

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 <div style="font-size: 24pt; font-weight: bold; text-align: center;">2024</div> This Form is Open to Public Inspection
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Part I	Annual Report Identification Information
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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) M

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
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1a Name of plan <u>MISSISSIPPI POWER COMPANY MEDICAL BENEFITS TRUST</u>	1b Three-digit plan number (PN) ▶ <u>501</u> 1c Effective date of plan
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>SOUTHERN COMPANY SERVICES, INC.</u> <u>30 IVAN ALLEN JR BLVD NW</u> <u>BIN SC900</u> <u>ATLANTA, GA 30308</u>	2b Employer Identification Number (EIN) <u>64-0737285</u> 2c Plan Sponsor's telephone number <u>404-506-0282</u> 2d Business code (see instructions)

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	Filed with authorized/valid electronic signature.		
	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	Filed with authorized/valid electronic signature.	10/14/2025	JAMES GARVIE
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor SOUTHERN COMPANY SERVICES, INC. 30 IVAN ALLEN JR BLVD NW BIN SC900 ATLANTA, GA 30308	3b Administrator's EIN 64-0737285 3c Administrator's telephone number 404-506-0282																				
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																				
5 Total number of participants at the beginning of the plan year	5																				
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits..... c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:100px;">6a(1)</td><td></td></tr> <tr><td>6a(2)</td><td></td></tr> <tr><td>6b</td><td></td></tr> <tr><td>6c</td><td></td></tr> <tr><td>6d</td><td></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)		6a(2)		6b		6c		6d		6e		6f		6g(1)		6g(2)		6h	
6a(1)																					
6a(2)																					
6b																					
6c																					
6d																					
6e																					
6f																					
6g(1)																					
6g(2)																					
6h																					
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7																				

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

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

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

a Pension Schedules (1) <input type="checkbox"/> R (Retirement Plan Information) (2) <input type="checkbox"/> MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) <input type="checkbox"/> SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (4) <input type="checkbox"/> DCG (Individual Plan Information) – Number Attached _____ (5) <input type="checkbox"/> MEP (Multiple-Employer Retirement Plan Information)	b General Schedules (1) <input checked="" type="checkbox"/> H (Financial Information) (2) <input type="checkbox"/> I (Financial Information – Small Plan) (3) <input type="checkbox"/> A (Insurance Information) – Number Attached <u> 0 </u> (4) <input checked="" type="checkbox"/> C (Service Provider Information) (5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information) (6) <input type="checkbox"/> G (Financial Transaction Schedules)
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Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

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

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

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

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

Receipt Confirmation Code _____

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

A Name of plan MISSISSIPPI POWER COMPANY MEDICAL BENEFITS TRUST	B Three-digit plan number (PN) ▶	501
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN COMPANY SERVICES, INC.	D Employer Identification Number (EIN) 64-0737285	

Part I Service Provider Information (see instructions)

You must complete this Part, in accordance with the instructions, to report the information required for **each person** who received, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of monetary value) in connection with services rendered to the plan or the person's position with the plan during the plan year. If a person received **only** eligible indirect compensation for which the plan received the required disclosures, you are required to answer line 1 but are not required to include that person when completing the remainder of this Part.

1 Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions)... Yes No

b If you answered line 1a "Yes," enter the name and EIN or address of each person providing the required disclosures for the service providers who received only eligible indirect compensation. Complete as many entries as needed (see instructions).

(b) Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation

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2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "Yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, \$5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

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

AON

1 CHASE MANHATTAN PLAZA
NEW YORK, NY 10005

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 50	NONE	39667	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

HANCOCK WHITNEY BANK

64-0169065

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
21 50	NONE	19091	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

SCHEDULE D (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small>	DFE/Participating Plan Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection.
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024

A Name of plan <u>MISSISSIPPI POWER COMPANY MEDICAL BENEFITS TRUST</u>	B Three-digit plan number (PN)	<u>501</u>
C Plan or DFE sponsor's name as shown on line 2a of Form 5500 <u>SOUTHERN COMPANY SERVICES, INC.</u>	D Employer Identification Number (EIN) <u>64-0737285</u>	

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

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

a Plan name	SOUTHERN CO SERVICES HEALTH CARE PLAN FOR RETIREES	
b Name of plan sponsor	SOUTHERN COMPANY SERVICES INC	c EIN-PN 63-0274273-608

a Plan name	SOUTHERN CO SERVICES LIFE INSURANCE PLAN FOR RETIREES	
b Name of plan sponsor	SOUTHERN COMPANY SERVICES INC	c EIN-PN 63-0274273-518

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

a Plan name		
b Name of plan sponsor		c EIN-PN

SCHEDULE H (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Financial Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2024 This Form is Open to Public Inspection
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For calendar plan year 2024 or fiscal plan year beginning 01/01/2024 and ending 12/31/2024	
A Name of plan MISSISSIPPI POWER COMPANY MEDICAL BENEFITS TRUST	B Three-digit plan number (PN) ▶ 501
C Plan sponsor's name as shown on line 2a of Form 5500 SOUTHERN COMPANY SERVICES, INC.	D Employer Identification Number (EIN) 64-0737285

Part I	Asset and Liability Statement
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1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. **Round off amounts to the nearest dollar.** MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

	(a) Beginning of Year	(b) End of Year
Assets		
a Total noninterest-bearing cash	1a	
b Receivables (less allowance for doubtful accounts):		
(1) Employer contributions	1b(1)	
(2) Participant contributions	1b(2)	
(3) Other	1b(3)	
c General investments:		
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	295352
(2) U.S. Government securities	1c(2)	4416069
(3) Corporate debt instruments (other than employer securities):		
(A) Preferred	1c(3)(A)	
(B) All other	1c(3)(B)	
(4) Corporate stocks (other than employer securities):		
(A) Preferred	1c(4)(A)	
(B) Common	1c(4)(B)	
(5) Partnership/joint venture interests	1c(5)	
(6) Real estate (other than employer real property)	1c(6)	
(7) Loans (other than to participants)	1c(7)	
(8) Participant loans	1c(8)	
(9) Value of interest in common/collective trusts	1c(9)	
(10) Value of interest in pooled separate accounts	1c(10)	
(11) Value of interest in master trust investment accounts	1c(11)	
(12) Value of interest in 103-12 investment entities	1c(12)	
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)	
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)	
(15) Other	1c(15)	

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities.....	1d(1)		
(2) Employer real property.....	1d(2)		
e Buildings and other property used in plan operation.....	1e		
f Total assets (add all amounts in lines 1a through 1e).....	1f	4633584	4711421
Liabilities			
g Benefit claims payable.....	1g		
h Operating payables.....	1h		
i Acquisition indebtedness.....	1i		
j Other liabilities.....	1j		
k Total liabilities (add all amounts in lines 1g through 1j).....	1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f).....	1l	4633584	4711421

Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers.....	2a(1)(A)		
(B) Participants.....	2a(1)(B)		
(C) Others (including rollovers).....	2a(1)(C)		
(2) Noncash contributions.....	2a(2)		
(3) Total contributions. Add lines 2a(1)(A) , (B) , (C) , and line 2a(2)	2a(3)		0
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit).....	2b(1)(A)	32535	
(B) U.S. Government securities.....	2b(1)(B)	95195	
(C) Corporate debt instruments.....	2b(1)(C)		
(D) Loans (other than to participants).....	2b(1)(D)		
(E) Participant loans.....	2b(1)(E)		
(F) Other.....	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		127730
(2) Dividends:			
(A) Preferred stock.....	2b(2)(A)		
(B) Common stock.....	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds).....	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A) , (B) , and (C)	2b(2)(D)		0
(3) Rents.....	2b(3)		
(4) Net gain (loss) on sale of assets:			
(A) Aggregate proceeds.....	2b(4)(A)	2593842	
(B) Aggregate carrying amount (see instructions).....	2b(4)(B)	2574580	
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result.....	2b(4)(C)		19262
(5) Unrealized appreciation (depreciation) of assets:			
(A) Real estate.....	2b(5)(A)	-10397	
(B) Other.....	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		-10397

		(a) Amount	(b) Total
(6) Net investment gain (loss) from common/collective trusts	2b(6)		
(7) Net investment gain (loss) from pooled separate accounts	2b(7)		
(8) Net investment gain (loss) from master trust investment accounts	2b(8)		
(9) Net investment gain (loss) from 103-12 investment entities	2b(9)		
(10) Net investment gain (loss) from registered investment companies (e.g., mutual funds)	2b(10)		
c Other income	2c		
d Total income. Add all income amounts in column (b) and enter total	2d		136595

Expenses

e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)		
(2) To insurance carriers for the provision of benefits	2e(2)		
(3) Other	2e(3)		
(4) Total benefit payments. Add lines 2e(1) through (3)	2e(4)		0
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Interest expense	2h		
i Administrative expenses:			
(1) Salaries and allowances	2i(1)		
(2) Contract administrator fees	2i(2)	39667	
(3) Recordkeeping fees	2i(3)		
(4) IQPA audit fees	2i(4)		
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	19091	
(7) Actuarial fees	2i(7)		
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)		
(12) Total administrative expenses. Add lines 2i(1) through (11)	2i(12)		58758
j Total expenses. Add all expense amounts in column (b) and enter total	2j		58758

Net Income and Reconciliation

k Net income (loss). Subtract line 2j from line 2d	2k		77837
l Transfers of assets:			
(1) To this plan	2l(1)		
(2) From this plan	2l(2)		

Part III Accountant's Opinion

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

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

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

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

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

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

(1) Name:

(2) EIN:

d The opinion of an independent qualified public accountant is **not attached** as part of Schedule H because:

(1) This form is filed for a CCT, PSA, DCG or MTIA. (2) It will be attached to the next Form 5500 pursuant to 29 CFR 2520.104-50.

Part IV Compliance Questions

4 CCTs and PSAs do not complete Part IV. MTIAs, 103-12 IEs, and GIAs do not complete lines 4a, 4e, 4f, 4g, 4h, 4k, 4m, 4n, or 5. 103-12 IEs also do not complete lines 4j and 4l. MTIAs also do not complete line 4l. DCGs do not complete lines 4e, 4f, 4k, 4l, and 5, and DCGs generally complete the rest of Part IV collectively for all plans in the DCG, except as otherwise provided (see instructions).

During the plan year:

	Yes	No	Amount
a Was there a failure to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? Continue to answer "Yes" for any prior year failures until fully corrected. (See instructions and DOL's Voluntary Fiduciary Correction Program.)			
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by participant's account balance. (Attach Schedule G (Form 5500) Part I if "Yes" is checked.)		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible? (Attach Schedule G (Form 5500) Part II if "Yes" is checked.)		X	
d Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a. Attach Schedule G (Form 5500) Part III if "Yes" is checked.)		X	
e Was this plan covered by a fidelity bond?			
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?			
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?			
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?			
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	X		
j Were any plan transactions or series of transactions in excess of 5% of the current value of plan assets? (Attach schedule of transactions if "Yes" is checked and see instructions for format requirements.)	X		
k Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?			
l Has the plan failed to provide any benefit when due under the plan?			
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)			
n If 4m was answered "Yes," check the "Yes" box if you either provided the required notice or one of the exceptions to providing the notice applied under 29 CFR 2520.101-3.			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? Yes No
If "Yes," enter the amount of any plan assets that reverted to the employer this year _____.

5b If, during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

5c Was the plan a defined benefit plan covered under the PBGC insurance program at any time during this plan year? (See ERISA section 4021 and instructions.) Yes No Not determined

If "Yes" is checked, enter the My PAA confirmation number from the PBGC premium filing for this plan year _____.

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

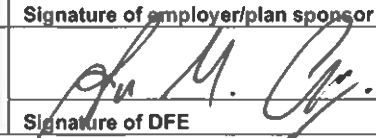
- A** This return/report is for: a multiemployer plan a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- a single-employer plan a DFE (specify) M
- B** This return/report is: the first return/report the final 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 MISSISSIPPI POWER COMPANY MEDICAL BENEFITS TRUST		1b Three-digit plan number (PN) ▶ 501
		1c Effective date of plan
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) SOUTHERN COMPANY SERVICES, INC. 30 IVAN ALLEN JR BLVD NW BIN SC900 ATLANTA GA 30308		2b Employer Identification Number (EIN) 64-0737285
		2c Plan Sponsor's telephone number 404-506-0282
		2d Business code (see instructions)

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	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		10/14/25	James Garvie
	Signature of DFE	Date	Enter name of individual signing as DFE

STATEMENT OF ACTIVITY

Statement Period
Account Number

01/01/2024 through 12/31/2024
M01479
MS POWER CO MEDICAL BENEFITS PL
TTEE 110386

Schedule Of Reportable Transactions

PLAN NUMBER:

EIN NUMBER:

DESCRIPTION	PURCH/SELL PRICE EXPENSE INCURRED	COST OF ASSET	VALUE OF ASSET ON TXN DATE	NET GAIN OR LOSS
BEGINNING MARKET VALUE:	4,633,583.85			
SECURITY TRANSACTIONS EXCEEDING 5%:				
SHORT TERM INV				
CUSIP # 38141W273 GOLDMAN SACHS GOVERNMENT FUND CLASS INST (#465)				
TOTAL ACTIVITY FROM 01/01/2024 TO 12/31/2024				
PURCHASED	1,267,669.51	1,267,669.51	1,267,669.51	
ACCOUNT 2061000046 ACCOUNT 2061000055				
SOLD	1,458,842.31	1,458,842.31	1,458,842.31	
TOTAL	2,726,511.82	2,726,511.82	2,726,511.82	
TOTAL SHORT TERM INV	2,726,511.82	2,726,511.82	2,726,511.82	
US GOV'T OBLIGATIONS				
CUSIP # 3133EEKE9 FFCB 2.3% 03/20/2024				
MATURED	140,000.00	146,624.80	140,000.00	6,624.80
ACCOUNT 2061000046				
MATURED	120,000.00	125,678.40	120,000.00	5,678.40
ACCOUNT 2061000055				
TOTAL	260,000.00	272,303.20	260,000.00	12,303.20
CUSIP # 912828G38 UNITED STATES TREASURY 2.25% 11/15/2024				
MATURED	325,000.00	328,042.00	325,000.00	3,042.00
ACCOUNT 2061000046				
MATURED	200,000.00	208,439.84	200,000.00	8,439.84
ACCOUNT 2061000055				
TOTAL	525,000.00	536,481.84	525,000.00	11,481.84
CUSIP # 91282CLK5 UNITED STATES TREASURY NOTES 3.625% 08/31/2029				
PURCHASED AT 100.660 THRU BANK OF AMERICA SEC ACCOUNT 2061000046	201,320.31	201,320.31	200,954.00	
PURCHASED AT 100.660 THRU BANK OF AMERICA SEC ACCOUNT 2061000055	301,980.47	301,980.47	301,431.00	



STATEMENT OF ACTIVITY

Statement Period
Account Number

01/01/2024 through 12/31/2024
M01479
MS POWER CO MEDICAL BENEFITS PL
TTEE 110386

Schedule Of Reportable Transactions

PLAN NUMBER:

EIN NUMBER:

DESCRIPTION	PURCH/SELL PRICE EXPENSE INCURRED	COST OF ASSET	VALUE OF ASSET ON TXN DATE	NET GAIN OR LOSS
TOTAL	503,300.78	503,300.78	502,385.00	
CUSIP # 91282CLW9 UNITED STATES TREASURY NOTES 4.25% 11/15/2034				
PURCHASED AT 99.875 THRU WELLS FARGO SECURITIES ACCOUNT 2061000046	249,687.50	249,687.50	248,945.00	
PURCHASED AT 97.336 THRU WELLS FARGO SECURITIES ACCOUNT 2061000055	121,669.92	121,669.92	121,680.00	
TOTAL	371,357.42	371,357.42	370,625.00	
TOTAL US GOV'T OBLIGATIONS	1,659,658.20	1,683,443.24	1,658,010.00	23,785.04
TOTAL SECURITY TRANSACTIONS EXCEEDING 5%		4,409,955.06		





HANCOCK WHITNEY

Trust & Asset Management
2285 Lakeshore Dr., Building 4
New Orleans, LA 70122

STATEMENT OF ACTIVITY

Statement Period
Account Number

01/01/2024 through 12/31/2024
M01479
MS POWER CO MEDICAL BENEFITS PL
TTEE 110386

Schedule Of Reportable Transactions

PLAN NUMBER:

EIN NUMBER:

DESCRIPTION	PURCH/SELL PRICE EXPENSE INCURRED	COST OF ASSET	VALUE OF ASSET ON TXN DATE	NET GAIN OR LOSS
BEGINNING MARKET VALUE:	4,633,583.85			
SINGLE TRANSACTIONS EXCEEDING 5%:				
09/25/2024 PURCHASED 300,000 UNITS UNITED STATES TREASURY NOTES 3.625% 08/31/2029 ON 09/24/2024 AT 100.6602 THRU BANK OF AMERICA SEC ACCOUNT 2061000055		301,980.47		
09/25/2024 SOLD 302,731.51 GOLDMAN SACHS GOVERNMENT FUND - CLASS: INST (#465) ON 09/25/2024 AT 1.00 ACCOUNT 2061000055		302,731.51		
11/15/2024 MATURED 325,000 UNITS UNITED STATES TREASURY 2.25% 11/15/2024 ACCOUNT 2061000046		328,042.00		
11/15/2024 PURCHASED 330,843.75 GOLDMAN SACHS GOVERNMENT FUND - CLASS: INST (#465) ON 11/15/2024 AT 1.00 ACCOUNT 2061000046		330,843.75		
11/26/2024 PURCHASED 250,000 UNITS UNITED STATES TREASURY NOTES 4.25% 11/15/2034 ON 11/25/2024 AT 99.875 THRU WELLS FARGO SECURITIES ACCOUNT 2061000046		249,687.50		
11/26/2024 SOLD 250,010.36 GOLDMAN SACHS GOVERNMENT FUND - CLASS: INST (#465) ON 11/26/2024 AT 1.00 ACCOUNT 2061000046		250,010.36		
TOTAL SINGLE TRANSACTIONS EXCEEDING 5%		1,763,295.59		

STATEMENT OF ACTIVITY

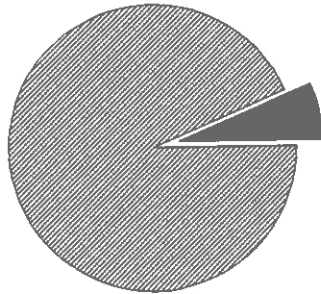
Statement Period
 Account Number

01/01/2024 through 12/31/2024
 M01479
 MS POWER CO MEDICAL BENEFITS PL
 TTEE 110386

Asset Summary As Of 12/31/2024

DESCRIPTION	MARKET VALUE	COST	% OF PORT
SHORT TERM INV	295,351.90	295,351.90	6
US GOV'T OBLIGATIONS	4,416,070.45	4,655,389.72	94
TOTAL INVESTMENTS	4,711,422.35	4,950,741.62	
CASH	0.00		
DUE FROM BROKER	0.00		
DUE TO BROKER	0.00		
TOTAL MARKET VALUE	4,711,422.35		

Ending Asset Allocation



6.3%	SHORT TERM INV	295,351.90
93.7%	US GOV'T OBLIGATIONS	4,416,070.45
100.0%	Total	4,711,422.35





HANCOCK WHITNEY

Trust & Asset Management
2285 Lakeshore Dr., Building 4
New Orleans, LA 70122

STATEMENT OF ACTIVITY

Statement Period
Account Number

01/01/2024 through 12/31/2024
M01479
MS POWER CO MEDICAL BENEFITS PL
TTEE 110386

Asset Detail As Of 12/31/2024

UNITS/BOOK VALUE	DESCRIPTION	MARKET VALUE	COST	% OF PORT
SHORT TERM INV				
295,351.9	CUSIP # 38141W273 GOLDMAN SACHS GOVERNMENT FUND - CLASS: INST (#465)	295,351.90	295,351.90	6
		295,351.90	295,351.90	6
US GOVT OBLIGATIONS				
125,000	CUSIP # 3133EHSK0 FFCB 2.35% 07/28/2025	123,620.00	124,476.25	3
250,000	CUSIP # 912828M56 UNITED STATES TREASURY 2.25% 11/15/2025	245,720.00	256,757.81	5
150,000	CUSIP # 912828U24 UNITED STATES TREASURY 2% 11/15/2026	143,953.50	159,084.94	3
400,000	CUSIP # 912828Z78 UNITED STATES TREASURY 1.625% 01/31/2027	378,252.00	426,359.38	8
150,000	CUSIP # 912828Z94 UNITED STATES TREASURY 1.5% 02/15/2030	130,230.00	162,336.91	3
330,000	CUSIP # 91282CAB7 UNITED STATES TREASURY NOTES (AB 2025) 2.5% 07/31/2025	322,495.80	324,856.64	7
200,000	CUSIP # 91282CDJ7 UNITED STATES TREASURY NOTES 1.375% 11/15/2031	163,422.00	198,109.38	3
425,000	CUSIP # 91282CDL2 UNITED STATES TREASURY NOTES 1.5% 11/30/2028	381,654.25	427,689.45	8
185,000	CUSIP # 91282CFM8 UNITED STATES TREASURY NOTES 4.125% 09/30/2027	184,248.90	184,184.77	4
375,000	CUSIP # 91282CGE5 UNITED STATES TREASURY NOTES 3.875% 01/15/2026	373,743.75	374,531.25	8
375,000	CUSIP # 91282CGH8 UNITED STATES TREASURY NOTES 3.5% 01/31/2028	366,356.25	372,700.20	8
375,000	CUSIP # 91282CGJ4 UNITED STATES TREASURY NOTES 3.5% 01/31/2030	359,722.50	373,007.81	8

Statement Period
 Account Number

01/01/2024 through 12/31/2024
 M01479
 MS POWER CO MEDICAL BENEFITS PL
 TTEE 110386

Asset Detail As Of 12/31/2024

UNITS/BOOK VALUE	DESCRIPTION	MARKET VALUE	COST	% OF PORT
500,000	CUSIP # 91282CLK5 UNITED STATES TREASURY NOTES 3.625% 08/31/2029	484,065.00	503,300.78	10
200,000	CUSIP # 91282CLL3 UNITED STATES TREASURY NOTES (AS-2027) 3.375% 09/15/2027	195,422.00	199,156.25	4
375,000	CUSIP # 91282CLW9 UNITED STATES TREASURY NOTES 4.25% 11/15/2034	365,332.50	371,357.42	8
100,000	CUSIP # 91282CLY5 UNITED STATES TREASURY NOTES 4.25% 11/30/2026	99,973.00	99,812.51	2
100,000	CUSIP # 91282CLZ2 UNITED STATES TREASURY NOTES 4.125% 11/30/2031	97,859.00	97,667.97	2
		4,416,070.45	4,655,389.72	94
	TOTAL INVESTMENTS	4,711,422.35		
	CASH	0.00		
	DUE FROM BROKER	0.00		
	DUE TO BROKER	0.00		
	NET ASSETS	4,711,422.35		
	TOTAL MARKET VALUE	4,711,422.35		

