

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

2024

This Form is Open to Public Inspection

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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

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

Part I Annual Report Identification Information

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

- A This return/report is for: [] a multiemployer plan [] a multiple-employer plan... [X] a single-employer plan [] a DFE... B This return/report is: [] the first return/report [] the final return/report... C If the plan is a collectively-bargained plan, check here... [X] D Check box if filing under: [X] Form 5558 [] automatic extension [] the DFVC program... 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: LONG ISLAND ELECTRIC UTILITY SERVCO LLC HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN): 501
1c Effective date of plan: 01/01/2014
2a Plan sponsor's name (employer, if for a single-employer plan): LONG ISLAND ELECTRIC UTILITY SERVCO LLC
2b Employer Identification Number (EIN): 45-4652143
2c Plan Sponsor's telephone number: 973-430-7000
2d Business code (see instructions): 221100

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

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

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

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

Form 5500 (2024) v. 240311

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor EMPLOYEE BENEFITS COMMITTEE OF SERVCO 80 PARK PLAZA, T5E NEWARK, NJ 07102-4194	3b Administrator's EIN 45-4652143 3c Administrator's telephone number 973-430-7000
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4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN
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5 Total number of participants at the beginning of the plan year	5	2589
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6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d).		
a(1) Total number of active participants at the beginning of the plan year	6a(1)	2551
a(2) Total number of active participants at the end of the plan year	6a(2)	2669
b Retired or separated participants receiving benefits.....	6b	27
c Other retired or separated participants entitled to future benefits	6c	5
d Subtotal. Add lines 6a(2) , 6b , and 6c	6d	2701
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	6e	
f Total. Add lines 6d and 6e	6f	
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g(2)	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	6h	

7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
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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 4H 4Q

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

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

(1) **R** (Retirement Plan Information)

(2) **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary

(3) **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

(4) **DCG** (Individual Plan Information) – Number Attached _____

(5) **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

(1) **H** (Financial Information)

(2) **I** (Financial Information – Small Plan)

(3) **A** (Insurance Information) – Number Attached 3

(4) **C** (Service Provider Information)

(5) **D** (DFE/Participating Plan Information)

(6) **G** (Financial Transaction Schedules)

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

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

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

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

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

Receipt Confirmation Code _____

**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 LONG ISLAND ELECTRIC UTILITY SERVCO LLC HEALTH AND WELFARE PLAN		B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 LONG ISLAND ELECTRIC UTILITY SERVCO LLC		D Employer Identification Number (EIN) 45-4652143

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

AFLAC

(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
52-0807803	60380	NHY71	582	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 112085	(b) Total amount of fees paid 425
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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

VARIOUS AGENTS-PLEASE SEE ATTACHED

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
112085	425	COMMISSIONS AND FEES	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	

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	10a		672019
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. ▶

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

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	4858521
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**

A Name of plan LONG ISLAND ELECTRIC UTILITY SERVCO LLC HEALTH AND WELFARE PLAN	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 LONG ISLAND ELECTRIC UTILITY SERVCO LLC	D Employer Identification Number (EIN) 45-4652143	

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 GENERAL 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
22-2342710	39950	6090596	593	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	(b) Total amount of fees paid
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3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b Premiums paid to carrier **6b**

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

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

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

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

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

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

b Balance at the end of the previous year			7b	
c Additions: (1) Contributions deposited during the year	7c(1)			
	7c(2)			
	7c(3)			
	7c(4)			
	7c(5)			
(6) Total additions			7c(6)	0
d Total of balance and additions (add lines 7b and 7c(6))			7d	0
e Deductions:				
	7e(1)			
	7e(2)			
	7e(3)			
	7e(4)			
(5) Total deductions			7e(5)	0
f Balance at the end of the current year (subtract line 7e(5) from line 7d).....			7f	0

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

8 Benefit and contract type (check all applicable boxes)

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

9 Experience-rated contracts:

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

10 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier	10a	102290
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. ▶

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110 1210-0089

Department of the Treasury Internal Revenue Service

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).

2024

Department of Labor Employee Benefits Security Administration

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

Pension Benefit Guaranty Corporation

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... [x] a single-employer plan [] a DFE... B This return/report is: [] the first return/report [] the final return/report... C If the plan is a collectively-bargained plan, check here... [x] D Check box if filing under: [x] Form 5558 [] automatic extension [] the DFVC program... 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 LONG ISLAND ELECTRIC UTILITY SERVCO LLC HEALTH AND WELFARE PLAN
1b Three-digit plan number (PN) 501
1c Effective date of plan 01/01/2014
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) LONG ISLAND ELECTRIC UTILITY SERVCO LLC 999 STEWART AVE BETHPAGE NY 11714
2b Employer Identification Number (EIN) 45-4652143
2c Plan Sponsor's telephone number 973-430-7000
2d Business code (see instructions) 221100

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

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

Table with 4 columns: SIGN HERE, Signature, Date, and Name. Row 1: Mark D. Pepe, 10/02/2025, MARK PEPE. Row 2: Signature of employer/plan sponsor, Date, Enter name of individual signing as employer or plan sponsor. Row 3: 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

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor EMPLOYEE BENEFITS COMMITTEE OF SERVCO 80 PARK PLAZA, T5E NEWARK NJ 07102-4194	3b Administrator's EIN 45-4652143 3c Administrator's telephone number 973-430-7000																				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																				
5 Total number of participants at the beginning of the plan year	5 2,589																				
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:10%;">6a(1)</td><td style="width:90%;">2,551</td></tr> <tr><td>6a(2)</td><td>2,669</td></tr> <tr><td>6b</td><td>27</td></tr> <tr><td>6c</td><td>5</td></tr> <tr><td>6d</td><td>2,701</td></tr> <tr><td>6e</td><td></td></tr> <tr><td>6f</td><td></td></tr> <tr><td>6g(1)</td><td></td></tr> <tr><td>6g(2)</td><td></td></tr> <tr><td>6h</td><td></td></tr> </table>	6a(1)	2,551	6a(2)	2,669	6b	27	6c	5	6d	2,701	6e		6f		6g(1)		6g(2)		6h	
6a(1)	2,551																				
6a(2)	2,669																				
6b	27																				
6c	5																				
6d	2,701																				
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).....	7																				

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

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:
 4A 4B 4D 4H 4Q

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

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

*Amounts provided under the "Commissions Paid" column include all earned commission paid on all lines of business relative to your account during this reporting period.
 **Amounts provided under the "Fees Paid" column include the total value of any fees, awards, prizes, bonuses or other forms of non-monetary compensation paid relative to your account. These amounts are calculated based on a calendar year. Some bonuses, fees, and contests are paid based on the aggregate amount of sales for all accounts throughout the calendar year. To determine the value of these items relative to your account, the amount of sales for your account is divided by the total amount of sales during the reporting period. This percentage is then multiplied by the value of the bonus, fee or contest.

SCHEDULE A EARNINGS REPORT

Group Number	Total Premium Collected	Group Covered Count
NHY71	\$672,018.89	582

Group Address	Name of Insurance Carrier
PSEG LI 333 EARLE OVINGTON BLVD STE 403 UNIONDALE, NY 00001-1553	AFLAC 1932 WYNNTON ROAD COLUMBUS, GA 31999
	PLAN YEAR 01/01/2024 to 12/31/2024
CONTRACT NUMBER	NAIC CODE
52-0807803	60380

Agent Address Block w/ Full Name	Commissions Paid	Fees Paid
KIMBERLY DEMETRI 14 WALL ST NEW YORK, NY 10005	\$32,202.81	\$344.52
- NFP CORPORATE SERVICES (PA) INC 2600 KELLY RD STE 300 WARRINGTON, PA 18976	\$18,530.65	\$0.00
PATRICK C HARDIE 14 WALL ST STE 8C NEW YORK, NY 10005	\$8,208.15	\$40.18
- COMPREHENSIVE BENEFIT CONSULTANTS 1373 VETERANS HWY STE 10 HAUPPAUGE, NY 11788	\$7,654.30	\$0.00

ENIDA MICI 353 E 82ND ST APT 9 NEW YORK, NY 10028	\$6,325.04	\$40.18
PATRICIA RUPPEL 70 VICTORIA DR HILTON HEAD, SC 29926	\$5,026.70	\$0.00
- KOBER ASSOCIATES LLC 57-12 12TH AVE BEECHHURST, NY 11357	\$4,507.08	\$0.00
- KENNETH C MEIER CORP 170 OLD COUNTRY RD STE 410 MINEOLA, NY 11501	\$3,454.58	\$0.00
JOHN E GLASER 85 ARLINGTON RD LAKE RONKONKOMA, NY 11779	\$3,049.78	\$0.00
BRADLEY S RUPPEL 70 VICTORIA DR HILTON HEAD ISLAND, SC 29926	\$3,033.34	\$0.00
STEPHEN P WHITE 5 EMERALD LN MONTEBELLO, NY 10901	\$2,975.83	\$0.00
ANTHONY A LIBECCI 4864 ARTHUR KILL RD STE 3 STATEN ISLAND, NY 10309	\$2,509.27	\$0.00
- BENCHMARK INSURANCE AGENCY LLC 18 SUMMER ST FOREST HILLS, NY 11375	\$2,142.25	\$0.00
- KENNETH C MEIER CORP 19 MARKWOOD RD GARDEN CITY, NY 11530	\$1,628.94	\$0.00
JASON G DENIVO 199 WATER ST FL 23 NEW YORK, NY 10038	\$1,512.05	\$0.00

DANIELLE L SCHOFS 21 W 76TH ST APT 1BW NEW YORK, NY 10023	\$1,305.24	\$0.00
GERARD M QUINN 5934 GRISBY HOUSE CT CENTREVILLE, VA 20120	\$1,254.36	\$0.00
JAMES (JAY) GRIMES 614 ROBERT WILLIAMS RD PINE MOUNTAIN, GA 31822	\$1,104.27	\$0.00
DOUGLAS R MEIER 23 ROCKLEDGE TER POMPTON PLAINS, NJ 07444	\$1,039.65	\$0.00
JENNIFER ELIA LUBELSKY 80 JOHN ST APT 11C NEW YORK, NY 10038	\$492.85	\$0.00
TIMOTHY C CAVAZOS 11551 NUCKOLS RD STE P GLEN ALLEN, VA 23059	\$447.36	\$0.00
- BENCHMARK INSURANCE AGENCY LLC ATTN: PARK STRATEGIES 101 PARK AVE RM 2506 NEW YORK, NY 10178	\$428.70	\$0.00
- BENITO A ROTONDI II INC 23 PINE RIDGE RD SARATOGA SPRINGS, NY 12866	\$362.34	\$0.00
BRIAN WHITE 6 COWDIN LN CHAPPAQUA, NY 10514	\$333.48	\$0.00
- NATIONAL ALLOTMENT INS. AGENCY 491 DEKALB AVE STE 2 BROOKLYN, NY 11205	\$318.76	\$0.00
MICHAEL S CHILLE 6760 VALHALLA WAY WINDERMERE, FL 34786	\$256.34	\$0.00

BETH MCLEOD 45 CAROLIN RD MONTCLAIR, NJ 07043	\$190.84	\$0.00
ANDREW HENRY 316 E WALNUT ST LONG BEACH, NY 11561	\$160.49	\$0.00
PATRICK NEGRI 214 DORIS AVE NORTH BELLMORE, NY 11710	\$154.31	\$0.00
DOMENICO V MAUTARELLI PO BOX 767 MATTITUCK, NY 11952	\$140.28	\$0.00
PATRICK RUHLE 200 GARDEN CITY PLZ STE 410 GARDEN CITY, NY 11530	\$134.23	\$0.00
J MICHAEL BUTLER 1440 OLD LENOIR RD STE A HICKORY, NC 28601	\$120.77	\$0.00
- JACQUES P DAVID CORPORATION 5 MONFORT DR HUNTINGTON, NY 11743	\$114.76	\$0.00
KATHERINE D GRIMES 601 WHITE CHAPEL CIR CHARLESTON, SC 29412	\$111.74	\$0.00
TODD BURKE 199 WATER ST FL 23 NEW YORK, NY 10038	\$97.39	\$0.00
JACK KOHEN 13955 TAHITI WAY APT 157 MARINA DEL REY, CA 90292	\$94.64	\$0.00
SALVATORE RESTIVO 248 ROUTE 25A # 3009 EAST SETAUKET, NY 11733	\$83.19	\$0.00

KEITH LEPACK 1991 BROADWAY APT 12B NEW YORK, NY 10023	\$75.27	\$0.00
- ACRISURE WALLSTREET PARTNERS LLC 1530 RAX CT JEFFERSON CITY, MO 65109	\$63.44	\$0.00
MARY ANN MASTROIANNI 788 CAPTAINS GATE WESTBURY, NY 11590	\$62.79	\$0.00
MARC BERT HEINBERG 4293 BEDFORD AVE BROOKLYN, NY 11229	\$52.00	\$0.00
TYLER RUPPEL 125 JERICHO TPKE STE 201 JERICHO, NY 11753	\$45.94	\$0.00
- S BEIN INC 8676 SW CARRARA WAY PORT ST LUCIE, FL 34987	\$37.83	\$0.00
KARL WASHWICK 860 E MAIN ST STE A RIVERHEAD, NY 11901	\$34.20	\$0.00
MICHAEL A FORNARO 271 US HIGHWAY 46 STE H119 FAIRFIELD, NJ 07004	\$31.98	\$0.00
- INSURANCE PLANNING ASSOCIATES 6800 JERICHO TPKE STE 118W SYOSSET, NY 11791	\$31.59	\$0.00
MICHAEL P DESTEFANO 4250 VETERANS MEMORIAL HWY STE 1015W HOLBROOK, NY 11741	\$30.84	\$0.00
WILLIAM H WHICHER 11 KEENAN PL GARDEN CITY, NY 11530	\$22.49	\$0.00

MICHAEL WOLFF 500 TRAIL DUST DR CEDAR PARK, TX 78613	\$22.23	\$0.00
WILLIAM J LOEFFERT 545 DAVIS ST NORTH BABYLON, NY 11703	\$18.59	\$0.00
J MICHAEL BUTLER 1440 OLD LENOIR RD STE A HICKORY, NC 28601	\$12.61	\$0.00
- INTERNATIONAL BENEFIT ADMIN,LLC 100 GARDEN CITY PLZ STE 102 GARDEN CITY, NY 11530	\$10.27	\$0.00
THOMAS G GIORDANO 139 CONCORD AVE OCEANSIDE, NY 11572	\$10.27	\$0.00
JANET C DREW 4 ASH AVE UNIT 10 KENTFIELD, CA 94904	\$9.88	\$0.00
ALBERT SHUST 200 CENTENNIAL AVE STE 105 PISCATAWAY, NJ 08854	\$5.72	\$0.00
- MCINERNEY GROUP LLC 14 STILLMAN LN PLEASANTVILLE, NY 10570	\$0.78	\$0.00
Sum:	\$112,085.48	\$424.88