

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

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

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

Part II Basic Plan Information—enter all requested information

1a Name of plan <u>CENTER FOR SPECTRUM SERVICES</u>	1b Three-digit plan number (PN) ▶ <u>501</u>
	1c Effective date of plan <u>01/01/2024</u>
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) <u>CENTER FOR SPECTRUM SERVICES</u> <u>70 KUKUK LN</u> <u>KINGSTON, NY 12401-6943</u>	2b Employer Identification Number (EIN) <u>14-1604884</u>
	2c Plan Sponsor's telephone number <u>845-336-3302</u>
	2d Business code (see instructions) <u>611000</u>

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

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

SIGN HERE	<u>Filed with authorized/valid electronic signature.</u>	<u>07/21/2025</u>	<u>SHELLY M. BECK</u>
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2024)
v. 240311

<p>3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor</p> <p style="color: blue;">CENTER FOR SPECTRUM SERVICES</p> <p style="color: blue;">70 KUKUK LN KINGSTON, NY 12401-6943</p>	<p>3b Administrator's EIN 14-1604884</p> <p>3c Administrator's telephone number 845-336-2616</p>
<p>4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:</p> <p>a Sponsor's name</p> <p>c Plan Name</p>	<p>4b EIN</p> <p>4d PN</p>
<p>5 Total number of participants at the beginning of the plan year</p>	<p>5 123</p>
<p>6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).</p> <p>a(1) Total number of active participants at the beginning of the plan year</p> <p>a(2) Total number of active participants at the end of the plan year</p> <p>b Retired or separated participants receiving benefits.....</p> <p>c Other retired or separated participants entitled to future benefits</p> <p>d Subtotal. Add lines 6a(2), 6b, and 6c.....</p> <p>e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.</p> <p>f Total. Add lines 6d and 6e</p> <p>g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)</p> <p>g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)</p> <p>h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....</p>	<p>6a(1) 123</p> <p>6a(2) 114</p> <p>6b 1</p> <p>6c</p> <p>6d 115</p> <p>6e</p> <p>6f 115</p> <p>6g(1)</p> <p>6g(2)</p> <p>6h</p>
<p>7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)</p>	<p>7</p>

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4B 4D 4E 4F

<p>9a Plan funding arrangement (check all that apply)</p> <p>(1) <input type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input type="checkbox"/> Trust</p> <p>(4) <input checked="" type="checkbox"/> General assets of the sponsor</p>	<p>9b Plan benefit arrangement (check all that apply)</p> <p>(1) <input type="checkbox"/> Insurance</p> <p>(2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts</p> <p>(3) <input type="checkbox"/> Trust</p> <p>(4) <input checked="" type="checkbox"/> General assets of the sponsor</p>
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10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

<p>a Pension Schedules</p> <p>(1) <input type="checkbox"/> R (Retirement Plan Information)</p> <p>(2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary</p> <p>(3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary</p> <p>(4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____</p> <p>(5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)</p>	<p>b General Schedules</p> <p>(1) <input type="checkbox"/> H (Financial Information)</p> <p>(2) <input type="checkbox"/> I (Financial Information – Small Plan)</p> <p>(3) <input checked="" type="checkbox"/> A (Insurance Information) – Number Attached <u>7</u></p> <p>(4) <input type="checkbox"/> C (Service Provider Information)</p> <p>(5) <input type="checkbox"/> D (DFE/Participating Plan Information)</p> <p>(6) <input type="checkbox"/> G (Financial Transaction Schedules)</p>
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Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) Yes No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) Yes No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan CENTER FOR SPECTRUM SERVICES		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES		D Employer Identification Number (EIN) 14-1604884

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
METROPOLITAN 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
13-5581829	65978	0232395	20	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 2254	(b) Total amount of fees paid 592
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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

NFP INS SERVICES INC.
1250 S CAPITAL OF TEXAS HWY
BLDG 2 STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
62	0		3

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

ROSE & KIERNAN INC.
PO BOX 640
EAST GREENBUSH, NY 12061

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
	513	TPA ADMIN FEES	3

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

ROSE & KIERNAN INC.

PO BOX 786677
PHILADELPHIA, PA 19178

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2192	79	SUPPLEMENTAL COMPENSATION	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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	8481
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan CENTER FOR SPECTRUM SERVICES	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES	D Employer Identification Number (EIN) 14-1604884

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
METROPOLITAN 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
13-5581829	65978	0232392	35	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 1120	(b) Total amount of fees paid 384
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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
NFP INS SERVICES INC. **1250 S CAPITAL OF TEXAS HWY**
BLDG 2 STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
37	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid
ROSE & KIERNAN INC **PO BOX 640**
EAST GREENBUSH, NY 12061

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	339	TPA ADMIN FEES	3

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

ROSE & KIERNAN INC

PO BOX 786677
PHILADELPHIA, PA 19178

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1083	45	SUPPLEMENTAL COMPENSATION	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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	6227
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan CENTER FOR SPECTRUM SERVICES		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES		D Employer Identification Number (EIN) 14-1604884

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

METROPOLITAN 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
13-5581829	65978	0232393	76	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 1426	(b) Total amount of fees paid 359
--	--

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

NFP INS SERVICES INC.

**1250 S CAPITAL OF TEXAS HWY
BLDG 2 STE 125
AUSTIN, TX 78746**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
42	0		3

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

ROSE & KIERNAN

**PO BOX 640
EAST GREENBUSH, NY 12061**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	322	TPA ADMIN FEES	3

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

ROSE & KIERNAN INC.

PO BOX 786677
PHILADELPHIA, PA 19178

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
1384	37	SUPPLEMENTAL COMPENSATION	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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	5692
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan CENTER FOR SPECTRUM SERVICES		B Three-digit plan number (PN) ▶ 501	
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES		D Employer Identification Number (EIN) 14-1604884	

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

METROPOLITAN 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
13-5581829	65978	0232394	39	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 677	(b) Total amount of fees paid 177
---	--

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

NFP INS SERVICES INC.

**1250 S CAPITAL OF TEXAS HWY
BLDG 2 STE 125
AUSTIN, TX 78746**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
18	0		3

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

ROSE & KIERNAN

**PO BOX 640
EAST GREENBUSH, NY 12061**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	155	TPA ADMIN FEES	3

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

ROSE & KIERNAN

PO BOX 786677
PHILADELPHIA, PA 19178

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
659	22	SUPPLEMENTAL COMPENSATION	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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a	2550
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.	10b	

Part IV Provision of Information

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

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

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

<p>A Name of plan CENTER FOR SPECTRUM SERVICES</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES</p>	<p>D Employer Identification Number (EIN) 14-1604884</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
MVP

(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
14-1640868	95521	490127	93	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 52868</p>	<p>(b) Total amount of fees paid</p>
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

ROSE & KIERNAN **PO BOX 640**
EAST GREENBUSH, NY 12601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
35703			

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

NFP CORPORATE SERVICES (NY) LLC **1250 S CAPITAL OF TEXAS HWY**
BLDG 2 STE 125
AUSTIN, TX 78746

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
17164			

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

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

<p>A Name of plan CENTER FOR SPECTRUM SERVICES</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES</p>	<p>D Employer Identification Number (EIN) 14-1604884</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
GUARDIAN

(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
13-5123390	64246	00505661	139	01/01/2024	12/31/2024

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

<p>(a) Total amount of commissions paid 4295</p>	<p>(b) Total amount of fees paid 0</p>
--	--

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
NFP PROPERTY & CASUALTY SERVICE **99TROY ROAD**
EAST GREENBUSH, NY 12061

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
4295			

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year **7b**

c Additions: (1) Contributions deposited during the year **7c(1)**
 (2) Dividends and credits..... **7c(2)**
 (3) Interest credited during the year..... **7c(3)**
 (4) Transferred from separate account **7c(4)**
 (5) Other (specify below)..... **7c(5)**
 ▶

(6) Total additions **7c(6)**

d Total of balance and additions (add lines **7b** and **7c(6)**) **7d**

e Deductions:
 (1) Disbursed from fund to pay benefits or purchase annuities during year **7e(1)**
 (2) Administration charge made by carrier..... **7e(2)**
 (3) Transferred to separate account **7e(3)**
 (4) Other (specify below)..... **7e(4)**
 ▶

(5) Total deductions **7e(5)**

f Balance at the end of the current year (subtract line **7e(5)** from line **7d**)..... **7f**

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Insurance Information

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

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

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

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

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

A Name of plan CENTER FOR SPECTRUM SERVICES		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES		D Employer Identification Number (EIN) 14-1604884

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

(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
11-1980218	55263	10639	98	01/01/2024	12/31/2024

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

(a) Total amount of commissions paid 5737	(b) Total amount of fees paid 3824
--	---

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

ROSE & KIERNAN

**PO BOX 640
EAST GREENBUSH, NY 12601**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
5737	3824		

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier	6b	
c Premiums due but unpaid at the end of the year	6c	
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	6d	

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

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

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

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

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

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

Specify nature of costs.

Part IV Provision of Information

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

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

March 7, 2025

ATTENTION: KATHY DUDA
CENTER FOR SPECTRUM SERVICES
70 KUKUK LANE
KINGSTON, NY 12401

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

ALICIA SIMMONS, (813) 673-3803 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

Official Use Only

**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.

- ▶ **File as an attachment to Form 5500**
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

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

A Name of plan	B Three digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES	D Employer Identification Number

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN 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
13-5581829	65978	0232393	76	01/01/2024	12/31/2024

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
1,426	359

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2024

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 786677				City: PHILADELPHIA		ST: PA ZIP: 19178-6677
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Health	1,384	Base Commissions	Health	37	Supplemental Compensation	03
	1,384	Sub-total		37	Sub-total	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 640				City: EAST GREENBUSH		ST: NY ZIP: 12061-0640
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
	0	Sub-total	Health	322	TPA Admin Fees	03
				322	Sub-total	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: NFP INS SERVICES INC						
Address: 1250 S CAPITAL OF TEXAS HWY BLDG 2 STE 125				City: AUSTIN		ST: TX ZIP: 78746-6446
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Health	42	Base Commissions				03
	42	Sub-total		0	Sub-total	

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts

Coverage	Amount
Health	5,692
	5,692

a Total premiums or subscription charges paid to carrier

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, item 2 above, report amount
Specify nature of costs below ▶

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

March 7, 2025

ATTENTION: KATHY DUDA
CENTER FOR SPECTRUM SERVICES
70 KUKUK LANE
KINGSTON, NY 12401

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

ALICIA SIMMONS, (813) 673-3803 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

**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.

- ▶ **File as an attachment to Form 5500**
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

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

A Name of plan	B Three digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES	D Employer Identification Number

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN 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
13-5581829	65978	0232392	35	01/01/2024	12/31/2024

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
1,120	384

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 786677			City: PHILADELPHIA		ST: PA ZIP: 19178-6677	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
CII	1,083	Base Commissions	CII	45	Supplemental Compensation	03
	1,083	Sub-total		45	Sub-total	
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 640			City: EAST GREENBUSH		ST: NY ZIP: 12061-0640	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
	0		CII	339	TPA Admin Fees	03
	0	Sub-total		339	Sub-total	
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: NFP INS SERVICES INC						
Address: 1250 S CAPITAL OF TEXAS HWY BLDG 2 STE 125			City: AUSTIN		ST: TX ZIP: 78746-6446	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
CII	37	Base Commissions				03
	37	Sub-total		0	Sub-total	

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts

Coverage	Amount
CII	6,227
	6,227

a Total premiums or subscription charges paid to carrier

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, item 2 above, report amount

Specify nature of costs below ▶

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

March 7, 2025

ATTENTION: KATHY DUDA
CENTER FOR SPECTRUM SERVICES
70 KUKUK LANE
KINGSTON, NY 12401

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

ALICIA SIMMONS, (813) 673-3803 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

Official Use Only

**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.

- ▶ **File as an attachment to Form 5500**
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

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

A Name of plan	B Three digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES	D Employer Identification Number

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN 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
13-5581829	65978	0232394	39	01/01/2024	12/31/2024

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
677	177

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2024

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: ROSE & KIERNAN INC
 Address: PO BOX 786677
 City: PHILADELPHIA ST: PA ZIP: 19178-6677

Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Health	659	Base Commissions	Health	22	Supplemental Compensation	03
	659	Sub-total		22	Sub-total	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: ROSE & KIERNAN INC
 Address: PO BOX 640
 City: EAST GREENBUSH ST: NY ZIP: 12061-0640

Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
	0	Sub-total	Health	155	TPA Admin Fees	03
				155	Sub-total	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

Name: NFP INS SERVICES INC
 Address: 1250 S CAPITAL OF TEXAS HWY BLDG 2 STE 125
 City: AUSTIN ST: TX ZIP: 78746-6446

Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
Health	18	Base Commissions				03
	18	Sub-total		0	Sub-total	

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts	Coverage	Amount
	Health	2,550
a Total premiums or subscription charges paid to carrier		2,550
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, item 2 above, report amount Specify nature of costs below ▶		

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.



Schedule A - Form 5500

Carrier:	MVP HealthCare
MVP TIN:	14-1640868
NAIC Code:	95521

Group ID: 490127
 Group Name: CENTER FOR SPECTRUM SERVICES
 Sub Group Number: 0001

0001	
Approximate Number of Covered persons at End of Policy or	93
Policy or Contract Year from Date	1/1/2024
Policy or Contract Year to Date	12/31/2024
Premium Billed	\$1,218,051.25
Premium Received	\$1,214,965.84
Premium Billed but not Paid	\$3,085.41

Commission Paid To	Commissions Paid
NFP Corporate Services (NY) LLC	\$17,164.61
Rose & Kiernan, Inc.	\$35,703.61

March 12, 2025

ATTENTION: KATHY DUDA
CENTER FOR SPECTRUM SERVICES
70 KUKUK LANE
KINGSTON, NY 12401

The Employee Retirement Income Security Act of 1974 ("ERISA") requires an annual financial report on employee welfare benefit plans and pension benefit plans which cover 100 or more participants at the beginning of the plan year and are subject to ERISA. The administrator of such a plan is required to file an annual report on I.R.S./DOL Form 5500, including the accompanying Schedule A, with the Employee Benefits Security Administration.

Your Metropolitan Life Insurance Company ("MetLife") employee welfare benefit plan may be subject to ERISA's annual reporting requirements and MetLife is therefore providing you with the information needed to complete Schedule A of Form 5500. The attached report is not an actual Schedule A form and should not be attached to the Form 5500 for regulatory filing. The information should be forwarded to the person who will be completing your annual filing. The information is taken from the data MetLife maintains within its normal business records and is, to the best of MetLife's knowledge and belief, complete and accurate.

Part I, Section 2 of this report lists the compensation paid to intermediaries related to your plan. Intermediaries may include brokers, consultants, agents and third-party administrators. There are several categories of compensation that may be paid to an intermediary. For your reference, the categories of compensation are listed below.

- Base Commissions - Base commissions are generally paid to an intermediary on a monthly basis and are usually calculated as a percentage of premium. Base commissions are typically factored into the cost of the customer's plan.
- Supplemental Compensation - Supplemental compensation may be paid to qualifying intermediaries based on an intermediary's new business or total inforce premium for a specified year. It is not MetLife's practice to specifically factor supplemental compensation into the cost of customer's plan. Supplemental compensation is factored into the price structure of MetLife's institutional business products.
- Fees - Fees may include payments made to intermediaries for services such as administration, communication, enrollment, billing, eligibility, recordkeeping, printing and mailing. Fees may be directly charged to the customer's plan.
- Award - If your intermediary received an award (such as travel or a gift) from MetLife, MetLife allocated the value of the award to all plans that were considered in the qualification criteria proportionately.

Note, the non-monetary compensation amount included in the Schedule A, Fees Paid section of the enclosed report is based on the calendar year tracking of all individual gifts or items of non-monetary compensation such as dinners, tickets for shows or other entertainment events, membership dues, hotels, equal to or greater than \$10, that are given to or provided directly or indirectly to brokers, producers, and other insurance intermediaries and/or their spouses, companions or family members. This information is tracked and aggregated at the brokerage firm or company level. The total value is divided by the total number of active contracts or policies in place with that firm for that year except for items relating directly to a specific customer or customers (which are reported to the specific customer(s)). This allocation is reported on the Schedule A reports for all ERISA customers who are part of a given broker firm's book of business.

Before submitting the Schedule A with your annual report to the Employee Benefits Security Administration, in addition to the information MetLife has provided, you should enter in the Schedule the appropriate name of the plan, three-digit plan number and employer identification number in the appropriate spaces immediately preceding Part I.

You may also wish to consult with your counsel concerning any need for attaching an opinion by an independent qualified public accountant.

This letter, together with your copy of the complete annual report should be retained for at least the 6-year period required by ERISA.

* The Gross Dealer Concession is based on premiums received and represents the total compensation and fees paid by the Insurance Company to the selling firm for the coverage used to fund the plan. Your representative(s) received payments subject to selling agreements that they have with the selling firm. The remaining compensation is used by the distributor or selling firm to pay other expenses, including Management Compensation, Conference expenses, etc. The Gross Dealer Concession includes the Commission Paid which is listed separately. The Metropolitan Life Insurance Company attests that the foregoing statement is complete and accurate to the best of its knowledge, information, and belief.

If you have any questions please contact your MetLife Account Representative:

CONNOR BOLAND, (813) 673-3771 or 800-ASK-4-MET and MetLife will assist you in obtaining this information.

MetLife appreciates your business.

**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.

- ▶ **File as an attachment to Form 5500**
- ▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection.

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

A Name of plan	B Three digit plan number ▶
C Plan sponsor's name as shown on line 2a of Form 5500 CENTER FOR SPECTRUM SERVICES	D Employer Identification Number

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 can be reported on a single Schedule A

1 Coverage:

(a) Name of insurance carrier

METROPOLITAN 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
13-5581829	65978	0232395	20	01/01/2024	12/31/2024

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part 1.

Totals *

Total amount of commissions paid	Total Fees Paid / amount
2,254	592

Part II

Official Use Only

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 786677			City: PHILADELPHIA		ST: PA ZIP: 19178-6677	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
WSTD	2,192	Base Commissions	WSTD	79	Supplemental Compensation	03
	2,192	Sub-total		79	Sub-total	
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: ROSE & KIERNAN INC						
Address: PO BOX 640			City: EAST GREENBUSH		ST: NY ZIP: 12061-0640	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
	0		WSTD	513	TPA Admin Fees	03
	0	Sub-total		513	Sub-total	
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid						
Name: NFP INS SERVICES INC						
Address: 1250 S CAPITAL OF TEXAS HWY BLDG 2 STE 125			City: AUSTIN		ST: TX ZIP: 78746-6446	
Commissions Paid			Fees Paid			Organization code
Coverage	Amount	Purpose	Coverage	Amount	Purpose	
WSTD	62	Base Commissions				03
	62	Sub-total		0	Sub-total	

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 organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. 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.

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts **N/A**

10 Nonexperience-rated contracts

Coverage	Amount
WSTD	8,481
	8,481

a Total premiums or subscription charges paid to carrier

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, item 2 above, report amount
Specify nature of costs below ▶

Footnote(s)

The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

If the plan named in Item A on the first page of Schedule A (the "Plan") retains the services of a broker, consultant, agent or third-party administrator (each an "Intermediary") for the Plan, MetLife may in addition to paying base commission provide additional compensation to the Intermediary under various preferred broker and other compensation programs and expense reimbursement. Under such programs, an Intermediary may qualify for additional compensation that may or may not be directly charged to the Plan. Such compensation may not be included in the amount listed in Item 2 on the first page of Schedule A. Please contact MetLife if you would like additional information or details.

2025 Schedule A/5500 Information

[Print](#) [Email](#)

2024 Schedule A/5500 Information

From	To
01/01/2024	12/31/2024

	Plan Name
Plan Number	CENTER FOR
00505661	SPECTRUM
	SERVICES

Guardian's EIN	Guardian's NAIC
13-5123390	64246

Approximate number of employees covered at the end of the plan year

139

Group Insurance coverage(s) included under this plan

Vision (Insured)

Optional Life

Optional AD&D

Long Term Disability

Life

AD&D

Collapse all

Commissions



Total Commissions

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

0009N638
NFP PROPERTY & CASUALTY SERVIC
\$4,295.63

Total	
commissions for	\$4,295.63
plan	

0009N638-NFP PROPERTY & CASUALTY SERVIC

99 TROY ROAD EAST GREENBUSH NY 12061

AD&D <hr/> <hr/> \$88.63
Life <hr/> <hr/> \$843.41
Long Term Disability <hr/> <hr/> \$1,096.67
Optional AD&D <hr/> <hr/> \$157.61
Optional Life <hr/> <hr/> \$1,039.31

Vision (Insured)	
<hr/>	
	\$1,070.00

Total commissions for contract **\$4,295.63**

Fees



Total fees

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

0009H365	
<hr/>	
	\$0.00

Total Fees Paid

One time reimbursement

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

Total Fees Paid

AD&D

\$886.28

Life

\$8,434.06

Long Term Disability

\$7,868.41

Optional AD&D

\$1,211.68

Optional Life

	\$7,995.30
Vision (Insured)	
<hr/>	
<hr/>	
	\$10,966.62

Total premium paid	\$37,362.35
<hr/>	
Premium due (unpaid) at the end of the year	\$0.00
<hr/>	

Indirect compensation - Schedule C, Part 1,3, Elements (a & c)

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

Total Indirect Compensation Paid:
<hr/>

Indirect compensation - Schedule C, Part 1,3, Elements (b, d & e)

The following figure represents indirect Compensation information to be reported on Schedule C, Part 1,3,

Elements(b. d & e)

[Back](#)

Form 5500 - Insurance Information

Group Name: THE CENTER FOR SPECTRUM SERVICES
Group Number: 10639
Division Number:
Number of Subscribers: 98
Number of Members: 159
Commissions Paid: \$5,737.40
Other fee: \$3,824.92
Plan Year: 01/01/2024 -12/31/2024
Premium Paid: \$95,623.59
Carrier: Delta Dental of New York
Delta EIN: 11-1980218
Delta NAIC: 55263

**This statement contains only the data necessary to complete your Form 5500.
It does not represent the actual form. For further information about filing,
please contact your attorney or tax consultant.**

APPENDIX**BROKER COMMISSIONS**

Broker Name:	\$Commissions Paid:	\$Other fee:
ROSE & KIERNAN INC	\$5,737.40	\$3,824.92