

|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| <div>Form 5500</div> <div>Department of the Treasury<br/>Internal Revenue Service</div> <div>Department of Labor<br/>Employee Benefits Security<br/>Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Annual Return/Report of Employee Benefit Plan</div> <div>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).</div> <div>▶ Complete all entries in accordance with the instructions to the Form 5500.</div> | <div>OMB Nos. 1210-0110<br/>1210-0089</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|

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

|         |                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II | Basic Plan Information—enter all requested information                                                                                                                                                                                                                                                                                                                                                                   |
| 1a      | Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                                                                                                                                                                                                                                                                                                                                                           |
| 1b      | Three-digit plan number (PN) ▶ 501                                                                                                                                                                                                                                                                                                                                                                                       |
| 1c      | Effective date of plan<br>01/01/2025                                                                                                                                                                                                                                                                                                                                                                                     |
| 2a      | Plan sponsor's name (employer, if for a single-employer plan)<br>Mailing address (include room, apt., suite no. and street, or P.O. Box)<br>City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)<br>MCWANE, INC<br><br>MCWANE BENEFITS DEPARTMENT<br>PO BOX 43327<br>BIRMINGHAM, AL 35243-0327<br><br>2900 HIGHWAY 280 S STE 250<br>SUITE 250<br>BIRMINGHAM, AL 35223 |
| 2b      | Employer Identification Number (EIN)<br>63-0139000                                                                                                                                                                                                                                                                                                                                                                       |
| 2c      | Plan Sponsor's telephone number<br>205-578-3823                                                                                                                                                                                                                                                                                                                                                                          |
| 2d      | Business code (see instructions)<br>331500                                                                                                                                                                                                                                                                                                                                                                               |

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. | 09/08/2026 | LESLIE MAWHORTER                                             |
|           | 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                      |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>3a</b> Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>3b</b> Administrator's EIN<br><br><b>3c</b> Administrator's telephone number<br><br><div style="background-color: #cccccc; height: 40px; width: 100%;"></div>                                                                           |
| <b>4</b> If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:<br><b>a</b> Sponsor's name<br><b>c</b> Plan Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>4b</b> EIN<br><br><b>4d</b> PN                                                                                                                                                                                                          |
| <b>5</b> Total number of participants at the beginning of the plan year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>5</b> 5877                                                                                                                                                                                                                              |
| <b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines <b>6a(1)</b> , <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).<br><b>a(1)</b> Total number of active participants at the beginning of the plan year .....<br><b>a(2)</b> Total number of active participants at the end of the plan year .....<br><b>b</b> Retired or separated participants receiving benefits .....<br><b>c</b> Other retired or separated participants entitled to future benefits .....<br><b>d</b> Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b> .....<br><b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. ....<br><b>f</b> Total. Add lines <b>6d</b> and <b>6e</b> .....<br><b>g(1)</b> Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item) .....<br><b>g(2)</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....<br><b>h</b> Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested ..... | <div style="background-color: #cccccc; height: 20px; width: 100%;"></div> <b>6a(1)</b> 5877<br><b>6a(2)</b> 6604<br><b>6b</b><br><b>6c</b> 0<br><b>6d</b> 6604<br><b>6e</b><br><b>6f</b> 6604<br><b>6g(1)</b><br><b>6g(2)</b><br><b>6h</b> |
| <b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>7</b>                                                                                                                                                                                                                                   |

**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 4B 4D 4E 4F 4H

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

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

**a Pension Schedules**

- (1) ☐ **R** (Retirement Plan Information)
- (2) ☐ **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- (3) ☐ **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- (4) ☐ **DCG** (Individual Plan Information) – Number Attached \_\_\_\_\_
- (5) ☐ **MEP** (Multiple-Employer Retirement Plan Information)

**b General Schedules**

- (1) ☐ **H** (Financial Information)
- (2) ☐ **I** (Financial Information – Small Plan)
- (3) ☒ **A** (Insurance Information) – Number Attached 15
- (4) ☒ **C** (Service Provider Information)
- (5) ☐ **D** (DFE/Participating Plan Information)
- (6) ☐ **G** (Financial Transaction Schedules)

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

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

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

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

**11c** Enter the Receipt Confirmation Code for the 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 \_\_\_\_\_

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>PRINCIPAL 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     |
| 42-0127290 | 61271         | 1069964                               | 311                                                                         | 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<br>9083 | (b) Total amount of fees paid<br>510 |
|----------------------------------------------|--------------------------------------|

|                                                                                                       |
|-------------------------------------------------------------------------------------------------------|
| 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<br>AP BENEFIT ADVISORS<br>10 N PARK DR SUITE 200<br>HUNT VALLEY, MD 21030 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 0                                             | 510                             | BONUS       | 3                     |

|                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid<br>ASSUREDPARTNERS OF OHIO LLC<br>4406 TIMBERS COMMONS DR<br>SANDUSKY, OH 44870 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 9083                                          | 0                               |             | 3                     |

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

**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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 101014 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |        |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>AMERITAS LIFE INSURANCE CORP OF NY |               |                                       |                                                                             |                         |            |
|---------------------------------------------------------------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| (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     |
| 13-3758127                                                          | 60033         | 026201644                             | 686                                                                         | 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<br>18417 | (b) Total amount of fees paid<br>6755 |
|-----------------------------------------------|---------------------------------------|

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<br>LOCKTON COMPANIES, LLC<br>3800 COLONNADE PKWY STE 150<br>BIRMINGHAM, AL 35243 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 18417                                         | 6755                            | FEES        | 3                     |

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

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                 |            |        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                           | <b>10a</b> | 184173 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... | <b>10b</b> |        |

Specify nature of costs.

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>UNITED OF OMAHA 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     |
| 47-0322111                                                              | 69868         | G00025L6                              | 280                                                                         | 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<br>12800 | (b) Total amount of fees paid<br>7560 |
|-----------------------------------------------|---------------------------------------|

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<br>MCGRIFF INSURANCE SERVICES INC<br>1150 JULIAN DR<br>WATKINSVILLE, GA 30677 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 12800                                         | 7560                            | FEES        | 3                     |

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

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

---

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

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 128002 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |        |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶ 501                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>COMPSYCH CORPORATION |               |                                       |                                                                             |                         |            |
|-------------------------------------------------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| (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     |
| 36-3739783                                            | 00000         |                                       | 5634                                                                        | 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 |
| 0                                    | 0                             |

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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 54397 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |       |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
BLUE CROSS AND BLUE SHIELD OF AL

| (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     |
| 63-0103830 | 55433         | 75038                                 | 452                                                                         | 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 |
| 0                                    | 0                             |

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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

|                                                                                                                                                    |                 |                 |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|---------|
| <b>a</b> Premiums: (1) Amount received .....                                                                                                       | <b>9a(1)</b>    | 2943733         |         |
| (2) Increase (decrease) in amount due but unpaid .....                                                                                             | <b>9a(2)</b>    |                 |         |
| (3) Increase (decrease) in unearned premium reserve .....                                                                                          | <b>9a(3)</b>    |                 |         |
| (4) Earned ((1) + (2) - (3)) .....                                                                                                                 |                 | <b>9a(4)</b>    | 2943733 |
| <b>b</b> Benefit charges (1) Claims paid .....                                                                                                     | <b>9b(1)</b>    | 2529764         |         |
| (2) Increase (decrease) in claim reserves .....                                                                                                    | <b>9b(2)</b>    |                 |         |
| (3) Incurred claims (add (1) and (2)) .....                                                                                                        |                 | <b>9b(3)</b>    | 2529764 |
| (4) Claims charged .....                                                                                                                           |                 | <b>9b(4)</b>    | 2620464 |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                      |                 |                 |         |
| (A) Commissions .....                                                                                                                              | <b>9c(1)(A)</b> |                 |         |
| (B) Administrative service or other fees .....                                                                                                     | <b>9c(1)(B)</b> |                 |         |
| (C) Other specific acquisition costs .....                                                                                                         | <b>9c(1)(C)</b> | 213407          |         |
| (D) Other expenses .....                                                                                                                           | <b>9c(1)(D)</b> |                 |         |
| (E) Taxes .....                                                                                                                                    | <b>9c(1)(E)</b> | 47100           |         |
| (F) Charges for risks or other contingencies .....                                                                                                 | <b>9c(1)(F)</b> | 62923           |         |
| (G) Other retention charges .....                                                                                                                  | <b>9c(1)(G)</b> |                 |         |
| (H) Total retention .....                                                                                                                          |                 | <b>9c(1)(H)</b> | 323430  |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |         |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                |                 | <b>9d(1)</b>    |         |
| (2) Claim reserves .....                                                                                                                           |                 | <b>9d(2)</b>    | 250600  |
| (3) Other reserves .....                                                                                                                           |                 | <b>9d(3)</b>    |         |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....                                           |                 | <b>9e</b>       |         |

**10** Nonexperience-rated contracts:

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

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶ 501                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
THE STANDARD

| (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     |
| 93-0242990 | 69019         | 758445                                | 2708                                                                        | 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<br>31711 | (b) Total amount of fees paid<br>0 |
|-----------------------------------------------|------------------------------------|

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  
LOCKTON COMPANIES, LLC  
410 S RAMPART BLVD  
SUITE 390  
LAS VEGAS, NV 89145

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                 | (e) Organization code |
|-----------------------------------------------|---------------------------------|-----------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose     |                       |
|                                               | 2194                            | CONTINGENT COMP | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
LOCKTON COMPANIES, LLC  
3280 PEACHTREE RD NE  
SUITE 800  
ATLANTA, GA 30305

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 29517                                         | 0                               |             | 3                     |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

|                                                                                                                                                    |                 |        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------|--|
| <b>a</b> Premiums: (1) Amount received .....                                                                                                       | <b>9a(1)</b>    | 290987 |  |
| (2) Increase (decrease) in amount due but unpaid .....                                                                                             | <b>9a(2)</b>    | 8409   |  |
| (3) Increase (decrease) in unearned premium reserve .....                                                                                          | <b>9a(3)</b>    |        |  |
| (4) Earned ((1) + (2) - (3)) .....                                                                                                                 | <b>9a(4)</b>    | 299396 |  |
| <b>b</b> Benefit charges (1) Claims paid .....                                                                                                     | <b>9b(1)</b>    | 148977 |  |
| (2) Increase (decrease) in claim reserves .....                                                                                                    | <b>9b(2)</b>    | 437    |  |
| (3) Incurred claims (add (1) and (2)) .....                                                                                                        | <b>9b(3)</b>    | 149414 |  |
| (4) Claims charged .....                                                                                                                           | <b>9b(4)</b>    |        |  |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                      |                 |        |  |
| (A) Commissions .....                                                                                                                              | <b>9c(1)(A)</b> | 31711  |  |
| (B) Administrative service or other fees .....                                                                                                     | <b>9c(1)(B)</b> |        |  |
| (C) Other specific acquisition costs .....                                                                                                         | <b>9c(1)(C)</b> |        |  |
| (D) Other expenses .....                                                                                                                           | <b>9c(1)(D)</b> | 60909  |  |
| (E) Taxes .....                                                                                                                                    | <b>9c(1)(E)</b> | 4565   |  |
| (F) Charges for risks or other contingencies .....                                                                                                 | <b>9c(1)(F)</b> | 7576   |  |
| (G) Other retention charges .....                                                                                                                  | <b>9c(1)(G)</b> | 31161  |  |
| (H) Total retention .....                                                                                                                          | <b>9c(1)(H)</b> | 135922 |  |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... | <b>9c(2)</b>    |        |  |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                | <b>9d(1)</b>    |        |  |
| (2) Claim reserves .....                                                                                                                           | <b>9d(2)</b>    | 24831  |  |
| (3) Other reserves .....                                                                                                                           | <b>9d(3)</b>    |        |  |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....                                           | <b>9e</b>       |        |  |

**10** Nonexperience-rated contracts:

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

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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 | 65597         | 0121275                               | 6604                                                                        | 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<br>303685 | (b) Total amount of fees paid<br>20652 |
|------------------------------------------------|----------------------------------------|

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  
LOCKTON COMPANIES LLC  
PO BOX 123042 DEPT 3042  
DALLAS, TX 75312

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 0                                             | 331                             | FEES        | 3                     |

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid  
LOCKTON COMPANIES LLC  
PO BOX 65083  
DALLAS, TX 75265

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 0                                             | 20251                           | FEES        | 3                     |

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

LOCKTON COMPANIES, LLC

3800 COLONNADE PKWY STE 150  
BIRMINGHAM, AL 35243

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 305642                                        | 70                              | FEES        | 3                     |

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

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

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

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

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

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

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

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

**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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------------------------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | <a href="#">2310898</a> |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |                         |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
BLUE CROSS AND BLUE SHIELD OF ALABAMA

| (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     |
| 63-0103830 | 55433         | 70542                                 | 826                                                                         | 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 |
| 0                                    | 0                             |

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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

|                                                                                                                                                    |                 |                 |         |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------|---------|
| <b>a</b> Premiums: (1) Amount received .....                                                                                                       | <b>9a(1)</b>    | 4633562         |         |
| (2) Increase (decrease) in amount due but unpaid .....                                                                                             | <b>9a(2)</b>    |                 |         |
| (3) Increase (decrease) in unearned premium reserve .....                                                                                          | <b>9a(3)</b>    |                 |         |
| (4) Earned ((1) + (2) - (3)) .....                                                                                                                 |                 | <b>9a(4)</b>    | 4633562 |
| <b>b</b> Benefit charges (1) Claims paid .....                                                                                                     | <b>9b(1)</b>    | 5216480         |         |
| (2) Increase (decrease) in claim reserves .....                                                                                                    | <b>9b(2)</b>    |                 |         |
| (3) Incurred claims (add (1) and (2)) .....                                                                                                        |                 | <b>9b(3)</b>    | 5216480 |
| (4) Claims charged .....                                                                                                                           |                 | <b>9b(4)</b>    | 5368980 |
| <b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --                                                                      |                 |                 |         |
| (A) Commissions .....                                                                                                                              | <b>9c(1)(A)</b> |                 |         |
| (B) Administrative service or other fees .....                                                                                                     | <b>9c(1)(B)</b> | 351408          |         |
| (C) Other specific acquisition costs .....                                                                                                         | <b>9c(1)(C)</b> |                 |         |
| (D) Other expenses .....                                                                                                                           | <b>9c(1)(D)</b> |                 |         |
| (E) Taxes .....                                                                                                                                    | <b>9c(1)(E)</b> | 74089           |         |
| (F) Charges for risks or other contingencies .....                                                                                                 | <b>9c(1)(F)</b> | 86442           |         |
| (G) Other retention charges .....                                                                                                                  | <b>9c(1)(G)</b> | -2753           |         |
| (H) Total retention .....                                                                                                                          |                 | <b>9c(1)(H)</b> | 509186  |
| (2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) ..... |                 | <b>9c(2)</b>    |         |
| <b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....                                |                 | <b>9d(1)</b>    |         |
| (2) Claim reserves .....                                                                                                                           |                 | <b>9d(2)</b>    | 518800  |
| (3) Other reserves .....                                                                                                                           |                 | <b>9d(3)</b>    |         |
| <b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....                                           |                 | <b>9e</b>       |         |

**10** Nonexperience-rated contracts:

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

Specify nature of costs.

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Part I | Information Concerning Insurance Contract Coverage, Fees, and Commissions | Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A. |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|

1 Coverage Information:

(a) Name of insurance carrier  
DELTA DENTAL 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     |
| 94-2761537 | 81396         | 11558                                 | 2801                                                                        | 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<br>78168 | (b) Total amount of fees paid<br>0 |
|-----------------------------------------------|------------------------------------|

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  
LOCKTON COMPANIES, LLC  
3800 COLONNADE PKWY STE 150  
BIRMINGHAM, AL 35243

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 78168                                         | 0                               |             | 3                     |

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

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

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 921525 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |        |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
NEW YORK LIFE GROUP BENEFIT SOLUTIONS

| (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     |
| 23-1503749 | 65498         | FLK0960802                            | 403                                                                         | 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 |
| 0                                    | 0                             |

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>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 56346 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |       |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
NEW YORK LIFE GROUP BENEFIT SOLUTIONS

| (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     |
| 23-1503749 | 65498         | VDT0961651                            | 202                                                                         | 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 |
| 0                                    | 0                             |

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>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 69588 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |       |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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  
WELLPOINT

| (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     |
| 35-0980405 | 61069         | 10829-00                              | 3508                                                                        | 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<br>260551 | (b) Total amount of fees paid<br>130275 |
|------------------------------------------------|-----------------------------------------|

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  
LOCKTON COMPANIES, LLC  
3800 COLONNADE PKWY STE 150  
BIRMINGHAM, AL 35243

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 260551                                        | 130275                          | FEES        | 3                     |

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

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

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 2605507 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |         |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>THE HARTFORD LIFE AND ACCIDENT |
|-----------------------------------------------------------------|

| (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     |
| 06-0838648 | 70815         | 876969G                               | 208                                                                         | 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<br>3586 | (b) Total amount of fees paid<br>384 |
|----------------------------------------------|--------------------------------------|

|                                                                                                       |
|-------------------------------------------------------------------------------------------------------|
| 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<br>NORTH RISK PARTNERS, LLC<br>615 HORSESHOE DR<br>GRINNELL, IA 50112 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| -2                                            |                                 |             | 3                     |

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

|                                                                               |
|-------------------------------------------------------------------------------|
| LOCKTON COMPANIES, LLC<br>3800 COLONNADE PKWY STE 150<br>BIRMINGHAM, AL 35243 |
|-------------------------------------------------------------------------------|

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 2953                                          |                                 |             | 3                     |

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

NORTH RISK PARTNERS LLC

1045 76TH ST STE 4000  
WEST DES MOINES, IA 50266

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 636                                           |                                 |             | 3                     |

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

LOCKTON INSURANCE BROKERS LLC

2100 ROSS AVENUE SUITE  
DALLAS, TX 75201

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 0                                             | 384                             | BONUS       | 3                     |

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

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

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

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

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

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

**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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                 |            |       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                           | <b>10a</b> | 76896 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. .... | <b>10b</b> |       |

Specify nature of costs.

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A<br/>(Form 5500)<br/><div>Department of the Treasury<br/>Internal Revenue Service</div><div>Department of Labor<br/>Employee Benefits Security Administration</div><div>Pension Benefit Guaranty Corporation</div></div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶ 501                 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>DELTA DENTAL OF IOWA |               |                                       |                                                                             |                         |            |
|-------------------------------------------------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|------------|
| (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     |
| 42-0959302                                            | 55786         | 40822                                 | 322                                                                         | 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<br>7586 | (b) Total amount of fees paid<br>826 |
|----------------------------------------------|--------------------------------------|

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 |                                               |
| NORTH RISK PARTNERS, LLC                                                                         | 2048 SUPERIOR DRIVE NW<br>ROCHESTER, IA 55901 |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 6222                                          | 826                             | FEES        | 3                     |

|                                                                                                  |                                                                      |
|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid |                                                                      |
| LOCKTON COMPANIES, LLC                                                                           | HEALTH AND WELFARE PR 444 W<br>47TH ST #600<br>KANSAS CITY, MO 64112 |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| 6963                                          | 0                               |             | 3                     |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> Purpose |                                 |
|                                                      |                                 |                    |                                 |

---

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

---

| <b>(b)</b> Amount of sales and base commissions paid | Fees and other commissions paid |                    | <b>(e)</b><br>Organization code |
|------------------------------------------------------|---------------------------------|--------------------|---------------------------------|
|                                                      | <b>(c)</b> Amount               | <b>(d)</b> 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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 230951 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |        |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                    |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <div>SCHEDULE A</div> <div>(Form 5500)</div> <div>Department of the Treasury</div> <div>Internal Revenue Service</div> <div>Department of Labor</div> <div>Employee Benefits Security Administration</div> <div>Pension Benefit Guaranty Corporation</div> | <div>Insurance Information</div> <div>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</div> <div>▶ File as an attachment to Form 5500.</div> <div>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</div> | <div>OMB No. 1210-0110</div> <div>2025</div> <div>This Form is Open to Public Inspection</div> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|

|                                                                                            |                                                      |     |
|--------------------------------------------------------------------------------------------|------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                      |     |
| A Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                           | B Three-digit plan number (PN) ▶                     | 501 |
| C Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC                      | D Employer Identification Number (EIN)<br>63-0139000 |     |

|        |                                                                           |                                                                                                                                                                    |
|--------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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<br>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         | 0214757                               | 356                                                                         | 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<br>20851 | (b) Total amount of fees paid<br>1303 |
|-----------------------------------------------|---------------------------------------|

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 |                                                |
| PLANSOURCE BENEFITS ADMINISTRATION                                                               | 101 S GARLAND AVE STE 203<br>ORLANDO, FL 32801 |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |             | (e) Organization code |
|-----------------------------------------------|---------------------------------|-------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose |                       |
| -280                                          |                                 |             | 3                     |

|                                                                                                  |                                             |
|--------------------------------------------------------------------------------------------------|---------------------------------------------|
| (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid |                                             |
| LOCKTON COMPANIES, LLC                                                                           | PO BOX 123042 DEPT 3042<br>DALLAS, TX 75312 |

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                | (e) Organization code |
|-----------------------------------------------|---------------------------------|----------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose    |                       |
|                                               | 22                              | MARKETING FEES | 3                     |

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

LOCKTON COMPANIES, LLC

PO BOX 650823  
DALLAS, TX 75265

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                           | (e) Organization code |
|-----------------------------------------------|---------------------------------|---------------------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose               |                       |
|                                               | 1211                            | SUPPLEMENTAL COMPENSATION | 3                     |

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

LOCKTON COMPANIES, LLC

3800 COLONNADE PKWY STE 150  
BIRMINGHAM, AL 35243

| (b) Amount of sales and base commissions paid | Fees and other commissions paid |                           | (e) Organization code |
|-----------------------------------------------|---------------------------------|---------------------------|-----------------------|
|                                               | (c) Amount                      | (d) Purpose               |                       |
| 21131                                         | 70                              | NON MONETARY COMPENSATION | 3                     |

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

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

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

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

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

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

**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.

|                                                                                                        |          |  |
|--------------------------------------------------------------------------------------------------------|----------|--|
| <b>4</b> Current value of plan's interest under this contract in the general account at year end ..... | <b>4</b> |  |
| <b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....   | <b>5</b> |  |

**6** Contracts With Allocated Funds:**a** State the basis of premium rates ▶

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

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

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7** Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

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

**Part III Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts:

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

**10** Nonexperience-rated contracts:

|                                                                                                                                                                                                                                                             |            |        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------|
| <b>a</b> Total premiums or subscription charges paid to carrier .....                                                                                                                                                                                       | <b>10a</b> | 178951 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. ....<br>Specify nature of costs. | <b>10b</b> |        |

**Part IV Provision of Information**

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

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

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        |                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>SCHEDULE C</b><br><b>(Form 5500)</b><br><br>Department of the Treasury<br>Internal Revenue Service<br><br>Department of Labor<br>Employee Benefits Security Administration<br><br>Pension Benefit Guaranty Corporation | <b>Service Provider Information</b><br><br>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).<br><br>▶ <b>File as an attachment to Form 5500.</b> | OMB No. 1210-0110                              |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>2025</b>                                    |
|                                                                                                                                                                                                                           |                                                                                                                                                                                                                        | <b>This Form is Open to Public Inspection.</b> |

|                                                                                            |                                                             |     |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----|
| For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025 |                                                             |     |
| <b>A</b> Name of plan<br>MCWANE HEALTH AND WELFARE PLAN                                    | <b>B</b> Three-digit plan number (PN) ▶                     | 501 |
|                                                                                            |                                                             |     |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br>MCWANE, INC               | <b>D</b> Employer Identification Number (EIN)<br>63-0139000 |     |

|               |                                                        |
|---------------|--------------------------------------------------------|
| <b>Part I</b> | <b>Service Provider Information (see instructions)</b> |
|---------------|--------------------------------------------------------|

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>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
| DELTA DENTAL OF TN                                                                                                |
| 62-0812197                                                                                                        |

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
| BLUE CROSS AND BLUE SHIELD OF AL                                                                                  |
| 63-0103830                                                                                                        |

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</b> Enter name and EIN or address of person who provided you disclosures on eligible indirect compensation |
|                                                                                                                   |

|                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------|
| <b>(b)</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)

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

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

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

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

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

**Part I Service Provider Information (continued)**

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

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

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

|                    |                     |
|--------------------|---------------------|
| <b>a</b> Name:     | <b>b</b> EIN:       |
| <b>c</b> Position: |                     |
| <b>d</b> Address:  | <b>e</b> Telephone: |
|                    |                     |

Explanation:

entered  
8/24



## PLAN YEAR 5500 SUMMARY

**Policyholder** McWane, Inc.  
**Policy Year** 01/01/2025 - 12/31/2025  
**Policy Number** 10829-00  
**Carrier** Wellpoint Stop Loss  
**NAIC** 61069  
**EIN** 35-0980405

### Rates

| Schedule            | Coverage           | Rate  | Enrollment |
|---------------------|--------------------|-------|------------|
| Kennedy Valve Union | Specific Composite | 61.89 | 2,734      |
| McWane Ductile New  | Composite          | 61.89 | 1,631      |
| McWane Ductile Ohio | Composite          | 61.89 | 4,576      |
| McWane, Inc.        | Composite          | 61.89 | 33,158     |

### Premium

| Period           | Amount       |
|------------------|--------------|
| 1/2025 - 12/2025 | 2,605,507.11 |

### Commissions

| Payee               | TIN        | Amount     |
|---------------------|------------|------------|
| Lockton Companies L | 20-3354970 | 260,550.80 |

### Admin Fee

| Payee               | TIN        | Amount     |
|---------------------|------------|------------|
| Lockton Companies L | 20-3354970 | 130,275.43 |

### Supplemental Compensation

| Payee | TIN | Amount |
|-------|-----|--------|
|       |     | -      |

Schedule C

McWane, Inc. - Salary  
Group #: 40531, 40532, 40533, 70534, 70535, 70537  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

entire 7/9

Administrator: Blue Cross and Blue Shield of Alabama  
EIN: 630103830  
NAIC: 55433

|                                                    | <u>Health</u> |
|----------------------------------------------------|---------------|
| # of contracts at the end of the reporting period: | 3,336         |
| # of members at the end of the reporting period:   | 6,776         |

**Direct Compensation**

|                          |              |
|--------------------------|--------------|
| Administrative Services: | \$454,201.18 |
| Air Medical Services:    | \$31,615.33  |
| Rewards and Incentives:  | \$2,994.97   |
| FlexAccess Fee:          | \$1,425.95   |
| Teladoc:                 | \$32,636.00  |
| Smart RxAssist Fee:      | \$7,099.60   |
| Disease Management:      | \$0.00       |

**Indirect Compensation**

|                                                                 |        |
|-----------------------------------------------------------------|--------|
| Other Fees (Attorney, Broker, Consultant, Pass-Throughs, etc.): | \$0.00 |
| Settlement/Performance Guarantees:                              | \$0.00 |

**EIC (Eligible Indirect Compensation)**

|                                       |             |
|---------------------------------------|-------------|
| Value Based Program Fees:             | \$28,415.48 |
| Total Access Fees (Host Blue Plan): * | \$149.07    |

\* When Blue Cross and Blue Shield of Alabama ("BCBSAL") is charged a BlueCard Program access fee, BCBSAL may pass the charge along to you as a claim expense or as a separate amount. These fees are included in this annual report.

|                |        |
|----------------|--------|
| Recovery Fees: | \$0.00 |
|----------------|--------|

---

**Other**

|                                                            |                 |
|------------------------------------------------------------|-----------------|
| Paid Claims: Includes (\$906,321.29) in rebates & credits. | \$11,246,112.63 |
| Taxes:                                                     | \$193,419.75    |
| C-Plus/Medicare:                                           | \$0.00          |

**Outstanding Liabilities**

|                                                              |                |
|--------------------------------------------------------------|----------------|
| Estimate of Outstanding Claims Liability (OCL) @ 12/31/2025: | \$3,728,800.00 |
| Administrative Fee on OCL @ 12/31/2025:                      | \$242,372.00   |

**Note:** We administer your group on a self insured basis as an Administrative Services Only (ASO) contract. According to the Form 5500 instructions, ASO contracts are not required to file a Schedule A. It is our understanding, that in most cases, self insured groups would file a Schedule C. The reporting requirements for Schedule C were revised for plan years beginning calendar year 2009 and later. We have updated our reporting format based on our interpretation of these new rules. However, since your group is responsible for satisfying the government filing requirements, please consult your accounting/tax department to determine the appropriate schedule(s) to file.

Amerex Corporation  
Group #: 05365  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

*Schedule C*

|                |                                       |
|----------------|---------------------------------------|
| Administrator: | Blue Cross and Blue Shield of Alabama |
| EIN:           | 630103830                             |
| NAIC:          | 55433                                 |

|                                                    |                      |
|----------------------------------------------------|----------------------|
| # of contracts at the end of the reporting period: | <u>Dental</u><br>860 |
| # of members at the end of the reporting period:   | 1,878                |

**Direct Compensation**

|                                      |             |
|--------------------------------------|-------------|
| Administrative Services:             | \$23,652.81 |
| Air Medical Services:                | N/A         |
| Baby Yourself:                       | N/A         |
| Expanded Psychiatric Services (EPS): | N/A         |
| Teladoc:                             | N/A         |
| Disease Management:                  | N/A         |

**Indirect Compensation**

|                                                                 |                  |
|-----------------------------------------------------------------|------------------|
| Other Fees (Attorney, Broker, Consultant, Pass-Throughs, etc.): | N/A              |
| Settlement/Performance Guarantees:                              | \$0.00<br>\$0.00 |

**EIC (Eligible Indirect Compensation)**

|                |                  |
|----------------|------------------|
| Recovery Fees: | \$0.00<br>\$0.00 |
|----------------|------------------|

---

**Other**

|                  |              |
|------------------|--------------|
| Paid Claims:     | \$173,917.75 |
| Taxes:           | \$0.00       |
| C-Plus/Medicare: | N/A          |

**Outstanding Liabilities**

|                                                              |             |
|--------------------------------------------------------------|-------------|
| Estimate of Outstanding Claims Liability (OCL) @ 12/31/2025: | \$30,400.00 |
| Administrative Fee on OCL @ 12/31/2025:                      | \$4,134.40  |

**Note:** We administer your group on a self insured basis as an Administrative Services Only (ASO) contract. According to the Form 5500 instructions, ASO contracts are not required to file a Schedule A. It is our understanding, that in most cases, self insured groups would file a Schedule C. The reporting requirements for Schedule C were revised for plan years beginning calendar year 2009 and later. We have updated our reporting format based on our interpretation of these new rules. However, since your group is responsible for satisfying the government filing requirements, please consult your accounting/tax department to determine the appropriate schedule(s) to file.

New York Life Group Benefit Solutions  
P.O. Box 20643  
Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
SOLUTIONS

McWane dba Manchester Tank  
1000 Corporate Center  
Suite 300  
FRANKLIN, TN 37067

Date Prepared: March 6, 2026

entire  
7/23/26

Anniversary  
**Annual Policy Information Report**

|                            |                                         |
|----------------------------|-----------------------------------------|
| Name of Insurance Carrier  | Life Insurance Company of North America |
| EIN                        | 23-1503749                              |
| NAIC Code                  | 65498                                   |
| Contract/Policy Number     | VDT0961651                              |
| Contract/Policy Year From: | 01/01/2025                              |
| Contract/Policy Year To:   | 12/31/2025                              |

|                                   |
|-----------------------------------|
| Policy or Benefit Type            |
| STD Fully Insured Basic Group     |
| STD Fully Insured Voluntary Group |

Approximate Number of persons covered at the end of the policy year:\*

202

\*Please refer to your census reports or billing statement for this information.

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: \$ 69,587.69

See below for total commissions and fees paid by Insurance Company during the policy year.

| Agent Number | Name and Address of Each Recipient of Fees and/or Commissions | Amount of Commissions Paid | Amount of Fees Paid | Purpose for Which Paid |
|--------------|---------------------------------------------------------------|----------------------------|---------------------|------------------------|
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact Client Service Center at 800.557.7975

New York Life Group Benefit Solutions  
P.O. Box 20643  
Lehigh Valley, PA 18002-0643



GROUP BENEFIT  
SOLUTIONS

entered  
7/23/26

McWane dba Manchester Tank  
1000 Corporate Center  
Suite 300  
FRANKLIN, TN 37067

Date Prepared: March 6, 2026

Anniversary  
**Annual Policy Information Report**

|                            |                                         |
|----------------------------|-----------------------------------------|
| Name of Insurance Carrier  | Life Insurance Company of North America |
| EIN                        | 23-1503749                              |
| NAIC Code                  | 65498                                   |
| Contract/Policy Number     | FLK0960802                              |
| Contract/Policy Year From: | 01/01/2025                              |
| Contract/Policy Year To:   | 12/31/2025                              |

|                                            |
|--------------------------------------------|
| Policy or Benefit Type                     |
| LTD Fully Insured Basic Group - 296        |
| LTD Fully Insured Buy-up Group - 107 > 403 |

Approximate Number of persons covered at the end of the policy year:\*

\*Please refer to your census reports or billing statement for this information.

*Premiums, Commissions and Fees are as paid during the policy year. This may include payments made during the policy year which may be attributable to prior policy years. It may also include premium payments made by terminated employees. If overrides are shown, the amount reflects the allocation made with respect to the policy year.*

Total premiums paid to Insurance Company during the policy year: \$ 56,346.47

See below for total commissions and fees paid by Insurance Company during the policy year.

| Agent Number | Name and Address of Each Recipient of Fees and/or Commissions | Amount of Commissions Paid | Amount of Fees Paid | Purpose for Which Paid |
|--------------|---------------------------------------------------------------|----------------------------|---------------------|------------------------|
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |
|              |                                                               | \$<br>\$                   | \$<br>\$            |                        |

If you have any questions regarding the information being provided on this Annual Policy Information Report, please feel free to contact Client Service Center at 800.557.7975

*entered  
7/9/20*

M & H Valve Company  
Group #: 70538  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

Part I:

1.(A.) Name of insurance carrier: Blue Cross and Blue Shield of Alabama  
(B.) EIN: 630103830  
(C.) NAIC code: 55433  
(D.) Contract or Identification #: 70538  
(E.) Approximate # of persons covered at the end of the contract year:  
Health: 197  
Dental: 190  
(F.) - (G.) Policy or Contract Year: 1/1/2025 - 12/31/2025

Employee Contracts

Total Members

452

438

2. Insurance Fees/ Commissions paid, etc. \$0.00

Part II:

Health

Dental

Combined

6.(C.) Premiums due and unpaid at the end of the plan year: \$0.00 \$0.00 \$0.00

Part III:

8. Benefit and contract type:

|                                     |                                        |
|-------------------------------------|----------------------------------------|
| <input checked="" type="checkbox"/> | Health                                 |
| <input checked="" type="checkbox"/> | Dental                                 |
| <input type="checkbox"/>            | Vision                                 |
| <input checked="" type="checkbox"/> | Prescription Drugs                     |
| <input type="checkbox"/>            | Stop Loss (large deductible)           |
| <input checked="" type="checkbox"/> | PPO contract                           |
| Other:                              |                                        |
| <input type="checkbox"/>            | ...Expanded Psychiatric Services (EPS) |
| <input type="checkbox"/>            | ...C-Plus/Medicare                     |
| <input checked="" type="checkbox"/> | ...Baby Yourself                       |
| <input checked="" type="checkbox"/> | ...Air Medical Services (AirMed)       |
| <input type="checkbox"/>            | ...Disease Management                  |
| <input type="checkbox"/>            | ...Flexible Spending Account (FSA)     |
| <input type="checkbox"/>            | ...Health Reimbursement Account (HRA)  |

9. Experience rated contracts:

Health

Dental

Combined

(A.) Premiums

|                                                      |                |              |                |
|------------------------------------------------------|----------------|--------------|----------------|
| (1.) Amount received                                 | \$2,823,750.04 | \$119,983.39 | \$2,943,733.43 |
| (2.) Increase (decrease) in Amount Due and Unpaid    | \$0.00         | \$0.00       | \$0.00         |
| (3.) Increase (decrease) in Unearned Premium Reserve | \$0.00         | \$0.00       | \$0.00         |
| (4.) Earned: (1.) + (2.) - (3.)                      | \$2,823,750.04 | \$119,983.39 | \$2,943,733.43 |

(B.) Benefit Charges

|                                            |                |             |                |
|--------------------------------------------|----------------|-------------|----------------|
| (1.) Claims Paid                           | \$2,434,255.38 | \$95,508.15 | \$2,529,763.53 |
| (2.) Increase (decrease) in Claim Reserves | \$89,200.00    | \$1,500.00  | \$90,700.00    |
| (3.) Incurred Claims: (1.) + (2.)          | \$2,523,455.38 | \$97,008.15 | \$2,620,463.53 |
| (4.) Claims Charged                        | \$2,523,455.38 | \$97,008.15 | \$2,620,463.53 |

*entered  
7/9/26*

M & H Valve Company  
Group #: 70538  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

Part III: (continued)

|                                                                               | <u>Health</u> | <u>Dental</u> | <u>Combined</u> |
|-------------------------------------------------------------------------------|---------------|---------------|-----------------|
| 9. (C.) Remainder of Premium                                                  |               |               |                 |
| (1.) Retention Charges                                                        |               |               |                 |
| (a.) Commissions                                                              | \$0.00        | \$0.00        | \$0.00          |
| (b.) Administrative Services or Other Fees                                    | \$200,328.46  | \$13,078.19   | \$213,406.64    |
| (c.) Other Specific Acquisition Costs                                         | \$0.00        | \$0.00        | \$0.00          |
| (d.) Other Expenses                                                           | \$0.00        | \$0.00        | \$0.00          |
| (e.) Taxes                                                                    | \$45,180.00   | \$1,919.73    | \$47,099.73     |
| (f.) Charges for Risks or Other Contingencies                                 | \$58,123.46   | \$4,799.34    | \$62,922.80     |
| (g.) Other Retention Charges - Investment Income Credit                       | \$0.00        | \$0.00        | \$0.00          |
| (h.) Total Retention*                                                         | \$303,631.92  | \$19,797.26   | \$323,429.18    |
| (2.) Dividends or Retroactive Rate Refunds                                    |               |               |                 |
| (Note: These amounts were Paid in Cash (1) or Credited (2).)                  | \$0.00        | \$0.00        | \$0.00          |
| (D.) Status of Policyholders Reserves at the End of the Year                  |               |               |                 |
| (1.) Amount Held to Provide Benefits After Retirement                         | N/A           | N/A           | N/A             |
| (2.) Claim Reserves                                                           | \$243,400.00  | \$7,200.00    | \$250,600.00    |
| (3.) Other Reserves                                                           | \$0.00        | \$0.00        | \$0.00          |
| (E.) Dividends or Retroactive Rate Refunds Due                                |               |               |                 |
| (Do not include amount in (C.)(2.).)                                          | \$0.00        | \$0.00        | \$0.00          |
| 10. Nonexperience Rated Contracts:                                            |               |               |                 |
| (A.) Total Premiums or Subscription Charges Paid                              |               |               |                 |
| (B.) ...any specific costs...other than reported in Part I, item 2 above, ... | \$0.00        | \$0.00        | \$0.00          |

\* Excludes 2% Administrative Fee collected from COBRA Subscribers.

---



ComPsych

enter  
07/07/24

July 7, 2026

Re: McWane, Inc Schedule A Information

Dear Valued Client:

The information for the **Schedule A** (Form 5500) for McWane, Inc is as follows:

*January 1, 2025, thru December 31, 2025*

**Paid invoices for the period =\$54,396.76**

**Last head count = 5,634**

ComPsych's **FEIN #** is **36-3739783** and there is no NAIC code assigned. Please contact me at anytime, should you have any questions or concerns.

Thank You,

Amanda Weir  
**ComPsych Corporation**  
(312) 595-4086

1 Prudential Plaza \* 7<sup>th</sup> Floor  
130 East Randolph Street-Suite 700 \* Chicago, Illinois 60601-5322  
Telephone 312-595-4020 \* Fax 312-595-4036  
Website [www.compsych.com](http://www.compsych.com)



Ameritas Life Insurance Corp. of New York

Dental and Vision  
PO BOX 81889 / LINCOLN NE 68501-1889

**Electronic Service Requested**

**ROBERTA HOOVER**  
**KENNEDY VALVE, A DIVISION OF MCWANE DBA**  
**KENNEDY VALVE**  
**1021 E WATER ST**  
**ELMIRA NY 14901-3332**

**Contact Us**



Scan this QR code with your phone to access your account online.

**Have questions?** Speak with our customer service representatives at **800-659-2223**.  
Monday-Friday 7:30 a.m.-4:30 p.m. CT

May 12, 2026

Policy #026-201644  
Policyholder: Roberta Hoover  
**Re: Schedule A (Form 5500) Information**

Dear Policyholder,

The following provides you with group insurance benefit information, if needed, for a Schedule A report. This information is distributed to all policyholders who have around 100 or more participants (insured employees or COBRA qualified participants) as of the beginning of plan year. Questions on completing or filing Form 5500 and its related schedules should be addressed by your legal or accounting advisors.

At your service,

**Group Licensing and Compensation**

Schedule A (Form 5500) information For January 1, 2025 Through December 31, 2025

**Plan\*: Welfare Plan**

**Gross Premium Paid: \$184,173.00**

**Benefit: Dental**

**Tax ID: 13-3758127**

**NAIC code: 60033**

| <b>Benefit</b> | <b>Participants**</b> | <b>People covered as of end of year plan***</b> |
|----------------|-----------------------|-------------------------------------------------|
| Total          | 312                   | 686                                             |

**Broker Name and Address**

**LOCKTON COMPANIES LLC**  
3800 COLONNADE PKWY STE 150  
BIRMINGHAM AL 35243 3383

**Commission**

\$18,417.00

**Fees**

\$6,755.00

**Groups with multiple benefit coverages (i.e. dental and vision):**

\* When preparing this information, we assumed that the benefits listed above were provided in accordance with a single welfare plan, as defined by ERISA, sponsored by you. Let us know at the phone number above if this is not the case, and we will provide separate information for each plan you sponsor.

\*\* When a policy contains multiple benefit coverages, the number of participants enrolled in each coverage is shown above.

\*\*\* When determining number of people covered, we multiplied the number of participants by our standard actuarial factor of 2.2 to arrive at the approximate total number.

entered 4/3



**Contract #** 1069964  
**Name of Plan** MCWANE DUCTILE  
**Data Period** January 01, 2025 to December 31, 2025

**Principal Life Insurance Company**  
**Schedule A (Form 5500) Worksheet**

**Section 1: Coverage**

|                                                                |         |                                                                           |                     |     |
|----------------------------------------------------------------|---------|---------------------------------------------------------------------------|---------------------|-----|
| (a) Name of Insurance Carrier Principal Life Insurance Company |         | (b) EIN 42-0127290                                                        | (c) NAIC Code 61271 |     |
| (d) Contract or ID Number                                      | 1069964 | Approximate Number of<br><br>Persons Covered at End<br><br>of Policy Year | Total (e)           | 311 |
| Combined Numbers                                               |         |                                                                           | Employees           | 132 |
|                                                                |         |                                                                           | Dependents          | 179 |

|                         |                                  |                                 |
|-------------------------|----------------------------------|---------------------------------|
| Policy or Contract Year | From <b>(f)</b> January 01, 2025 | To <b>(g)</b> December 31, 2025 |
|-------------------------|----------------------------------|---------------------------------|

**Section 2: Insurance fee and commissions information**

|                    |                             |                      |
|--------------------|-----------------------------|----------------------|
|                    | <b>(a) Commissions Paid</b> | <b>(b) Fees Paid</b> |
| Total (from below) | 9,083                       | 510                  |

**Section 3: Persons receiving commissions and fees**

| <b>(a) Name &amp; Address of Agents or Brokers<br/>to whom Commissions or Fees Paid</b> | <b>(b) Amount of<br/>Commissions Paid</b> | <b>Fees Paid<br/>(c) Amount / (d) Purpose</b> | <b>(e)<br/>Org Code</b>       |
|-----------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------|
| Assuredpartners Of Ohio LLC<br>4406 TIMBER COMMONS DR<br>SANDUSKY, OH 44870-7116        | 9,083                                     |                                               | 3 - Ins Agent<br>Or<br>Broker |
| AP BENEFIT ADVISORS LLC<br>10 N PARK DR STE 200<br>HUNT VALLEY, MD 21030-1827           |                                           | 510 *Bonus                                    | 3 - Ins Agent<br>Or<br>Broker |

Reportable commissions and fees include all forms of compensation directly or indirectly attributable to your Principal Life Insurance Company policies.  
 \* This part of the compensation amount reflects a portion of administrative expenses that are allocated across all policies sold by PLIC. It is not part of your actual cost.

**Section 8: Benefit and Contract Type**

|                                                            |                                                       |                                                             |                               |
|------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------|-------------------------------|
| <b>(a)</b> Health<br>(other than dental or vision)         | <b>(b)</b> <input checked="" type="checkbox"/> Dental | <b>(c)</b> Vision                                           | <b>(d)</b> Life Ins.          |
| <b>(e)</b> Temporary Disability<br>(accident and sickness) | <b>(f)</b> Long Term Disability                       | <b>(g)</b> Supplemental<br>Unemployment                     | <b>(h)</b> Prescription Drug  |
| <b>(i)</b> Stop Loss<br>(large deductible)                 | <b>(j)</b> HMO Contract                               | <b>(k)</b> <input checked="" type="checkbox"/> PPO Contract | <b>(l)</b> Indemnity Contract |
| <b>(m)</b> Other                                           |                                                       |                                                             |                               |

If applicable, the Schedule A worksheet includes voluntary products. If applicable, Basic Life and VTL coverages included AD&D.

**Section 10: Non-Experience Rated Contracts**

|                                           |         |
|-------------------------------------------|---------|
| <b>(a) Total Premiums Paid to Carrier</b> | 101,014 |
|-------------------------------------------|---------|

SUPPORT FOR FORM 5500, SCHEDULE A, INSURANCE INFORMATION  
INFORMATION FOR COMPLETION OF PART I

UNION FOUNDRY CO A DIV OF MCWANE INCOR  
ANNISTON, AL

Name of Carrier: United of Omaha Life Insurance Company - NAIC Code 69868  
EIN Number: 47-0322111  
Group Identification Number: G00025L6  
Legacy Group ID: GUG 025L6  
Type of Contract:

Data for Period: 01-01-2025 to 01-01-2026

| Benefits Provided             | Persons Covered |
|-------------------------------|-----------------|
| Short Term Disability Insured | 280             |

| Name of Each Recipient                                                     | Amount of Commission Paid | Amount of Service Fees Paid or Other Fees | Purpose for Which Paid    | Organization Type |
|----------------------------------------------------------------------------|---------------------------|-------------------------------------------|---------------------------|-------------------|
| MCGRIFF INSURANCE SERVICES INC<br>1150 JULIAN DR<br>WATKINSVILLE, GA 30677 | 0                         | 7,560                                     | Other Compensation        | 3                 |
| MCGRIFF INSURANCE SERVICES INC<br>1150 JULIAN DR<br>WATKINSVILLE, GA 30677 | 12,800                    |                                           | Agent or Broker of Record | 3                 |

INFORMATION FOR COMPLETION OF PART III

10. Non-experience Rated Contracts:

Premiums ..... 128,002

Memo Items: Benefit Charges – Claims Paid ..... 0  
Administrative Service Fees ..... 0

Group Office: ATLANTA

entered  
7/23/27



## Form 5500 - Insurance Information

|                               |                                |
|-------------------------------|--------------------------------|
| <b>Group Name:</b>            | MCWANE, INC.                   |
| <b>Group Number:</b>          | 11558                          |
| <b>Division Number:</b>       |                                |
| <b>Number of Subscribers:</b> | 1,355                          |
| <b>Number of Members:</b>     | 2,801                          |
| <b>Commissions Paid:</b>      | \$78,168.47                    |
| <b>Plan Year:</b>             | 01/01/2025 -12/31/2025         |
| <b>Premium Paid:</b>          | \$921,524.50                   |
| <b>Carrier:</b>               | Delta Dental Insurance Company |
| <b>Delta EIN:</b>             | 94-2761537                     |
| <b>Delta NAIC:</b>            | 81396                          |

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

### APPENDIX

#### BROKER COMMISSIONS

|                       |                            |
|-----------------------|----------------------------|
| <b>Broker Name:</b>   | <b>\$Commissions Paid:</b> |
| LOCKTON COMPANIES LLC | \$78,168.47                |

entered  
7/23/26

Tyler Union  
Group #: 70542  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

Part I:

1.(A.) Name of insurance carrier: Blue Cross and Blue Shield of Alabama  
(B.) EIN: 630103830  
(C.) NAIC code: 55433  
(D.) Contract or Identification #: 70542  
(E.) Approximate # of persons covered at the end of the contract year:  
Health: Employee Contracts 346  
Dental: 332  
(F.) - (G.) Policy or Contract Year: 1/1/2025 - 12/31/2025

Total Members  
826  
792

2. Insurance Fees/ Commissions paid, etc. \$0.00

Part II:

6.(C.) Premiums due and unpaid at the end of the plan year: Health Dental Combined  
\$0.00 \$0.00 \$0.00

Part III:

8. Benefit and contract type:

|                                     |                                        |
|-------------------------------------|----------------------------------------|
| <input checked="" type="checkbox"/> | Health                                 |
| <input checked="" type="checkbox"/> | Dental                                 |
| <input type="checkbox"/>            | Vision                                 |
| <input checked="" type="checkbox"/> | Prescription Drugs                     |
| <input type="checkbox"/>            | Stop Loss (large deductible)           |
| <input checked="" type="checkbox"/> | PPO contract                           |
| <input type="checkbox"/>            | Other:                                 |
| <input type="checkbox"/>            | ...Expanded Psychiatric Services (EPS) |
| <input type="checkbox"/>            | ...C-Plus/Medicare                     |
| <input checked="" type="checkbox"/> | ...Baby Yourself                       |
| <input checked="" type="checkbox"/> | ...Air Medical Services (AirMed)       |
| <input type="checkbox"/>            | ...Disease Management                  |
| <input type="checkbox"/>            | ...Flexible Spending Account (FSA)     |
| <input type="checkbox"/>            | ...Health Reimbursement Account (HRA)  |

9. Experience rated contracts:

(A.) Premiums

|                                                      | Health         | Dental       | Combined       |
|------------------------------------------------------|----------------|--------------|----------------|
| (1.) Amount received                                 | \$4,447,050.66 | \$183,511.04 | \$4,630,561.70 |
| (2.) Increase (decrease) in Amount Due and Unpaid    | \$0.00         | \$0.00       | \$0.00         |
| (3.) Increase (decrease) in Unearned Premium Reserve | \$0.00         | \$0.00       | \$0.00         |
| (4.) Earned: (1.) + (2.) - (3.)                      | \$4,447,050.66 | \$183,511.04 | \$4,630,561.70 |

(B.) Benefit Charges

|                                            |                |              |                |
|--------------------------------------------|----------------|--------------|----------------|
| (1.) Claims Paid                           | \$5,080,644.03 | \$135,835.88 | \$5,216,479.91 |
| (2.) Increase (decrease) in Claim Reserves | \$150,600.00   | \$1,900.00   | \$152,500.00   |
| (3.) Incurred Claims: (1.) + (2.)          | \$5,231,244.03 | \$137,735.88 | \$5,368,979.91 |
| (4.) Claims Charged                        | \$5,231,244.03 | \$137,735.88 | \$5,368,979.91 |

Tyler Union  
Group #: 70542  
Form 5500 Information  
Reporting Period: 1/1/2025 - 12/31/2025

Part III: (continued)

|                                                                               | <u>Health</u> | <u>Dental</u> | <u>Combined</u> |
|-------------------------------------------------------------------------------|---------------|---------------|-----------------|
| 9. (C.) Remainder of Premium                                                  |               |               |                 |
| (1.) Retention Charges                                                        |               |               |                 |
| (a.) Commissions                                                              | \$0.00        | \$0.00        | \$0.00          |
| (b.) Administrative Services or Other Fees                                    | \$326,413.51  | \$24,994.21   | \$351,407.72    |
| (c.) Other Specific Acquisition Costs                                         | \$0.00        | \$0.00        | \$0.00          |
| (d.) Other Expenses                                                           | \$0.00        | \$0.00        | \$0.00          |
| (e.) Taxes                                                                    | \$71,152.81   | \$2,936.18    | \$74,088.99     |
| (f.) Charges for Risks or Other Contingencies                                 | \$80,936.33   | \$5,505.33    | \$86,441.66     |
| (g.) Other Retention Charges - Investment Income Credit                       | \$0.00        | (\$2,752.67)  | (\$2,752.67)    |
| (h.) Total Retention*                                                         | \$478,502.65  | \$30,683.05   | \$509,185.70    |
| (2.) Dividends or Retroactive Rate Refunds                                    |               |               |                 |
| (Note: These amounts were Paid in Cash (1) or Credited (2).)                  | \$0.00        | \$0.00        | \$0.00          |
| (D.) Status of Policyholders Reserves at the End of the Year                  |               |               |                 |
| (1.) Amount Held to Provide Benefits After Retirement                         | N/A           | N/A           | N/A             |
| (2.) Claim Reserves                                                           | \$508,600.00  | \$10,200.00   | \$518,800.00    |
| (3.) Other Reserves                                                           | \$0.00        | \$0.00        | \$0.00          |
| (E.) Dividends or Retroactive Rate Refunds Due                                |               |               |                 |
| (Do not include amount in (C.)(2.))                                           | \$0.00        | \$0.00        | \$0.00          |
| 10. Nonexperience Rated Contracts:                                            |               |               |                 |
| (A.) Total Premiums or Subscription Charges Paid                              |               |               |                 |
| (B.) ...any specific costs...other than reported in Part I, item 2 above, ... | \$0.00        | \$0.00        | \$0.00          |

\* Excludes 2% Administrative Fee collected from COBRA Subscribers.

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

► **File as an attachment to Form 5500**

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

Official Use Only

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

**B** Three digit  
plan number ►

**D** Employer Identification Number

**C** Plan sponsor's name as shown on line 2a of Form 5500  
**MCWANE, INC.**

**Part I**

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

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit can be reported  
on a single Schedule A

**1** Coverage:

(a) Name of insurance carrier

**METROPOLITAN LIFE INSURANCE COMPANY**

| (b) EIN           | (c) NAIC<br>code | (d) Contract or<br>identification number | (e) Approximate number of persons<br>covered at end of policy or contract<br>year | Policy or contract year |                   |
|-------------------|------------------|------------------------------------------|-----------------------------------------------------------------------------------|-------------------------|-------------------|
|                   |                  |                                          |                                                                                   | (f) From                | (g) To            |
| <b>13-5581829</b> | <b>65978</b>     | <b>0121275</b>                           | <b>6,604</b>                                                                      | <b>01/01/2025</b>       | <b>12/31/2025</b> |

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

| <b>Totals *</b>                  |                          |
|----------------------------------|--------------------------|
| Total amount of commissions paid | Total Fees Paid / amount |
| <b>303,685</b>                   | <b>20,652</b>            |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2025

## Part II

Official Use Only

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

Name: LOCKTON COMPANIES LLC

Address: 3800 COLONNADE PKWY STE 150

City: BIRMINGHAM ST: AL

ZIP: 35243-3383

| Commissions Paid     |         |                  | Fees Paid |        |                           | Organization<br>code |
|----------------------|---------|------------------|-----------|--------|---------------------------|----------------------|
| Coverage             | Amount  | Purpose          | Coverage  | Amount | Purpose                   |                      |
| LIFE                 | 222,010 | Base Commissions | Multiple  | 70     | Non-Monetary Compensation | 03                   |
| AD&D                 | 38,298  | Base Commissions |           |        |                           |                      |
| Long Term Disability | 34,843  | Base Commissions |           |        |                           |                      |
| Temporary Disability | 10,311  | Base Commissions |           |        |                           |                      |
|                      | 305,462 | <b>Sub-total</b> |           | 70     | <b>Sub-total</b>          |                      |

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

Name: LOCKTON COMPANIES LLC

Address: PO BOX 650823

City: DALLAS

ST: TX

ZIP: 75265-0823

| Commissions Paid |        |                  | Fees Paid            |        |                           | Organization<br>code |
|------------------|--------|------------------|----------------------|--------|---------------------------|----------------------|
| Coverage         | Amount | Purpose          | Coverage             | Amount | Purpose                   |                      |
|                  |        |                  | LIFE                 | 13,435 | Supplemental Compensation | 03                   |
|                  |        |                  | Long Term Disability | 3,181  | Supplemental Compensation |                      |
|                  |        |                  | AD&D                 | 2,303  | Supplemental Compensation |                      |
|                  |        |                  | Temporary Disability | 1,332  | Supplemental Compensation |                      |
|                  | 0      | <b>Sub-total</b> |                      | 20,251 | <b>Sub-total</b>          |                      |

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

Name: LOCKTON COMPANIES LLC

Address: PO BOX 123042 DEPT 3042

City: DALLAS

ST: TX

ZIP: 75312-3042

| Commissions Paid |        |                  | Fees Paid |        |                  | Organization<br>code |
|------------------|--------|------------------|-----------|--------|------------------|----------------------|
| Coverage         | Amount | Purpose          | Coverage  | Amount | Purpose          |                      |
|                  |        |                  | Multiple  | 331    | Marketing Fees   | 03                   |
|                  | 0      | <b>Sub-total</b> |           | 331    | <b>Sub-total</b> |                      |

|                                                                                                    |               |                  |                  |               |                  |                              |
|----------------------------------------------------------------------------------------------------|---------------|------------------|------------------|---------------|------------------|------------------------------|
| (a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid |               |                  |                  |               |                  |                              |
| Name: PLANSOURCE BENEFITS ADMINISTRATION INC                                                       |               |                  |                  |               |                  |                              |
| Address: 101 S Garland Ave Ste 203                                                                 |               |                  | City: Orlando    |               | ST: FL           | ZIP: 32801                   |
| <b>Commissions Paid</b>                                                                            |               |                  | <b>Fees Paid</b> |               |                  | <b>Organization<br/>code</b> |
| <b>Coverage</b>                                                                                    | <b>Amount</b> | <b>Purpose</b>   | <b>Coverage</b>  | <b>Amount</b> | <b>Purpose</b>   |                              |
| Temporary Disability                                                                               | 129           | Base Commissions |                  |               |                  | 03                           |
| AD&D                                                                                               | (245)         | Base Commissions |                  |               |                  |                              |
| Long Term Disability                                                                               | (319)         | Base Commissions |                  |               |                  |                              |
| LIFE                                                                                               | (1,342)       | Base Commissions |                  |               |                  |                              |
|                                                                                                    | (1,777)       | <b>Sub-total</b> |                  | 0             | <b>Sub-total</b> |                              |

Official Use Only

**Part III****Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts

N/A

**10** Nonexperience-rated contracts

|          | Coverage                                                                                                                                                                                                         | Amount    |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
|          | LIFE                                                                                                                                                                                                             | 1,509,709 |
|          | Long Term Disability                                                                                                                                                                                             | 349,982   |
|          | AD&D                                                                                                                                                                                                             | 262,939   |
|          | Temporary Disability                                                                                                                                                                                             | 188,268   |
| <b>a</b> | Total premiums or subscription charges paid to carrier                                                                                                                                                           | 2,310,898 |
| <b>b</b> | If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount |           |

Specify nature of costs below ►

**Footnote(s)**

The commissions and fees reported on page 2 have been aggregated at a total coverage level. The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

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

Official Use Only

**SCHEDULE A  
(Form 5500)**

Department of the Treasury  
Internal Revenue Service

Department of Labor  
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information**

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

► **File as an attachment to Form 5500**

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

OMB No. 1210-0110

**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**

|                                                                                      |                                         |
|--------------------------------------------------------------------------------------|-----------------------------------------|
| <b>A</b> Name of plan                                                                | <b>B</b> Three digit plan number ►      |
| <b>C</b> Plan sponsor's name as shown on line 2a of Form 5500<br><b>MCWANE, INC.</b> | <b>D</b> Employer Identification Number |

**Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit can be reported on a single Schedule A

**1 Coverage:**

(a) Name of insurance carrier

**METROPOLITAN LIFE INSURANCE COMPANY**

| (b) EIN           | (c) NAIC code | (d) Contract or identification number | (e) Approximate number of persons covered at end of policy or contract year | Policy or contract year |                   |
|-------------------|---------------|---------------------------------------|-----------------------------------------------------------------------------|-------------------------|-------------------|
|                   |               |                                       |                                                                             | (f) From                | (g) To            |
| <b>13-5581829</b> | <b>65978</b>  | <b>0214757</b>                        | <b>356</b>                                                                  | <b>01/01/2025</b>       | <b>12/31/2025</b> |

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

**Totals \***

| Total amount of commissions paid | Total Fees Paid / amount |
|----------------------------------|--------------------------|
| <b>20,851</b>                    | <b>1,303</b>             |

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. V7.2 Schedule A (Form 5500) 2025

## Part II

Official Use Only

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

Name: LOCKTON COMPANIES LLC

Address: 3800 COLONNADE PKWY STE 150

City: BIRMINGHAM ST: AL ZIP: 35243-3383

| Commissions Paid     |        |                  | Fees Paid |        |                           | Organization code |
|----------------------|--------|------------------|-----------|--------|---------------------------|-------------------|
| Coverage             | Amount | Purpose          | Coverage  | Amount | Purpose                   |                   |
| LIFE                 | 16,617 | Base Commissions | Multiple  | 70     | Non-Monetary Compensation | 03                |
| AD&D                 | 2,343  | Base Commissions |           |        |                           |                   |
| Long Term Disability | 2,171  | Base Commissions |           |        |                           |                   |
|                      | 21,131 | Sub-total        |           | 70     | Sub-total                 |                   |

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

Name: LOCKTON COMPANIES LLC

Address: PO BOX 650823

City: DALLAS ST: TX ZIP: 75265-0823

| Commissions Paid |        |           | Fees Paid            |        |                           | Organization code |
|------------------|--------|-----------|----------------------|--------|---------------------------|-------------------|
| Coverage         | Amount | Purpose   | Coverage             | Amount | Purpose                   |                   |
|                  |        |           | LIFE                 | 903    | Supplemental Compensation | 03                |
|                  |        |           | Long Term Disability | 179    | Supplemental Compensation |                   |
|                  |        |           | AD&D                 | 129    | Supplemental Compensation |                   |
|                  | 0      | Sub-total |                      | 1,211  | Sub-total                 |                   |

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

Name: LOCKTON COMPANIES LLC

Address: PO BOX 123042 DEPT 3042

City: DALLAS ST: TX ZIP: 75312-3042

| Commissions Paid |        |           | Fees Paid |        |                | Organization code |
|------------------|--------|-----------|-----------|--------|----------------|-------------------|
| Coverage         | Amount | Purpose   | Coverage  | Amount | Purpose        |                   |
|                  |        |           | Multiple  | 22     | Marketing Fees | 03                |
|                  | 0      | Sub-total |           | 22     | Sub-total      |                   |

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

Name: PLANSOURCE BENEFITS ADMINISTRATION INC

Address: 101 S Garland Ave Ste 203

City: Orlando ST: FL ZIP: 32801

| Commissions Paid     |        |                  | Fees Paid |        |           | Organization code |
|----------------------|--------|------------------|-----------|--------|-----------|-------------------|
| Coverage             | Amount | Purpose          | Coverage  | Amount | Purpose   |                   |
| AD&D                 | (24)   | Base Commissions |           |        |           | 03                |
| Long Term Disability | (34)   | Base Commissions |           |        |           |                   |
| Temporary Disability | (47)   | Base Commissions |           |        |           |                   |
| LIFE                 | (175)  | Base Commissions |           |        |           |                   |
|                      | (280)  | Sub-total        |           | 0      | Sub-total |                   |

**Part III****Welfare Benefit Contract Information**

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

**8** Benefit and contract type (check all applicable boxes)

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

**9** Experience-rated contracts

N/A

**10** Nonexperience-rated contracts

|                                                                                                                                                                                                                           | Coverage             | Amount  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------|
|                                                                                                                                                                                                                           | LIFE                 | 116,382 |
|                                                                                                                                                                                                                           | Long Term Disability | 23,488  |
|                                                                                                                                                                                                                           | Temporary Disability | 22,024  |
|                                                                                                                                                                                                                           | AD&D                 | 17,057  |
| <b>a</b> Total premiums or subscription charges paid to carrier                                                                                                                                                           |                      | 178,951 |
| <b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount |                      |         |

Specify nature of costs below ►

**Footnote(s)**

The commissions and fees reported on page 2 have been aggregated at a total coverage level. The approximate number of persons covered as shown on the first page of the Schedule A is MetLife's estimated view of participants, spouses and dependents at the end of the policy period. This estimation should be used for reporting purposes only.

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



## LONG FORM INFORMATION

THE FINANCIAL DATA BELOW IS PROVIDED FOR YOUR INFORMATION  
IT CAN BE USED TO COMPLETE THE SCHEDULE A FOR THE FORM 5500  
IF YOUR PLAN IS REQUIRED TO FILE SUCH A SCHEDULE

*submitted  
7/22/24*

C) PLAN SPONSOR: MCWANE INC

## PART I

## 1) COVERAGE - VISION

a) CARRIER: Standard Insurance Company  
b) EIN: 93-0242990  
c) NAIC CODE: 000-69019  
d) CONTRACT NUMBER: 758445  
e) NUMBER OF PERSONS COVERED: 2,708  
f) FROM: 1/1/2025  
g) TO: 12/31/2025

## 2) INSURANCE FEES AND COMMISSIONS PAID TO AGENTS, BROKERS AND OTHER PERSONS:

AMOUNT OF COMMISSIONS PAID: \$31,710.85  
FEES PAID / AMOUNT: \$0.00

| A) ID, NAME & ADDRESS OF AGENT OR<br>BROKER TO WHOM COMMISSION OR<br>FEES WERE PAID                | B) AMOUNT OF COMMISSION PAID |             |         | FEES PAID   |            | E) ORG.<br>CODE |
|----------------------------------------------------------------------------------------------------|------------------------------|-------------|---------|-------------|------------|-----------------|
|                                                                                                    | COMM.                        | CONT. COMP* | GA OVR. | C) AMOUNT   | D) PURPOSE |                 |
| 0000482239<br>LOCKTON COMPANIES LLC<br>3280 PEACHTREE ROAD NE<br>SUITE 800<br>ATLANTA, GA 30305    | \$29,516.56                  | \$0.00      | \$0.00  | \$0.00      |            | 3               |
| 0000482238<br>LOCKTON COMPANIES LLC<br>410 S RAMPART BOULEBARD<br>SUITE 390<br>LAS VEGAS, NV 89145 | \$0.00                       | \$2,194.29  | \$0.00  | \$0.00      |            | 3               |
| TOTAL COMMISSIONS PAID                                                                             |                              |             |         | \$29,516.56 |            |                 |
| TOTAL CONTINGENT COMP PAID                                                                         |                              |             |         | \$2,194.29  |            |                 |
| TOTAL GA OVERRIDES PAID                                                                            |                              |             |         | \$0.00      |            |                 |

\*'Contingent Compensation', sometimes referred to as contingent commissions, means compensation that is contingent on the satisfaction of one or more minimum requirements, such as a specified minimum amount of new premium volume or persistency in connection with the producer's block of business. The amount in Column B represents that portion of compensation attributable to the coverage referenced above. The Contingent Compensation is allocated to each policyholder in the same proportion that the policyholder's premium bears to the producer's total premium with The Standard.

## LONG FORM INFORMATION

PART III - 758445

7) BENEFIT TYPE: VISION

## EXPERIENCE RATED CONTRACTS

|                                                      |              |              |
|------------------------------------------------------|--------------|--------------|
| a) PREMIUMS: (1) AMOUNT RECEIVED:                    | \$290,987.42 |              |
| (2) INCREASE (DECREASE) IN DUE BUT UNPAID:           | \$8,409.00   |              |
| (3) INCREASE (DECREASE) IN UNEARNED PREMIUM RESERVE: | \$0.00       |              |
| (4) EARNED PREMIUM ((1)+(2) - (3)):                  |              | \$299,396.42 |
| b) BENEFIT CHARGES: (1) CLAIMS PAID:                 | \$148,977.40 |              |
| (2) INCREASE (DECREASE) CLAIM RESERVES:              | \$437.00     |              |
| (3) INCURRED CLAIMS ((1)+(2)):                       |              | \$149,414.40 |
| (4) CLAIMS CHARGED:                                  |              | \$149,414.40 |
| c) REMAINDER OF PREMIUM: (1) RETENTION CHARGES:      |              |              |
| (A) COMMISSIONS:                                     | \$31,710.85  |              |
| (B) ADMINISTRATIVE SERVICE OR OTHER FEES:            | \$0.00       |              |
| (C) OTHER SPECIFIC ACQUISITION COSTS:                | \$0.00       |              |
| (D) OTHER EXPENSES:                                  | \$60,909.00  |              |
| (E) TAXES:                                           | \$4,565.39   |              |
| (F) CHARGES FOR RISK OR OTHER CONTINGENCIES:         | \$7,576.00   |              |
| (G) OTHER RETENTION CHARGES:                         | \$31,161.36  |              |
| (H) TOTAL RETENTION:                                 |              | \$135,922.60 |
| ci) DIVIDEND OR RETROACTIVE RATE REFUND:             |              |              |
| d) STATUS OF POLICY HOLDER RESERVES AT END OF YEAR   |              |              |
| (1) AMOUNT HELD TO PROVIDE BENEFITS AFTER RETIREMENT |              | \$ 0.00      |
| (2) CLAIM RESERVES:                                  |              | \$24,831.00  |
| (3) OTHER RESERVES:                                  |              | \$0.00       |
| di) DIVIDENDS OR RETROACTIVE RATE REFUNDS DUE:       |              | \$0.00       |



## INSURANCE INFORMATION

This information is used on your Schedule A (Form 5500)

Name of Plan CLOW VALVE COMPANY

### Part I, Section 1

Delta Dental of Iowa

EIN: 42-0959302

NAIC CODE: 55786

Contract or ID Number: 40822

Approximate Number of Persons Covered @ End of Policy or Contract Year: 322

Policy or Contract Year 01/01/2025 - 12/31/2025

### Part I, Section 2

Total Amount of Commissions Paid: \$7,585.58

Total Fees Paid/Amount: \$826.19

Name and Address of Recipient of Fees or Commissions

LOCKTON COMPANIES, LLC  
HEALTH & WELFARE PR. 444 W  
47TH ST #600  
KANSAS CITY, MO 64112

Organization Code 3  
Amount of Commissions Paid: \$6,963.38

Fees Paid/Amount \$0.00  
Fees Paid/Purpose Sales and Persistency Bonus

NORTH RISK PARTNERS LLC  
2048 Superior Drive NW  
Rochester, MN 55901

Organization Code 3  
Amount of Commissions Paid: \$622.20

Fees Paid/Amount \$826.19  
Fees Paid/Purpose Sales and Persistency Bonus

### Part III, Section 7

Benefit and Contract Type: Dental

### Part III, Section 9

Non-experience rated contracts

(a) Total premiums or subscription charges paid to carrier \$230,951.07

Delta Dental of Iowa hereby certifies that the foregoing statement furnished pursuant to 29 CFR 2520.103-5(c) is complete and accurate.

The Hartford  
Group Benefits Division  
Annual Statement of Premiums and Producer Compensation  
For: CLOW VALVE COMPANY



**Policyholder and Address**

CLOW VALVE COMPANY  
902 S. 2ND ST.  
OSKALOOSA, IA 52577

**Plan/Policy Year - 01/01/2025 to 12/31/2025**

| Name of Insurance Carrier  | EIN        | NAIC Code | Policy Number |
|----------------------------|------------|-----------|---------------|
| HARTFORD LIFE AND ACCIDENT | 06-0838648 | 70815     | 876969G       |

**Premium was applied as follows during the Plan/Policy Year -**

| Policy Number | Type of Benefit | Premium Applied | Approximate # of Lives Covered |
|---------------|-----------------|-----------------|--------------------------------|
| 876969G       | WD-NST          | \$76,896.00     | 208                            |
|               |                 |                 |                                |
|               | Total           | \$76,896.00     |                                |

The Hartford Financial Services Group, Inc., (NYSE: HIG) operates through its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company under the brand name, The Hartford®, and is headquartered at One Hartford Plaza, Hartford, CT 06155. For additional details, please read The Hartford's legal notice at [www.thehartford.com](http://www.thehartford.com). The Hartford is the administrator for certain group benefits business written Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). © 2022 The Hartford

The Hartford  
Group Benefits Division  
Annual Statement of Premiums and Producer Compensation  
For: CLOW VALVE COMPANY



**Insurer paid the following compensation during the Plan/Policy Year -**

| Producer and Address                                                                   | Org Code | Policy Number | Commissions Paid | Fees Paid     | (1) Bonus Paid  | (2) Additional Compensation Paid |
|----------------------------------------------------------------------------------------|----------|---------------|------------------|---------------|-----------------|----------------------------------|
| LOCKTON INSURANCE<br>BROKERS LLC<br>2100 ROSS AVENUE SUITE<br>1200<br>DALLAS, TX 75201 | 3        | 876969-GRH    | \$0.00           | \$0.00        | \$383.52        | \$0.00                           |
|                                                                                        |          | <b>Total</b>  | <b>\$0.00</b>    | <b>\$0.00</b> | <b>\$383.52</b> | <b>\$0.00</b>                    |

| Producer and Address                                                                | Org Code | Policy Number | Commissions Paid | Fees Paid     | (1) Bonus Paid | (2) Additional Compensation Paid |
|-------------------------------------------------------------------------------------|----------|---------------|------------------|---------------|----------------|----------------------------------|
| NORTH RISK PARTNERS<br>LLC<br>1045 76TH ST STE 4000<br>WEST DES MOINES, IA<br>50266 | 3        | 876969-GRH    | \$636.48         | \$0.00        | \$0.00         | \$0.00                           |
|                                                                                     |          | <b>Total</b>  | <b>\$636.48</b>  | <b>\$0.00</b> | <b>\$0.00</b>  | <b>\$0.00</b>                    |

| Producer and Address                                                       | Org Code | Policy Number | Commissions Paid | Fees Paid     | (1) Bonus Paid | (2) Additional Compensation Paid |
|----------------------------------------------------------------------------|----------|---------------|------------------|---------------|----------------|----------------------------------|
| NORTH RISK PARTNERS<br>LLC<br>615 HORSESHOE DR STE G<br>GRINNELL, IA 50112 | 3        | 876969-GRH    | -\$2.24          | \$0.00        | \$0.00         | \$0.00                           |
|                                                                            |          | <b>Total</b>  | <b>-\$2.24</b>   | <b>\$0.00</b> | <b>\$0.00</b>  | <b>\$0.00</b>                    |

| Producer and Address                                                                         | Org Code | Policy Number | Commissions Paid  | Fees Paid     | (1) Bonus Paid | (2) Additional Compensation Paid |
|----------------------------------------------------------------------------------------------|----------|---------------|-------------------|---------------|----------------|----------------------------------|
| LOCKTON INSURANCE<br>BROKERS LLC<br>3800 COLONADE PARKWAY<br>STE 150<br>BIRMINGHAM, AL 35243 | 3        | 876969-GRH    | \$2,952.80        | \$0.00        | \$0.00         | \$0.00                           |
|                                                                                              |          | <b>Total</b>  | <b>\$2,952.80</b> | <b>\$0.00</b> | <b>\$0.00</b>  | <b>\$0.00</b>                    |

(1) Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium,