefit obligation is determined by an actuary and is the amount that results from applying actuarial assumptions to historical claims-cost data to estimate future annual incurred claims costs per participant and to adjust such estimates for the time value of money (through discounts for interest) and the probability of payment (by means of decrements such as those for deaths, disability, withdrawal or retirement) between the valuation date and the expected date of payment.

The weighted-average health care cost-trend rate assumption has a significant effect on the amounts reported in the accompanying financial statements. If the assumed rates increased by 1 percentage point in each year, it would increase the obligation as of the year ended December 31, 2024 by \$3,650,409.

NOTE 3. BENEFIT OBLIGATIONS (continued)

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

	December 31, 2024	December 31, 2023
Weighted-average discount rate	5.50%	5.00%
Health trend rates:		
Under 65 medical	6.75% graded by 0.25% to 4.50% over 9 years	7.0% graded by .25% to 4.5% over 10 years
Under 65 prescription drug	7.19% for 2025 then 10% graded by 0.50% to 4.50% over 11 years	11% graded by .5% to 4.5% over 13 years
Over 65 medical and prescription	6.75% graded by 0.25% to 4.50% over 9 years	9.25% then 6.75% graded by .25% to 4.5% over 9 years
Mortality	Pri-2012 Blue Collar Headcount - Weighted Mortality tables (sex distinct and separate for active employees and annuitants) with rates of death increased 4%, projected generationally from 2012 with Scale MP-2021.	Pri-2012 Blue Collar Headcount - Weighted Mortality tables (sex distinct and separate for active employees and annuitants) with rates of death increased 4%, projected generationally from 2012 with Scale MP-2021.
Per capita cost development: Post-65 medical and prescription drug	Per capita costs were based on a weighted average of the fully insured Blue Chip for Medicare, HealthMate Coast-to-Coast with Blue Medicare Rx, and Managed Blue for Seniors with Blue Medicare Rx premium rates effective January 1, 2024, trended forward based on January 1, 2025 renewals, and adjusted using actuarial factors to estimate individual retiree and spouse costs by age and gender.	Per capita costs were based on a weighted average of the fully insured Blue Chip for Medicare, HealthMate Coast-to-Coast with Blue Medicare Rx, and Managed Blue for Seniors with Blue Medicare Rx premium rates effective January 1, 2024, trended forward based on January 1, 2025 renewals, and adjusted using actuarial factors to estimate individual retiree and spouse costs by age and gender.

Per capita cost development for pre-65 medical, prescription drug and dental are derived as follows:

- Per capita medical and prescription drug costs were based on incurred claims experience from the Segal SHAPE warehouse for the period January 1, 2021, to December 31, 2023.

NOTE 3. BENEFIT OBLIGATIONS (continued)

For the valuation, the claims were separated by plan year and adjusted as follows:

- total claims were divided by the number of adult members to yield a per capita claim,
- the per capita claim was trended to the midpoint of the valuation year at assumed trend rates, and
- the per capita claim was adjusted for the effect of any plan changes or changes in contract terms.

Per capita claims for each plan year were then combined by taking a weighted average. The weights used in this average account for a number of factors including each plan year's volatility of claims experience and distance to the valuation year. Actuarial factors were then applied to the weighted average cost to estimate individual retiree and spouse costs by age and by gender.

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

The Plan's surplus of net assets over benefit obligations at December 31, 2024, relates to the postretirement benefit obligation, which is funded on a pay-as-you-go basis by the contribution rate provided by the current bargaining agreement. It is expected that the postretirement benefit will continue to be funded through the collective bargaining contribution rate. The Trustees have the right to terminate or change the terms of the Plan at any time, with appropriate note to participants.

Effective January 1, 2023, all new Medicare-eligible retirees will be enrolled in the Coast-to-Coast plan.

Other Benefit Obligations: Benefit claims currently payable include the Plan's liability for claims incurred as of the year ended December 31, 2024 but not reported, and the Plan's liability for claims reported as of the year ended December 31, 2024 but not yet processed. The Plan's liability for claims incurred but not yet reported is estimated by the Plan's actuary utilizing actuarial methods which take into consideration prior claims experience and the expected time period from the date such claims are incurred to the date that the related claims are submitted and paid.

NOTE 4. FAIR VALUE MEASUREMENTS

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

NOTE 4. FAIR VALUE MEASUREMENTS (continued)

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 following is a description of the valuation methodologies used for assets and liabilities measured at fair value, as well as the general classification of such assets and liabilities pursuant to the valuation hierarchy. There have been no changes in the methodologies used at December 31, 2024 and 2023.

Corporate bonds: Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds: Valued at unadjusted quoted market prices which represent the net asset value of the shares held by the Plan at year-end. The mutual funds held by the Plan are deemed to be actively traded.

Exchange traded funds: The exchange traded funds are valued at the net assets value of shares held by the Plan at year end and are classified within level 1 of the valuation hierarchy.

U.S. Government and Agency securities: Valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

Wholly-owned subsidiary - real estate property: Valued based on an independent appraisal using an aggregate land plus building formula appraisal.

NOTE 4. FAIR VALUE MEASUREMENTS (continued)

Real estate investment funds: Valued based on the pro rata ownership of the net assets of the real estate investment funds. The Plan obtains valuations of its investments based upon independent third party appraiser reports. Valuations are prepared based on income capitalization, cost and sales comparison approaches. Investors may request redemption on a quarterly basis. There are no unfunded commitments outstanding.

Because of the inherent uncertainty of the valuations of the investments noted above, the estimated values may differ significantly from the values that would have been used had a ready market for these investments existed, and the difference could be material.

Common stocks: Valued at the closing price on the active market on which the individual securities were traded. Values are updated automatically by independent pricing service.

Savings accounts, certificate of deposits and money market accounts: Cash investments in money market funds are valued under the Market approach through the use of quoted market prices in an active market, which is the NAV of the underlying funds, and are classified within Level 1 of the valuation hierarchy.

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2024:

	Fair Value Measurements at December 31, 2024			
	Total	Level 1	Level 2	Level 3
Mutual funds	\$ 10,288,025	\$ 10,288,025	\$ -	\$ -
Exchange traded funds	21,836,441	21,836,441	-	-
Corporate bonds	5,362,871	-	5,362,871	-
Wholly-owned subsidiary - real estate property	8,482,225	-	-	8,482,225
United States Government and Agency securities	5,057,098	-	5,057,098	-
Savings accounts, certificate of deposits and money market accounts	27,441,810	27,441,810	-	-
Other foreign bonds	100,000	-	100,000	-
Total assets in the fair value hierarchy	78,568,470	<u>\$ 59,566,276</u>	<u>\$ 10,519,969</u>	<u>\$ 8,482,225</u>
Investments measured at NAV	<u>2,988,180</u>			
Total investments	<u>\$ 81,556,650</u>			

NOTE 4. FAIR VALUE MEASUREMENTS (continued)

The following table presents assets and liabilities measured at fair value on a recurring basis at December 31, 2023:

	Fair Value Measurements at December 31, 2023			
	Total	Level 1	Level 2	Level 3
Mutual funds	\$ 12,804,038	\$ 12,804,038	\$ -	\$ -
Common stocks	44,584	44,584	-	-
Exchange traded funds	25,177,117	25,177,117	-	-
Corporate bonds	5,282,036	-	5,282,036	-
Wholly-owned subsidiary - real estate property	8,740,043	-	-	8,740,043
United States Government and Agency securities	6,065,805	-	6,065,805	-
Savings accounts, certificate of deposits and money market accounts	23,827,808	23,827,808	-	-
Other foreign bonds	100,000	-	100,000	-
Total assets in the fair value hierarchy	82,041,431	\$ 61,853,547	\$ 11,447,841	\$ 8,740,043
Investments measured at NAV	3,188,612			
Total investments	\$ 85,230,043			

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

The following table summarizes investments for which fair values are measured using the net asset value per share as practical expedient at December 31, 2024 and 2023:

	2024 Fair Value	2023 Fair Value	Unfunded Commitment	Redemption Frequency	Redemption Notice Period
Real estate investment funds:					
U.S. Real Estate Investments Fund, LLC	\$ 2,083,607	\$ 2,194,111	\$ -	Quarterly	90 days, Redemption Queue instituted
Boyd Watterson GSA Fund, L.P.	904,573	994,501	-	Quarterly	60 days, Redemption Queue instituted
	<u>\$ 2,988,180</u>	<u>\$ 3,188,612</u>	<u>\$ -</u>		

The U.S. Real Estate Investment Fund, LLC'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. The manager of the Fund is Intercontinental Real Estate Corporation. The Fund is an open-end, commingled real estate investment fund and is intended to have an indefinite term. The Fund may be terminated sooner by the Manager or by the written consent of the members owning not less than two-thirds of the outstanding interests.

NOTE 4. FAIR VALUE MEASUREMENTS (continued)

Boyd Watterson GSA Fund, L.P. and Subsidiary (the Fund), a Delaware limited partnership, was formed on August 16, 2013, to acquire, develop, own, and operate a diversified portfolio of real estate investments in commercial property. The Fund was formed as a partnership between Boyd Watterson GSA GP, LLC (the General Partner) and numerous limited partners (collectively, the Partners). The Fund is managed by the General Partner and Boyd Watterson Asset Manage, LLC (the Advisor). The Fund was formed to operate as a perpetual like, open-end, commingled collective investment fund and intends to invest primarily leased to the U.S. federal government either through the General Services Administration (GSA) or other federal government agencies.

As required under ASC-820, the following presents a reconciliation of the beginning and ending balances for all assets and liabilities measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the years ended December 31, 2024 and 2023.

	2024	2023
Beginning balance	\$ 8,740,043	\$ 8,651,318
Unrealized gain (loss) relating to assets still held at reporting date	(257,818)	88,725
Ending balance	<u>\$ 8,482,225</u>	<u>\$ 8,740,043</u>
Unrealized gain (loss) for the period ending to level 3 assets that were still held at the reporting date	<u>\$ (257,818)</u>	<u>\$ 88,725</u>

Quantitative Information Regarding Level 3 Assets

The table that follows represents quantitative information about the significant unobservable inputs in fair value measurement of Level 3 Assets. Significant changes in any of those inputs in isolation would result in a significant change in fair value measurement.

Investment Type	Fair Value at December 31, 2024	Fair Value at December 31, 2023	Valuation Technique	Unobservable Inputs	Range (Weighed Average)
290 Post Road West, Inc.	\$ 8,482,225	\$ 8,740,043	Comparable Sales	Price per square foot	\$206

NOTE 5. TAX STATUS

The Plan obtained its latest determination letter dated April 1959, in which the Internal Revenue Service stated that the Plan, as then designed, was in compliance with the applicable requirements of the Internal Revenue Code, and was, therefore, exempt from Federal income taxes under Section 501(c)(9). The Plan has been amended since receiving the determination letter. The Plan's Trustees and the Plan's tax counsel believe that the Plan is currently designed and being operated in compliance with the applicable requirements of the Internal Revenue Code.

NOTE 5. TAX STATUS (continued)

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

NOTE 6. RELATED PARTY LEASES

The Plan leases office space from its wholly-owned subsidiary, 290 Post Road West Corp., under an operating lease that was transferred from the Amalgamated Welfare Trust Fund Local 371 which commenced April 1, 2020 and expired March 31, 2022. The monthly rent was \$18,026. On September 31, 2022 the Plan entered into a new lease with 290 Post Road West Corp., and is set to expire on August 31, 2025. The monthly rent is \$18,634. The rent expense was \$223,608 for each of the years ended December 31, 2024 and 2023.

NOTE 7. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	December 31,	
	2024	2023
Net assets available for benefits per the financial statements	\$ 87,346,427	\$ 89,791,991
Insurance premiums	(145,768)	-
Health claims payable and incurred but not reported	<u>(14,453,824)</u>	<u>(11,630,040)</u>
Net assets available for benefits per Form 5500	<u>\$ 72,746,835</u>	<u>\$ 78,161,951</u>

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

	Year Ended December 31, 2024
Benefits paid to participants per the financial statements	\$ 150,231,486
Add: Amounts currently payable at December 31, 2024	14,599,592
Less: Amounts currently payable at December 31, 2023	<u>(11,630,040)</u>
Benefits paid to participants per the Form 5500	<u>\$ 153,201,038</u>

NOTE 7. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500 (continued)

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

NOTE 8. PLAN TERMINATION

Although it has no current intent to do so, upon termination of the Plan, the trustees shall continue as trustees for the purpose of winding up the affairs of the Plan and shall apply the assets of the Plan to pay, or to provide for the payment, of any obligations of the Plan. The trustees shall distribute and apply any remaining surplus in such manner as will, in their sole opinion, best effectuate the purpose of the agreement provided, however, no part of the assets of the Plan shall be diverted to purposes other than for the exclusive benefit of the employees, their families, beneficiaries, the administrative expenses of the Plan, and other payments in accordance with the provisions of the trust.

NOTE 9. BENEFIT ADMINISTRATION

The Plan has an agreement with Anthem Blue Cross/Blue Shield (Anthem). Under the terms of the agreement Anthem provides medical claims processing services and access to 1) the Anthem PPO for all eligible participants; 2) mental/nervous and alcohol/drug treatment. The level of benefits and eligibility for benefits are determined by the Plan's Board of Trustees. The Plan office handles administrative issues regarding eligibility for benefits.

The Plan provides accidental death and dismemberment and life insurance coverage through policies with Dearborn Life Insurance Company.

The Plan provides dental insurance coverage through policies with Delta Dental.

The Plan has an agreement with Optum Rx to administer prescription benefits. Under the agreement, the Board of Trustees determines the type and limits of covered prescriptions and is responsible for funding all prescription claims. Optum Rx provides processing services and administers actual payment of prescription benefits.

The Plan has retained Blue Cross Blue Shield of Massachusetts, Inc. and Blue Cross Blue Shield of Rhode Island, Inc. for group Medicare Advantage Plan for health care and prescription drug coverage.

The Plan has an agreement with EyeMed to administer vision benefits. Under the agreement, the Board of Trustees determines the type and limits of the covered vision benefits and is responsible for funding all vision claims. EyeMed provides processing services and administers actual payment of the vision claims.

The Plan has an agreement with Virta Medical P.C. for related services for the management of chronic health conditions.

NOTE 9. BENEFIT ADMINISTRATION (continued)

The Plan has retained The University of Connecticut Speech & Hearing Clinic for the hearing health care of eligible participants and their dependents.

The Plan retained Hinge Health to provide digital physical therapy to diagnose, manage, and treat musculoskeletal pain.

NOTE 10. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN

Employees of the UFCW and Participating Employers New England Health Fund participate in one multiemployer defined benefit pension plan under the terms of a participation agreement that covers its non-collectively bargained employees. The Plan remits the contributions to this multiemployer defined benefit pension plan for the shared employees on behalf of the Benefits Funds. The Pension Fund reimburses the Plan for its share of the contributions based on a cost allocation study. The risks of participating in this multiemployer defined benefit pension plan are different from a single-employer plan in the following aspects:

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

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

NOTE 10. MULTIEMPLOYER DEFINED BENEFIT PENSION PLAN (continued)

Legal Name of Pension Plan	Pension Plan's Employer Identification Number	Pension Plan's Plan Number	Pension Protection Act Zone Status				Expiration Date of Collective Bargaining Agreement
			Zone Status	Extended Amortization Provisions Used?	Zone Status	Extended Amortization Provisions Used?	
UFCW National Pension Fund	51-6055922	001	Green as of 07/1/2025	No	Green as of 7/1/2024	No	*

*The full-time employees of the Fund participate in the UFCW National Pension Fund through a participation agreement between the Fund and the UFCW National Pension Fund. The participation agreement does not have an expiration date.

Legal Name of Pension Plan	Contributions to the Pension Plan		Contributions to the Pension Plan greater than 5% of total Pension Plan Contributions (Plan year ending)		Employer Contribution Rates		Number of Employees Covered by Plan	
	12/31/2024	12/31/2023	No, Plan year ending 12/31/2024.	No, Plan year ending 12/31/2023.	12/31/2024	12/31/2023	12/31/2024	12/31/2023
UFCW National Pension Fund	\$ 21,197	\$ 23,946			\$76.37 to \$263.25 per month.	\$76.37 to \$263.25 per month.	8	9

NOTE 11. RETIREMENT PLANS

The Plan also sponsors two defined contribution pension plans. Contributions amounted to \$53,211 and \$51,457 for the years ended December 31, 2024 and 2023, respectively.

The Plan also sponsors a 401(k) plan, and the matching contribution amounted to \$19,292 and \$15,763 for the years ended December 31, 2024 and 2023, respectively.

NOTE 12. RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS

Parties-in-interest are defined under Department of Labor (DOL) regulations as any fiduciary of the Plan, any party rendering service to the Plan, the contributing employers, and certain others. In addition, the Plan has arrangements with service providers providing legal, actuary, audit, and tax services. These transactions are party-in-interest transactions, which are exempt from the prohibited transactions under ERISA.

Administrative Allocation - The Plan is affiliated with the United Food and Commercial Workers' Union Local 919 and Contributing Employers' Food Pension Plan. Both are Multiemployer Funds and share common Trustees. Certain common costs are paid by the Pension Fund and reimbursed by the Plan. A portion of these common expenses are allocated and reimbursed to the Pension Fund in accordance with policies established by the Trustees of both funds. Costs reimbursed to the Pension Fund totaled \$382,289 and \$368,332 for the years ended December 31, 2024 and 2023, respectively.

NOTE 13. RISKS AND UNCERTAINTIES

The Plan invests in various investments. Investments are exposed to various risks such as economic, interest rate, market and sector risks. Due to the level of risks 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 Statements of Net Assets Available for Benefits.

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

NOTE 14. SUBSEQUENT EVENTS

The Plan has evaluated subsequent events through October 13, 2025, the date the financial statements were available to be issued, and they have been evaluated in accordance with relevant accounting standards.

SUPPLEMENTAL INFORMATION

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

SCHEDULES OF BENEFITS, INSURANCE PREMIUMS AND ADMINISTRATIVE SERVICE FEES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
BENEFITS		
Health	\$ 106,985,212	\$ 106,908,191
Prescription drug program	31,205,664	30,290,329
Dental	7,283,492	7,033,741
Disability and taxes	1,193,896	1,078,219
Vision benefits	465,040	459,033
Scholarships	31,500	30,000
Total benefits	\$ 147,164,804	\$ 145,799,513
INSURANCE PREMIUMS AND ADMINISTRATIVE SERVICE FEES		
Insurance premiums		
Life and accidental death and dismemberment insurance	\$ 682,166	\$ 671,018
Retiree medical and prescription program	2,339,339	2,459,799
Administrative service fees		
Network access/claims repricing fees (Anthem)	2,731,069	2,911,008
Optum Rx fees	-	17,159
Legacy funds claim processing fees	182,240	-
Diabetes management	231,106	320,413
Virtual physical therapy	146,844	56,215
Vision fees	75,564	74,062
PCORI tax	45,177	39,933
Total insurance premiums and administrative service fees	\$ 6,433,505	\$ 6,549,607

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

SCHEDULES OF ADMINISTRATIVE EXPENSES

YEARS ENDED DECEMBER 31, 2024 AND 2023

	2024	2023
Salaries	\$ 499,274	\$ 562,547
UFCW Local 919 Pension Fund salary and benefit reimbursement	382,289	368,332
Consultant	280,376	275,801
Rent, subsidiary	223,608	223,608
Computer	170,641	165,261
Printing	135,439	155,050
Accounting	120,524	141,577
Employee pension	93,700	90,627
Legal	91,614	83,134
Postage	67,556	77,580
Fiduciary liability insurance	63,296	63,609
Employee health	54,985	96,710
Payroll taxes	40,790	46,006
Conference and seminars	26,236	60,876
Machine rental	22,627	23,931
Insurance	15,256	14,843
Telephone	13,457	18,119
Payroll service	12,936	12,789
Office	9,873	12,299
Depreciation and amortization	8,510	8,510
Dues and subscriptions	1,825	1,685
Connecticut personal property tax	380	1,290
Bank fees	175	200
	\$ 2,335,367	\$ 2,504,384
Total administrative expenses	\$ 2,335,367	\$ 2,504,384

**UFCW AND PARTICIPATING EMPLOYERS
NEW ENGLAND HEALTH FUND**

SCHEDULE OF ASSETS HELD AT END OF YEAR

DECEMBER 31, 2024

Form 5500, Schedule H, Item 4i

EIN: 06-606908
Plan No. 502

(a)	(b)	(c)	(d)	(e)		
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value		Cost	Current Value		
	Type	Shares/ Principal	Interest Rate	Maturity Date		
<u>US Government and Agency securities:</u>						
Fed Natl Mtg Assoc 10yr Pool MA4200	Note	160,000	1.500 %	11/01/30	\$ 60,005	\$ 60,208
Fed Natl Mtg Assoc 10yr Pool MA4332	Note	125,000	2.000	05/01/31	53,807	53,808
Fed Natl Mtg Assoc Pool MA4154	Note	150,000	1.500	10/01/35	70,890	69,808
Fed Natl Mtg Assoc Pool MA4404	Note	125,000	2.500	08/01/36	74,799	73,825
FHLMC 10yr Gold RD5058	Note	125,000	2.000	05/01/31	56,005	55,983
FHLMC 10yr Gold RD5067	Note	125,000	1.500	09/01/31	63,528	63,577
FHLMC 15yr Gold SB8115	Note	70,644	2.000	08/01/36	42,083	41,060
US Treasury Note	Note	100,000	4.000	01/31/29	99,256	98,672
US Treasury Note	Note	87,000	3.125	11/15/28	84,424	83,272
US Treasury Note	Note	130,000	2.875	05/15/28	125,046	124,231
US Treasury Note	Note	913,000	4.250	10/15/25	913,940	913,446
US Treasury Note	Note	155,000	2.375	05/15/29	142,181	142,903
US Treasury Note	Note	195,000	2.000	08/15/25	189,173	192,357
US Treasury Note	Note	924,000	4.000	12/15/26	926,939	922,592
US Treasury Note	Note	100,000	1.625	02/15/26	95,422	97,170
US Treasury Note	Note	225,000	4.000	10/31/29	230,442	221,291
US Treasury Note Inflation Indexed	Note	25,000	0.250	01/15/25	32,589	33,265
US Treasury Note	Note	280,000	2.000	11/15/26	267,862	268,800
US Treasury Note	Note	45,000	2.250	02/15/27	42,272	43,204
US Treasury Note	Note	350,000	2.250	08/15/27	335,165	332,787
US Treasury Note	Note	948,000	5.000	09/30/25	971,792	953,092
US Treasury Note	Note	65,000	4.375	08/15/26	66,241	65,134
US Treasury Note	Note	150,000	3.500	01/31/28	149,868	146,613
Total US Government and Agency securities					5,093,729	5,057,098
<u>Corporate bonds:</u>						
Abbvie Inc		238,000	3.800	03/15/25	235,220	237,572
American Honda Finance Corp		204,000	1.000	09/10/25	197,636	198,965
Amxca		160,000	3.390	05/17/27	156,918	159,289
Bank of America Fixed/Var		202,000	1.319	06/19/26	196,492	198,699
Bank of America Fixed/Var		65,000	4.948	07/22/28	66,302	65,125
Bank of Montreal		183,000	1.500	01/10/25	179,704	182,846
Bank of New York Mellon Corp		134,000	4.414	07/24/26	135,996	133,640
Bank of Nova Scotia		33,000	4.750	02/02/26	33,531	33,008
Berkshire Hathaway Energy Co		195,000	3.500	02/01/25	196,395	194,810
CarMax Auto Owner TR 2020-2 A-3		40,000	3.490	02/16/27	16,335	16,489
Charles Schwab Corp/The		207,000	0.900	03/11/26	194,070	198,090
Dollar General Corp		50,000	3.875	04/15/27	48,903	48,899
Dominion Energy Inc		50,000	2.850	08/15/26	47,765	48,550
Drive 2021 1-D		25,000	1.450	01/16/29	13,199	13,401
DuPont de Nemours Inc		50,000	4.493	11/15/25	49,996	49,900
Enterprise Products Operating LLC		65,000	4.150	10/16/28	64,783	63,488
Equinix Inc		50,000	3.200	11/18/29	47,427	45,961
Exelon Corp		50,000	3.400	04/15/26	48,793	49,174
Ford Credit Aut Lease TR 2023		45,000	4.940	03/15/26	10,339	10,352
GM Sachs Group Inc FXD to Var		60,000	4.223	05/01/29	58,079	58,375
GM Fin Cons Atmb Rec TR 2020		240,000	0.700	09/16/26	41,024	49,893

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Shares/ Type	Principal	Interest Rate	Maturity Date		
	<u>Corporate bonds (continued):</u>					
Home Depot Inc	95,000		3.350 %	09/15/25	\$ 95,109	\$ 94,267
JP Morgan Chase & Co. Fixed/Var	139,000		1.045	11/19/26	134,498	134,520
JP Morgan Chase & Co. Fixed/Var	65,000		6.087	10/23/29	68,871	67,410
Lennar Corp	50,000		4.750	11/29/27	50,291	49,883
Lennox Intn'l	50,000		5.500	09/15/28	52,115	50,820
Marriott International Inc/Md	50,000		5.000	10/15/27	51,049	50,404
Meta Platforms Inc	25,000		4.600	05/15/28	25,518	25,031
MetLife Inc	239,000		3.000	03/01/25	235,029	238,333
PayPal Holdings Inc	65,000		3.900	06/01/27	64,251	64,067
PNC Financial Services	65,000		2.600	07/23/26	62,374	62,997
PNC Financial Services	186,000		5.812	06/12/26	188,909	186,790
Prologis LP	70,000		2.125	04/15/27	65,088	66,313
Reinsurance Group of America Inc	50,000		3.900	05/15/29	48,205	47,770
Roper Technologies Inc.	55,000		3.800	12/15/26	53,928	54,146
Sierra Pacific Power Co.	65,000		2.600	05/01/26	62,253	63,276
Southern Co/The	50,000		3.250	07/01/26	49,070	48,982
Starbucks Corp.	45,000		3.800	08/15/25	44,869	44,772
Sysco Corp	50,000		3.300	07/15/26	49,091	48,985
T-Mobile USA Inc	45,000		4.950	03/15/28	46,356	45,018
Target Corp	196,000		2.250	04/15/25	194,881	194,676
Toronto-Dominion Bank	130,000		5.103	01/09/26	132,971	130,603
Toronto-Dominion Bank	67,000		1.450	01/10/25	66,372	66,950
Toyota Motor Credit Corp	193,000		5.400	11/10/25	195,874	194,442
Union Electric Co	60,000		2.950	06/15/27	57,354	57,675
US Bancorp	185,000		5.727	10/21/26	186,873	186,239
Velero Energy Partners LP	50,000		4.500	03/15/28	49,767	49,317
Verisk Analytics Inc	50,000		4.125	03/15/29	47,963	48,437
Verizon Communications Inc.	50,000		2.625	08/15/26	48,154	48,529
Verizon Master TR 2023	321,000		4.890	04/13/28	319,369	321,221
Verizon Master Trust 2022	244,000		1.530	07/20/28	235,573	243,618
Walt Disney Co/The	238,000		3.350	03/24/25	233,882	237,299
Wells Fargo & Co.	50,000		3.000	10/23/26	47,796	48,494
World Omni Aut Lea Sec 2023	35,000		5.070	09/15/26	35,072	35,061
	Total corporate bonds				<u>5,337,682</u>	<u>5,362,871</u>
	<u>Exchange traded funds:</u>					
Pimco Enhanced Shrt Mtrt Exc (MINT)	56,914				5,682,815	5,710,751
Vanguard Growth ETF	6,012				1,871,071	2,467,565
Vanguard Index FDS S&P 500 ETF	7,006				3,067,011	3,774,903
Vanguard Int High DVD Yld In	40,624				2,705,597	2,757,557
Vanguard Short Term Gov Bd	64,714				3,774,362	3,765,061
Vanguard Value ETF Index	19,850				2,975,271	3,360,604
	Total exchange traded funds				<u>20,076,127</u>	<u>21,836,441</u>
	<u>Wholly-owned subsidiary-real estate property:</u>					
290 Post Road West Corp.					<u>3,533,245</u>	<u>8,482,225</u>
	<u>Mutual funds:</u>					
JP Morgan Large Cap Value I	115,178				2,186,922	2,263,257
Nuveen Preferred Sec & Inc I	150,213				2,260,633	2,332,807
Pimco Invest Grade Cred BD 12	156,375				1,405,604	1,390,176
Vanguard Growth Index ADM	9,770				1,564,998	2,063,693
Vanguard Sh Tm Federal Adm	203,036				2,048,740	2,060,818
DNP Select Income Fund Inc	1,266				11,166	11,166
Franklin Conservative Alloc CL A	2,204				28,787	30,703
Nuveen Real Asset Inc. & Growth	805				9,765	9,765
Pimco Real Return Fund CL A	3,846				42,200	38,346
Pimco All Asset CL A	2,918				34,331	31,576
Pimco Dynamic Bond CL A	1,642				17,854	16,385
Templeton Global Bond CL A	4,013				40,716	26,044

(a)	(b)	(c)			(d)	(e)
Issuer, Borrower	Description of Investment Including Maturity Date, Rate of Interest, Collateral, Par or Maturity Value			Cost	Current Value	
	Type	Shares/ Principal	Interest Rate	Maturity Date		
	<u>Mutual funds (continued):</u>					
Virtus		1,266			\$ 13,995	\$ 13,289
	Total mutual funds				<u>9,665,711</u>	<u>10,288,025</u>
	<u>Real estate investment funds:</u>					
Boyd Watterson GSA Fund L.P.					986,605	904,573
U.S. Real Estate Investment Fund, LLC					1,854,808	2,083,607
	Total real estate investment funds				<u>2,841,413</u>	<u>2,988,180</u>
	<u>Other foreign bonds:</u>					
State of Israel Bonds	Bond	100,000	3.850 %		<u>100,000</u>	<u>100,000</u>
	<u>Savings accounts, certificates of deposit and money market accounts:</u>					
M&T Trust Company	MMKT		0.100		3,873	3,873
Invesco Treasury PTF INSTL	MMKT		4.520		11,547,062	11,547,062
Merrill Lynch	MMKT		4.960		1,203	1,203
Morgan Stanley Bank N.A	MMKT		0.010		105,023	105,023
The Lending Club Bank, NA	MMKT		0.850		15,749,137	15,749,137
Truist Capital Bank	MMKT		0.400		35,501	35,501
Tristate Capital Bank	MMKT		0.010		11	11
	Total savings accounts, certificates of deposit and money market accounts				<u>27,441,810</u>	<u>27,441,810</u>
	Total investments				<u>\$ 74,089,717</u>	<u>\$ 81,556,650</u>

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

**NEW ENGLAND HEALTH FUND
HEALTH AND WELFARE FUND**

SCHEDULE OF REPORTABLE TRANSACTIONS

YEAR ENDED DECEMBER 31, 2024

Form 5500, Schedule H, Item 4j

EIN 06-6069081
Plan No. 502

(a)	(b)	(c)	(d)	(g)	(h)	(i)
Description of Asset	Purchase Price	Selling Price	Cost of Asset	Current value of asset on transaction date	Net gain or (loss)	
<u>Series Transactions</u>						
The Lending Club Bank, NA	\$166,120,961	N/A	\$ 166,120,961	\$ 166,120,961	N/A	
The Lending Club Bank, NA	N/A	\$ 160,784,946	160,784,946	160,784,946	\$ -	

* 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 1210-0088 2024 This Form Is Open to Public Inspection
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Part I Annual Report Identification Information	
For calendar plan year 2024 or fiscal plan year beginning <u>01/01/2024</u> and ending <u>12/31/2024</u>	
A This return/report is for:	<input checked="" type="checkbox"/> a multiemployer plan <input type="checkbox"/> a multiple-employer plan (filers checking this box must provide participating employer information in accordance with the form instructions.) <input type="checkbox"/> a single-employer plan <input type="checkbox"/> a DFE (specify) _____ <input type="checkbox"/> the first return/report <input type="checkbox"/> the final return/report <input type="checkbox"/> an amended return/report <input type="checkbox"/> a short plan year return/report (less than 12 months)
B This return/report is:	
C If the plan is a collectively-bargained plan, check here	<input checked="" type="checkbox"/>
D Check box if filing under:	<input checked="" type="checkbox"/> Form 5558 <input type="checkbox"/> automatic extension <input type="checkbox"/> the DFVC program <input type="checkbox"/> special extension (enter description)
E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here	<input type="checkbox"/>

Part II Basic Plan Information - enter all requested information											
1a Name of plan UFCW AND PARTICIPATING EMPLOYERS NEW ENGLAND HEALTH FUND	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">1b Three-digit plan number (PN)</td> <td style="width:40%; text-align: center;">502</td> </tr> <tr> <td>1c Effective date of plan</td> <td style="text-align: center;">01/01/2021</td> </tr> <tr> <td>2b Employer Identification Number (EIN)</td> <td style="text-align: center;">06-6069081</td> </tr> <tr> <td>2c Plan Sponsor's telephone number</td> <td style="text-align: center;">860-470-8551</td> </tr> <tr> <td>2d Business code (see instructions)</td> <td style="text-align: center;">493100</td> </tr> </table>	1b Three-digit plan number (PN)	502	1c Effective date of plan	01/01/2021	2b Employer Identification Number (EIN)	06-6069081	2c Plan Sponsor's telephone number	860-470-8551	2d Business code (see instructions)	493100
1b Three-digit plan number (PN)	502										
1c Effective date of plan	01/01/2021										
2b Employer Identification Number (EIN)	06-6069081										
2c Plan Sponsor's telephone number	860-470-8551										
2d Business code (see instructions)	493100										
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) TRUSTEES UFCW AND PARTICIPATING EMPLOYERS NEW ENGLA 290 POST ROAD WEST, P.O. BOX 5160 WESTPORT CT 06880-9917											

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		10/2/25	TIM MELIA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE		10/7/25	JASON PARADIS
	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>
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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
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5 Total number of participants at the beginning of the plan year	5	24,720
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)	24,093
a(2) Total number of active participants at the end of the plan year	6a(2)	24,247
b Retired or separated participants receiving benefits	6b	623
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2), 6b, and 6c	6d	24,870
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	46

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 4K

9a Plan funding arrangement (check all that apply) (1) <input 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	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
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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>5</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)
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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