

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

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

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

- A This return/report is for: a multiemployer plan, a multiple-employer plan, a single-employer plan, a DFE (specify) E
B This return/report is: the first return/report, the final return/report, an amended return/report, a short plan year return/report
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
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: WISECHOICE HEALTHCARE ALLIANCE TRUST BENEFIT PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan
2a Plan sponsor's name, mailing address, city or town, state or province, country, and ZIP or foreign postal code
2b Employer Identification Number (EIN): 92-0735173
2c Plan Sponsor's telephone number: 804-644-1607
2d Business code

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

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

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

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number <div style="background-color: #cccccc; height: 40px; width: 100%;"></div>
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
5 Total number of participants at the beginning of the plan year	5
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.....	<div style="background-color: #cccccc; height: 20px; width: 100%;"></div> 6a(1) 6a(2) 6b 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

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:

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 type="checkbox"/> Trust (4) <input type="checkbox"/> General assets of the sponsor	9b Plan benefit arrangement (check all that apply) (1) <input type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input 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 checked="" 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 160292557

**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 **03/01/2024** and ending **02/28/2025**

A Name of plan WISECHOICE HEALTHCARE ALLIANCE TRUST BENEFIT PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 WISECHOICE HEALTHCARE ALLIANCE TRUST	D Employer Identification Number (EIN) 92-0735173

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
ANTHEM HEALTH PLANS OF VIRGINIA, INC DBA ANTHEM BLUE CROSS BLUE SHIELD

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
54-0357120	71835	0000	1409	03/01/2024	02/28/2025

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
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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	

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	(c) Amount	(d) Purpose	

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
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(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(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)	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account		
(5) Other (specify below)..... ▶		
(6) Total additions	7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))	7d	0
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
	7e(4)	
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier.....		
(3) Transferred to separate account		
(4) Other (specify below)..... ▶		
(5) Total deductions	7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....	7f	0

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)	0
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)	0
	(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)	0
	(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		395184
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 **03/01/2024** and ending **02/28/2025**

A Name of plan WISECHOICE HEALTHCARE ALLIANCE TRUST BENEFIT PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 WISECHOICE HEALTHCARE ALLIANCE TRUST	D Employer Identification Number (EIN) 92-0735173	

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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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 OF VIRGINIA

54-0357120

(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	N/A	206732	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)

MALONEY + NOVOTNY LLC

34-0677006

(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 16	N/A	58533	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)

CONSOLIPLEX VIRGINIA LLC

93-2688456

(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 15 16	N/A	39946	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)

AFFINITY BENEFITS CONSULTING LLC

85-1504433

(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	N/A	33000	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)

OPTUM

41-1858498

(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	N/A	9333	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)

HUNTINGTON NATIONAL BANK

31-0966785

(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	N/A	7751	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 HEALTH ACTUARIAL SERVICES

04-3738148

(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	N/A	6387	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 03/01/2024 and ending 02/28/2025

A Name of plan <u>WISECHOICE HEALTHCARE ALLIANCE TRUST BENEFIT PLAN</u>	B Three-digit plan number (PN)	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>WISECHOICE HEALTHCARE ALLIANCE TRUST</u>	D Employer Identification Number (EIN) <u>92-0735173</u>	

Part I	Information on interests in MTIAs, CCTs, PSAs, and 103-12 IEs (to be completed by plans and DFEs) (Complete as many entries as needed to report all interests in DFEs)
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a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)
a Name of MTIA, CCT, PSA, or 103-12 IE:		
b Name of sponsor of entity listed in (a):		
c EIN-PN	d Entity code	e Dollar value of interest in MTIA, CCT, PSA, or 103-12 IE at end of year (see instructions)

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	89 PAINT CORPORATION WHAT BENEFIT PLAN	
b Name of plan sponsor	89 PAINT CORPORATION	c EIN-PN 20-4936541-501
a Plan name	A P S INC WHAT BENEFIT PLAN	
b Name of plan sponsor	A P S INC	c EIN-PN 75-3075483-501
a Plan name	AGILIS LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	AGILIS LLC	c EIN-PN 82-4459748-501
a Plan name	AIR TECH INC WHAT BENEFIT PLAN	
b Name of plan sponsor	AIR TECH INC	c EIN-PN 41-2105175-501
a Plan name	ANDRE JULIUS LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	ANDRE JULIUS LLC	c EIN-PN 88-0817613-501
a Plan name	APPALACHIAN PROPERTY PRESERVATION LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	APPALACHIAN PROPERTY PRESERVATION LLC	c EIN-PN 47-3925974-501
a Plan name	AUTISM SOCIETY CENTRAL VIRGINIA WHAT BENEFIT PLAN	
b Name of plan sponsor	AUTISM SOCIETY CENTRAL VIRGINIA	c EIN-PN 46-1250829-501
a Plan name	BONUMOSE INC WHAT BENEFIT PLAN	
b Name of plan sponsor	BONUMOSE INC	c EIN-PN 82-3134684-501
a Plan name	BOSCHEN MASONRY INC WHAT BENEFIT PLAN	
b Name of plan sponsor	BOSCHEN MASONRY INC	c EIN-PN 54-0930107-501
a Plan name	CAF2CODE LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	CAF2CODE LLC	c EIN-PN 82-3028469-501
a Plan name	CDR INVESTMENTS WHAT BENEFIT PLAN	
b Name of plan sponsor	CDR INVESTMENTS	c EIN-PN 27-0658104-501
a Plan name	CENTRAL VIRGINIA INTERNAL MEDICINE WHAT BENEFIT PLAN	
b Name of plan sponsor	CENTRAL VIRGINIA INTERNAL MEDICINE	c EIN-PN 54-2034483-501

Part II	Information on Participating Plans (to be completed by DFEs, other than DCGs)	
	(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)	
a	Plan name CHARLES CITY TIMBER MAT WHAT BENEFIT PLAN	
b	Name of plan sponsor CHARLES CITY TIMBER & MAT LLC	c EIN-PN 20-5189077-501
a	Plan name CHARLOTTESVILLE AREA COMMUNITY FOUNDATION WHAT BENEFIT PLAN	
b	Name of plan sponsor CHARLOTTESVILLE AREA COMMUNITY FOUNDATION	c EIN-PN 54-1506312-501
a	Plan name CHASE BENEFIT ADVISORS WHAT BENEFIT PLAN	
b	Name of plan sponsor CHASE BENEFIT ADVISORS	c EIN-PN 54-1370499-501
a	Plan name CLINKER TILE COMPANY WHAT BENEFIT PLAN	
b	Name of plan sponsor CLINKER TILE COMPANY	c EIN-PN 85-2789313-501
a	Plan name CONSTRUCTION MANAGEMENT WHAT BENEFIT PLAN	
b	Name of plan sponsor CONSTRUCTION MANAGEMENT	c EIN-PN 54-1023508-501
a	Plan name CROATAN INVESTMENTS WHAT BENEFIT PLAN	
b	Name of plan sponsor CROATAN INVESTMENTS	c EIN-PN 81-1678057-501
a	Plan name CRYSTAL BAY ENTERPRISES INC WHAT BENEFIT PLAN	
b	Name of plan sponsor CRYSTAL BAY ENTERPRISES INC	c EIN-PN 54-1717043-501
a	Plan name CT JAMISON PRECAST INC. WHAT BENEFIT PLAN	
b	Name of plan sponsor CT JAMISON PRECAST INC.	c EIN-PN 47-5486861-501
a	Plan name D & B RESTAURANTS INC WHAT BENEFIT PLAN	
b	Name of plan sponsor D & B RESTAURANTS INC	c EIN-PN 54-2028337-501
a	Plan name DAMON COMPANY OF SALEM INC WHAT BENEFIT PLAN	
b	Name of plan sponsor DAMON COMPANY OF SALEM INC	c EIN-PN 54-1121486-501
a	Plan name DAVID JUNE ENTERPRISES WHAT BENEFIT PLAN	
b	Name of plan sponsor DAVID JUNE ENTERPRISES	c EIN-PN 85-1058125-501
a	Plan name DICKENS CONSTRUCTION INC WHAT BENEFIT PLAN	
b	Name of plan sponsor DICKENS CONSTRUCTION INC	c EIN-PN 30-0736319-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
<small>(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)</small>			
a	Plan name	DOMINON SEVEN ARCHITECTS WHAT BENEFIT PLAN	
b	Name of plan sponsor	DOMINON SEVEN ARCHITECTS	c EIN-PN 20-0263198-501
a	Plan name	DUCKINGHOLE CREEK FARM INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	DUCKINGHOLE CREEK FARM INC	c EIN-PN 81-1635826-501
a	Plan name	E & I SERVICES LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	E & I SERVICES LLC	c EIN-PN 81-3922993-501
a	Plan name	ELITE AC & HEATING WHAT BENEFIT PLAN	
b	Name of plan sponsor	ELITE AC & HEATING	c EIN-PN 99-3493350-501
a	Plan name	EMERSON GRAHAM + ASSOCIATES WHAT BENEFIT PLAN	
b	Name of plan sponsor	EMERSON GRAHAM + ASSOCIATES	c EIN-PN 82-3805772-501
a	Plan name	FJ INDUSTRIAL & MECHANICAL LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	FJ INDUSTRIAL & MECHANICAL LLC	c EIN-PN 26-3018179-501
a	Plan name	FORESIGHT DESIGN SERVICES INC. WHAT BENEFIT PLAN	
b	Name of plan sponsor	FORESIGHT DESIGN SERVICES INC.	c EIN-PN 54-1829868-501
a	Plan name	FOSTER ELECTRIC COMPANY INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	FOSTER ELECTRIC COMPANY INC	c EIN-PN 54-0839555-501
a	Plan name	FOUNDATION HOMES INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	FOUNDATION HOMES INC	c EIN-PN 45-5227280-501
a	Plan name	FREDERICKSBURG TECHNOLOGY WHAT BENEFIT PLAN	
b	Name of plan sponsor	FREDERICKSBURG TECHNOLOGY	c EIN-PN 87-4489828-501
a	Plan name	FRONT STREET GARAGE WHAT BENEFIT PLAN	
b	Name of plan sponsor	FRONT STREET GARAGE	c EIN-PN 20-5704556-501
a	Plan name	GARY V LAYNE WHAT BENEFIT PLAN	
b	Name of plan sponsor	GARY V LAYNE	c EIN-PN 26-6295688-501

Part II	Information on Participating Plans (to be completed by DFEs, other than DCGs)	
	(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)	
a	Plan name GLASS INNOVATIONS INC WHAT BENEFIT PLAN	
b	Name of plan sponsor GLASS INNOVATIONS INC	c EIN-PN 36-4569962-501
a	Plan name GREENSWARD CONSULTING LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor GREENSWARD CONSULTING LLC	c EIN-PN 47-1527159-501
a	Plan name GRIZZARD HOMES AND BUILD WHAT BENEFIT PLAN	
b	Name of plan sponsor GRIZZARD HOMES AND BUILD	c EIN-PN 47-3951109-501
a	Plan name GYMNASTICS AND DANCE LTD WHAT BENEFIT PLAN	
b	Name of plan sponsor GYMNASTICS AND DANCE LTD	c EIN-PN 54-1244722-501
a	Plan name HARRY LEE SELF JR WHAT BENEFIT PLAN	
b	Name of plan sponsor HARRY LEE SELF JR	c EIN-PN 54-6435304-501
a	Plan name HOME BUILDERS ASSOCIATION OF VIRGINIA WHAT BENEFIT PLAN	
b	Name of plan sponsor HOME BUILDERS ASSOCIATION OF VIRGINIA	c EIN-PN 54-0681477-501
a	Plan name INSIDE & OUT LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor INSIDE & OUT LLC	c EIN-PN 47-5386037-501
a	Plan name J CARTER PRODUCE LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor J CARTER PRODUCE LLC	c EIN-PN 27-2133791-501
a	Plan name JAMES RIVER DAY SCHOOL WHAT BENEFIT PLAN	
b	Name of plan sponsor JAMES RIVER DAY SCHOOL	c EIN-PN 54-0891225-501
a	Plan name JEFFERSON HVAC WHAT BENEFIT PLAN	
b	Name of plan sponsor JEFFERSON HVAC	c EIN-PN 85-1916564-501
a	Plan name JOHN CALHOUN ELECTRIC LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor JOHN CALHOUN ELECTRIC LLC	c EIN-PN 82-3749121-501
a	Plan name JPW CONSTRUCTION WHAT BENEFIT PLAN	
b	Name of plan sponsor JPW CONSTRUCTION	c EIN-PN 81-3174523-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)

(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	K5 CORPORATION WHAT BENEFIT PLAN	
b Name of plan sponsor	K5 CORPORATION	c EIN-PN 94-3109115-501
a Plan name	KCA LOGISTICS INC WHAT BENEFIT PLAN	
b Name of plan sponsor	KCA LOGISTICS INC	c EIN-PN 47-4594444-501
a Plan name	KEGLEY ELECTRIC COMPANY LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	KEGLEY ELECTRIC COMPANY LLC	c EIN-PN 46-4262601-501
a Plan name	KIM MOODY DESIGN LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	KIM MOODY DESIGN LLC	c EIN-PN 30-0811194-501
a Plan name	LANDSALES INC WHAT BENEFIT PLAN	
b Name of plan sponsor	LANDSALES INC	c EIN-PN 54-0949336-501
a Plan name	LAS TRUCKING & CONSTRUCTION INC WHAT BENEFIT PLAN	
b Name of plan sponsor	LAS TRUCKING & CONSTRUCTION INC	c EIN-PN 26-0250893-501
a Plan name	LEES BODY SHOP WHAT BENEFIT PLAN	
b Name of plan sponsor	LEES BODY SHOP	c EIN-PN 54-1790933-501
a Plan name	LOCAL FINANCE WHAT BENEFIT PLAN	
b Name of plan sponsor	LOCAL FINANCE	c EIN-PN 33-1036289-501
a Plan name	LOCUST GROVE HONEY CO LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	LOCUST GROVE HONEY CO LLC	c EIN-PN 99-3914909-501
a Plan name	LYNCHBURG POWERSPORTS, INC WHAT BENEFIT PLAN	
b Name of plan sponsor	LYNCHBURG POWERSPORTS, INC	c EIN-PN 92-3803193-501
a Plan name	MARQUESS CUSTOM GLASS LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	MARQUESS CUSTOM GLASS LLC	c EIN-PN 92-3014160-501
a Plan name	MD ROBINSON CONSULTING LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	MD ROBINSON CONSULTING LLC	c EIN-PN 83-4580938-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
<small>(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)</small>			
a	Plan name	MEALS ON WHEELS OF GREATER LYNCHBURG WHAT BENEFIT PLAN	
b	Name of plan sponsor	MEALS ON WHEELS OF GREATER LYNCHBURG	c EIN-PN 23-7399875-501
a	Plan name	METAFITRX WHAT BENEFIT PLAN	
b	Name of plan sponsor	METAFITRX	c EIN-PN 87-2372244-501
a	Plan name	NEW AGE COMFORT LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	NEW AGE COMFORT LLC	c EIN-PN 85-2634124-501
a	Plan name	OBGYN ASSOCIATION OF DANVILLE WHAT BENEFIT PLAN	
b	Name of plan sponsor	OBGYN ASSOCIATION OF DANVILLE	c EIN-PN 54-0994775-501
a	Plan name	ORANGE TIRE INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	ORANGE TIRE INC	c EIN-PN 46-3395706-501
a	Plan name	OSCAR W SMITH MECHANICAL CONTRACTOR INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	OSCAR W SMITH MECHANICAL CONTRACTOR INC	c EIN-PN 54-0915268-501
a	Plan name	PACTAMERE FARM LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	PACTAMERE FARM LLC	c EIN-PN 84-3222722-501
a	Plan name	PADEL PLANT WHAT BENEFIT PLAN	
b	Name of plan sponsor	PADEL PLANT	c EIN-PN 93-3807002-501
a	Plan name	PIEDMONT FOUNDRY SUPPLY INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	PIEDMONT FOUNDRY SUPPLY INC	c EIN-PN 54-0841326-501
a	Plan name	PLDR LAW PC WHAT BENEFIT PLAN	
b	Name of plan sponsor	PLDR LAW PC	c EIN-PN 54-1740034-501
a	Plan name	POWER CONCEPTS ELECTRIC LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	POWER CONCEPTS ELECTRIC LLC	c EIN-PN 99-1572617-501
a	Plan name	REYNOLDS & EASLEY MFG CO WHAT BENEFIT PLAN	
b	Name of plan sponsor	REYNOLDS & EASLEY MFG CO	c EIN-PN 54-0829385-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	RICHARD BUCK INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	RICHARD BUCK INC	c EIN-PN 20-2082656-501
a	Plan name	RICHWEB INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	RICHWEB INC	c EIN-PN 54-1779281-501
a	Plan name	RISE ELEVATOR SERVICES WHAT BENEFIT PLAN	
b	Name of plan sponsor	RISE ELEVATOR SERVICES	c EIN-PN 88-3241503-501
a	Plan name	RISING TIDE ANALYTICS LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	RISING TIDE ANALYTICS LLC	c EIN-PN 92-3351831-501
a	Plan name	RIVERSTREET LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	RIVERSTREET LLC	c EIN-PN 46-3211287-501
a	Plan name	RX SOUTH WHAT BENEFIT PLAN	
b	Name of plan sponsor	RX SOUTH	c EIN-PN 54-1969747-501
a	Plan name	SALEM MUSEUM WHAT BENEFIT PLAN	
b	Name of plan sponsor	SALEM MUSEUM	c EIN-PN 54-1088887-501
a	Plan name	SALEM SPECIALTIES INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	SALEM SPECIALTIES INC	c EIN-PN 54-0801755-501
a	Plan name	SALEM SURGICAL ASSOCIATES WHAT BENEFIT PLAN	
b	Name of plan sponsor	SALEM SURGICAL ASSOCIATES	c EIN-PN 54-1980953-501
a	Plan name	SCOTT & SCOTT CONSTRUCTION INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	SCOTT & SCOTT CONSTRUCTION INC	c EIN-PN 54-2044930-501
a	Plan name	SHENANDOAH REFRIGERATION WHAT BENEFIT PLAN	
b	Name of plan sponsor	SHENANDOAH REFRIGERATION	c EIN-PN 54-1711395-501
a	Plan name	SLLIM ADVANTAGE BUSINESS TRUST WHAT BENEFIT PLAN	
b	Name of plan sponsor	SLLIM ADVANTAGE BUSINESS TRUST	c EIN-PN 86-6701508-501

Part II		Information on Participating Plans (to be completed by DFEs, other than DCGs)	
(Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)			
a	Plan name	SOLID ROCK WHAT BENEFIT PLAN	
b	Name of plan sponsor	SOLID ROCK	c EIN-PN 20-8041764-501
a	Plan name	SOUTHSIDE MECHANICAL WHAT BENEFIT PLAN	
b	Name of plan sponsor	SOUTHSIDE MECHANICAL	c EIN-PN 54-1888893-501
a	Plan name	SOUTHWEST EXCAVATING INC WHAT BENEFIT PLAN	
b	Name of plan sponsor	SOUTHWEST EXCAVATING INC	c EIN-PN 54-1867601-501
a	Plan name	SPORTSWAR LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	SPORTSWAR LLC	c EIN-PN 52-2181887-501
a	Plan name	SUSHIQUIK LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	SUSHIQUIK LLC	c EIN-PN 45-3066741-501
a	Plan name	THE ARC OF CENTRAL VIRGINIA WHAT BENEFIT PLAN	
b	Name of plan sponsor	THE ARC OF CENTRAL VIRGINIA	c EIN-PN 23-7221570-501
a	Plan name	THE WHITLOCK GROUP LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	THE WHITLOCK GROUP LLC	c EIN-PN 84-4030561-501
a	Plan name	THRIVE BIRTH TO FIVE FOUNDATION WHAT BENEFIT PLAN	
b	Name of plan sponsor	THRIVE BIRTH TO FIVE FOUNDATION	c EIN-PN 93-4568218-501
a	Plan name	TOMAHAWK WAREHOUSING SERVICES WHAT BENEFIT PLAN	
b	Name of plan sponsor	TOMAHAWK WAREHOUSING SERVICES	c EIN-PN 20-1567974-501
a	Plan name	TRUEFARMS LLC WHAT BENEFIT PLAN	
b	Name of plan sponsor	TRUEFARMS LLC	c EIN-PN 37-1583540-501
a	Plan name	TVTM CONTRACTORS WHAT BENEFIT PLAN	
b	Name of plan sponsor	TVTM CONTRACTORS	c EIN-PN 88-1089312-501
a	Plan name	VALLEY FOREST SCHOOL WHAT BENEFIT PLAN	
b	Name of plan sponsor	VALLEY FOREST SCHOOL	c EIN-PN 83-4047617-501

Part II Information on Participating Plans (to be completed by DFEs, other than DCGs)
 (Complete as many entries as needed to report all participating plans. DCGs must report each participating plan using Schedule DCG.)

a Plan name	VIRGINIA CHAMBER OF COMMERCE WHAT BENEFIT PLAN	
b Name of plan sponsor	VIRGINIA CHAMBER OF COMMERCE	c EIN-PN 54-0421190-501
a Plan name	VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION WHAT BENEFIT PLAN	
b Name of plan sponsor	VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION	c EIN-PN 54-0701665-501
a Plan name	WEIGHSTAR WHAT BENEFIT PLAN	
b Name of plan sponsor	WEIGHSTAR	c EIN-PN 85-2486056-501
a Plan name	WHITT CORPORATION WHAT BENEFIT PLAN	
b Name of plan sponsor	WHITT CORPORATION	c EIN-PN 54-1665814-501
a Plan name	WHOLE HEALTH PHYSICIANS WHAT BENEFIT PLAN	
b Name of plan sponsor	WHOLE HEALTH PHYSICIANS	c EIN-PN 82-5257640-501
a Plan name	WOHLFORD CONTRACTING WHAT BENEFIT PLAN	
b Name of plan sponsor	WOHLFORD CONTRACTING	c EIN-PN 45-2279843-501
a Plan name	ZENPOINT SOLUTIONS LLC WHAT BENEFIT PLAN	
b Name of plan sponsor	ZENPOINT SOLUTIONS LLC	c EIN-PN 27-0314944-501
a Plan name		
b Name of plan sponsor		c EIN-PN
a Plan name		
b Name of plan sponsor		c EIN-PN
a Plan name		
b Name of plan sponsor		c EIN-PN
a Plan name		
b Name of plan sponsor		c EIN-PN
a Plan name		
b Name of plan sponsor		c EIN-PN

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 03/01/2024 and ending 02/28/2025	
A Name of plan WISECHOICE HEALTHCARE ALLIANCE TRUST BENEFIT PLAN	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 WISECHOICE HEALTHCARE ALLIANCE TRUST	D Employer Identification Number (EIN) 92-0735173

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
a Total noninterest-bearing cash	1a	0	25000
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	0	625072
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	0	3970755
(2) U.S. Government securities	1c(2)	0	554358
(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)	0	9314

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		
f Total assets (add all amounts in lines 1a through 1e).....	1f	0	5184499
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h	0	45352
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	0	890458
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	0	935810
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	0	4248689

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)		
(B) Participants.....	2a(1)(B)		
(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)		0
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	223907	
(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)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		223907
(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)		0
(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)		0
(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)		0

		(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		
d Total income. Add all income amounts in column (b) and enter total.....	2d		223907

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers.....	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other.....	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		0
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)		
(2) Contract administrator fees	2i(2)	279678	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)	58533	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	7750	
(7) Actuarial fees	2i(7)	15720	
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses.....	2i(11)	87331	
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		449012
j Total expenses. Add all expense amounts in column (b) and enter total.....	2j		449012

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d.....	2k		-225105
l Transfers of assets:			
(1) To this plan.....	2l(1)		7386136
(2) From this plan	2l(2)		2912342

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: MALONEY + NOVOTNY LLC

(2) EIN: 34-0677006

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.)			
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?			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
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?			
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?			
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.)			
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
l Has the plan failed to provide any benefit when due under the plan?			
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 _____.

**WISECHOICE HEALTHCARE ALLIANCE
BENEFIT PLAN TRUST**

FINANCIAL REPORT

FEBRUARY 28, 2025



WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

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Independent Auditors' Report

To the Board of Trustees of
WiseChoice Healthcare Alliance Benefit Plan Trust
Richmond, Virginia

Opinion

We have audited the financial statements of the WiseChoice Healthcare Alliance Benefit Plan Trust (the "Trust"), which comprise the statement of net assets as of February 28, 2025, and the related statement of changes in net assets for the year then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets of the Trust as of February 28, 2025, and the changes in its net assets for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

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

Other Matter

The accompanying financial statements are those of the Trust. These financial statements do not purport to present the net assets available for benefits and benefit obligations or the changes in net assets available for benefits or changes in benefit obligations of the participating plans and do not contain certain information and other disclosures necessary for a fair presentation of the financial statements of the participating plans in accordance with accounting principles generally accepted in the United States of America. Further, these financial statements do not purport to satisfy the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 ("ERISA") relating to the financial statements of employee benefit plans.

Responsibilities of Management for the Financial Statements

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

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

Auditors' 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 auditors' report that includes our opinion. Reasonable assurance is a high level of assurance but it 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 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 Trust'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 Trust's ability to continue as a going concern for a reasonable period of time.

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

Supplemental Schedules Required by ERISA and Other Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedule of operating expenses for the year ended February 28, 2025, and the supplemental schedule of assets (held at end of year) as of February 28, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements. The supplemental schedule of assets (held at end of year) as of February 28, 2025 is supplementary information required by the DOL's Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedule of assets (held at end of year) as of February 28, 2025, including its form and content, is presented in conformity with the DOL'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 DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

Meloney + Novotny LLC

Cleveland, Ohio
December 15, 2025

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

STATEMENT OF NET ASSETS

February 28, 2025

<u>ASSETS</u>	
Cash	\$ 25,000
Investments, at fair value:	
Interest-bearing cash	3,747,506
Money market funds	223,249
U.S. Government securities	<u>554,358</u>
Total investments	4,525,113
Receivables:	
Investment income receivable	8,193
Contributions from participating plans	<u>616,879</u>
Total receivables	625,072
Prepaid expenses	<u>9,314</u>
Total assets	<u>5,184,499</u>
 <u>LIABILITIES</u>	
Accounts payable	45,352
Net reinsurance payable	885,958
Other	<u>4,500</u>
Total liabilities	<u>935,810</u>
NET ASSETS	<u><u>\$4,248,689</u></u>

The accompanying notes are an integral part of these financial statements.

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

STATEMENT OF CHANGES IN NET ASSETS

Year Ended February 28, 2025

ADDITIONS

Contributions from participating plans	\$ 3,386,136
Interest income	<u>223,907</u>
Total additions	3,610,043

DEDUCTIONS

Distributions to participating plans for benefit claims paid, net of reinsurance recoveries	181,462
Distributions to participating plans for premiums paid for the provision of benefits, net of ceding allowances	<u>2,730,880</u>
Total distributions to participating plans	2,912,342
Operating expenses	<u>449,012</u>
Total deductions	<u>3,361,354</u>

INCREASE IN NET ASSETS 248,689

NET ASSETS

BEGINNING OF YEAR	-
Transfer	<u>4,000,000</u>
END OF YEAR	<u><u>\$ 4,248,689</u></u>

The accompanying notes are an integral part of these financial statements.

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

NOTES TO FINANCIAL STATEMENTS

Note 1. Description of the Trust

The following description of the WiseChoice Healthcare Alliance Benefit Plan Trust (the "Trust") provides only general information. Participating plans should refer to the Trust agreement for a more complete description of the Trust's provisions.

General:

The Trust is intended to be a voluntary employees' beneficiary association ("VEBA") under Section 501(c)(9) of the Internal Revenue Code ("IRC"). The purpose of the Trust is to hold Plan assets of a non-plan multiple employer welfare arrangement ("MEWA") as described in Virginia Code Title 59.1 Chapter 55 and to pay benefits and expenses on behalf of the plans participating in the MEWA (the "Plans"). The Plans represent employers in good standing with the Virginia Chamber of Commerce. The transfer of \$4,000,000 on the statement of changes in net assets represents the initial contribution made by the Virginia Chamber of Commerce to fund the Trust.

Contributions:

The Trust receives contributions for health and welfare coverage from participating Plans. Such funds are utilized for the payment of premiums to Anthem Health Plans of Virginia, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem") for the provision of benefits on behalf of the Plans.

Distributions:

In addition to distributions for the premium payments to Anthem described above, distributions are made for the payment of benefit claims. These benefit claims are paid out of the Trust, on behalf of the participating Plans, to Anthem. Anthem administers payment of hospital charges, medical/surgical claims and prescription coverage.

Operating Expenses:

All administrative fees are paid by the Trust or the participating Plans at the option of the trustees of the Trust.

Note 2. Summary of Significant Accounting Policies

The following are the significant accounting policies followed by the Trust:

Basis of Presentation:

The accompanying financial statements have been prepared on the accrual basis of accounting.

Net Reinsurance Payable:

Net reinsurance payable represents the net of amounts recoverable for claims paid (including stop loss recoveries) and amounts recoverable for administrative expenses under the quota share reinsurance agreement offset by the amounts payable for premium ceded under the quota share and stop loss agreements.

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

Note 2. Summary of Significant Accounting Policies (Continued)

Recognition of Contribution Revenue:

Contribution revenue is recognized in the month for which coverage is being paid. Contributions received after the coverage months are recorded as receivables. Management has determined no allowance is necessary for contributions receivable from participating plans as of February 28, 2025.

Investment Valuation and Income Recognition:

The Trust's investments are reported 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. Reference Note 4 for discussion of fair value measurements.

Purchases and sales of securities are recorded on a trade-date basis. Interest income is recorded on the accrual basis.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires the plan administrator to make estimates and assumptions that affect the reported amounts of assets, liabilities and changes therein and disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

Distributions for the Payment of Premiums and Benefits:

Distributions for the payment of premiums and benefit claims are recorded when processed and approved for payment to Anthem.

Subsequent Events:

The Trust has evaluated subsequent events through December 15, 2025, the date the financial statements were available to be issued.

Note 3. Cash and Investments

The Trust holds its temporary cash as cash or money market funds with national financial institutions which at times may exceed federally insured amounts. The actual balance may exceed reported balances due to outstanding checks.

The Trust's investments are held by Huntington Bank and Principal Bank in non-insured trust funds.

Note 4. Fair Value Measurements

The Trust estimates the fair value of financial instruments using available market information and other generally accepted valuation methodologies. The inputs used to measure fair value are classified into three levels:

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

Note 4. Fair Value Measurements (Continued)

- Level 1 – Quoted market prices in active markets for identical assets and liabilities
- Level 2 – Observable market-based inputs or unobservable inputs that are corroborated by market data
- Level 3 – Unobservable inputs in which little or no market data exists

The following is a description of the valuation methodologies used for Trust assets measured at fair value:

- Interest-bearing cash is classified as a Level 1 investment.
- Money market funds consist of short-term investment funds that maintain daily liquidity and have constant unit values of \$1.00. These are classified as Level 1 instruments.
- U.S. Government securities are reported at amortized cost which approximates fair value. These are classified as Level 2 instruments.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. There have been no changes in methodologies used in 2025. Furthermore, while the Trust believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table summarizes the Trust's investments at February 28, 2025 at fair value and indicates the level of valuation techniques utilized by the Trust:

	Level	July 31,
Interest-bearing cash	1	\$3,747,506
Money market funds	1	223,249
U.S. Government securities	2	554,358

Note 5. Reinsurance

During the year ended February 28, 2025, the participating Plans were subject to a quota share reinsurance agreement with Anthem to cede 90% of the participating Plans' health business.

During the year ended February 28, 2025, the participating Plans were subject to a stop loss reinsurance agreement with Anthem for medical and prescription drug coverage. The premium is based upon the monthly funding rates and number of participants in each month of the contract with a specific stop loss threshold per covered person of \$250,000 per year. The total amount of reinsurance recovered due to stop loss was \$28,559 for the year ended February 28, 2025.

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

NOTES TO FINANCIAL STATEMENTS (CONTINUED)

Note 6. Related Party/Party-in-Interest Transactions

The Trust has entered into an administrative services contract with Anthem, whereby Anthem collects premiums on behalf of participating Plans, provides quoting, servicing and renewing employers of participating Plans and administers payment of hospital charges, medical/surgical claims and prescription coverage on behalf of participating Plans. These transactions qualify as party-in-interest. Total fees paid from the Trust to Anthem for these services amounted to \$206,731 for the year ended February 28, 2025.

The Trust has appointed Consoliplex Virginia, LLC to act as plan manager of the participating Plans and Trust. Fees paid to Consoliplex Virginia, LLC for the year ended February 28, 2025 were \$39,946.

Note 7. Tax Status

The Trust is a taxable trust. Investment income, less attributable deductions, is subject to federal and state income taxes. For the year ended February 28, 2025, the Trust incurred \$29,988 and \$ 2,998 in federal and state income taxes, respectively, that is included in operating expenses on the statement of changes in net assets. The Trust's management has analyzed the tax positions taken by the Trust and has concluded that, as of February 28, 2025, 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 Trust is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress.

Note 8. Trust Termination

The Trust may only be terminated by the Virginia Chamber of Commerce with at least 180 days' written notice to the trustees. Any Trust assets at the time of termination will be distributed or will be transferred to another trust that complies with the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

The participating Plans' sponsors have the right under the Plans to discontinue their contributions at any time and to terminate the Plans, subject to provisions set forth in ERISA.

SUPPLEMENTAL SCHEDULES

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

SCHEDULE OF OPERATING EXPENSES

Year Ended February 28, 2025

Outsourced services	\$ 279,678
Income tax	32,986
Professional services	74,253
Regulatory fees	20,356
Insurance expense	29,888
Investment fees	7,750
Other expenses	<u>4,101</u>
Total operating expenses	<u>\$ 449,012</u>

WISECHOICE HEALTHCARE ALLIANCE BENEFIT PLAN TRUST

EMPLOYER NO. 92-0735173

PLAN NO. 501

SCHEDULE H, LINE 4(i)

SCHEDULE OF ASSETS (HELD AT END OF YEAR)

February 28, 2025

(a)	(b) <u>Identity of Party</u>	(c) <u>Description of Investments</u>	(d) <u>Cost</u>	Current (e) <u>Value</u>
		<u>Interest-bearing cash</u>		
	Huntington Bank	Cash	\$3,747,506	\$3,747,506
		<u>Money market funds</u>		
	Fidelity	Institutional Government Money Market Fund - Class I	223,249	223,249
		<u>U.S. Government securities</u>		
	U.S. Treasury	U.S. Treasury Note 4.625% due 11/15/2026	<u>557,391</u>	<u>554,358</u>
			<u>\$4,528,146</u>	<u>\$4,525,113</u>