

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	2007
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)	1445
	6a(2)	0
	6b	0
	6c	
	6d	0
	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	3

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 4H

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) <input checked="" 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>1</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 **02/01/2024** and ending **12/31/2024**

<p>A Name of plan UFCW LOCAL 400 & EMPLOYERS HEALTH & WELFARE FUND</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES- UFCW LOCAL 400 HEALTH & WELFARE FUND</p>	<p>D Employer Identification Number (EIN) 55-0393244</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
HARTFORD LIFE AND ACCIDENT

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0838648	70815	805784G	0	01/01/2024	12/31/2024

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

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

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

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

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

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(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	7c(6)
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	

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

8 Benefit and contract type (check all applicable boxes)

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

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	229854
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 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 **02/01/2024** and ending **12/31/2024**

A Name of plan UFCW LOCAL 400 & EMPLOYERS HEALTH & WELFARE FUND	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES- UFCW LOCAL 400 HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 55-0393244	

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

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

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

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

ANTHEM INSURANCE COMPANIES

35-0781558

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 62	NONE	695505	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)

EMPLOYEES

55-0393244

(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	EMPLOYEE	240319	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)

REINHART, BOERNER, VAN DEUREN

39-1126909

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	133097	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)

SLEVIN & HART, P.C.

52-1708613

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
29	NONE	119630	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)

CALIBRE CPA GROUP, PLLC

47-0900880

(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	NONE	87575	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)

MILLIMAN INC.

91-0675641

(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?
70	NONE	68805	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)

DELTA DENTAL OF PENNSYLVANIA

23-1667011

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 14	NONE	39041	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)

HEARTLAND BENEFIT PLAN ADMINISTRATO

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
14	NONE	37232	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

D STREET LLC

20-4337584

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
99	NONE	32043	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)

UNITED ACTUARIAL

35-2156428

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
11	NONE	11075	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)

GROUP VISION SERVICES

26-3323202

(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	NONE	9724	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

13-2619259

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
49	NONE	6500	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

Part I Service Provider Information (continued)

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

(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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE H (Form 5500) <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.	OMB No. 1210-0110 2024 This Form is Open to Public Inspection
--	--	---

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 12/31/2024	
A Name of plan UFCW LOCAL 400 & EMPLOYERS HEALTH & WELFARE FUND	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 BOARD OF TRUSTEES- UFCW LOCAL 400 HEALTH & WELFARE FUND	D Employer Identification Number (EIN) 55-0393244

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

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

		(a) Beginning of Year	(b) End of Year
Assets			
a Total noninterest-bearing cash	1a	1783899	0
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)	282605	0
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	21894	
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)		
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts).....	1c(14)		
(15) Other.....	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e	10683	0
f Total assets (add all amounts in lines 1a through 1e).....	1f	2099081	0
Liabilities			
g Benefit claims payable.....	1g	140000	0
h Operating payables.....	1h	113217	0
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	7939	
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	261156	0
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	1837925	0

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)	21717745	
(B) Participants.....	2a(1)(B)	888177	
(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)		22605922
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	4625	
(B) U.S. Government securities.....	2b(1)(B)		
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)	2941	
(G) Total interest. Add lines 2b(1)(A) through (F).....	2b(1)(G)		7566
(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)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C).....	2b(2)(D)		
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)		
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)		
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B).....	2b(5)(C)		

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		34839
d Total income. Add all income amounts in column (b) and enter total	2d		22648327

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	21894509	
(2) To insurance carriers for the provision of benefits	2e(2)	229854	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		22124363
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)	312488	
(2) Contract administrator fees	2i(2)	196218	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	87575	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)		
(7) Actuarial fees	2i(7)	86380	
(8) Legal fees	2i(8)	252727	
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	204202	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		1139590
j Total expenses. Add all expense amounts in column (b) and enter total	2j		23263953

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		-615626
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		1222299

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: CALIBRE CPA GROUP, PLLC

(2) EIN: 47-9000880

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	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)		X	
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)		X	
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	X		
l Has the plan failed to provide any benefit when due under the plan?		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)		X	
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
 If "Yes," enter the amount of any plan assets that reverted to the employer this year 0.

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)
HEARTLAND HEALTH AND WELLNESS FUND	31-6173363	501

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 _____.



**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

FINANCIAL STATEMENTS
(LIQUIDATION BASIS)

DECEMBER 31, 2024





**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

FINANCIAL STATEMENTS
(LIQUIDATION BASIS)

11 MONTH PERIOD ENDED DECEMBER 31, 2024 AND
YEAR ENDED JANUARY 31, 2024

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BETHESDA, MD 20814
T: 202.331.9880 | F: 202.331.9890

INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
United Food and Commercial Workers
Local 400 and Employers Health and Welfare Plan

Opinion

We have audited the accompanying financial statements of the United Food and Commercial Workers Local 400 and Employers Health and Welfare Plan (the Plan), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), which comprise the statements of net assets available for benefits and of accumulated plan benefit obligations as of December 31, 2024 (in liquidation), and the related statement of changes in net assets available for benefits and of changes in accumulated plan benefit obligations for the 11 month period ended December 31, 2024 (in liquidation) and the statements of net assets available for benefits and of accumulated plan benefit obligations as of January, 31, 2024 (ongoing), and the related statement of changes in net assets available for benefits and of changes in accumulated plan benefit obligations for year then ended (ongoing) and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the net assets available for benefits and accumulated plan benefit obligations of the Plan as of December 31, 2024 (in liquidation) and January 31, 2024 (ongoing), and the changes in its net assets available for benefits and accumulated plan benefit obligations for the 11 month period and year, respectively, then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of 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.





Emphasis of Matter - Plan Termination and Liquidation Basis of Accounting

As discussed in Note 1 to the financial statements, the governing body of the Plan approved a plan of liquidation on May 7, 2024, and management determined liquidation is imminent. As a result, the Plan has changed its basis of accounting from the accrual basis used in presenting the January 31, 2024 financial statements to the liquidation basis used in presenting the December 31, 2024 financial statements. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

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


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

Auditor's Responsibilities for the Audit of the Financial Statements

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

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- 
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of 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.

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 information on page 14 is presented for the purpose of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with generally accepted auditing standards.

In our opinion, the information in the accompanying schedule is fairly stated, in all material respects, in relation to the financial statements as a whole.

Calibre CPA Group, PLLC

Bethesda, MD
October 10, 2025



**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS
(LIQUIDATION BASIS)

DECEMBER 31, 2024 AND JANUARY 31, 2024

	December 31, 2024	January 31, 2024
Assets		
Assets		
Cash and cash equivalents		
Checking accounts	\$ -	\$ 1,783,899
Receivables		
Participating employer contributions	-	283,244
Total receivables	-	283,244
Office equipment - net of accumulated depreciation of \$0- and \$65,802	-	2,909
Prepaid expenses	-	21,255
Right-of-use assets - finance leases	-	7,774
Total assets	-	2,099,081
Liabilities		
Current liabilities		
Accounts payable and accrued expenses	-	113,217
Finance lease liabilities	-	7,939
Total liabilities	-	121,156
Net assets available for benefits	\$ -	\$ 1,977,925

See accompanying notes to financial statements.



**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

STATEMENTS OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS
(LIQUIDATION BASIS)

11 MONTH PERIOD ENDED DECEMBER 31, 2024 AND
YEAR ENDED JANUARY 31, 2024

	December 31, 2024	January 31, 2024
Additions		
Contribution income		
Participating employer	\$ 21,717,745	\$ 26,046,337
Participant and retiree	888,177	975,720
Total contribution income	22,605,922	27,022,057
Subrogation income	3,380	50,514
Drug program rebate	31,459	36,344
Interest income	7,566	-
Total additions	22,648,327	27,108,915
Deductions		
Benefits paid to or for benefit of participants		
Death benefits	84,000	104,000
Dental	422,860	449,805
Medical, drug, and short-term disability claims	20,830,392	24,490,704
PPO access fees	697,257	780,331
Total benefits paid to or for benefit of participants	22,034,509	25,824,840
Premiums to insurance underwriters	229,854	284,280
Administrative expenses	1,139,590	1,292,631
Total deductions	23,403,953	27,401,751
Transfer to other fund	(1,222,299)	-
Net change	(1,977,925)	(292,836)
Net assets available for benefits		
Beginning of year	1,977,925	2,270,761
End of year	\$ -	\$ 1,977,925

See accompanying notes to financial statements.



**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

STATEMENTS OF ACCUMULATED PLAN BENEFIT OBLIGATIONS
(LIQUIDATION BASIS)

DECEMBER 31, 2024 AND JANUARY 31, 2024

	December 31, 2024	January 31, 2024
	<u> </u>	<u> </u>
Amounts currently payable to or for participants, beneficiaries, and dependents		
Health claims payable	\$ -	\$ 140,000
Other obligations for current benefit coverage, at present value of estimated amounts		
Claims incurred but not reported	<u>-</u>	<u>2,792,900</u>
Total obligations other than postretirement benefit obligations	<u>-</u>	<u>2,932,900</u>
Postretirement benefit obligations		
Current retirees	-	30,956,447
Other participants fully eligible for benefits	-	35,545,850
Other participants not yet fully eligible for benefits	<u>-</u>	<u>26,619,349</u>
Total postretirement benefit obligations	<u>-</u>	<u>93,121,646</u>
 Total accumulated plan benefit obligations	 <u>\$ -</u>	 <u>\$ 96,054,546</u>

See accompanying notes to financial statements.



**UNITED FOOD AND COMMERCIAL WORKERS
LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN**

STATEMENTS OF CHANGES IN ACCUMULATED PLAN BENEFIT OBLIGATIONS
(LIQUIDATION BASIS)

11 MONTH PERIOD ENDED DECEMBER 31, 2024 AND
YEAR ENDED JANUARY 31, 2024

	<u>December 31, 2024</u>	<u>January 31, 2024</u>
Amounts currently payable to or for participants, beneficiaries, and dependents		
Balance at beginning of year	\$ 140,000	\$ 199,000
Benefits reported and approved for payment	21,113,252	24,881,509
Claims paid	<u>(21,253,252)</u>	<u>(24,940,509)</u>
Balance at end of year	<u>-</u>	<u>140,000</u>
Other obligations for current benefit coverage, present value of estimated amounts		
Balance at beginning of year	2,792,900	3,788,500
Change during the year attributable to		
Claims incurred but not reported	<u>(2,792,900)</u>	<u>(995,600)</u>
Balance at end of year	<u>-</u>	<u>2,792,900</u>
Total obligations other than postretirement benefit obligations	<u>-</u>	<u>2,932,900</u>
Postretirement benefit obligations		
Balance at beginning of year	93,121,646	76,200,318
Change during the year attributable to		
Assumption changes	-	(1,167,437)
Estimated net benefits paid	-	(3,013,856)
Interest	-	3,619,515
Benefits earned and other changes	-	17,483,106
Liabilities transfers to Heartland Fund	<u>(93,121,646)</u>	<u>-</u>
Balance at end of year	<u>-</u>	<u>93,121,646</u>
Total accumulated plan benefit obligations	<u>\$ -</u>	<u>\$ 96,054,546</u>

See accompanying notes to financial statements.



UNITED FOOD AND COMMERCIAL WORKERS LOCAL 400 AND EMPLOYERS HEALTH AND WELFARE PLAN

NOTES TO FINANCIAL STATEMENTS (LIQUIDATION BASIS)

11 MONTH PERIOD ENDED DECEMBER 31, 2024 AND
YEAR ENDED JANUARY 31, 2024

NOTE 1. DESCRIPTION OF THE PLAN

General - The Food Store Employees Union Insurance Plan was established in 1955 under agreements between Food Store Employees Union Local 347, U.F.C.W., AFL-CIO and various subscribing employers. Effective February 1, 2001, the Plan's name was amended creating the United Food and Commercial Workers Local 400 and Employers Health and Welfare Plan (the Plan). Basic benefits are provided by employer contributions based on hours worked by union members and other eligible employees. In certain cases, eligible members are allowed to make contributions in order to maintain coverage for themselves and their dependents. The following description provides only general information.

On May 7, 2024, the Union and The Kroger Company signed a memorandum of understanding which fully merged the Plan into the Heartland Health and Wellness Fund (the Heartland Fund) effective January 1, 2025. As of that date all Plan participants which are covered under the memorandum of understanding will become participants of the Heartland Fund. Employers covering Plan participants under other agreements can request, if desired, to become participating employers in the Heartland Fund.

Additionally, as of the merger date, all Plan assets and liabilities also transferred to the Heartland Fund.

Contributions - Participating employers contribute on a dollar-by-dollar basis pursuant to the current collective bargaining agreement between employers and the union or other agreement. Employees may contribute specified amounts, determined by the bargaining parties, to extend coverage to eligible dependents. The costs of the postretirement benefit plan are shared by the Plan's participating employers and retirees.

Benefits - The Plan provides for emergency accident, hospital, basic and major medical, surgical, diagnostic laboratory and x-ray, disability, accidental death and dismemberment, total and permanent disability and life benefits, eye examination, physical examination, and dental services covering diagnostic, preventative and emergency treatment, and death benefits for retired members, as specified by the Plan. Prescription drug benefits are provided for these participants and dependents through a separate Kroger plan with KPP. Substantially all benefits are self-insured by the Plan with exception of vision, dental, life insurance and short-term disability for the Richmond and Roanoke groups which are fully insured.



NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting - The financial statements have been prepared using the liquidation basis of accounting.

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

Depreciation - Office equipment is stated at cost less accumulated depreciation, and is depreciated using the straight-line method, with estimated useful lives of five to ten years. Depreciation expense was \$2,487 and \$1,767 for the 11 month period ended December 31, 2024 and the year ended January 31, 2024, respectively.

Accumulated Benefit Obligations - Claims payable and claims incurred but not reported were estimated by the Plan's actuary based on claims data provided by the Plan's third-party claims administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment. The postretirement benefit obligation represents the actuarial present value of those estimated future benefits that are attributable to participant service rendered through January 31, 2024. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated participants and their beneficiaries and dependents; and (2) active participants and their beneficiaries and dependents after retirement from service with the participating employers. Prior to an active participant's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that participant's service in the industry rendered prior to the valuation date.

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

Finance Lease - In its statements of net assets available for benefits, the Plan recorded right-of-use assets and lease liabilities, initially measured at the present value of total lease payments using a risk-free rate that approximates the remaining term of the lease. The Plan considers the likelihood of exercising renewal or termination clauses in measuring its right-of-use assets and lease liabilities. The Plan has options to extend the lease for the Avaya and Komax equipment, however the option is not recognized as the exercise option is not reasonably certain at this time. A single lease cost calculated so that the cost of the lease is allocated over the lease term on straight-line basis. Short-term leases (those with an initial term of twelve months or less and no purchase option) are expensed over their terms, with no corresponding right-of-use asset or lease liability recorded. The Plan does not separate non-lease components from lease components in determining the lease payments for leases of office equipment.



NOTE 3. INCOME TAXES

The Internal Revenue Service (IRS) has advised that the Plan qualifies under Section 501(c)(9) of the Internal Revenue Code (IRC) and is, therefore, not subject to tax under present income tax laws. The Plan received its most recent exemption letter dated June 22, 2018 in which the IRS stated that the Plan, as then designed, was in compliance with the applicable requirements of the IRC. The Plan has been amended since receiving the exemption letter. The Plan administrator and the Plan counsel believe the Plan is currently designed and being operated in compliance with the applicable requirements of the IRC. They believe that the Plan was qualified, and the related trust was tax exempt as of the financial statements date.

Accounting principles generally accepted in the United States of America require the Plan's management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain tax position that more likely than not would not be sustained upon examination by the IRS. The Plan's management has analyzed the tax positions taken by the Plan, and has concluded that as of December 31, 2024, there are no uncertain positions taken or expected to be taken that would require recognition of a liability (or asset) or disclosure in the financial statements. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. The Plan's income tax return for the years ended January 31, 2024, 2023, and 2022 remain subject to examination, based on the normal statutory periods subject to audit.

NOTE 4. FUNDING POLICY

The Plan is financed by employer and retiree contributions, as specified in the collective bargaining agreements (CBA), and members electing Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. Required employer contributions are paid on a dollar-by-dollar basis, in accordance with the provisions of the applicable CBA.

NOTE 5. POSTRETIREMENT BENEFIT OBLIGATIONS

The actuarial present value of the expected postretirement benefit obligation is determined by the Plan's 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 death, disability, withdrawal, or retirement) between the valuation date and the expected date of payment.

NOTE 5. POSTRETIREMENT BENEFIT OBLIGATIONS (CONTINUED)

The following were the significant assumptions in the valuation as of January 31, 2024:

Discount Rates: 5.00%

Medical/Drug Trend Rates:	Year	Pre-65	Post-65
	2025	8.30%	7.90%
	2026	7.60%	7.40%
	2027	6.90%	6.80%
	2028	6.30%	6.20%
	2029	6.20%	6.10%
	2030	6.10%	6.00%
	2031	6.00%	5.90%
	2032	5.80%	5.80%
	2033	5.70%	5.70%
	2034	5.50%	5.50%
	2035	5.20%	5.20%
	2036	4.90%	4.90%
	2037	4.60%	4.60%
	2038	4.30%	4.30%
	2039	4.10%	4.10%
	2040+	4.00%	4.00%

Mortality Rates: 105% of the PRI-2012 Blue Collar Mortality Table for male participants and 110% of the PRI-2012 Blue Collar Mortality Table for female participants at January 31, 2024.

Percent Electing Coverage at Retirement: 80%.

Administrative Expenses: 5% addition to claims costs.

Valuation Date: Census date is collected as of January 31, 2024.

Actuarial Method: Projected Unit Credit Service Prorate.

Retirement Rates:

Age	Rate
55	10%
56	10%
57	10%
58	10%
59	10%
60	20%
61	20%
62	50%
63	50%
64	50%
65+	100%



NOTE 5. POSTRETIREMENT BENEFIT OBLIGATIONS (CONTINUED)

The health care cost trend rate assumption has a significant effect on the amounts reported. If the assumed rate increased by one percentage point at January 31, 2024, it would increase the postemployment obligation as of by \$14,280,124.

NOTE 6. RISKS AND UNCERTAINTIES

The actuarial present value of accumulated plan benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates, and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimates 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 7. CONCENTRATION OF CONTRIBUTION SOURCES

During the 11 month period ended December 31, 2024 and the year ended January 31, 2024, there was one major employer that accounted for 99% of participating employers' contributions.

NOTE 8. RELATED PARTY AND PARTY-IN-INTEREST TRANSACTIONS

The Plan paid certain expenses related to fund operations and investment activity to various service providers. These transactions are party-in-interest transactions under Employee Retirement Income Security Act (ERISA).

NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500

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

	December 31, 2024	January 31, 2024
Net assets available for benefits per the financial statements	\$ -	\$ 1,977,925
Less: claims incurred but not reported	<u>-</u>	<u>(140,000)</u>
Net assets available for benefits per the Form 5500	<u>\$ -</u>	<u>\$ 1,837,925</u>



**NOTE 9. RECONCILIATION OF FINANCIAL STATEMENTS TO FORM 5500
(CONTINUED)**

The following table is a reconciliation of the changes in net assets available for benefits per the financial statements to the Form 5500 for the 11 month period ended December 31, 2024 and the year ended January 31, 2024:

	December 31, 2024	January 31, 2024
Benefits paid to and for participants per the financial statements	\$ 22,034,509	\$ 25,824,840
Add: amounts currently payable at end of period	-	140,000
Less: amounts currently payable at beginning of period	<u>(140,000)</u>	<u>(199,000)</u>
Benefits paid to and for participants per the Form 5500	<u>\$ 21,894,509</u>	<u>\$ 25,765,840</u>

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 January 31, 2024, but not yet paid as of that date.

NOTE 10. SUBSEQUENT EVENTS

Subsequent events have been evaluated through October 10, 2025, which is the date the financial statements were available to be issued. This review and evaluation revealed no other material event or transaction which would require an adjustment to or disclosure in the accompanying financial statements.

<p>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>Annual Return/Report of Employee Benefit Plan</p> <p>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).</p> <p>▶ Complete all entries in accordance with the instructions to the Form 5500.</p>	<p>OMB Nos. 1210 - 0110 1210 - 0089</p> <hr/> <p>2024</p> <hr/> <p>This Form is Open to Public Inspection</p>
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Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 02/01/2024 and ending 12/31/2024

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

B This return/report is: a single-employer plan a DFE (specify) _____
 the first return/report the final return/report
 an amended return/report a short plan year return/report (less than 12 months)

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

D Check box if filing under: Form 5558 automatic extension the DFVC program
 special extension (enter description)

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

Part II Basic Plan Information - enter all requested information

1a Name of plan UFCW LOCAL 400 & EMPLOYERS HEALTH & WELFARE FUND	1b Three-digit plan number (PN) ▶	501
	1c Effective date of plan	05/01/1959
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) BOARD OF TRUSTEES- UFCW LOCAL 400 HEALTH & WELFARE	2b Employer Identification Number (EIN)	55-0393244
	2c Plan Sponsor's telephone number	304-343-7682
600 D STREET, SUITE 250 SOUTH CHARLESTON WV 25303	2d Business code (see instructions)	525100

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	SIGNED BY: <i>Bob Blair</i> Signature of plan administrator	10/9/2025 Date	BOB BLAIR Enter name of individual signing as plan administrator
SIGN HERE	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <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	2,007
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)	1,445
a (2) Total number of active participants at the end of the plan year	6a(2)	0
b Retired or separated participants receiving benefits	6b	0
c Other retired or separated participants entitled to future benefits	6c	
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d	0
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	3

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 4H

9a Plan funding 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	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>1</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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