

<p style="text-align: center;"><b>Form 5500</b></p> <p style="font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="font-size: x-small;">Pension Benefit Guaranty Corporation</p>	<p><b>Annual Return/Report of Employee Benefit Plan</b></p> <p style="font-size: x-small;">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 style="text-align: center;"><b>▶ Complete all entries in accordance with the instructions to the Form 5500.</b></p>	<p style="font-size: x-small;">OMB Nos. 1210-0110 1210-0089</p> <hr/> <p style="font-size: large; text-align: center;"><b>2022</b></p> <hr/> <p style="text-align: center;"><b>This Form is Open to Public Inspection</b></p>
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**Part I Annual Report Identification Information**  
 For calendar plan year 2022 or fiscal plan year beginning 10/01/2022 and ending 09/30/2023

**A** This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of 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>REILLY ELECTRICAL CONTRACTORS, INC. EMPLOYEE BENEFITS PLAN</u></p>	<p><b>1b</b> Three-digit plan number (PN) ▶ <u>505</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>REILLY ELECTRICAL CONTRACTORS, INC.</u>   <u>14 NORFOLK AVENUE</u>  <u>SOUTH EASTON, MA 02375</u></p>	<p><b>1c</b> Effective date of plan  <u>10/01/1990</u></p> <p><b>2b</b> Employer Identification Number (EIN)  <u>04-3197615</u></p> <p><b>2c</b> Plan Sponsor's telephone number  <u>508-230-8001</u></p> <p><b>2d</b> Business code (see instructions)  <u>238210</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.	03/26/2024	JENNIFER STRATFORD
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>	Filed with authorized/valid electronic signature.	03/26/2024	JENNIFER STRATFORD
	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

<b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	<b>3b</b> Administrator's EIN  <b>3c</b> Administrator's telephone number
<b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: <b>a</b> Sponsor's name <b>c</b> Plan Name	<b>4b</b> EIN  <b>4d</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b> 181
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).  <b>6a(1)</b> Total number of active participants at the beginning of the plan year ..... <b>6a(2)</b> Total number of active participants at the end of the plan year .....  <b>b</b> Retired or separated participants receiving benefits ..... <b>c</b> Other retired or separated participants entitled to future benefits..... <b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> ..... <b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. .... <b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....  <b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).....  <b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<b>6a(1)</b> 125 <b>6a(2)</b> 131  <b>6b</b> 2  <b>6c</b>  <b>6d</b> 133  <b>6e</b>  <b>6f</b> 133  <b>6g</b>  <b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:  <b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4B 4D 4E 4F	
<b>9a</b> Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information – Small Plan) (3) <input checked="" type="checkbox"/> <b>3</b> <b>A</b> (Insurance Information) (4) <input type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

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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

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**11c** Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 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 \_\_\_\_\_

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<p style="text-align: center;"><b>SCHEDULE A</b> <b>(Form 5500)</b></p> <p style="text-align: center; font-size: small;">Department of the Treasury Internal Revenue Service</p> <hr/> <p style="text-align: center; font-size: small;">Department of Labor Employee Benefits Security Administration</p> <hr/> <p style="text-align: center; font-size: small;">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 style="text-align: center;">▶ <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 style="font-size: large;"><b>2022</b></p> <hr/> <p style="text-align: center;"><b>This Form is Open to Public Inspection</b></p>
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For calendar plan year 2022 or fiscal plan year beginning **10/01/2022** and ending **09/30/2023**

<p><b>A</b> Name of plan <b>REILLY ELECTRICAL CONTRACTORS, INC. EMPLOYEE BENEFITS PLAN</b></p>	<p><b>B</b> Three-digit plan number (PN) ▶</p>	<p><b>505</b></p>
<p><b>C</b> Plan sponsor's name as shown on line 2a of Form 5500 <b>REILLY ELECTRICAL CONTRACTORS, INC.</b></p>	<p><b>D</b> Employer Identification Number (EIN) <b>04-3197615</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  
**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-1031071	67369	00630592	131	10/01/2022	09/30/2023

**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
5944	73613

**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

**BROWN & BROWN OF MASSACHUSETTS LLC**                      **980 WASHINGTON STREET**  
**ST 325**  
**DEDHAM, MA 02026**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5944	73613	ADVISOR FEE	3

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

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

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

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	(c) Amount	(d) Purpose	

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<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>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	<b>6d</b>	

**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>			
(6) Total additions .....		<b>7c(6)</b>		
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....		<b>7d</b>		
<b>e</b> Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>		
	(2) Administration charge made by carrier.....	<b>7e(2)</b>		
	(3) Transferred to separate account.....	<b>7e(3)</b>		
(4) Other (specify below) .....	<b>7e(4)</b>			
(5) Total deductions .....		<b>7e(5)</b>		
<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>		

**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>	
	(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>
<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>
	(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>
	(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>	2651788
<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. ▶



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

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

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

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<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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.
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<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>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	<b>6d</b>	

**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>	
▶		
(6) Total additions.....	<b>7c(6)</b>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions:		
	<b>7e(1)</b>	
	<b>7e(2)</b>	
	<b>7e(3)</b>	
<b>7e(4)</b>		
▶		
(5) Total deductions.....	<b>7e(5)</b>	
<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>	

**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
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- 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>	
	(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>
<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>
	(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>
	(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>	47050
<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. ▶



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

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

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

<b>Part II</b>	<b>Investment and Annuity Contract Information</b> 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>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount..... Specify nature of costs ▶	<b>6d</b>	

**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>	
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	
<b>e</b> Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
(2) Administration charge made by carrier.....	<b>7e(2)</b>	
(3) Transferred to separate account.....	<b>7e(3)</b>	
(4) Other (specify below) .....	<b>7e(4)</b>	
▶		
(5) Total deductions.....	<b>7e(5)</b>	
<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>	

**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)
- |  |  |   |  |
|--|--|---|--|
| <b>a</b> <input type="checkbox"/> Health (other than dental or vision)         | <b>b</b> <input type="checkbox"/> Dental               | <b>c</b> <input checked="" type="checkbox"/> Vision         | <b>d</b> <input type="checkbox"/> Life insurance     |
| <b>e</b> <input type="checkbox"/> Temporary disability (accident and sickness) | <b>f</b> <input type="checkbox"/> Long-term disability | <b>g</b> <input type="checkbox"/> Supplemental unemployment | <b>h</b> <input type="checkbox"/> Prescription drug  |
| <b>i</b> <input type="checkbox"/> Stop loss (large deductible)                 | <b>j</b> <input type="checkbox"/> HMO contract         | <b>k</b> <input type="checkbox"/> PPO contract              | <b>l</b> <input type="checkbox"/> Indemnity contract |
| <b>m</b> <input type="checkbox"/> Other (specify) ▶                            |  |   |  |

**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>	
<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>	
(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>	
(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>	
<b>10</b> Nonexperience-rated contracts:			
<b>a</b> Total premiums or subscription charges paid to carrier .....	<b>10a</b>		8136
<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. ▶



Reilly Electrical Contractors, Inc.  
Jennifer Stratford  
14 Norfolk Avenue

South Easton MA 02375

Dear Employer:

Enclosed is the information you may need to complete and file Form 5500 with the Internal Revenue Service (IRS). Plans that are required to file the 5500 series forms must do so within a specified time period following the end of their plan year.

The Form 5500 series filing requirements are highly technical. It is your responsibility as plan sponsor to determine with your tax or legal advisor whether and when your plan is required to file a Form 5500 and any of the attendant schedules.

The information we provide for your use in preparing Schedule A and/or Schedule C of Form 5500 reflects premiums or compensation received and posted during the timeframes noted and may be adjusted in the future.

The amounts reported may not reconcile with your accounting due to timing.

Compensation for Service and / or General Agent Agreements are reflected on Schedule A and C reporting but may not have been directly paid to the producer by the Plan. Please note that even though these additional payments are associated with your plan for reporting purposes, the expenses associated with the payments may not impact your specific case level rates and premiums.

If you have any questions regarding the information provided, please contact Cigna at [SelectUnderwritingOperationsSupport@Cigna.com](mailto:SelectUnderwritingOperationsSupport@Cigna.com). For questions regarding the preparation of the Form 5500 consult your tax or legal advisor.

Sincerely,

Cigna

"Cigna Healthcare" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by The Cigna Group and its operating subsidiaries. All products and services are provided by such operating subsidiaries and not by The Cigna Group. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Sys 11/7/2023

# Cigna

## INFORMATION FOR COMPLETING SCHEDULE A ON THE IRS FORM 5500

*This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule A, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.*

**For Plan Year Beginning: October 01, 2022 and Ending: September 30, 2023**

**Name of Plan: Reilly Electrical Contractors, Inc.**

### SCHEDULE A - INSURANCE INFORMATION:

#### Information Concerning Insurance Contract Coverage, Fees and Commissions

Name of Insurance Carrier: Cigna Health and Life Insurance Company

EIN number	NAIC code	Contract or identification number	Policy or contract year:	
			From	To
59-1031071	67369	00630592	10/1/2022	9/30/2023

Approximate number of persons covered at end of policy or contract year:

<b><u>Benefit</u></b>	<b><u>Employee</u></b>	<b><u>Dependent</u></b>	<b><u>Spouse</u></b>	<b><u>Family</u></b>	<b><u>Child</u></b>
DENTAL	131	0	0	77	0
MEDICAL	131	0	0	76	0
VISION	129	0	0	76	0

Insurance fees, benefit advisor fees and commissions paid to agents, brokers, and other persons:

Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent / broker for specific information about their participation.

Name and address of the agents, brokers or other persons to whom commissions or fees were paid	Amount of commissions paid	Service/Gen. Agent Fees	Benefit Advisor Fees
BROWN & BROWN OF MASSACHUSETTS LLC	\$5,944.70	\$0.00	\$0.00
980 WASHINGTON ST STE 325 DEDHAM MA 02026			
BROWN & BROWN OF MASSACHUSETTS LLC	\$0.00	\$0.00	\$73,613.05
980 WASHINGTON ST STE 325 DEDHAM MA 02026			

Incentive Compensation Payments based on membership in your plan/or lump sum amount:

<u>Producer</u>	<u>Amount</u>
-----------------	---------------

Incentive Compensation Payments are funded by the insurer. Contact your agent, broker or consultant for details.

Total premiums\* or subscription charges paid to carrier: **\$2,578,175.12**

State Continuation includes payments made by continuants in amount of **\$0.00** administered by CHLIC and applicable to your account.

The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium /commissions) where applicable.

\*Premium may reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

# Cigna

## INFORMATION FOR COMPLETING SCHEDULE C ON THE IRS FORM 5500

*This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule C, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.*

**For Plan Year Beginning:**      **October 01, 2022**      **and Ending:**      **September 30, 2023**  
**Name of Plan:**                      **Reilly Electrical Contractors, Inc.**

### SCHEDULE C - SERVICE PROVIDER INFORMATION:

Service Provider	EIN#	Administration fees paid to the service provider *
Cigna Health and Life Insurance Company	59-1031071	\$73,613.05

**The following amounts were paid to your broker(s) and/or consultant(s) during the plan year:**

**Commissions:**                                      \$0.00  
**Service / Gen. Agent Fees:**                      \$0.00

**Incentive Compensation Payments based on membership in your plan/or lump sum amount:**                      \$0.00

**Incentive Compensation Payments are funded by the Service Provider. Contact your broker(s)/consultant(s) for details.**

\*This amount includes administrative service fees for reporting period and other fees paid by the plan, known as "Direct Compensation" as applicable.

If you have a CHLIC administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium/commissions) where applicable.

**Direct Compensation for calendar year      2022 :**                      \$0.00

\*\*Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

Direct compensation amount does not include the following compensation received, if any, by affiliated companies:

- Plan benefit payments, if any, made to eviCore
- Utilization management fees paid to eviCore
- Plan benefit payment made to Evernorth Care Solutions, Inc. or Evernorth Behavioral Health, Inc.
- Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

The amount of such compensation, if any, with respect to your plan is available upon request.

Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:

- eviCore
- Evernorth Care Solutions, Inc.
- Evernorth Behavioral Health, Inc.
- Cigna HealthCare of Arizona, Inc. (Cigna Medical Group)

# Cigna

## Plan Detail Report

The following information will assist you in completing the Schedule A with respect to your Cigna insurance policy.

For Plan Year Beginning: October 01, 2022

and Ending: September 30, 2023

Name of Plan: Reilly Electrical Contractors, Inc.

Plan #: 00630592

### PREMIUMS PLAN DETAIL

<u>BENEFIT</u>	<u>PREMIUMS</u>	<u>ADMIN FEES*</u>	<u>TERMINATION PREMIUM</u>	<u>TERMINATION FEES</u>	<u>STATE CONTINUATION FEES</u>	<u>TOTAL PAID</u>
DENTAL	\$118,893.65	\$0.00	\$0.00	\$0.00	\$0.00	\$118,893.65
MEDICAL	\$2,453,789.06	\$73,613.05	\$0.00	\$0.00	\$0.00	\$2,527,402.11
VISION	\$5,492.41	\$0.00	\$0.00	\$0.00	\$0.00	\$5,492.41
<b>TOTALS</b>	<b>\$2,578,175.12</b>	<b>\$73,613.05</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$2,651,788.17</b>

### COMMISSIONS PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL COMM PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
DENTAL	\$5,944.70	417937	BROWN & BROWN OF MASSACHUSETTS LLC
<b>TOTAL</b>	<b>\$5,944.70</b>		

### BENEFIT ADVISOR FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
MEDICAL	\$73,613.05	417937	BROWN & BROWN OF MASSACHUSETTS LLC
<b>TOTAL</b>	<b>\$73,613.05</b>		

### SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
<b>TOTAL</b>			

### INCENTIVE COMPENSATION PAYMENTS BASED ON MEMBERSHIP IN YOUR PLAN/OR LUMP SUM AMOUNT

<u>TOTAL PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
<b>TOTAL</b>		

### EXPOSURES DETAIL (Last Month of the Plan Period)

<u>BENEFIT</u>	<u>EMPLOYEE</u>	<u>DEPENDENT</u>	<u>SPOUSE</u>	<u>FAMILY</u>	<u>CHILD</u>
DENTAL	131	0	0	77	0
MEDICAL	131	0	0	76	0
VISION	129	0	0	76	0

\*Admin Fees Include Commissions

Sys 11/7/2023



10 Hudson Yards  
New York, NY 10001  
guardianlife.com

JENNIFER STRATFORD  
REILLY ELECTRICAL CONTRACTORS INC  
14 NORFOLK AVENUE  
SOUTH EASTON, MA 02375

**January 09, 2024**

Plan Number : 00910446  
Anniversary Date : 1/1/23

To help you with the preparation of your form 5500 (Annual Return / Report of Employee Benefit Plan ERISA) for filing with the Department of Labor, we are providing the following information.

You are required to transfer the information from this form to the appropriate schedule, forming Part of the 5500 form furnished by the United States Department of Labor. You will also need Guardian's Tax ID (EIN) and NAIC numbers, which are as follows :

EIN : 13-5123390

NAIC: 64246

A copy of this form should be retained for your records.

Certified to be correct

The Guardian Life Insurance Company of America.

1-888-278-4542



Name of Plan : REILLY ELECTRICAL CONTRACTORS INC

Plan Number : 00910446

Data for Period From : 10/1/22 To : 9/30/23

The approximate number of employees covered at the end of the plan year : 140

Group Insurance coverage(s) included under this Plan :

Short Term Disability

The following figure represents commissions that are to be reported on Schedule A, Line 3, Element (b):

Contract Identification	Name and Address of Recipient of Commissions
0006J485	BROWN & BROWN OF MASSACHUSETTS 181 WELLS AVE. NEWTON MA 02459
Group Insurance Coverage(s) For Above Contract	Commissions Paid
Short Term Disability	2,305.42
<b>Total For Contract:</b>	<b>2,305.42</b>
<b>Total Commissions Paid On Plan:</b>	<b>2,305.42</b>

The following figure represents fees that are to be reported on Schedule A, Line 3, Element (c):

Contract Identification	Name of Recipient of Fees	Amount
000DK605	BROWN & BROWN OF NEW YORK INC	\$3,775.33
<b>Total Fees Paid</b>		<b>\$3,775.33</b>

However, the compensation listed above is not charged to your case in calculating new rates.

Recipient of One Time Reimbursement	Amount Paid
<b>Total Fees Paid:</b>	

Group Insurance Coverage(s) For Above Contract	Gross Premium Paid
Short Term Disability	47,050.31
<b>Totals:</b>	<b>47,050.31</b>
<b>Premium due and unpaid at the end of plan year:</b>	<b>0</b>



**Name of Plan:** REILLY ELECTRICAL CONTRACTORS INC

**Plan Number:** 00910446

*The following figure represents Indirect Compensation to be reported on Schedule C, Part 1, 3, Elements (a & c)*

Contract Identification (a)	Name and Address of Recipient of Indirect Compensation (a)	Amount (c)
Total Indirect Compensation Paid:		

*The following is for Indirect Compensation information to be reported on Schedule C, Part 1, 3, Elements (b, d & e)*

Service Code (b)	Name and Address (d)	Indirect Compensation (e)

# Vision Insurance Information For Form 5500

Information Compiled By: EyeMed Vision Care on behalf of the Fidelity Security Life Insurance Company

Report Start Date	Report End Date
10/1/2022	9/30/2023

Payments Received by carrier from plan or plan sponsor:

Name of Plan	Contract or ID #	Enrollment Group	Approximate number of persons covered at end of policy or contract year:	EIN	NAIC		Amount
RELCO (REILLY ELECTRIC)	10184601001	RELCO (REILLY ELECTRIC)	117	430949844	71870		\$8,136.78
			117			<b>Total:</b>	<b>\$8,136.78</b>

Commissions or fees paid by carrier to agents, brokers or other persons:

Payee Name	Address Line 1	City	State	Zip Code	Commission Type Code		Amount
Brown & Brown of MA	333 Elm Street, Ste. 300	Dedham	MA	02026	COMM		\$66.43
Brown & Brown of MA	P. O. Box 745957	Atlanta	GA	30374-5957	COMM		\$551.15