

<p><b>Form 5500</b></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><b>Annual Return/Report of Employee Benefit Plan</b></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>▶ <b>Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p>OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: 24pt; font-weight: bold;">2024</p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

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

a single-employer plan  a DFE (specify) \_\_\_\_\_

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

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

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

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

special extension (enter description) \_\_\_\_\_

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

**Part II Basic Plan Information—enter all requested information**

<p><b>1a</b> Name of plan <u>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>502</u></p>
<p><b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>SOUTHERN STATES COOPERATIVE, INC.</u></p> <p><u>6606 WEST BROAD STREET</u> <u>RICHMOND, VA 23230</u></p>	<p><b>1c</b> Effective date of plan <u>08/25/1975</u></p> <p><b>2b</b> Employer Identification Number (EIN) <u>54-0387200</u></p> <p><b>2c</b> Plan Sponsor's telephone number <u>804-281-1249</u></p> <p><b>2d</b> Business code (see instructions) <u>424990</u></p>

**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.

<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	02/19/2026	JAKISHA ROBINSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE



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

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**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.

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**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 114129811

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<p><b>SCHEDULE A</b> <b>(Form 5500)</b></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><b>Insurance Information</b></p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ <b>File as an attachment to Form 5500.</b></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><b>2024</b></p> <hr/> <p><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<p><b>A</b> Name of plan <b>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶ <b>502</b></p>	
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SOUTHERN STATES COOPERATIVE, INC.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>54-0387200</b></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  
**ANTHEM HEALTH PLANS OF VIRGINIA, INC.**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
54-0357120	71835	201038	553	07/01/2024	06/30/2025

**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
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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.

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

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

**9** Experience-rated contracts:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>		
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....		<b>9a(4)</b>	0
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>		
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....		<b>9b(3)</b>	0
	(4) Claims charged .....		<b>9b(4)</b>	
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>		
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....		<b>9c(1)(H)</b>	0
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		<b>9c(2)</b>	
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		<b>9d(1)</b>	
	(2) Claim reserves .....		<b>9d(2)</b>	
	(3) Other reserves .....		<b>9d(3)</b>	
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		<b>9e</b>	

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>		1225506
<b>b</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. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<b>A</b> Name of plan <b>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>502</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SOUTHERN STATES COOPERATIVE, INC.</b>	<b>D</b> Employer Identification Number (EIN) <b>54-0387200</b>

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

**1 Coverage Information:**

**(a)** Name of insurance carrier

**DELTA DENTAL OF VA**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>54-0844477</b>	<b>55611</b>	<b>000008612</b>	<b>930</b>	<b>07/01/2024</b>	<b>06/30/2025</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

<b>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> 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.

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

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

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	301477	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		301477
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	216890	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>	-6217	
	(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		210673
	(4) Claims charged .....	<b>9b(4)</b>		210673
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	23051	
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>	2260	
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....	<b>9c(1)(H)</b>		25311
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
	(2) Claim reserves .....	<b>9d(2)</b>		5443
	(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	0	
<b>b</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. ....	<b>10b</b>		

Specify nature of costs.

**Part IV Provision of Information**

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

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

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration  
Pension Benefit Guaranty Corporation

**Insurance Information**

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

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

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

OMB No. 1210-0110

**2024**

**This Form is Open to Public Inspection**

For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<b>A</b> Name of plan <b>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>502</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SOUTHERN STATES COOPERATIVE, INC.</b>	<b>D</b> Employer Identification Number (EIN) <b>54-0387200</b>

**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

**VISION SERVICE PLAN**

<b>(b)</b> EIN	<b>(c)</b> NAIC code	<b>(d)</b> Contract or identification number	<b>(e)</b> Approximate number of persons covered at end of policy or contract year	<b>Policy or contract year</b>	
				<b>(f)</b> From	<b>(g)</b> To
<b>23-7089668</b>	<b>53031</b>	<b>40161566</b>	<b>506</b>	<b>07/01/2024</b>	<b>06/30/2025</b>

**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.

<b>(a)</b> Total amount of commissions paid	<b>(b)</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>(b)</b> Amount of sales and base commissions paid	<b>Fees and other commissions paid</b>		<b>(e)</b> Organization code
	<b>(c)</b> Amount	<b>(d)</b> Purpose	

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

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

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	(c) Amount	(d) Purpose	

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

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

(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.

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

**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>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	<b>7c(2)</b>	
	<b>7c(3)</b>	
	<b>7c(4)</b>	
	<b>7c(5)</b>	
(2) Dividends and credits.....		
(3) Interest credited during the year.....		
(4) Transferred from separate account .....		
(5) Other (specify below).....		
▶		
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
	<b>7e(4)</b>	
(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 .....	<b>7e(5)</b>	0
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ).....	<b>7f</b>	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:

<b>a</b>	Premiums: (1) Amount received .....	<b>9a(1)</b>	28061	
	(2) Increase (decrease) in amount due but unpaid .....	<b>9a(2)</b>		
	(3) Increase (decrease) in unearned premium reserve .....	<b>9a(3)</b>		
	(4) Earned ((1) + (2) - (3)) .....	<b>9a(4)</b>		28061
<b>b</b>	Benefit charges (1) Claims paid .....	<b>9b(1)</b>	25726	
	(2) Increase (decrease) in claim reserves .....	<b>9b(2)</b>		
	(3) Incurred claims (add (1) and (2)) .....	<b>9b(3)</b>		25726
	(4) Claims charged .....	<b>9b(4)</b>		25726
<b>c</b>	Remainder of premium: (1) Retention charges (on an accrual basis) --			
	(A) Commissions .....	<b>9c(1)(A)</b>		
	(B) Administrative service or other fees .....	<b>9c(1)(B)</b>	7857	
	(C) Other specific acquisition costs .....	<b>9c(1)(C)</b>		
	(D) Other expenses .....	<b>9c(1)(D)</b>		
	(E) Taxes .....	<b>9c(1)(E)</b>		
	(F) Charges for risks or other contingencies .....	<b>9c(1)(F)</b>		
	(G) Other retention charges .....	<b>9c(1)(G)</b>		
	(H) Total retention .....	<b>9c(1)(H)</b>		7857
	(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....	<b>9c(2)</b>		
<b>d</b>	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....	<b>9d(1)</b>		
	(2) Claim reserves .....	<b>9d(2)</b>		
	(3) Other reserves .....	<b>9d(3)</b>		
<b>e</b>	Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....	<b>9e</b>		

**10** Nonexperience-rated contracts:

<b>a</b>	Total premiums or subscription charges paid to carrier .....	<b>10a</b>	0
<b>b</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.	<b>10b</b>	

**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. ▶

<b>SCHEDULE C</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Service Provider Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>▶ File as an attachment to Form 5500.</b>	<small>OMB No. 1210-0110</small>  <b>2024</b>  <b>This Form is Open to Public Inspection.</b>
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For calendar plan year 2024 or fiscal plan year beginning **07/01/2024** and ending **06/30/2025**

<b>A</b> Name of plan <b>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶	<b>502</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SOUTHERN STATES COOPERATIVE, INC.</b>	<b>D</b> Employer Identification Number (EIN) <b>54-0387200</b>	

**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

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**(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 DBA

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	CLAIMS PROCESSING	159611	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)

MERCER HEALTH & BENEFITS LLC

34-2015463

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16	CONSULTING	99142	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	0	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

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

CASTLIGHT HEALTH INC.

26-1989091

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	RECORDKEEPING	36489	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)

PERSONIFY

32-0457121

(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	CLAIMS PROCESSING	27022	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)

WEX HEALTH INC.

06-1593514

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
15	RECORDKEEPING	10143	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)

WELLS FARGO BANK, N.A.

94-1347393

(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?
21	TRUSTEE	5000	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

**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.

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

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

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

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

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

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

<b>(a)</b> Enter name and EIN or address of service provider (see instructions)	<b>(b)</b> Nature of Service Code(s)	<b>(c)</b> 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)

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>a</b> Name:	<b>b</b> EIN:
<b>c</b> Position:	
<b>d</b> Address:	<b>e</b> Telephone:

Explanation:

<b>SCHEDULE H</b> <b>(Form 5500)</b>  <small>Department of the Treasury Internal Revenue Service</small>  <small>Department of Labor Employee Benefits Security Administration</small>  <small>Pension Benefit Guaranty Corporation</small>	<b>Financial Information</b>  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).  ▶ <b>File as an attachment to Form 5500.</b>	OMB No. 1210-0110  <b>2024</b>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2024 or fiscal plan year beginning <b>07/01/2024</b> and ending <b>06/30/2025</b>	
<b>A</b> Name of plan <b>SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN</b>	<b>B</b> Three-digit plan number (PN) ▶ <b>502</b>
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>SOUTHERN STATES COOPERATIVE, INC.</b>	<b>D</b> Employer Identification Number (EIN) <b>54-0387200</b>

<b>Part I</b>	<b>Asset and Liability Statement</b>
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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
<b>Assets</b>			
<b>a</b> Total noninterest-bearing cash .....	<b>1a</b>		
<b>b</b> Receivables (less allowance for doubtful accounts):			
<b>(1)</b> Employer contributions .....	<b>1b(1)</b>		
<b>(2)</b> Participant contributions .....	<b>1b(2)</b>		
<b>(3)</b> Other .....	<b>1b(3)</b>	7300	158361
<b>c</b> General investments:			
<b>(1)</b> Interest-bearing cash (include money market accounts & certificates of deposit) .....	<b>1c(1)</b>	1633876	1078249
<b>(2)</b> U.S. Government securities .....	<b>1c(2)</b>		
<b>(3)</b> Corporate debt instruments (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(3)(A)</b>		
<b>(B)</b> All other .....	<b>1c(3)(B)</b>		
<b>(4)</b> Corporate stocks (other than employer securities):			
<b>(A)</b> Preferred .....	<b>1c(4)(A)</b>		
<b>(B)</b> Common .....	<b>1c(4)(B)</b>		
<b>(5)</b> Partnership/joint venture interests .....	<b>1c(5)</b>		
<b>(6)</b> Real estate (other than employer real property) .....	<b>1c(6)</b>		
<b>(7)</b> Loans (other than to participants) .....	<b>1c(7)</b>		
<b>(8)</b> Participant loans .....	<b>1c(8)</b>		
<b>(9)</b> Value of interest in common/collective trusts .....	<b>1c(9)</b>		
<b>(10)</b> Value of interest in pooled separate accounts .....	<b>1c(10)</b>		
<b>(11)</b> Value of interest in master trust investment accounts .....	<b>1c(11)</b>		
<b>(12)</b> Value of interest in 103-12 investment entities .....	<b>1c(12)</b>		
<b>(13)</b> Value of interest in registered investment companies (e.g., mutual funds) .....	<b>1c(13)</b>		
<b>(14)</b> Value of funds held in insurance company general account (unallocated contracts) .....	<b>1c(14)</b>		
<b>(15)</b> Other .....	<b>1c(15)</b>		

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	1641176	1236610
<b>Liabilities</b>			
g Benefit claims payable.....	1g	0	0
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j	111370	227563
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	111370	227563
<b>Net Assets</b>			
l Net assets (subtract line 1k from line 1f).....	1l	1529806	1009047

**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.

<b>Income</b>		(a) Amount	(b) Total
<b>a Contributions:</b>			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)	7143754	
(B) Participants.....	2a(1)(B)	2572520	
(C) Others (including rollovers).....	2a(1)(C)	78741	
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2).....	2a(3)		9795015
<b>b Earnings on investments:</b>			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	83355	
(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)		83355
(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)		
(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)		
<b>c</b> Other income .....	2c		
<b>d</b> Total income. Add all <b>income</b> amounts in column (b) and enter total.....	2d		9878370

**Expenses**

<b>e</b> 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)	10213997	
(4) Total benefit payments. Add lines 2e(1) through (3) .....	2e(4)		10213997
<b>f</b> Corrective distributions (see instructions) .....	2f		
<b>g</b> Certain deemed distributions of participant loans (see instructions).....	2g		
<b>h</b> Interest expense.....	2h		
<b>i</b> Administrative expenses:			
(1) Salaries and allowances .....	2i(1)		
(2) Contract administrator fees .....	2i(2)		
(3) Recordkeeping fees .....	2i(3)		
(4) IQPA audit fees .....	2i(4)		
(5) Investment advisory and investment management fees .....	2i(5)		
(6) Bank or trust company trustee/custodial fees .....	2i(6)		
(7) Actuarial fees .....	2i(7)		
(8) Legal fees .....	2i(8)		
(9) Valuation/appraisal fees .....	2i(9)		
(10) Other trustee fees and expenses .....	2i(10)		
(11) Other expenses.....	2i(11)	185132	
(12) Total administrative expenses. Add lines 2i(1) through (11) .....	2i(12)		185132
<b>j</b> Total expenses. Add all <b>expense</b> amounts in column (b) and enter total.....	2j		10399129

**Net Income and Reconciliation**

<b>k</b> Net income (loss). Subtract line 2j from line 2d.....	2k		-520759
<b>l</b> Transfers of assets:			
(1) To this plan.....	2l(1)		
(2) From this plan .....	2l(2)		

**Part III Accountant's Opinion**

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

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

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

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

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

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

(1) Name: CLIFTONLARSONALLEN LLP

(2) EIN: 47-0746749

**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
<b>a</b> 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>b</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	
<b>c</b> 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	
<b>d</b> 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	
<b>e</b> Was this plan covered by a fidelity bond?	X		5000000
<b>f</b> Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
<b>g</b> 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	
<b>h</b> 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	
<b>i</b> Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
<b>j</b> 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		
<b>k</b> Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
<b>l</b> Has the plan failed to provide any benefit when due under the plan?		X	
<b>m</b> If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
<b>n</b> 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.)

<b>5b(1)</b> Name of plan(s)	<b>5b(2)</b> EIN(s)	<b>5b(3)</b> 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 \_\_\_\_\_.

**SOUTHERN STATES INSURED (MEWA)  
MEDICAL AND DENTAL PLAN**

**FINANCIAL STATEMENTS AND  
ERISA-REQUIRED SUPPLEMENTAL SCHEDULES**

**AS OF JUNE 30, 2025 AND 2024, AND  
FOR THE YEAR ENDED JUNE 30, 2025**



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**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
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AS OF JUNE 30, 2025 AND 2024, AND  
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## INDEPENDENT AUDITORS' REPORT

Employee Benefits Administrative Committee  
Southern States Insured (MEWA) Medical and Dental Plan  
Richmond, Virginia

### Report on the Audit of the Financial Statements

#### ***Scope and Nature of the ERISA Section 103(a)(3)(C) Audit***

We have performed an audit of the financial statements of Southern States Insured (MEWA) Medical and Dental Plan, an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 (ERISA), as permitted by ERISA Section 103(a)(3)(C) (ERISA Section 103(a)(3)(C) audit). The financial statements comprise the statement of net assets available for benefits as of June 30, 2025, and the related statement of changes in net assets available for benefits for the year then ended, and the related notes to the financial statements.

Management, having determined it is permissible in the circumstances, has elected to have the audit of Southern States Insured (MEWA) Medical and Dental Plan's financial statements performed in accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA. As permitted by ERISA Section 103(a)(3)(C), our audit need not extend to any statements or information related to assets held for investment of the Plan (investment information) by a bank or similar institution or insurance carrier that is regulated, supervised, and subject to periodic examination by a state or federal agency, provided that the statements or information regarding assets so held are prepared and certified to by the bank or similar institution or insurance carrier in accordance with 29 CFR 2520.103-5 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA (qualified institution).

Management has obtained certification from a qualified institution as of and for the year ended June 30, 2025, stating the certified investment information, as described in Note 3 to the financial statements, is complete and accurate.

#### ***Opinion***

In our opinion, based on our audit and on the procedures performed as described in the Auditors' Responsibilities for the Audit of the Financial Statements section

- the amounts and disclosures in the accompanying financial statements, other than those agreed to or derived from the certified investment information, are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America.
- the information in the accompanying financial statements related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

***Basis for Opinion***

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Southern States Insured (MEWA) Medical and Dental 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 ERISA Section 103(a)(3)(C) audit opinion.

***Responsibilities of Management for the Financial Statements***

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error. Management's election of the ERISA Section 103(a)(3)(C) audit does not affect management's responsibility for the financial statements.

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 Southern States Insured (MEWA) Medical and Dental Plan's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

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

***Auditors' Responsibilities for the Audit of the Financial Statements***

Except as described in the Scope and Nature of the ERISA Section 103(a)(3)(C) Audit of the Financial Statements section of our report, 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 is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

Employee Benefits Administrative Committee  
Southern States Insured (MEWA) Medical and Dental Plan

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 Southern States Insured (MEWA) Medical and Dental Plan's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Southern States Insured (MEWA) Medical and Dental Plan's ability to continue as a going concern for a reasonable period of time.

Our audit did not extend to the certified investment information, except for obtaining and reading the certification, comparing the certified investment information with the related information presented and disclosed in the financial statements, and reading the disclosures relating to the certified investment information to assess whether they are in accordance with the presentation and disclosure requirements of accounting principles generally accepted in the United States of America.

Accordingly, the objective of an ERISA Section 103(a)(3)(C) audit is not to express an opinion about whether the financial statements as a whole are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

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.

***Other Matter — Supplemental Schedules Required by ERISA***

The supplemental schedule of assets (held at end of year) and of reportable transactions as of and for the year ended June 30, 2025 is presented for purposes of additional analysis and is not a required part of the financial statements but is supplementary information required by the Department of Labor'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 included in the supplemental schedules, other than that agreed to or derived from the certified investment information, has been subjected to 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. For information included in the supplemental schedules that agreed to or is derived from the certified investment information, we compared such information to the related certified investment information.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, other than the information agreed to or derived from the certified investment information, including its form and content, are presented in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion:

- the form and content of the supplemental schedules, other than the information in the supplemental schedule that agreed to or is derived from the certified investment information, are presented, in all material respects, in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA.
- the information in the supplemental schedules related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C).

#### **Auditor's Report on the 2024 Financial Statements**

Predecessor auditors performed an audit of the 2024 financial statements of Southern States Insured (MEWA) Medical and Dental Plan. In accordance with ERISA Section 103(a)(3)(C) pursuant to 29 CFR 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA, the prior year audit did not extend to any statements or information related to assets held for investment of the Plan that were certified by a qualified institution. Their report dated January 31, 2025 indicated that (a) the amounts and disclosures in the 2024 financial statements, other than those agreed to or derived from the certified investment information, were presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America, and (b) the information in the 2024 financial statements related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determined meets the requirements of ERISA Section 103(a)(3)(C). Their report also indicated that the form and content of the 2024 supplemental schedules, other than the information in the 2024 supplemental schedules that agreed to or is derived from the certified investment information, were presented, in all material respects, in conformity with the Department of Labor's Rules and Regulations for Reporting and Disclosure under ERISA; and the information in the 2024 supplemental schedules related to assets held by and certified to by a qualified institution agrees to, or is derived from, in all material respects, the information prepared and certified by an institution that management determines meets the requirements of ERISA Section 103(a)(3)(C).



**CliftonLarsonAllen LLP**

Raleigh, North Carolina  
February 11, 2026

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
STATEMENTS OF NET ASSETS AVAILABLE FOR BENEFITS  
JUNE 30, 2025 AND 2024**

	2025	2024
<b>ASSETS</b>		
Cash and Cash Equivalents	\$ 1,078,249	\$ 1,633,876
Prepaid Insurance Premiums	24,667	-
Interest Receivable	5,102	7,300
Other Receivables	128,592	169,632
Total Assets	1,236,610	1,810,808
<b>LIABILITIES</b>		
Payable to Claims Administrator	227,563	281,002
<b>NET ASSETS AVAILABLE FOR BENEFITS</b>	<b>\$ 1,009,047</b>	<b>\$ 1,529,806</b>

See accompanying Notes to Financial Statements.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
STATEMENT OF CHANGES IN NET ASSETS AVAILABLE FOR BENEFITS  
YEAR ENDED JUNE 30, 2025**

**ADDITIONS:**

Interest Income	\$ 83,355
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Contributions

Employee Contributions	2,572,520
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Employer Contributions	7,143,754
------------------------	-----------

FSA Employee Contributions	78,741
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Total Contributions	<u>9,795,015</u>
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Total Additions	9,878,370
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**DEDUCTIONS:**

Benefit Claims Paid	8,549,176
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Dental and Vision Premiums	357,497
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Stop-Loss	1,211,658
-----------	-----------

Other Benefits Paid	95,666
---------------------	--------

Administrative Expenses	<u>185,132</u>
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Total Deductions	<u>10,399,129</u>
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**DECREASE IN NET ASSETS AVAILABLE FOR BENEFITS**

(520,759)

**NET ASSETS AVAILABLE FOR BENEFITS:**

Beginning of Year	<u>1,529,806</u>
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End of Year	<u><u>\$ 1,009,047</u></u>
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See accompanying Notes to Financial Statements.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 1 DESCRIPTION OF THE PLAN**

The following description of the Southern States Insured (MEWA) Medical and Dental Plan (the Plan) provides only general information. Participants should refer to the Plan document for a more complete description of the Plan's provisions.

**General**

The Plan was established August 25, 1975, to provide health and other benefits to eligible employees and covered dependents of participating member employers by issuance of one or more fully insured insurance policies. Certain Plan assets are held in a voluntary employees' beneficiary association (VEBA) trust. The Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Effective July 1, 1989, Southern States Cooperative, Inc. (the Company) and each of its subsidiaries, affiliates, or related corporations established the Southern States Group Benefits Trust, a Voluntary Employees' Beneficiary Association Trust (the Trust), to hold assets required to pay claims and premiums associated with the Southern States Medical and Dental Plan.

Effective July 1, 1998, the Southern States Medical and Dental Plan was amended to carve out the medical and dental programs for employees of Southern States and any of its subsidiaries that fall within the definition of a single employer under Internal Revenue Code Sections 414(b), (c), (m), and (o) into a separate, self-insured arrangement. Certain assets and plan benefit obligations of the Southern States Medical and Dental Plan were allocated to a new plan, the Southern States Uninsured (Corporate) Medical and Dental Plan. The Southern States Medical and Dental Plan was then renamed the Southern States Insured (MEWA) Medical and Dental Plan.

The Plan covers employees of member cooperatives (the Employer) classified as regular employees who work at least 30 hours per week and their eligible family members (e.g., spouse and children).

**Contributions**

Participants contribute specified amounts based on applicable monthly premiums for their respective benefit elections. Employer contributions are based on percentages of employee gross wages as established in administrative agreements.

**Benefits**

The Plan provides comprehensive medical, prescription drug, dental, and vision benefits to eligible members and to their beneficiaries and dependents. The Plan also provides continuation of certain benefits upon termination of employment through the Consolidated Omnibus Budget Reconciliation Act (COBRA).

The Fund also provides a wellness program. The Fund pays an established monthly fee to the wellness provider for these services.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 1 DESCRIPTION OF THE PLAN (CONTINUED)**

**Insured Benefits**

The Plan fully insures dental and vision benefits. The Plan purchases annual insurance contracts for these insured benefits. Premiums for all insured benefits are paid from the assets of the VEBA trust.

**Self-Insured Benefits**

Medical and prescription drug benefits are self-insured. The claims for self-insured benefits are processed by the Plan's third-party claims processors under administrative services only (ASO) arrangements. The claims processors pay claims directly to or on behalf of participants and then are reimbursed by either the Plan's VEBA trust or the general assets of the Plan. Despite the Plan's utilization of third-party claims processors, ultimate responsibility for payments to providers and participants is retained by the Plan.

**Stop-Loss Coverage**

The Plan has entered into a stop-loss insurance arrangement in an effort to limit its exposure for self-insured benefits (individual participant claims over a specific dollar amount, as well as its aggregate exposure for all claims).

**Flexible Spending Account**

The Plan has flexible spending account (FSA) arrangements for health care, dependent care, and limited purpose reimbursements that are funded solely by active participant contributions. The FSAs allow eligible participants to be reimbursed tax-free for qualified health care and dependent care expenses subject to annual limitations established under the Plan. The employer is not permitted to refund any part of the FSA balances to the employee; the accounts cannot be used for anything other than qualified health care and dependent care expenses; remaining amounts are not portable upon termination once the employee leaves the employer, and any unused amount is forfeited back to the Plan sponsor. Residual FSA amounts unused at the end of the year can be carried over for two and one-half months into the next year to allow qualified expenses incurred during that period to be reimbursed from the account. Any residual FSA amounts remaining after the two and one-half month extension are immediately forfeited.

**NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Basis of Presentation**

The accompanying financial statements of the Plan have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP) on the accrual basis of accounting.

**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, benefit obligations, and changes therein, and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 2 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)**

**Investment Valuation and Income Recognition**

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. See Note 4 for discussion of fair value measurements. Interest income is recorded on the accrual basis.

**Payment of Benefits**

Claim payments are recorded when paid by the claims administrator and the claims administrator is reimbursed by the Plan sponsor at the end of each week. Therefore, amounts due to claims processors that have yet to be reimbursed by the Plan are reflected as claims payable in the statements of net assets available for benefits.

Premiums paid by either the Company or the VEBA trust are recorded as premium payments in the accompanying statements of changes in net assets available for benefits.

**Stop-Loss**

Stop-loss credits totaling \$1,046,464 have been netted with claims paid in the accompanying statement of changes in net assets available for benefits for the year ended June 30, 2025. As of June 30, 2025 and 2024, stop loss credits totaling \$62,814 and \$46,418 were due from the claims processor and are included in other receivables in the accompanying statements of net assets available for benefits.

**Prescription Rebates**

Prescription rebates totaling \$199,174 were netted against claims paid in the accompanying statement of changes in net assets available for benefits for the year ended June 30, 2025. As of June 30, 2025 and 2024, prescription rebates totaling \$ 65,778 and \$123,214 were due from claims processor and are included in other receivables in the accompanying statements of net assets available for benefits.

**Administrative Expenses**

The Plan pays administrative expenses that consist primarily of administrative fees paid to the third-party claims administrator. These expenses are reported on the statements of changes in net assets available for benefits as Administrative Expenses.

**Subsequent Events**

Management has evaluated subsequent events through February 11, 2026, the date the financial statements were available for issuance, and has determined there are no subsequent events to be reported in the accompanying financial statements.

**Reclassifications**

Certain amounts in the 2024 financial statements have been reclassified to conform with the 2025 presentation. These reclassifications do not affect net assets available for benefits as previously reported.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 3 CERTIFICATION OF INVESTMENT INFORMATION**

Principal Bank, the qualified institution of the Plan, has supplied the Plan administrator with a certification as to the completeness and accuracy of investments as of June 30, 2025 and 2024, and investment income for the year ended June 30, 2025, in the accompanying financial statements and ERISA-required supplemental schedule.

**NOTE 4 FAIR VALUE OF INVESTMENTS**

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

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

*Level 2* – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, such as:

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

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

*Level 3* – Inputs to the valuation methodology are unobservable and significant to the fair market value measurement.

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

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the valuation methodologies used at June 30, 2025 and 2024.

*Money Market Fund* – Valued at the daily closing price as reported by the fund which is \$1.00 per share.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 4 FAIR VALUE OF INVESTMENTS (CONTINUED)**

The following tables set forth by level, within the fair value hierarchy, the Fund's assets at fair value as of June 30, 2025 and 2024

	2025			Total
	Level 1	Level 2	Level 3	
Money Market Fund	\$ 1,078,249	\$ -	\$ -	\$ 2,156,498
	2024			
	Level 1	Level 2	Level 3	Total
Money Market Fund	\$ 1,633,876	\$ -	\$ -	\$ 1,633,876

**NOTE 5 BENEFIT OBLIGATIONS**

The Plan "self-funds" the medical and prescription drug benefits provided to participants. As of each June 30, there are many self-funded claims that have been incurred on which benefit payments will be made subsequent to that date. The liability for claims payable and claims incurred but not reported (IBNR) was estimated by Plan Management using Plan provisions, the number of eligible participants, and the historical lag patterns of the Plan. These amounts are paid by the Plan only if claims are submitted and approved for payment.

The following tables present the components of the Plan's benefit obligations and the related changes in the Plan's benefit obligations:

	2025	2024
<b>BENEFIT OBLIGATIONS</b>		
Claims Incurred But Not Reported	\$ 426,000	\$ 474,000
	Amount	
<b>CHANGE IN BENEFIT OBLIGATIONS</b>		
Benefit Obligations - Beginning of Year	\$ 474,000	
Claims Incurred	8,501,176	
Claims Paid	(8,549,176)	
<b>BENEFIT OBLIGATIONS - END OF YEAR</b>	<b>\$ 426,000</b>	

**NOTE 6 TAX STATUS**

The VEBA trust funding benefits of the Fund received an exemption letter from the Internal Revenue Service (IRS) dated February 5, 1990, stating that the VEBA trust is tax-exempt under the provisions of Section 501(c)(9) of the Internal Revenue Code (IRC). However, as a result of the Fund's funding policy, from time to time the VEBA trust may be subject to income taxes. For the year ended June 30, 2025, no federal or state income taxes have been recorded for unrelated business taxable income.

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**NOTES TO FINANCIAL STATEMENTS**  
**JUNE 30, 2025**

**NOTE 6 TAX STATUS (CONTINUED)**

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

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

**NOTE 7 PLAN TERMINATION**

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

**NOTE 8 PARTY-IN-INTEREST TRANSACTIONS**

Certain Plan assets are managed by the custodian of the Plan. As described in Notes 1 and 2, the Plan has several arrangements with service providers. These transactions qualify as party in interest transactions, which are exempt from the prohibited transaction rules of ERISA.

**NOTE 9 RISKS AND UNCERTAINTIES**

The liability for claims payable and claims incurred but not reported (IBNR) was estimated using Plan provisions, the number of eligible participants, and the historical lag patterns of the Plan. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

Multiple Employer Plan Participating Employer Information	
Southern States Cooperative Mewa Medical Dental Plan, 54-0387200, 502	
Augusta Petroleum Cooperative, Inc.	54-0129217
Culpeper Petroleum Cooperative, Inc.	54-0185807
Marshall County Cooperative, Inc.	54-0684219
Rockingham Petroleum Cooperative, Inc.	54-0362052
Russell County Cooperative, Inc.	54-0366573
Southern States Bowling Green Petroleum Cooperative, Inc.	54-0485422
Southern States Carroll County Cooperative, Inc.	54-0465250
Southern States Chesapeake Association, Inc.	54-0387176
Southern States Clark Cooperative, Inc.	54-0510084
Southern States Clarksburg Cooperative, Inc.	54-0387137
Southern States Cumberland Cooperative, Inc.	54-0387181
Southern States Flemingsburg Cooperative, Inc.	54-0463769
Southern States Frederick Cooperative, Inc.	54-0387183
Southern States Georgetown Cooperative, Inc.	54-0453856
Southern States Glasgow Cooperative, Inc.	54-0454403
Southern States Hardin Cooperative, Inc.	54-0502402
Southern States Henderson Cooperative, Inc.	54-0482365
Southern States Hopkinsville Cooperative, Inc.	54-0475002
Southern States Hopkinsville Petroleum Cooperative, Inc.	54-0485424
Southern States Lexington Cooperative, Inc.	54-0500375
Southern States London Cooperative, Inc.	54-0480833
Southern States Loudoun County Cooperative, Inc.	54-0387166
Southern States Marlinton Cooperative, Inc.	54-0387135
Southern States Milford Cooperative, Inc.	54-0484969
Southern States Mount Airy Cooperative, Inc.	54-0387204
Southern States Owenton Cooperative, Inc.	54-0488947
Southern States Russellville Cooperative, Inc.	54-0493246
Southern States Simpson Cooperative, Inc.	54-0536872
Southern States Smyrna-Clayton Cooperative, Inc.	54-0387392
Southern States Somerset Cooperative, Inc.	54-0454405
Southern States Spencer Cooperative, Inc.	54-0387134
Southern States Tidewater Petroleum Cooperative, Inc.	54-0619014
Southern States Cooperative, Inc.	54-0387200

Form 5500

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security  
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110  
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 07/01/2024 and ending 06/30/2025

- A This return/report is for: [ ] a multiemployer plan [x] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.) [ ] a single-employer plan [ ] a DFE (specify) \_\_\_\_
B This return/report is: [ ] the first return/report [ ] the final return/report [ ] an amended return/report [ ] a short plan year return/report (less than 12 months)
C If the plan is a collectively-bargained plan, check here. [ ]
D Check box if filing under: [x] 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: SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN
1b Three-digit plan number (PN): 502
1c Effective date of plan: 08/25/1975
2a Plan sponsor's name (employer, if for a single-employer plan): SOUTHERN STATES COOPERATIVE, INC.
2b Employer Identification Number (EIN): 54-0387200
2c Plan Sponsor's telephone number: 804-281-1381
2d Business code (see instructions): 424990

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, Date, and Name. Row 1: SIGN HERE, [Signature], 2/19/2026, Jakisha Robinson. Row 2: SIGN HERE, Signature of employer/plan sponsor, Date, Enter name of individual signing as employer or plan sponsor. Row 3: SIGN HERE, Signature of DFE, Date, Enter name of individual signing as DFE.

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

Form 5500 (2024)  
v. 240311

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4j--SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
	BEGINNING MARKET VALUE		1,641,176.05			
	COMPARATIVE VALUE (5%)		82,058.80			
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/05/24 B	368,248	1.000	0	368,248*	368,248	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/09/24 S	157,019	1.000	0	157,019 *	157,019	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/15/24 S	212,114	1.000	0	212,114 *	212,114	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/19/24 B	347,419	1.000	0	347,419*	347,419	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/22/24 S	188,633	1.000	0	188,633 *	188,633	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
08/05/24 B	242,410	1.000	0	242,410*	242,410	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
08/19/24 S	346,539	1.000	0	346,539 *	346,539	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
08/21/24 B	362,705	1.000	0	362,705*	362,705	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
08/26/24 S	134,760	1.000	0	134,760 *	134,760	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
08/30/24 B	329,063	1.000	0	329,063*	329,063	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/03/24 S	200,958	1.000	0	200,958 *	200,958	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/09/24 S	147,688	1.000	0	147,688 *	147,688	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/13/24 B	358,088	1.000	0	358,088*	358,088	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/16/24 S	352,246	1.000	0	352,246 *	352,246	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/23/24 S	204,960	1.000	0	204,960 *	204,960	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/27/24 B	360,165	1.000	0	360,165*	360,165	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
09/30/24 S	84,724	1.000	0	84,724 *	84,724	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/07/24 S	162,068	1.000	0	162,068 *	162,068	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/11/24 B	371,165	1.000	0	371,165*	371,165	0

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**E.I.N. 54-0387200 PLAN NO. 502**  
**SCHEDULE H, LINE 4j--SCHEDULE OF REPORTABLE TRANSACTIONS**  
**FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/15/24 S	130,933	1.000	0	130,933 *	130,933	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/21/24 S	238,203	1.000	0	238,203 *	238,203	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/25/24 B	366,159	1.000	0	366,159--*	366,159	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
10/28/24 S	130,064	1.000	0	130,064 *	130,064	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
11/04/24 S	101,487	1.000	0	101,487 *	101,487	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
11/08/24 B	358,529	1.000	0	358,529--*	358,529	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
11/12/24 S	106,198	1.000	0	106,198 *	106,198	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
11/18/24 S	182,630	1.000	0	182,630 *	182,630	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
11/21/24 B	206,653	1.000	0	206,653--*	206,653	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/06/24 B	369,351	1.000	0	369,351--*	369,351	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/09/24 S	122,840	1.000	0	122,840 *	122,840	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/16/24 S	223,046	1.000	0	223,046 *	223,046	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/23/24 S	88,385	1.000	0	88,385 *	88,385	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/26/24 B	366,935	1.000	0	366,935--*	366,935	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
12/31/24 S	198,715	1.000	0	198,715 *	198,715	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
01/03/25 B	369,411	1.000	0	369,411--*	369,411	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
01/22/25 B	397,899	1.000	0	397,899--*	397,899	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
01/28/25 S	867,689	1.000	0	867,689 *	867,689	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
02/04/25 B	384,463	1.000	0	384,463--*	384,463	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
02/04/25 S	204,658	1.000	0	204,658 *	204,658	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
02/10/25 S	108,192	1.000	0	108,192 *	108,192	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
02/14/25 B	377,125	1.000	0	377,125--*	377,125	0
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
02/19/25 S	298,576	1.000	0	298,576 *	298,576	0

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**E.I.N. 54-0387200 PLAN NO. 502**  
**SCHEDULE H, LINE 4j--SCHEDULE OF REPORTABLE TRANSACTIONS**  
**FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
02/24/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	160,566	1.000	160,566 *	160,566	0
02/28/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	393,716	1.000	393,716--*	393,716	0
03/03/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	117,729	1.000	117,729 *	117,729	0
03/10/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	147,578	1.000	147,578 *	147,578	0
03/14/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	387,120	1.000	387,120--*	387,120	0
03/17/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	312,477	1.000	312,477 *	312,477	0
03/24/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	279,475	1.000	279,475 *	279,475	0
03/28/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	400,422	1.000	400,422--*	400,422	0
03/31/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	183,824	1.000	183,824 *	183,824	0
04/07/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	139,405	1.000	139,405 *	139,405	0
04/11/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	387,549	1.000	387,549--*	387,549	0
04/14/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	131,945	1.000	131,945 *	131,945	0
04/21/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	395,008	1.000	395,008 *	395,008	0
04/25/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	392,531	1.000	392,531--*	392,531	0
04/28/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	466,323	1.000	466,323 *	466,323	0
05/05/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	101,053	1.000	101,053 *	101,053	0
05/09/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	389,254	1.000	389,254--*	389,254	0
05/19/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	234,716	1.000	234,716 *	234,716	0
05/23/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	392,584	1.000	392,584--*	392,584	0
05/27/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	162,455	1.000	162,455 *	162,455	0
06/02/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	117,635	1.000	117,635 *	117,635	0
06/06/25 B	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	398,852	1.000	398,852--*	398,852	0
06/09/25 S	ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802	363,066	1.000	363,066 *	363,066	0

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
**SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025****

DATE BOUGHT/ SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
ISSUE: VP7001218 - ALLSPRING GOVT MM		FUND-SELECT #3802				
06/16/25 S	364,217	1.000	0	364,217 *	364,217	0
ISSUE: VP7001218 - ALLSPRING GOVT MM		FUND-SELECT #3802				
06/23/25 S	205,188	1.000	0	205,188 *	205,188	0
ISSUE: VP7001218 - ALLSPRING GOVT MM		FUND-SELECT #3802				
06/23/25 B	387,556	1.000	0	387,556*	387,556	0
ISSUE: VP7001218 - ALLSPRING GOVT MM		FUND-SELECT #3802				
06/30/25 S	283,688	1.000	0	283,688 *	283,688	0
GRAND TOTAL						
			0	18,825,045	18,825,045	0

FOOTNOTES

\* = SINGLE TRANSACTION IS 5% REPORTABLE B = BUY TRANSACTION  
S = SELL TRANSACTION  
R = REINVESTMENT TRANSACTION

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**E.I.N. 54-0387200 PLAN NO. 502**  
**SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS**  
**FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT / SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
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BEGINNING MARKET VALUE		1,641,176.05				
COMPARATIVE VALUE (5%)		82,058.80				

\*\*\* NO TRANSACTIONS QUALIFIED \*\*\*

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4j--SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	TRANSACTION COST	REALIZED GAIN/LOSS
	BEGINNING MARKET VALUE		1,641,176.05			
	COMPARATIVE VALUE (5%)		82,058.80			
ISSUE: VP7001218 - ALLSPRING GOVT MM FUND-SELECT #3802						
07/01/24 B	7,300	1.000	0	7,300-	7,300	
07/05/24 B	368,248	1.000	0	368,248-*	368,248	
07/19/24 B	347,419	1.000	0	347,419-*	347,419	
08/01/24 B	7,848	1.000	0	7,848-	7,848	
08/05/24 B	242,410	1.000	0	242,410-*	242,410	
08/09/24 B	58,036	1.000	0	58,036-	58,036	
08/21/24 B	362,705	1.000	0	362,705-*	362,705	
08/30/24 B	329,063	1.000	0	329,063-*	329,063	
09/03/24 B	7,930	1.000	0	7,930-	7,930	
09/13/24 B	358,088	1.000	0	358,088-*	358,088	
09/13/24 B	0	1.000	0	0-	0	
09/27/24 B	360,165	1.000	0	360,165-*	360,165	
10/01/24 B	7,350	1.000	0	7,350-	7,350	
10/11/24 B	371,165	1.000	0	371,165-*	371,165	
10/25/24 B	366,159	1.000	0	366,159-*	366,159	
11/01/24 B	7,148	1.000	0	7,148-	7,148	
11/08/24 B	358,529	1.000	0	358,529-*	358,529	
11/21/24 B	206,653	1.000	0	206,653-*	206,653	
12/02/24 B	7,079	1.000	0	7,079-	7,079	
12/06/24 B	369,351	1.000	0	369,351-*	369,351	
12/17/24 B	20,000	1.000	0	20,000-	20,000	
12/26/24 B	366,935	1.000	0	366,935-*	366,935	
01/02/25 B	7,473	1.000	0	7,473-	7,473	
01/03/25 B	369,411	1.000	0	369,411-*	369,411	
01/22/25 B	397,899	1.000	0	397,899-*	397,899	
02/03/25 B	8,214	1.000	0	8,214-	8,214	
02/04/25 B	384,463	1.000	0	384,463-*	384,463	
02/14/25 B	377,125	1.000	0	377,125-*	377,125	
02/28/25 B	393,716	1.000	0	393,716-*	393,716	
03/03/25 B	6,251	1.000	0	6,251-	6,251	
03/14/25 B	387,120	1.000	0	387,120-*	387,120	
03/28/25 B	400,422	1.000	0	400,422-*	400,422	
04/01/25 B	6,917	1.000	0	6,917-	6,917	
04/11/25 B	387,549	1.000	0	387,549-*	387,549	
04/25/25 B	392,531	1.000	0	392,531-*	392,531	



**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	SERIES / BY ISSUE				TRANSACTION COST	REALIZED GAIN/LOSS
		UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH			
10/04/24 S	5,296	1.000	0	5,296	5,296	0	
10/07/24 S	162,068	1.000	0	162,068 *	162,068	0	
10/08/24 S	1,625	1.000	0	1,625	1,625	0	
10/09/24 S	669	1.000	0	669	669	0	
10/10/24 S	365	1.000	0	365	365	0	
10/11/24 S	1,052	1.000	0	1,052	1,052	0	
10/15/24 S	130,933	1.000	0	130,933 *	130,933	0	
10/15/24 S	502	1.000	0	502	502	0	
10/21/24 S	417	1.000	0	417	417	0	
10/21/24 S	238,203	1.000	0	238,203 *	238,203	0	
10/22/24 S	4,570	1.000	0	4,570	4,570	0	
10/25/24 S	1,165	1.000	0	1,165	1,165	0	
10/28/24 S	130,064	1.000	0	130,064 *	130,064	0	
10/30/24 S	5,043	1.000	0	5,043	5,043	0	
11/01/24 S	25,192	1.000	0	25,192	25,192	0	
11/04/24 S	101,487	1.000	0	101,487 *	101,487	0	
11/05/24 S	14,703	1.000	0	14,703	14,703	0	
11/08/24 S	682	1.000	0	682	682	0	
11/12/24 S	106,198	1.000	0	106,198 *	106,198	0	
11/15/24 S	345	1.000	0	345	345	0	
11/18/24 S	182,630	1.000	0	182,630 *	182,630	0	
11/20/24 S	417	1.000	0	417	417	0	
11/22/24 S	1,773	1.000	0	1,773	1,773	0	
11/29/24 S	401	1.000	0	401	401	0	
12/02/24 S	25,018	1.000	0	25,018	25,018	0	
12/03/24 S	75,478	1.000	0	75,478	75,478	0	
12/03/24 S	4,663	1.000	0	4,663	4,663	0	
12/05/24 S	5,043	1.000	0	5,043	5,043	0	
12/06/24 S	600	1.000	0	600	600	0	
12/09/24 S	10,000	1.000	0	10,000	10,000	0	
12/09/24 S	122,840	1.000	0	122,840 *	122,840	0	
12/10/24 S	11,920	1.000	0	11,920	11,920	0	
12/11/24 S	669	1.000	0	669	669	0	
12/13/24 S	895	1.000	0	895	895	0	
12/16/24 S	223,046	1.000	0	223,046 *	223,046	0	
12/20/24 S	417	1.000	0	417	417	0	
12/20/24 S	1,086	1.000	0	1,086	1,086	0	
12/23/24 S	88,385	1.000	0	88,385 *	88,385	0	
12/27/24 S	454	1.000	0	454	454	0	
12/30/24 S	25,946	1.000	0	25,946	25,946	0	
12/31/24 S	198,715	1.000	0	198,715 *	198,715	0	
12/31/24 S	4,570	1.000	0	4,570	4,570	0	
01/09/25 S	4,522	1.000	0	4,522	4,522	0	
01/10/25 S	251	1.000	0	251	251	0	

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
**SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025****

DATE BOUGHT/SOLD	SERIES / BY ISSUE				REALIZED GAIN/LOSS
	SHARES/ PAR VALUE	UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH	
01/13/25 S	13,375	1.000	0	13,375	0
01/14/25 S	674	1.000	0	674	0
01/15/25 S	391	1.000	0	391	0
01/17/25 S	2,181	1.000	0	2,181	0
01/21/25 S	417	1.000	0	417	0
01/23/25 S	9,613	1.000	0	9,613	0
01/24/25 S	2,615	1.000	0	2,615	0
01/28/25 S	867,689	1.000	0	867,689 *	0
01/31/25 S	28,004	1.000	0	28,004	0
02/04/25 S	204,658	1.000	0	204,658 *	0
02/07/25 S	1,292	1.000	0	1,292	0
02/07/25 S	4,616	1.000	0	4,616	0
02/10/25 S	108,192	1.000	0	108,192 *	0
02/12/25 S	2,951	1.000	0	2,951	0
02/13/25 S	5,194	1.000	0	5,194	0
02/18/25 S	156	1.000	0	156	0
02/19/25 S	298,576	1.000	0	298,576 *	0
02/20/25 S	417	1.000	0	417	0
02/21/25 S	1,537	1.000	0	1,537	0
02/24/25 S	160,566	1.000	0	160,566 *	0
02/28/25 S	26,130	1.000	0	26,130	0
03/03/25 S	117,729	1.000	0	117,729 *	0
03/05/25 S	4,769	1.000	0	4,769	0
03/06/25 S	5,194	1.000	0	5,194	0
03/07/25 S	1,760	1.000	0	1,760	0
03/10/25 S	147,578	1.000	0	147,578 *	0
03/17/25 S	312,477	1.000	0	312,477 *	0
03/19/25 S	265	1.000	0	265	0
03/20/25 S	417	1.000	0	417	0
03/21/25 S	2,390	1.000	0	2,390	0
03/21/25 S	44	1.000	0	44	0
03/24/25 S	279,475	1.000	0	279,475 *	0
03/25/25 S	4,334	1.000	0	4,334	0
03/31/25 S	183,824	1.000	0	183,824 *	0
04/07/25 S	139,405	1.000	0	139,405 *	0
04/09/25 S	4,674	1.000	0	4,674	0
04/10/25 S	4,007	1.000	0	4,007	0
04/14/25 S	131,945	1.000	0	131,945 *	0
04/16/25 S	749	1.000	0	749	0
04/17/25 S	1,901	1.000	0	1,901	0
04/21/25 S	417	1.000	0	417	0
04/21/25 S	395,008	1.000	0	395,008 *	0
04/24/25 S	1,274	1.000	0	1,274	0
04/28/25 S	466,323	1.000	0	466,323 *	0

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	UNIT PRICE	SERIES / BY ISSUE		TRANSACTION COST	REALIZED GAIN/LOSS
			EXPENSE INCURRED	PRINCIPAL CASH		
04/30/25 S	1,253	1.000	0	1,253	1,253	0
05/01/25 S	25,044	1.000	0	25,044	25,044	0
05/02/25 S	5,194	1.000	0	5,194	5,194	0
05/05/25 S	101,053	1.000	0	101,053 *	101,053	0
05/06/25 S	4,542	1.000	0	4,542	4,542	0
05/07/25 S	1,957	1.000	0	1,957	1,957	0
05/12/25 S	1,476	1.000	0	1,476	1,476	0
05/14/25 S	1,153	1.000	0	1,153	1,153	0
05/16/25 S	2,145	1.000	0	2,145	2,145	0
05/19/25 S	234,716	1.000	0	234,716 *	234,716	0
05/20/25 S	417	1.000	0	417	417	0
05/22/25 S	5,877	1.000	0	5,877	5,877	0
05/23/25 S	1,379	1.000	0	1,379	1,379	0
05/27/25 S	162,455	1.000	0	162,455 *	162,455	0
05/29/25 S	1,464	1.000	0	1,464	1,464	0
05/30/25 S	26,636	1.000	0	26,636	26,636	0
06/02/25 S	117,635	1.000	0	117,635 *	117,635	0
06/03/25 S	4,570	1.000	0	4,570	4,570	0
06/04/25 S	1,434	1.000	0	1,434	1,434	0
06/09/25 S	363,066	1.000	0	363,066 *	363,066	0
06/09/25 S	8	1.000	0	8	8	0
06/11/25 S	379	1.000	0	379	379	0
06/12/25 S	1,891	1.000	0	1,891	1,891	0
06/16/25 S	364,217	1.000	0	364,217 *	364,217	0
06/17/25 S	5,154	1.000	0	5,154	5,154	0
06/18/25 S	3,597	1.000	0	3,597	3,597	0
06/20/25 S	417	1.000	0	417	417	0
06/20/25 S	5,393	1.000	0	5,393	5,393	0
06/23/25 S	205,188	1.000	0	205,188 *	205,188	0
06/23/25 S	490	1.000	0	490	490	0
06/26/25 S	1,855	1.000	0	1,855	1,855	0
06/30/25 S	283,688	1.000	0	283,688 *	283,688	0
06/30/25 S	24,667	1.000	0	24,667	24,667	0
SUB-TOTAL OF SALES # 156			0	10,184,584	10,184,584	0
SUB-TOTAL			0	19,813,545	19,813,545	0
GRAND TOTAL			0	19,813,545	19,813,545	0

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS  
FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	SERIES / BY ISSUE				TRANSACTION COST	REALIZED GAIN/LOSS
		UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH			

F O O T N O T E S

\* = SINGLE TRANSACTION IS 5% REPORTABLE B =  
BUY TRANSACTION  
S = SELL TRANSACTION  
R = REINVESTMENT TRANSACTION

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN**  
**E.I.N. 54-0387200 PLAN NO. 502**  
**SCHEDULE H, LINE 4j—SCHEDULE OF REPORTABLE TRANSACTIONS**  
**FOR THE PERIOD JULY 1, 2024 THROUGH YEAR ENDED JUNE 30, 2025**

DATE BOUGHT/SOLD	SHARES/ PAR VALUE	SERIES / BY BROKER				TRANSACTION COST	REALIZED GAIN/LOSS
		UNIT PRICE	EXPENSE INCURRED	PRINCIPAL CASH			
	BEGINNING MARKET VALUE		1,641,176.05				
	COMPARATIVE VALUE (5%)		82,058.80				

\*\*\* NO TRANSACTIONS QUALIFIED \*\*\*

**SOUTHERN STATES INSURED (MEWA) MEDICAL AND DENTAL PLAN  
E.I.N. 54-0387200 PLAN NO. 502  
SCHEDULE H, LINE 4i—SCHEDULE OF ASSETS (HELD AT END OF YEAR)  
JUNE 30, 2025**

(a)	(b)	(c)	(d)	(e)
_____	Identity of Issue	Description of Investment	Cost **	Current Value
*	Allspring Government	Money Market Fund	\$ 1,078,249	\$ 1,078,249
			<u>\$ 1,078,249</u>	<u>\$ 1,078,249</u>