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

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) _____

B This return/report is:
- [ ] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

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

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

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

Part II Basic Plan Information—enter all requested information

1a Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

1b Three-digit plan number (PN) ▶ 553

1c Effective date of plan 01/01/1993

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)
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

4 IRVING PLACE - 15TH FLOOR SOUTH
NEW YORK, NY 10003

2b Employer Identification Number (EIN)
13-5009340

2c Plan Sponsor's telephone number
212-460-4600

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.

SIGN HERE	Filed with authorized/valid electronic signature.	10/14/2026	ANDREW PAGONIS
	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

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

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

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	4497
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)**	0
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	0
b	Retired or separated participants receiving benefits	**6b**	4399
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	4399
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**	

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

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

4A 4D 4E

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [X] Trust
- **(4)** [X] 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)** [X] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 5
- **(4)** [X] **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 2025 Form M-1 annual report. If the plan was not required to file the 2025 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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
EMBLEM HEALTH

(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
13-1828429	55247	1102163 007	44	01/01/2025	12/31/2025

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

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

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	0
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)	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)			
	(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)	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** [X] 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** [X] 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)	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 [ ] paid in cash, or [ ] 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	483992
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 [X] 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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
OXFORD HEALTH PLANS (NY), INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-1181200	95479	H3307	1	01/01/2025	12/31/2025

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

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

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	0
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)	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)			
	(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)	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** [X] 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** [X] 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)	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 [ ] paid in cash, or [ ] 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	6301
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 [X] 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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
AETNA HEALTH INSURANCE CO.

(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
06-6033492	60054	E00068364986	46	01/01/2025	12/31/2025

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

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

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	0
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)	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)			
	(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)	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** [X] 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)**	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 [ ] paid in cash, or [ ] 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**	348249
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 [X] 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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
AETNA LIFE INSURANCE CO.

(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
06-6033492	60054	0849856-COBRA	5	01/01/2025	12/31/2025

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

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

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	0
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)	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)			
	(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)	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** [X] 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)**	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 [ ] paid in cash, or [ ] 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**	62385
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 [X] 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

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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	0238945	2832	01/01/2025	12/31/2025

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

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

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	0
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)	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)			
	(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)	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** [X] 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)	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 [ ] paid in cash, or [ ] 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	1821190
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 [X] No

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

SCHEDULE C (Form 5500)	Service Provider Information	OMB No. 1210-0110
Department of the Treasury Internal Revenue Service Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	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.**	**2025** **This Form is Open to Public Inspection.**

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

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

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

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

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

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

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

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

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

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

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

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

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

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)

CIGNA HEALTH AND LIFE INSURANCE CO

59-1031071

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 31 38 49 50 56 62	NONE	977387	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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

CVS PHARMACY, INC

05-0340626

(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?
50 65	NONE	896792	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

COHNREZNICK LLP

33-4144829

(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?
10 50	NONE	55000	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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)

WEX HEALTH INC

06-1593514

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
50 65	NONE	40666	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

ERNST AND YOUNG

200 PLAZA DRIVE
SECAUCUS, NJ 07094

(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?
49 50	NONE	24088	Yes [ ] No [X]	Yes [ ] No [ ]		Yes [ ] No [ ]

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

THE BANK OF NEW YORK MELLON

13-5160382

(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?
25 50 59 62 99	INVESTMENT ADVISOR	21973	Yes [X] No [ ]	Yes [X] No [ ]	0	Yes [X] No [ ]

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)

WILLIS TOWERS WATSON US LLC

53-0181291

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0-.	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.	(h) Did the service provider give you a formula instead of an amount or estimated amount?
16 50	NONE	11750	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

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

BUCK GLOBAL, LLC

13-3964297

(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?
11 50	NONE	11424	Yes ☐ No ☒	Yes ☐ No ☐		Yes ☐ No ☐

(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 ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐

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
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
CASTLIGHT HEALTH 26-1989091	$3.24 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
OMADA COMPLETE 45-2355015	$0.17 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
OMADA HEALTH, INC. 45-2355015	$1.23 PER PARTICIPANT

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
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
VISION SERVICE PLAN 06-1227840	$0.67 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
BLOOMINGTON HOSPITAL 35-1720796	$0.06 PER PARTICIPANT

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
BANK OF AMERICA 59-1031071	$0.37 PER PARTICIPANT, WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 4.00%.

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
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
CITIBANK N.A. 59-1031071	$1.98 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.66%.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
CHLIC-COR DEPOSITS, PNC BANK 59-1031071	$1.02 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.25%.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
JP MORGAN CHASE 59-1031071	$4.38 PER PARTICIPANT WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 3.54%.

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
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
AMPLIFON HEARING HEALTHCARE 85-0437037	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
FITBIT 20-8920744	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
LCA-VISION INC. 11-2882328	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES.

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
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
AMERICAN SPECIALTY HEALTH INCORPORA 33-0883241	VOLUME BASED MARKETING FEES PAID BY VENDORS PARTICIPATING IN THE CIGNA HEALTHY REWARDS PROGRAM WHICH OFFERS PLAN PARTICIPANTS DISCOUNTS ON VARIOUS SERVICES.

(a) Enter service provider name as it appears on line 2	**(b)** Service Codes (see instructions)	**(c)** Enter amount of indirect compensation
CIGNA HEALTH AND LIFE INSURANCE CO	12 13 31 38 49 50 56 62	0

(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.
DEUTSCHE BANK 59-1031071	$0.00 PER PARTICIPANT, WITH THE AVERAGE ANNUAL RATE OF THE EARNINGS CREDIT AT 0.50%.

(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 H (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

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.**

OMB No. 1210-0110

2025

This Form is Open to Public Inspection

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A Name of plan
THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM FOR MANAGEMENT EMPLOYEES

B Three-digit plan number (PN) ▶ 553

C Plan sponsor's name as shown on line 2a of Form 5500
CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.

D Employer Identification Number (EIN)
13-5009340

Part I Asset and Liability Statement

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.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	2661000	2661000
b Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)	29943040	25581680
c General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)	9200457	7789024
(2) U.S. Government securities	1c(2)		
(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)		

		(a) Beginning of Year	(b) End of Year
1d Employer-related investments:			
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
1e Buildings and other property used in plan operation	1e		
1f Total assets (add all amounts in lines 1a through 1e)	1f	41804497	36031704
Liabilities			
1g Benefit claims payable	1g		
1h Operating payables	1h	153977	134328
1i Acquisition indebtedness	1i		
1j Other liabilities	1j		
1k Total liabilities (add all amounts in lines 1g through1j)	1k	153977	134328
Net Assets			
1l Net assets (subtract line 1k from line 1f)	1l	41650520	35897376

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)	2203156	
(B) Participants	2a(1)(B)	23187471	
(C) Others (including rollovers)	2a(1)(C)	23635617	
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines **2a(1)(A), (B), (C),** and line **2a(2)**	2a(3)		49026244
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)	275918	
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines **2b(1)(A)** through **(F)**	2b(1)(G)		275918
(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)		0
(4) Net gain (loss) on sale of assets: **(A)** Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line **2b(4)(B)** from line **2b(4)(A)** and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: **(A)** Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines **2b(5)(A)** and **(B)**	2b(5)(C)		0

		(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		49302162
Expenses			
e Benefit payment and payments to provide benefits:			
(1) Directly to participants or beneficiaries, including direct rollovers	2e(1)	61821737	
(2) To insurance carriers for the provision of benefits	2e(2)	943270	
(3) Other	2e(3)		
(4) Total benefit payments. Add lines **2e(1)** through **(3)**	2e(4)		62765007
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)	1874179	
(3) Recordkeeping fees	2i(3)	40666	
(4) IQPA audit fees	2i(4)	55000	
(5) Investment advisory and investment management fees	2i(5)		
(6) Bank or trust company trustee/custodial fees	2i(6)	21973	
(7) Actuarial fees	2i(7)	11424	
(8) Legal fees	2i(8)		
(9) Valuation/appraisal fees	2i(9)		
(10) Other trustee fees and expenses	2i(10)		
(11) Other expenses	2i(11)	287057	
(12) Total administrative expenses. Add lines **2i(1)** through **(11)**	2i(12)		2290299
j Total expenses. Add all **expense** amounts in column (b) and enter total	2j		65055306
Net Income and Reconciliation			
k Net income (loss). Subtract line **2j** from line **2d**	2k		-15753144
l Transfers of assets:			
(1) To this plan	2l(1)		10000000
(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) [X] 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)** [X] 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: COHNREZNICK LLP **(2)** EIN: 33-4144829

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.)	**4a**	X		16687041
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.)	**4b**		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.)	**4c**		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.)	**4d**		X	
e Was this plan covered by a fidelity bond?	**4e**	X		75000000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	**4f**		X	
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?	**4g**		X	
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?	**4h**		X	
i Did the plan have assets held for investment? (Attach schedule(s) of assets if "Yes" is checked, and see instructions for format requirements.)	**4i**	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.)	**4j**	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?	**4k**		X	
l Has the plan failed to provide any benefit when due under the plan?	**4l**		X	
m If this is an individual account plan, was there a blackout period? (See instructions and 29 CFR 2520.101-3.)	**4m**			
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.	**4n**			

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? [ ] Yes [X] 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 _____.

The Consolidated Edison Retiree Health Program for Management Employees

Financial Statements
(With Supplementary Information) and
Independent Auditor's Report
December 31, 2025 and 2024

Financial Statements:

Independent Auditor's Report	1-3
Statements of Net Assets Available for Benefits	4
Statements of Changes in Net Assets Available for Benefits	5
Statements of Plan Benefit Obligations	6
Statements of Changes in Plan Benefit Obligations	7
Notes to Financial Statements	8-24

Supplemental Schedules:

Schedule of Delinquent Participant Transactions (Schedule H, Line 4a)	25
Schedule of Assets (Held at End of Year)(Schedule H, Line 4i)	26
Schedule of Reportable Transactions (Schedule H, Line 4j)	27

Other supplemental schedules required by Section 2520.103-10 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974 have been omitted because they are not applicable.

Independent Auditor's Report

To the Plan Administrator of The ConEdison Retiree Health Program for Management

Opinion

We have audited the financial statements of The ConEdison Retiree Health Program for Management (the "Plan"), an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), which comprise the statements of net assets available for benefits and of benefit obligations as of December 31, 2025 and 2024, and the related statements of changes in net assets available for benefits and of changes in benefit obligations for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the net assets available for benefits and benefit obligations of The ConEdison Retiree Health Program for Management as of December 31, 2025 and 2024, and the changes in its net assets available for benefits and benefit obligations for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America ("GAAS"). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of The ConEdison Retiree Health Program for Management and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about The ConEdison Retiree Health Program for Management's ability to continue as a going concern for at least one year following the date that the financial statements are available to be issued.

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

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of The ConEdison Retiree Health Program for Management's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about The ConEdison Retiree Health Program for Management's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Supplemental Schedules Required by ERISA

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The supplemental schedules of Schedule of Delinquent Participant Contributions (Schedule H, Line 4a), Schedule of Assets (Held at End of Year) (Schedule H, Line 4i), and Schedule of Reportable Transactions (Schedule H, Line 4j), as of or for the year ended December 31, 2025 are presented for purposes of additional analysis and are not a required part of the financial statements but are supplementary information required by the Department of Labor's ("DOL") Rules and Regulations for Reporting and Disclosure under ERISA. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with GAAS.

In forming our opinion on the supplemental schedules, we evaluated whether the supplemental schedules, including their form and content, are presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.

In our opinion, the information in the accompanying supplemental schedules is fairly stated, in all material respects, in relation to the financial statements as a whole, and the form and content are presented in conformity with the DOL's Rules and Regulations for Reporting and Disclosure under ERISA.



Parsippany, New Jersey
October 14, 2026

The Consolidated Edison
Retiree Health Program for Management Employees

Statements of Net Assets Available for Benefits
As of December 31, 2025 and 2024

	December 31, 2025	December 31, 2024
Assets		
Investments at fair value	$ 7,789,024	$ 9,200,457
Net assets held in the Pension Plan Trust under The Consolidated Edison Retirement Plan and allocated to Management Participants – restricted for 401(h)	92,817,693	87,348,203
Employee contributions receivable	3,725,083	4,072,395
Contributions from other sources receivable	6,767,106	7,980,420
Rebates receivable	7,556,678	7,759,176
Interest and dividends receivable	29,180	27,721
Restricted cash (See Note 3)	2,661,000	2,661,000
Total assets	121,345,764	119,049,372
Liabilities		
Accrued administrative expenses	134,328	153,977
Total liabilities	134,328	153,977
Net assets available for benefits	$ 121,211,436	$ 118,895,395

The accompanying notes are an integral part of these financial statements.

The Consolidated Edison
Retiree Health Program for Management Employees

Statements of Changes in Net Assets Available for Benefits
For the Years Ended December 31, 2025 and 2024

	Years Ended December 31, 2025	2024
Additions		
Interest income	$ 275,918	$ 250,495
Total investment income	275,918	250,495
Contributions		
Net increase in 401(h)	5,469,490	—
Contributions from 401(h)	10,000,000	23,700,000
Employer contributions	2,203,156	2,135,779
Participant contributions (see Note 12)	23,187,471	22,760,602
Contributions from other sources	23,635,617	16,020,309
Total contributions	64,495,734	64,616,690
Total additions	64,771,652	64,867,185
Deductions		
Net decrease in 401(h)	—	14,251,199
Benefits paid on behalf of participants	59,222,042	56,065,459
Premiums paid	943,270	755,054
Administrative expenses	2,290,299	2,150,402
Total deductions	62,455,611	73,222,114
Increase (decrease) in net assets	2,316,041	(8,354,929)
Net assets available for benefits:		
Beginning of the Year	118,895,395	127,250,324
End of year	$ 121,211,436	$ 118,895,395

The accompanying notes are an integral part of these financial statements.

The Consolidated Edison
Retiree Health Program for Management Employees

Statements of Plan Benefit Obligations
As of December 31, 2025 and 2024

	December 31, 2025	December 31, 2024
Amounts currently payable to or for participants, beneficiaries and eligible dependents:		
Health claims payable	$ 5,057,367	$ 5,244,672
Other obligations for current benefit coverage at present value of estimated amounts:		
Claims incurred but not reported/(reimbursed)	(12,561,000)	(15,348,000)
Total obligations other than postretirement benefit obligations	(7,503,633)	(10,103,328)
Postretirement benefit obligations:		
Retired participants	146,462,039	141,825,681
Other participants fully eligible for benefits	49,158,962	47,088,207
Other participants not yet fully eligible for benefits	44,427,801	50,489,111
Total postretirement benefit obligations (See Note 6)	240,048,802	239,402,999
Plan benefit obligations	$ 232,545,169	$ 229,299,671

The accompanying notes are an integral part of these financial statements.

The Consolidated Edison
Retiree Health Program for Management Employees

Statements of Changes in Plan Benefit Obligations
For the Years Ended December 31, 2025 and 2024

	Years Ended December 31, 2025	2024
Amounts currently payable to or for participants, beneficiaries, and eligible dependents:		
Balance at beginning of year	$ 5,244,672	$ 3,932,910
Claims reported and approved for payment	35,156,317	43,628,180
Claims paid to/for participants	(35,343,622)	(42,316,418)
Balance at end of year	5,057,367	5,244,672
Other obligations for current benefit coverage at present value of estimated amounts:		
Balance at beginning of year	(15,348,000)	(12,293,000)
Net change during year	2,787,000	(3,055,000)
Balance at end of year	(12,561,000)	(15,348,000)
Total obligations other than postretirement benefit obligations	(7,503,633)	(10,103,328)
Postretirement benefit obligations:		
Balance, beginning of year	239,402,999	255,372,303
Increases (decreases) during the year attributed to:		
Actuarial gain	(3,742,786)	(4,701,969)
Benefits earned	2,581,227	2,697,889
Interest cost	12,747,086	12,394,620
Benefits paid on behalf of participants	(35,343,622)	(42,316,418)
Participant contributions	23,534,783	20,406,015
Administrative expenses	(1,838,455)	(1,645,103)
Change in assumptions	2,707,570	(2,804,338)
Balance at end of year (See Note 6)	240,048,802	239,402,999
Plan benefit obligations at end of year	$ 232,545,169	$ 229,299,671

The accompanying notes are an integral part of these financial statements.

1. Description of the Plan

The following description of The Consolidated Edison Retiree Health Program for Management Employees (the "Plan") provides only general information. Participants should refer to the Plan document for a complete description of the Plan's provisions. The Plan is incorporated into a single Consolidated Edison Retiree Health Program that includes The Consolidated Edison Retiree Health Program for Weekly Employees. For funding, tax and financial reporting purposes, the two underlying plans are maintained and accounted for separately. The health care benefits available to eligible retired management and weekly employees are identical.

General

The Plan provides eligible retired employees of The Consolidated Edison Company of New York, Inc. (the "Company") and certain eligible surviving spouses, spouses, and dependents with certain hospital, medical, vision care and prescription drug benefits. Hospital, medical and vision care benefits are provided through a self-insured arrangement with Connecticut General Life Insurance Company ("CIGNA") and certain fully-insured health maintenance organizations. Prescription drug benefits are self-insured and administered by CVS Caremark and certain fully-insured health maintenance organizations.

The Plan is an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). In 1993, the Company established a Voluntary Employees' Beneficiary Association ("VEBA") Trust (the "VEBA Trust") under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended (the "Code"), to fund management retiree health benefits under the Plan. Participant contributions are placed in the VEBA Trust. Bank of New York Mellon ("BNY Mellon") is the trustee for the VEBA Trust.

In addition, under The Consolidated Edison Retirement Plan (the "Retirement Plan"), the Company sets aside funds for retiree health benefits and their beneficiaries through a separate account within the Retirement Plan, as permitted under Section 401(h) of the Code ("401(h)"). In 2007, the Retirement Plan was amended to provide that commencing January 1, 2007, retiree health benefits for participants who, when actively employed were management employees, are first paid out of the VEBA Trust. To the extent the retiree benefits payable exceed the amount available for benefits from the VEBA Trust, they are to be paid out of the 401(h). In accordance with Code Section 401(h), the Plan's investments in the 401(h) may not be used for, or diverted to, any purpose other than providing health benefits for retirees and their beneficiaries. The related obligations for health benefits are not included in the Retirement Plan's obligations in the statements of accumulated plan benefits but are reported as obligations in the financial statements of the Plan.

Eligibility

Eligibility for retiree medical benefits for management employees requires attainment of 75 points, taking together one's age and service, or upon becoming permanently disabled as determined by the Federal Social Security Administration at or after age 50 with 20 years of service.

Benefits
The health benefits provided include medical, hospital, prescription, vision and hearing benefits, but exclude dental benefits. Participants should refer to the appropriate Plan description summary for a description of the Plan's benefits.

Funding Policy
The Company's policy is to fund the actuarially determined accounting cost for future benefits, and current accounting costs for eligible retirees for retiree health benefits, subject to statutory maximum limits based on the aggregate method. Under the aggregate method, maximum deductible employer contributions are determined as of the beginning of the year.

Cash Balance Participants (i.e., those participants covered under the cash balance formula in the Company's Retirement Plan) or employees who are covered under the defined contribution pension formula in The Consolidated Edison Thrift Savings Plan ("DCPF Participants") are eligible to participate in the Plan, but without an employer or company subsidy, which means he or she must pay the full cost of the coverage. Thus, the Company has no postretirement benefit obligation for Cash Balance Participants or DCPF Participants.

Contributions and Cost Sharing
The cost of the postretirement benefit plan is shared by the Plan's participating employers and retirees. There are three groups of Participants who contribute specified amounts for retiree health benefits as determined, periodically, by the Company. There is the Cash Balance Participant and DCPF Participant, described above, who contribute the full cost of benefits. Currently, the Company's share of health program obligations for a participant who is not a Cash Balance Participant but for whom his or her monthly pension benefit is more than $1,000 ("Capped Participant") is limited to a baseline figure established in 2008 and then increased, if at all, annually by the Consumer Price Index ("CPI"). If the annual cost for the Plan is more than the rise above the CPI, the increase above the CPI is passed on to and shared by participants. Finally, there is the retiree or surviving spouse who is not a Cash Balance Participant and for whom his or her monthly pension benefit is less than $1,000, who is referred to as an "Uncapped Participant."

In addition to deductibles and co-payments, participant contributions in 2025 and 2024, respectively, were as follows:

Schedule of Monthly Contributions Effective January 1, 2025				
Retirees With Pensions Greater Than $1,000 Per Month – Capped Participants				
Participants Retiring AFTER May 31, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$72		$107	
Aetna		$166		$166
Secure Horizons (Oxford)		$166		$166
Emblem Health (HIP)		$166		$166
Non Medicare-eligible				
CIGNA	$383		$556	
Emblem Health (HIP)		$559		$629
Prescription Drug Plan				
CVS Caremark		$175		$175

Participants Retiring BEFORE June 1, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$72		$107	
Aetna		$166		$166
Secure Horizons (Oxford)		$166		$166
Emblem Health (HIP)		$166		$166
Non Medicare-eligible				
CIGNA	$383		$556	
Emblem Health (HIP)		$559		$629
Prescription Drug Plan				
CVS Caremark		$175		$175

Schedule of Monthly Contributions Effective January 1, 2025				
Retirees With Pensions of $1,000 or Less Per Month – Uncapped Participants				
Participants Retiring AFTER May 31, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$61		$72	
Aetna		$151		$151
Secure Horizons (Oxford)		$151		$151
Emblem Health (HIP)		$151		$151
Non Medicare-eligible				
CIGNA	$310		$422	
Emblem Health (HIP)		$275		$343
Prescription Drug Plan				
CVS Caremark		$108		$108

Participants Retiring BEFORE June 1, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$61		$72	
Aetna		$151		$151
Secure Horizons (Oxford)		$151		$151
Emblem Health (HIP)		$151		$151
Non Medicare-eligible				
CIGNA	$310		$422	
Emblem Health (HIP)		$275		$309
Prescription Drug Plan				
CVS Caremark		$108		$108

Schedule of Monthly Contributions Effective January 1, 2024				
Retirees With Pensions Greater Than $1,000 Per Month – Capped Participants				
Participants Retiring AFTER May 31, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$71		$106	
Aetna		$168		$168
Secure Horizons (Oxford)		$168		$168
Emblem Health (HIP)		$168		$168
Non Medicare-eligible				
CIGNA	$367		$540	
Emblem Health (HIP)		$508		$572
Prescription Drug Plan				
CVS Caremark		$159		$159

Participants Retiring BEFORE June 1, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$71		$106	
Aetna		$168		$168
Secure Horizons (Oxford)		$168		$168
Emblem Health (HIP)		$168		$168
Non Medicare-eligible				
CIGNA	$367		$540	
Emblem Health (HIP)		$460		$499
Prescription Drug Plan				
CVS Caremark		$159		$159

Schedule of Monthly Contributions Effective January 1, 2024				
Retirees With Pensions of $1,000 or Less Per Month – Uncapped Participants				
Participants Retiring AFTER May 31, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$60		$71	
Aetna		$142		$142
Secure Horizons (Oxford)		$142		$142
Emblem Health (HIP)		$142		$142
Non Medicare-eligible				
CIGNA	$305		$417	
Emblem Health (HIP)		$275		$309
Prescription Drug Plan				
CVS Caremark		$103		$103

Participants Retiring BEFORE June 1, 1988:	**Retiree or Surviving Spouse**		Spouse, Same-Sex Domestic Partner and/or Other Dependents	
	Retiree Health	HMO	Retiree Health	HMO
Medicare-eligible				
CIGNA	$60		$71	
Aetna		$142		$142
Secure Horizons (Oxford)		$142		$142
Emblem Health (HIP)		$142		$142
Non Medicare-eligible				
CIGNA	$305		$417	
Emblem Health (HIP)		$275		$309
Prescription Drug Plan				
CVS Caremark		$103		$103

Plan Termination

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

2. Summary of Significant Accounting Policies

Accounting Basis

The Plan's financial statements are prepared on the accrual basis of accounting.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, benefit obligations and changes therein, claims incurred but not reported, claims payable and disclosure of contingent assets and liabilities at the date of the financial statements. Actual results could differ from those estimates.

Payment of Benefits

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

Claim payments are recorded when submitted to the Plan by the third-party claims processor for reimbursement. Amounts due to claims processors that have yet to be submitted to the Plan by the third-party claims processor are recorded as claims payable in the accompanying statements of plan benefit obligations.

Refunds

Refunds due from the Plan's prescription drug benefits manager and other sources are recorded when earned. Refunds due as of the financial statement date have been reported as a receivable, with the offset being netted against benefits paid. Prescription drug rebate adjustments and other rebates totaling $15,710,970 and $16,453,142 for the years ended December 31, 2025 and 2024, respectively, including a related receivable of $7,556,678 and $7,759,176 at December 31, 2025 and 2024, respectively, have been netted with benefits paid in the accompanying statements of changes in net assets available for benefits.

Investment Valuation and Income Recognition

Investments are reported at fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Plan's valuation policies and procedures are approved by management of the Plan Sponsor. See Note 9 for a discussion of fair value measurements.

Security transactions are recorded on a trade date basis. Interest income is accrued as earned and expenses are recorded when incurred. The Plan presents the net appreciation (depreciation) in the fair value of its investments in the statements of changes in net assets available for benefits, which consists of the realized gains or losses on those investments.

Contributions
Employer contributions to the VEBA Trust and 401(h) are recorded and funded as determined by an actuarial computation based on the aggregate cost method. General employer contributions and employee contributions are recorded on the accrual basis.

Administrative Expenses
Administrative expenses, including investment management and actuarial fees, that are Plan expenses, are paid through the VEBA Trust by the Plan. If, in accordance with the applicable law, the expenses cannot be paid out of the Trust fund, such expenses will be paid by the Company.

Concentrations of Credit Risk
Financial instruments which potentially subject the Plan to concentrations of credit risk consist primarily of cash. When the Plan maintains cash, it does so with high-credit quality financial institutions. At times, such amounts may exceed federally insured limits.

Subsequent Events
The Plan has evaluated subsequent events through October 14, 2026, which is the date the financial statements were available to be issued.

3. Restricted Cash

The Plan is required to maintain imprest cash to be restricted for the use of payment of retiree claims. The required reserve at both December 31, 2025 and 2024 was $2,661,000.

4. Risks and Uncertainties

In general, investment securities such as the money market mutual funds that the Plan invests in are exposed to various risks, such as interest rate, credit and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statements of net assets available for benefits.

The actuarial present value of benefit obligations is reported based on certain assumptions pertaining to interest rates, health care inflation rates and employee demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is reasonably possible that changes in these estimates and assumptions in the near term would be material to the financial statements.

5. Transactions with Parties-in-Interest

Plan assets in the VEBA Trust and 401(h) were invested in money market mutual funds managed by BNY Mellon Investment Adviser, Inc., an affiliate of BNY Mellon, and therefore, transactions in such investments qualify as party-in-interest transactions which are exempt from ERISA's prohibited transaction rules. Fees paid by the VEBA Trust to the trustees for trustee services amounted to $21,973 and $21,333 for the years ended December 31, 2025 and 2024, respectively. Fees paid by the 401(h) to the trustees for trustee services amounted to $3,919 and $3,640 for the years ended December 31, 2025 and 2024, respectively.

BNY Mellon Investment Adviser, Inc. manages securities lending transactions of the 401(h) that qualify as party-in-interest transactions and receives fees for such services. Fees paid by the 401(h) to the trustee for securities lending transactions amounted to $699 and $491 for the years ended December 31, 2025 and 2024, respectively.

6. Actuarial Present Value of Postretirement Benefit Obligation

The postretirement benefit obligation represents the total actuarial present value of those estimated future benefits that are attributed to employee service rendered to December 31, 2025 and 2024, reduced by the actuarial present value of contributions expected to be received in the future from the current Plan participants. That amount represents the benefit obligation that is to be funded by contributions from the Company, taking into account the participant contributions, and from existing Plan assets. Postretirement benefits include future benefits expected to be paid to or for (1) currently retired or terminated employees and their beneficiaries and dependents and (2) active employees and their beneficiaries and dependents after retirement from service with the Company. Prior to an active employee's full eligibility date, the postretirement benefit obligation is the portion of the expected postretirement benefit obligation that is attributed to that employee's service in the Company rendered to the valuation date. Cash Balance Participants and DCPF Participants are not taken into account in determining the postretirement benefit obligation since they do not receive Company-subsidized benefits.

The actuarial present value of the postretirement benefit obligation as of the valuation date is determined by the Plan's independent actuary, giving recognition to such factors as estimated investment earnings, participant terminations and retirements, health care costs and the effect of any Plan amendments on benefits.

For 2025 and 2024, the health care cost trend rate assumed was 7.00% and 6.80%, respectively, for pre-65 retiree medical, 4.50% for post-65 retiree medical, and 7.50% and 7.25%, respectively, for prescription drugs. The health care cost trend rate assumed for 2026 is 7.50% for pre-65 retiree medical and 8.00% for prescription drug benefits, of which is expected to decline gradually to 4.50% by 2040. The health care cost trend rate assumed for 2026 is 4.50% for post-65 retirees and is expected to remain at that level. If the assumed health care cost trend rates were to be increased by one percentage point for each year, the accumulated plan benefit obligations as of December 31, 2025 and 2024 would increase by approximately $19 million and $23 million, respectively, as a result of incremental Employer Group Waiver Plan ("EGWP") reimbursements exceeding incremental Plan costs.

The following were other significant assumptions used in the valuations as of December 31, 2025 and 2024:

	2025	2024
Weighted average discount rate	5.30%	5.55%
Expected long-term return on VEBA Trust assets	6.75%	6.75%
Expected long-term return on 401(h) assets	6.75%	6.75%
Average retirement age	Age 64	Age 62
Mortality	Pri.H-2012 Headcount Weighted, as adjusted based on actual company experience	Pri.H-2012 Headcount Weighted, as adjusted based on actual company experience

The foregoing assumptions are based on the presumption that the Plan will continue. Were the Plan to terminate, different actuarial assumptions and other factors might be applicable in determining the actuarial present value of the postretirement benefit obligation.

The Plan's deficiency of net assets to benefit obligations at December 31, 2025 reflects the Company's current intention to fund the deficiency through future Company contributions to the VEBA Trust and net investment income earned by the Trust.

7. Claims Incurred but not Reported/(Reimbursed)

Plan obligations at December 31 for claims incurred but not reported (reimbursed) are estimated by the Plan's actuary in accordance with accepted actuarial principles based on claims data provided by the Plan's third-party claims administrators. These amounts are paid by the Plan only if claims are submitted and approved for payment. The components in the net claims incurred but not reported (reimbursed) consist of claims incurred but not reported ("IBNR"), prescription drug rebates, EGWP subsidies, and claim reversals. EGWP subsidies are provided to companies, such as Consolidated Edison Company of New York, who offer their Medicare-eligible retirees a substantially similar Medicare D pharmaceutical plan. There may be a timing lag in the receipt of EGWP subsidies from the federal government and the drug rebates. In 2025 and 2024, the amount of rebates and subsidies to be received exceeded the IBNR. The net claims incurred but not reported (reimbursed) as of December 31, 2025 and 2024 were $(12,561,000) and $(15,348,000), respectively.

8. Allocation of the Pension Trust to 401(h)

The following represents the components of the net assets pertaining to the Consolidated Edison Pension Trust and 401(h) as of December 31, 2025 and 2024, respectively:

The Consolidated Edison
Retiree Health Program for Management Employees

Notes to Financial Statements

	As of December 31, 2025	
	Pension Trust	**401(h)**
Assets		
Investments at fair value		
Commingled real estate funds	$ 1,436,891,409	$ 8,199,108
Common collective trust funds	517,014,389	2,950,158
Corporate stocks (includes securities on loan of $83,368,342 and $475,712)		
Common	3,787,599,416	21,612,585
Preferred	21,118,418	120,505
U.S. government and agency securities (includes securities on loan of $225,206,141 and $1,285,059)	920,959,329	5,255,126
Bonds and notes (includes securities on loan of $479,711,691 and $2,737,304)	7,492,806,075	42,755,026
U.S. and Foreign currency	32,184,160	183,647
Short-term investments	279,884,080	1,597,059
Private equity	932,845,394	5,322,950
Hedge funds	749,402,416	4,276,198
Exchange traded funds (includes securities on loan of $79,370 and $453)	98,464	562
Other	121,385	693
Investment of securities lending cash collateral	599,163,961	3,418,915
Total Investments	16,770,088,896	95,692,532
Receivables		
Securities sold	30,286,964	172,822
Accrued interest and dividends	131,070,063	750,163
Employer contribution	2,010,980	—
Total Receivables	163,368,007	922,985
Total Assets	16,933,456,903	96,615,517
Liabilities		
Payable for collateral on securities loaned	599,163,961	3,418,915
Administrative fees payable	9,921,400	55,921
Securities purchased payable	56,218,226	320,789
401(h) benefits payable	21,733,798	—
Unrealized depreciation on foreign exchange forward contracts	385,402	2,199
Unrealized appreciation on investments payable	(17)	—
Total Liabilities	687,422,770	3,797,824
Net Assets	$ 16,246,034,133	$ 92,817,693

The Consolidated Edison
Retiree Health Program for Management Employees

Notes to Financial Statements

	As of December 31, 2024	
	Pension Trust	**401(h)**
Assets		
Investments at fair value		
Commingled real estate funds	$ 1,609,141,410	$ 9,082,929
Common collective trust funds	478,084,942	2,698,589
Corporate stocks (includes securities on loan of $79,621,190 and $449,428)		
Common	4,246,147,995	23,967,725
Preferred	13,988,490	78,959
U.S. government and agency securities (includes securities on loan of $108,096,647 and $610,160)	619,443,046	3,496,496
Bonds and notes (includes securities on loan of $358,216,834 and $2,021,984)	6,370,168,676	35,956,931
U.S. and Foreign currency	51,225,350	289,146
Short-term investments	292,106,985	1,648,821
Private equity	974,754,745	5,502,082
Hedge funds	788,268,624	4,449,446
Other	121,385	685
Investment of securities lending cash collateral	474,466,522	2,678,165
Total Investments	15,917,918,170	89,849,974
Receivables		
Unrealized appreciation on foreign exchange forward contracts	2,143,006	12,096
Securities sold	23,611,579	133,277
Accrued interest and dividends	119,279,914	675,429
Total Receivables	145,034,499	820,802
Total Assets	16,062,952,669	90,670,776
Liabilities		
Payable for collateral on securities loaned	474,466,524	2,678,165
Administrative fees payable	12,238,229	68,408
Securities purchased payable	102,015,006	575,832
401(h) benefits payable	17,017,088	—
Unrealized appreciation on investments payable	29,769	168
Total Liabilities	605,766,616	3,322,573
Net Assets	$ 15,457,186,053	$ 87,348,203

Changes in the net assets of the Pension Trust and 401(h) were as follows:

	Year Ended December 31, 2025	
	Pension Trust	**401(h)**
Net appreciation in fair value of investments	$ 1,139,373,370	$ 6,604,622
Interest income	400,413,143	2,299,611
Dividend income	121,231,290	698,030
Securities lending income	1,984,506	11,503
Contributions	14,529,581	6,075,000
Other income	5,648,091	25,345
Benefits paid to participants	(835,526,891)	—
401(h) benefits payable	(14,716,710)	(10,000,000)
Other tax	(4,883,810)	(25,737)
Administrative expenses	(39,204,493)	(218,884)
Net increase in net assets available	$ 788,848,077	$ 5,469,490

	Year Ended December 31, 2024	
	Pension Trust	**401(h)**
Net appreciation in fair value of investments	$ 237,854,043	$ 1,671,050
Interest income	370,651,875	2,330,564
Dividend income	123,105,736	777,815
Securities lending income	1,553,663	10,915
Contributions	5,418,246	4,900,000
Other income	4,456,085	14,445
Benefits paid to participants	(807,781,077)	—
401(h) benefits payable	(27,817,088)	(23,700,000)
Other tax	(4,459,378)	(22,867)
Administrative expenses	(41,937,691)	(233,121)
Net decrease in net assets available	$ (138,955,586)	$ (14,251,199)

Allocation of Net Assets and Investment Income
The net assets held for the 401(h) are calculated based on a pro-rata percentage allocation of the net assets in the Retirement Plan. The total investment income attributed to the 401(h) is calculated based on the income attributable to the allocated 401(h) assets, and the net appreciation/depreciation on those assets which is based on a pro-rata percentage allocation of the realized and unrealized gains/losses of the assets in the Retirement Plan.

Securities Lending

The Retirement Plan enters into a securities lending program with the trustee, in its corporate capacity as a lending agent. The program allows the trustee to loan securities, which are assets of the Retirement Plan, to approved brokers (the "Borrowers"). The trustee requires Borrowers, pursuant to a security loan agreement, to deliver collateral to secure each loan. The collateral is required to equal at least 102 percent of the fair value of U.S. securities borrowed and 105 percent for non-U.S. securities borrowed. The Retirement Plan bears the risk of loss with respect to the unfavorable change in fair value of the invested cash collateral. However, the Borrower bears the risk of loss related to the decrease in the fair value of the securities collateral and, therefore, will have to deliver additional securities to maintain the required collateral. In the event of default by the Borrower, the trustee shall indemnify the Retirement Plan by purchasing replacement securities equal to the number of unreturned loaned securities or, if replacement securities are not able to be purchased, the trustee shall credit the Retirement Plan for the market value of the unreturned securities. In each case, the trustee would apply the proceeds from the collateral for such a loan to make the Retirement Plan whole.

Cash collateral received was invested in the Consolidated Edison Collateral Fund, which is a fund affiliated with the trustee. A portion of the income generated upon investment of cash collateral is remitted to the Borrowers, and the remainder is allocated between the Retirement Plan and the trustee, in its capacity as a security agent. Noncash collateral consisted of U.S. government and agency securities held by the trustee on behalf of the Retirement Plan. The Retirement Plan may not repledge or relend the noncash collateral. Security lending activity and related collateral information for 2025 and 2024 are as follows:

	2025	2024
Market value of securities on loan to Borrowers	$4,498,527	$3,081,572
Cash collateral received for securities on loan	3,418,915	2,678,165
Noncash collateral received for securities on loan	1,195,255	482,825
Securities lending income allocated to the 401(h)	11,259	9,594
Securities lending income allocated to the trustee	699	491

9. Fair Value Measurements

Accounting Standards Codification 820, *Fair Value Measurement*, provides the framework for measuring fair value. That framework provides a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The Plan classifies fair value balances based on the fair value hierarchy defined as follows:

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

•Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical assets in inactive markets; inputs other than quoted prices that are observable for the assets or liabilities and inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset has a specific (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

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

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

Investment Valuation
Following is a description of the valuation methodology used for assets at fair value:

Money market mutual funds: valued at the daily closing price as reported by the fund. Money market mutual funds held by the Plan are open-end mutual funds that are registered with the Securities and Exchange Commission. These funds are required to publish their daily net asset value ("NAV") and to transact at that price.

The use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date. There have been no material changes in the methodology used at December 31, 2025 and 2024.

The following tables set forth by level, within the fair value hierarchy, the Plan's assets at fair value as of December 31, 2025 and 2024:

Fair Value Measurement as of December 31, 2025

Asset Category	Total	Level 1
Money market mutual funds	$7,789,024	$7,789,024
Totals	**$7,789,024**	**$7,789,024**

Fair Value Measurement as of December 31, 2024

Asset Category	Total	Level 1
Money market mutual funds	$9,200,457	$9,200,457
Totals	**$9,200,457**	**$9,200,457**

10. Contributions from Other Sources

Effective January 1, 2013, the Company began providing prescription drug coverage through an EGWP. The Plan Sponsor submitted an application for reimbursement from the EGWP and received reimbursements, which included a reimbursement receivable, and the total was $23,635,617 for 2025 and $16,020,309 for 2024. These reimbursements are reflected in the statements of changes in net assets available for benefits.

11. Tax Status

The Internal Revenue Service (the "IRS") determined by a letter dated October 19, 1993 that the Trust constitutes a VEBA pursuant to Section 501(c)(9) of the Code. The Trust as subsequently amended is subject to the provisions of Section 512 of the Code which pertains to unrelated business income tax ("UBIT"). The Company believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the Code.

Accounting principles generally accepted in the United States of America require Plan management to evaluate tax positions taken by the Plan and recognize a tax liability (or asset) if the Plan has taken an uncertain tax position that more likely than not would not be sustained upon examination by the IRS. Management of the Plan Sponsor analyzed the tax positions taken by the Plan and has concluded that as of December 31, 2025 and 2024, there was an estimated UBIT receivable of $862 and $9,284, respectively. These receivables are reflected in accrued administrative expenses in the statements of net assets available for benefits. The Plan is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management of the Plan Sponsor believes it is no longer subject to income tax examinations for years prior to 2022.

12. Delinquent Participant Contributions (Nonexempt Transaction)

The Plan received certain participant contributions subsequent to the date such amounts could reasonably be segregated from the Plan Sponsor's general assets in accordance with Department of Labor ("DOL") regulations. Accordingly, these late remittances constitute nonexempt prohibited transactions under ERISA.

The delinquent participant contributions in the amount of $16,687,041 have been reported on the supplemental Schedule H, Line 4a - Schedule of Delinquent Participant Contributions, included with the Plan's Form 5500 filing for the year ended December 31, 2025. The Plan Sponsor intends to take the necessary steps to correct the delinquency and comply with applicable DOL requirements.

13. Reconciliation of Financial Statements to Form 5500

The following is a reconciliation of net assets available for benefits per the financial statements to Form 5500:

	For the Years Ended December 31,	
	2025	**2024**
Net assets available for benefits per the financial statements	$ 121,211,436	$ 118,895,395
Claims payable	7,503,633	10,103,328
Net assets held in The Consolidated Edison Retirement Plan Management Participants - 401(h)	(92,817,693)	(87,348,203)
Net assets available for benefits per Form 5500	$ 35,897,376	$ 41,650,520

The following is a reconciliation of claims paid per the financial statements to Form 5500:

	For the Years Ended December 31,	
	2025	**2024**
Benefits paid per the financial statements	$ 59,222,042	$ 56,065,459
Add: Amounts payable at December 31, 2025 and 2024	(7,503,633)	(10,103,328)
Less: Amounts payable at December 31, 2024 and 2023	10,103,328	8,360,090
Claims paid per Form 5500	$ 61,821,737	$ 54,322,221

THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM
FOR MANAGEMENT EMPLOYEES
EIN 13-5009340
PLAN # 553

SCHEDULE OF DELINQUENT PARTICIPANT CONTRIBUTIONS **SUPPLEMENTAL SCHEDULE**
FOR THE YEAR ENDED DECEMBER 31, 2025 **FORM 5500 SCHEDULE H, LINE ITEM 4(a)**

Participant contributions transferred late to the Trust	Total that Constitute Nonexempt Prohibited Transactions
$ 16,687,041	$ -

See Independent Auditor's Report.

THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM
FOR MANAGEMENT EMPLOYEES
EIN 13-5009340
PLAN # 553

SCHEDULE OF ASSETS (HELD AT END OF YEAR)
AS OF DECEMBER 31, 2025

SUPPLEMENTAL SCHEDULE
FORM 5500 SCHEDULE H, LINE ITEM 4(i)

IDENTITY OF PARTY / DESCRIPTION OF INVESTMENT	SHARES, UNITS, PRINCIPAL AMOUNT	COST	CURRENT VALUE
MONEY MARKET MUTUAL FUNDS			
DREYFUS GOVT CASH MGMT INST 289 *	7,789,024	$ 7,789,024	$ 7,789,024
TOTAL MONEY MARKET MUTUAL FUNDS	**7,789,024**	**7,789,024**	**7,789,024**
TOTAL INVESTMENTS	**7,789,024**	**$ 7,789,024**	**$ 7,789,024**

* Party-in-interest

See Independent Auditor's Report.

THE CONSOLIDATED EDISON RETIREE HEALTH PROGRAM
FOR MANAGEMENT EMPLOYEES
EIN 13-5009340
PLAN # 553

SCHEDULE OF REPORTABLE TRANSACTIONS *
FOR THE YEAR ENDED DECEMBER 31, 2025

SUPPLEMENTAL INFORMATION
FORM 5500 SCHEDULE H, LINE 4 (j)

Description of Assets	Purchase Price	Selling Price	Cost of Assets Sold	Current Value of Assets on Transaction Date	Net Gain or (Loss)
Single transaction in excess of 5%					
DREYFUS GOVT CAS MGMT INST 289	$ 3,419,024	$ -	$ -	$ 3,419,024	$ -
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,870,029	$ 1,870,029	$ 1,870,029	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,693,577	$ 1,693,577	$ 1,693,577	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,758,858	$ 1,758,858	$ 1,758,858	-
DREYFUS GOVT CAS MGMT INST 289	$ 5,636,165	$ -	$ -	$ 5,636,165	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,782,623	$ 1,782,623	$ 1,782,623	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,954,028	$ 1,954,028	$ 1,954,028	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,119,146	$ 2,119,146	$ 2,119,146	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,852,432	$ 1,852,432	$ 1,852,432	-
DREYFUS GOVT CAS MGMT INST 289	$ 3,034,602	$ -	$ -	$ 3,034,602	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,926,086	$ 1,926,086	$ 1,926,086	-
DREYFUS GOVT CAS MGMT INST 289	$ 510,212	$ -	$ -	$ 510,212	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,780,937	$ 1,780,937	$ 1,780,937	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,813,692	$ -	$ -	$ 1,813,692	-
DREYFUS GOVT CAS MGMT INST 289	$ 820,134	$ -	$ -	$ 820,134	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,008,631	$ 2,008,631	$ 2,008,631	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,267,513	$ 1,267,513	$ 1,267,513	-
DREYFUS GOVT CAS MGMT INST 289	$ 6,243,237	$ -	$ -	$ 6,243,237	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,073,631	$ 2,073,631	$ 2,073,631	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,052,991	$ 2,052,991	$ 2,052,991	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,259,845	$ 1,259,845	$ 1,259,845	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,801,459	$ -	$ -	$ 1,801,459	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,097,792	$ 2,097,792	$ 2,097,792	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,593,546	$ 1,593,546	$ 1,593,546	-
DREYFUS GOVT CAS MGMT INST 289	$ 3,579,851	$ -	$ -	$ 3,579,851	-
DREYFUS GOVT CAS MGMT INST 289	$ 2,816,946	$ -	$ -	$ 2,816,946	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,000,228	$ 2,000,228	$ 2,000,228	-
DREYFUS GOVT CAS MGMT INST 289	$ 484,731	$ -	$ -	$ 484,731	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,693,904	$ 1,693,904	$ 1,693,904	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,540,565	$ 1,540,565	$ 1,540,565	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,183,528	$ -	$ -	$ 1,183,528	-
DREYFUS GOVT CAS MGMT INST 289	$ 563,074	$ -	$ -	$ 563,074	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,343,254	$ 2,343,254	$ 2,343,254	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,833,612	$ 1,833,612	$ 1,833,612	-
DREYFUS GOVT CAS MGMT INST 289	$ 5,475,806	$ -	$ -	$ 5,475,806	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,794,579	$ -	$ -	$ 1,794,579	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,988,563	$ 1,988,563	$ 1,988,563	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,154,435	$ -	$ -	$ 1,154,435	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,976,384	$ 1,976,384	$ 1,976,384	-
DREYFUS GOVT CAS MGMT INST 289	$ 622,665	$ -	$ -	$ 622,665	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,102,956	$ 2,102,956	$ 2,102,956	-
DREYFUS GOVT CAS MGMT INST 289	$ 483,446	$ -	$ -	$ 483,446	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,224,498	$ 2,224,498	$ 2,224,498	-
DREYFUS GOVT CAS MGMT INST 289	$ 2,840,107	$ -	$ -	$ 2,840,107	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,281,350	$ 2,281,350	$ 2,281,350	-
DREYFUS GOVT CAS MGMT INST 289	$ 1,538,935	$ -	$ -	$ 1,538,935	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 3,632,571	$ 3,632,571	$ 3,632,571	-
DREYFUS GOVT CAS MGMT INST 289	$ 5,161,961	$ -	$ -	$ 5,161,961	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,251,866	$ 2,251,866	$ 2,251,866	-
DREYFUS GOVT CAS MGMT INST 289	$ 488,269	$ -	$ -	$ 488,269	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 1,835,984	$ 1,835,984	$ 1,835,984	-
DREYFUS GOVT CAS MGMT INST 289	$ 3,206,019	$ -	$ -	$ 3,206,019	-
DREYFUS GOVT CAS MGMT INST 289	$ 5,933,711	$ -	$ -	$ 5,933,711	-
DREYFUS GOVT CAS MGMT INST 289	$ -	$ 2,063,472	$ 2,063,472	$ 2,063,472	-
DREYFUS GOVT CAS MGMT INST 289	$ 503,299	$ -	$ -	$ 503,299	-
CIGNA IMPREST CASH BALANCE					-
Series of transactions in excess of 5%					
DREYFUS GOVT CAS MGMT INST 289	65,166,861	66,578,294	66,578,294	131,745,155	-
CIGNA IMPREST CASH BALANCE					-

* Transactions or series of transactions in excess of 5 percent of the current value of the Plan's assets as of January 1, 2025 as defined in Section 2520.103-6 of the Department of Labor Rules and Regulations for Reporting and Disclosure under ERISA.

There were no lease rentals or expenses incurred for the above transactions.

See Independent Auditor's Report.

Plan Name	**The Consolidated Edison Retiree Health Program For Management Employees**
Plan Sponsor EIN	**13-5009340**
ERISA Plan #	**553**
Plan Year Ending	**12/31/2025**

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 3	Financial statements used in formulating the IQPA's opinion	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	X
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X

Plan Name	**The Consolidated Edison Retiree Health Program For Management Employees**
Plan Sponsor EIN	**13-5009340**
ERISA Plan #	**553**
Plan Year Ending	**12/31/2025**

The required attachment marked with an "X" in the Attachment column is included within the Accountant's Opinion attachment to Sch. H, Part III, Line 3, which consists of the entire audit report issued by the plan's Independent Qualified Public Accountant (IQPA).

Form/Schedule	Line #	Description	Attachment
5500 Sch. H	Line 3	Financial statements used in formulating the IQPA's opinion	X
5500 Sch. H	Line 4a	Schedule of Delinquent Participant Contributions	X
5500 Sch. H	Line 4i	Schedule of Assets (Held at End of Year)	X
5500 Sch. H	Line 4i	Schedule of Assets (Acquired and Disposed of Within Year)	
5500 Sch. H	Line 4j	Schedule of Reportable Transactions	X