#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

Part I

**Annual Report Identification Information** 

# Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public Inspection

For cale	ndar plan year 2022 or fisc	cal plan year beginning 01/01/2022		and ending 12/31/2022				
A This	This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)							
		X a single-employer plan	a DFE (specify	· · ·		dollorio.)		
<b>B</b> This	return/report is:	the first return/report	the final return	• • • • • • • • • • • • • • • • • • • •				
		an amended return/report	a short plan ye	ear return/report (less than 12 mo	onths)			
<b>C</b> If the	plan is a collectively-barg	ained plan, check here						
D Ohaa	le base if filian constant	X Form 5558	automatic exte	ension	the DFVC program	m		
<b>D</b> Chec	k box if filing under:	special extension (enter description		SHOOL	the bi ve program	"		
F If this	is a retroactively adopted	plan permitted by SECURE Act section	,	<b>√</b> I	П			
Part II		mation—enter all requested information						
	ne of plan	Traction—enter all requested information	OH		<b>1b</b> Three-digit pla	an		
	IANAGEMENT, INC. WEL	FARE BENEFIT PLAN			number (PN)	501		
					1c Effective date 01/01/2020	of plan		
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 95-3948968			
QTC MANAGEMENT, INC.					2c Plan Sponsor's telephone number 909-978-3928			
	ERLAND CT MAS, CA 91773				2d Business code instructions) 541600	s (see		
Caution	: A penalty for the late o	r incomplete filing of this return/repo	ort will be assessed	unless reasonable cause is es	stablished.			
Under pe	enalties of perjury and oth	er penalties set forth in the instructions, rell as the electronic version of this return	I declare that I have	examined this return/report, incli	uding accompanying			
SIGN HERE	Filed with authorized/valid	d electronic signature.	08/10/2023	BRISA LOPEZ				
	Signature of plan admi	inistrator	Date	Enter name of individual signing	ng as plan administra	tor		
SIGN HERE								
HERE	Signature of employer	/plan sponsor	Date	Enter name of individual signir	ng as employer or pla	an sponsor		
SIGN								
HERE	1		1	1				

Date

Enter name of individual signing as DFE

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 4b EIN 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: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 2212 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 2210 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 2658 a(2) Total number of active participants at the end of the plan year ..... 6a(2)658 Retired or separated participants receiving benefits 6b 0 Other retired or separated participants entitled to future benefits..... 3316 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4F 4H 4L 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1) Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust (4) General assets of the sponsor (4) 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 **b** General Schedules (1) R (Retirement Plan Information) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)X

(3)

(4)

(5)

(6)

Purchase Plan Actuarial Information) - signed by the plan

SB (Single-Employer Defined Benefit Plan Actuarial

Information) - signed by the plan actuary

actuary

(3)

A (Insurance Information)

C (Service Provider Information) **D** (DFE/Participating Plan Information)

G (Financial Transaction Schedules)

Page 3

Form 5500 (2022)

Receipt Confirmation Code

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

			pursuant to	ERISA section 103(a)(2)				Inspection
For calendar	plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022	
A Name of p		C. WELFARI	E BENEFIT PLAN		B Three	e-digit number (PN	N) <b>•</b>	501
C Plan spons			line 2a of Form 5500		-	yer Identific 3948968	ation Number (	EIN)
Part I	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 i								
4 > 5	-18.1	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
(b) E	:IN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
94-0360524		47732	WOO51201	2949		01/01/202	2	12/31/2022
		mission infor	mation. Enter the total fees and t d.	total commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid								
199 1139726								
3 Persons re	eceiving com	missions and	d fees. (Complete as many entri	es as needed to report all	persons).			
		(a) Name	e and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
INNOVA INSU	JRANCE SO	LUTIONS	SUIT	O S. BREA CANYON TE 200 MOND BAR, CA 91765				
(b) Amour	nt of sales ar	nd haaa	F	ees and other commissio	ns paid			
	missions pai		(c) Amount		(d) Purpose		(e) Organization code	
		199	1139726	PRODUCER SERVICE F	EES			3
		(a) Name	e and address of the agent, broke	er, or other person to who	m commissi	ons or fees	were paid	
(b) Amour	nt of sales ar	nd base	F	ees and other commissio	ns paid			
	missions pai		(c) Amount		(d) Purpose	е		(e) Organization code

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
commissions para			oodc	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated splead and hose	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Part III  Welfare Benefit Contract Information  If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such contemployees, the entire group of such individual contracts with each contemployees.	tracts are exp	erience-rated as a u	ınit. Where co	ntracts cover individual
8 Benefit and contract type (check all applicable boxes)		_		_
a X Health (other than dental or vision) b ☐ Dental	С	Vision		<b>d</b> Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability	ity <b>g</b>	Supplemental une	mployment	<b>h</b> X Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k k	PPO contract		I Indemnity contract
m ☐ Other (specify) ▶	L	_1		
<b>9</b> Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve				-
(4) Earned ((1) + (2) - (3))			9a(4)	0
<b>b</b> Benefit charges (1) Claims paid	9b(1)		Ju(+)	
(2) Increase (decrease) in claim reserves				_
(3) Incurred claims (add (1) and (2))			9b(3)	0
			9b(4)	<del> </del>
(4) Claims charged			30(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)	00(1)(A)			-
(A) Commissions	9c(1)(A)			-
(B) Administrative service or other fees	9c(1)(B) 9c(1)(C)			_
(C) Other specific acquisition costs	9c(1)(C)			_
(D) Other expenses				_
(E) Taxes	9c(1)(E)			_
(F) Charges for risks or other contingencies	0-(4)(0)			4
(G) Other retention charges	9c(1)(G)		T	
(H) Total retention				0
(2) Dividends or retroactive rate refunds. (These amounts were paid in	n cash, or	credited.)	·· 9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide	benefits after	r retirement	9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered	d in line <b>9c(2</b> )	<b>)</b> .)		
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	21658469
<b>b</b> If the carrier, service, or other organization incurred any specific costs in cretention of the contract or policy, other than reported in Part I, line 2 above			10b	
Specify nature of costs.	•			
Part IV Provision of Information				
11 Did the insurance company fail to provide any information necessary to comp	lata Schodula	Δ2 [	Yes	X No
12 If the answer to line 11 is "Yes" specify the information not provided	nete ochedule	5 M!	100	

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to FRISA section 103(a)(2)

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

		pursuant to	ERISA section 103(a)(2)	).			Inspection		
For calendar plan year 20	22 or fiscal pl	an year beginning 01/01/2022		and en	ding 12/3	31/2022			
A Name of plan B Three-digit									
QTC MANAGEMENT, IN			number (Pl	N) •	501				
				·	,	,			
C Plan sponsor's name a	s shown on l	ine 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number (	EIN)		
QTC MANAGEMENT, IN	C.			_	3948968				
	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 ca		LINC							
TOTOLIC TOTOLIC TIL	-ALIIII LAN								
<b>(b)</b> FINI	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or co	ontract year		
<b>(b)</b> EIN	code	identification number	'	persons covered at end of policy or contract year		From	<b>(g)</b> To		
94-1340523	00000	124175	507		01/01/202	2	12/31/2022		
2 Insurance fee and com- descending order of the		mation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and of	ther persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
116269 0									
3 Persons receiving com	missions and	fees. (Complete as many entrie	s as needed to report all	persons).					
	(a) Name	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid			
INNOVA INSURANCE		STE.	S. BREA CANYON RD 200 IOND BAR, CA 91765-40	)11					
<b>(b)</b> Amount of sales ar	nd base	Fe	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpose			(e) Organization code		
	116269						3		
	(a) Name	and address of the agent, broke	r or other person to who	m commiss	ions or fees	were naid			
	(a) Name	and address of the agent, broke	1, or outer person to wite	111 00111111100	10110 01 1000	word paid			
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code		

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
commissions para			oodc	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated sples and have	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Part III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the information may be combined for reporting purposes if such column to the information may be combined for reporting purposes if such column to the information may be combined for reporting purposes if such column to the information may be combined for reporting purposes if such column to the information may be combined for reporting purposes if such column to the information may be combined for reporting purposes.	ntracts are experience-rated as	a unit. Where contract	s cover individual
employees, the entire group of such individual contracts with each	carrier may be treated as a unit	for purposes of this rep	ort.
8 Benefit and contract type (check all applicable boxes)			
a X Health (other than dental or vision) b Dental	C Vision	d∐	Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disab	ility <b>g</b> Supplemental	unemployment <b>h</b>	Prescription drug
i Stop loss (large deductible) j HMO contract	<b>k</b> PPO contract	ıΠ	Indemnity contract
m  ☐ Other (specify) ▶		_	
9 Experience-rated contracts:			
a Premiums: (1) Amount received	. 9a(1)		
(2) Increase (decrease) in amount due but unpaid	The state of the s		
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ( <b>(1)</b> + <b>(2)</b> - <b>(3)</b> )		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid			
(2) Increase (decrease) in claim reserves	21 (2)		
(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )		9b(3)	0
(4) Claims charged			
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were paid	in cash, or credited.)	9c(2)	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provid	e benefits after retirement	` '	
(2) Claim reserves		2 1/2	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line <b>9c(2)</b> .)	9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier		10a	3180469
<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 about			
Specify nature of costs.			
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A?	Yes X No	)
12 If the answer to line 11 is "Yes," specify the information not provided.			

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

pursuant to ERISA section 103(a)(2).			Inspection					
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022		
A Name of plan QTC MANAGEMENT, IN	C. WELFARI	E BENEFIT PLAN			e-digit number (PI	N) <b>•</b>	501	
•	C Plan sponsor's name as shown on line 2a of Form 5500 QTC MANAGEMENT, INC.  D Employer Identification Number 95-3948968					cation Number (	EIN)	
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 ca		I OF GEORGIA						
	( ) ) ) ( )	(1) 0 1 1	(e) Approximate nu	umber of		Policy or co	ntract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract	t end of	(f)	From	<b>(g)</b> To	
58-1592076	96237	5184	12		01/01/202	2	12/31/2022	
2 Insurance fee and com- descending order of the		mation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
		4863					0	
3 Persons receiving com	missions and	fees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name	e and address of the agent, broker	, or other person to who	m commissi	ions or fees	were paid		
INNOVA INSURANCE		SUITE	S. BREA CANYON ROA E 200 OND BAR, CA 91765-40					
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	4863						3	
						.,		
	(a) Name	e and address of the agent, broker	, or other person to who	m commissi	ions or tees	were paid		
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
commissions para			oodc	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated sples and have	Fees and other commissions paid			
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

F	Part	Welfare Benefit Contract Informat If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individual	roup of employees of the ng purposes if such conti	racts are ex	perience-rated as a	a unit. Where co	ntracts cover individual
8	Ben	efit and contract type (check all applicable boxes)					
	a	X Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness)	f Long-term disabilit	ty <b>g</b>	Supplemental u	nemplovment	h Prescription drug
	i	Stop loss (large deductible)	j  HMO contract	k	PPO contract		I  Indemnity contract
	m	Other (specify)	<b>т</b> <u> </u>	'			<u> </u>
	_	_					
9	Expe	erience-rated contracts:					
	a I	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid.		9a(2)			
		(3) Increase (decrease) in unearned premium rese		9a(3)			
		(4) Earned ((1) + (2) - (3))	· ·			9a(4)	0
	b	Benefit charges (1) Claims paid	i	9b(1)		, , , , ,	
		(2) Increase (decrease) in claim reserves		9b(2)			1
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	0
		(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on				<u>35(4)</u>	
	C			00/11//41			╡ ,
		(A) Commissions		9c(1)(A)			-
		(B) Administrative service or other fees		9c(1)(B) 9c(1)(C)			-
		(C) Other specific acquisition costs		9c(1)(D)			-
		(D) Other expenses					╡ ,
		(E) Taxes		9c(1)(E)			4
		(F) Charges for risks or other contingencies		9c(1)(F)			
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention	_				0
		(2) Dividends or retroactive rate refunds. (These a	amounts were 🔲 paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1)	Amount held to provide	benefits afte	er retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not					
10	) No	onexperience-rated contracts:		,	7		
	а	Total premiums or subscription charges paid to ca	rrier			10a	77302
							11302
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report					
	Spe	ecify nature of costs.		o, . opo u			. 1
D	art	IV Provision of Information					
	_						
		d the insurance company fail to provide any informa		ete Schedu	le A?	Yes	X No
12	2 If t	the answer to line 11 is "Yes," specify the informatio	n not provided.				

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

#### File as an attachment to Form 5500.

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

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 20	22 or fiscal pla	an year beginning 01/01/2022		and er	nding 12/31/2022	
A Name of plan				<b>B</b> Thre	e-digit	
QTC MANAGEMENT, IN	C. WELFARE	BENEFIT PLAN		plan	n number (PN)	501
C Plan sponsor's name a	e shown on lir	ne 2a of Form 5500		D Emple	oyer Identification Numb	per (FIN)
QTC MANAGEMENT, IN	·				-3948968	Der (LIN)
QTO MANAGEMENT, IN	0.				00.0000	
Part I Informat	tion Conce ate Schedule	rning Insurance Contra  A. Individual contracts grouped	ct Coverage, Fees, I as a unit in Parts II and I	and Con	<b>nmissions</b> Provide i	nformation for each contract edule A.
1 Coverage Information:						
-						
(a) Name of insurance ca KAISER FOUNDATION H		OF HAWAII				
	(a) NIAIC	(d) Contract or	(e) Approximate n	umber of	Policy of	or contract year
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f) From	<b>(g)</b> To
94-1340523	60053	45034	4		01/01/2022	12/31/2022
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	total commissions paid. L	ist in line 3	the agents, brokers, ar	nd other persons in
(a) Total a	amount of com	nmissions paid		<b>(b)</b> To	otal amount of fees paid	<u> </u>
3 Persons receiving com	missions and	fees. (Complete as many entri	es as needed to report all	persons).		
		and address of the agent, broke			sions or fees were paid	
			Tage and other commission	no noid		
(b) Amount of sales ar			ees and other commission			(a) Organization and
commissions pa	iu	(c) Amount		(d) Purpos	e	(e) Organization code
	(a) Name					
	(a) Name	and address of the agent, broke	er, or otner person to who	m commiss	sions or tees were paid	
	<u> </u>					
(b) Amount of sales ar			ees and other commission			
commissions pa	id	(c) Amount		(d) Purpos	e	(e) Organization code

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	les and base			
commissions para			code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated sples and have		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art	III Welfare Benefit Contract Information If more than one contract covers the same group of employees of the the information may be combined for reporting purposes if such contremployees, the entire group of such individual contracts with each ca	acts are e	experi	ience-rated as a	unit. Where co	ontracts cover individual
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	С	c 🗌 🔻	Vision		<b>d</b> Life insurance
	е	Temporary disability (accident and sickness) <b>f</b> Long-term disabilit	y <b>g</b>	, ∐ ,	Supplemental ur	nemnlovment	h X Prescription drug
	: [			· 🗕	PPO contract	iompioyment	I Indemnity contract
	'		, ,	<b>`</b> ⊔ '	PPO Contract		I Indemnity contract
	m	Other (specify)					
9		perience-rated contracts:	0 (4)				_
	a	Premiums: (1) Amount received	9a(1)				_
		(2) Increase (decrease) in amount due but unpaid	9a(2)				_
		(3) Increase (decrease) in unearned premium reserve	9a(3)			0-(4)	0
		(4) Earned ((1) + (2) - (3))		·····		9a(4)	
	b	• • • • • • • • • • • • • • • • • • • •	9b(1)				_
		(2) Increase (decrease) in claim reserves	9b(2)			05/2)	0
		(3) Incurred claims (add (1) and (2))				21.40	
	_	(4) Claims charged				9b(4)	
	С	Remainder of premium: (1) Retention charges (on an accrual basis)	00/4\/A\	<b>.</b> [			_
		(A) Commissions	9c(1)(A)				-
		(B) Administrative service or other fees	9c(1)(B) 9c(1)(C)				-
		(C) Other specific acquisition costs	9c(1)(D)	_			-
		(D) Other expenses	9c(1)(E)				-
		(E) Charge for risks an other partitions risks	9c(1)(F)				_
		(F) Other retention charges	9c(1)(G)				-
		(G) Other retention charges				06/1)/Ц)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		(H) Total retention					,
		(2) Dividends or retroactive rate refunds. (These amounts were paid in	_				
	d	Status of policyholder reserves at end of year: (1) Amount held to provide by					
		(2) Claim reserves					
	_	(3) Other reserves					
40			in line 9c	(2).).		9e	
10		onexperience-rated contracts:				400	
	а	Total premiums or subscription charges paid to carrier					30241
	b	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, other than reported in Part I, line 2 above					
	Орс	ecify nature of costs.					
Р	art	IV Provision of Information					
11	Dic	id the insurance company fail to provide any information necessary to comple	ete Schedu	lule A	·?	Yes	X No
12	If t	the answer to line 11 is "Yes." specify the information not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

#### File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

		pursuant to	ERISA section 103(a)(2)				Inspection	
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022		
A Name of plan QTC MANAGEMENT, IN	C. WELFAR	E BENEFIT PLAN			e-digit number (Pl	N) •	501	
•	C Plan sponsor's name as shown on line 2a of Form 5500 QTC MANAGEMENT, INC.  D Employer Identification Number (EIN) 95-3948968						EIN)	
	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 ca		OF WASHINGTON						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate no persons covered a			Policy or co	contract year	
(b) EIN	code	identification number	policy or contrac		(f)	From	<b>(g)</b> To	
91-0511770	95672	2066200	1		01/01/202	2	12/31/2022	
2 Insurance fee and com- descending order of the		mation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
	493 0							
3 Persons receiving com	missions and	d fees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name	e and address of the agent, broke	r, or other person to who	m commissi	ions or fees	were paid		
INNOVA INSURANCE		STE 2	S. BREA CANYON ROA 200 IOND BAR, CA 91765-40					
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code	
	493						3	
	(a) Name	e and address of the agent, broke	r, or other person to who	m commissi	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	les and base			
commissions para			code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated sples and have		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art II	I Welfare Benefit Contract Informa If more than one contract covers the same of the information may be combined for report employees, the entire group of such individu	group of employees of the ing purposes if such cont	racts are exp	erience-rated as a unit	t. Where co	ontracts cover individual	
8	Bene	fit and contract type (check all applicable boxes)	-				•	
	a X	Health (other than dental or vision)	<b>b</b> Dental	сГ	Vision		<b>d</b> Life insurance	
			H	<u> </u>	<u></u>	-1		
	e	Temporary disability (accident and sickness)	f Long-term disabili		Supplemental unem	pioyment	h Prescription drug	
	' <u> </u>	Stop loss (large deductible)	j 📗 HMO contract	k _	PPO contract		I Indemnity contract	
	m	Other (specify)						
9 1	Exper	ience-rated contracts:						
	<b>a</b> P	remiums: (1) Amount received		9a(1)				
	(	2) Increase (decrease) in amount due but unpaid	l	9a(2)				
	(	3) Increase (decrease) in unearned premium res	erve	9a(3)				
	(	4) Earned ((1) + (2) - (3))				9a(4)	C	)
	b	Benefit charges (1) Claims paid		9b(1)				
	(	2) Increase (decrease) in claim reserves		9b(2)				
	(	3) Incurred claims (add (1) and (2))				9b(3)	C	)
	(	4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (o	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)				
		(E) Taxes		9c(1)(E)				
		(F) Charges for risks or other contingencies		9c(1)(F)				
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention				9c(1)(H)	0	)
	(	(2) Dividends or retroactive rate refunds. (These	amounts were paid in	cash, or	credited.)	9c(2)		
	d :	Status of policyholder reserves at end of year: (1	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	e i	Dividends or retroactive rate refunds due. (Do no	ot include amount entered	d in line <b>9c(2)</b>	).)	9e		
10	Non	experience-rated contracts:						
	a ·	Total premiums or subscription charges paid to c	arrier			10a	17973	3
	b	If the carrier, service, or other organization incurr	ed any specific costs in c	onnection wit	th the acquisition or			
		retention of the contract or policy, other than repo				10b		
	Spec	ify nature of costs.						
Pa	art I\	/ Provision of Information						_
11	Did	the insurance company fail to provide any inform	ation necessary to compl	ete Schedule	e A?	Yes	X No	
12	If the	e answer to line 11 is "Yes." specify the informati	on not provided.					

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

		pursuant to	ERISA section 103(a)(2)	).			Inspection
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022	
A Name of plan QTC MANAGEMENT, IN	C. WELFAR	E BENEFIT PLAN			e-digit number (Pl	N) •	501
•	C Plan sponsor's name as shown on line 2a of Form 5500 QTC MANAGEMENT, INC.  D Employer Identification Number (EIN) 95-3948968						EIN)
	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 ca		DMPANY OF AMERICA					
	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	ntract year
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To
13-5123390	64246	00353815	2935		01/01/202	2	12/31/2022
2 Insurance fee and com- descending order of the		mation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
121899 0							
3 Persons receiving com	missions and	d fees. (Complete as many entries	s as needed to report all	persons).			
	(a) Name	e and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
INNOVA INSURANCE		STE 2	S. BREA CANYON ROA 200 OND BAR, CA 91765-91				
(b) Amount of sales ar	nd hase	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose	е		(e) Organization code
	121899						3
	(a) Name	e and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid			
commissions pa		(c) Amount		(d) Purpose			(e) Organization code

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	les and base			
commissions para			code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(4)		,		
	Т			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
(h) Associated sples and have		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid		
	-			
			1-3	
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization	
commissions paid	(O) / Arribuint	(a) i dipose	code	

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Pa	art	III Welfare Benefit Contract If more than one contract covers the information may be combined employees, the entire group of su	the same g for reportii	group o	ooses if such c	ontracts are	exp	erience-rated as a	unit. Where co	ontract	s cover individual
8	Ben	nefit and contract type (check all applicat	ole boxes)								
	а	Health (other than dental or vision)		b X	Dental		CX	Vision		d X	Life insurance
	еĪ	Temporary disability (accident and si	ckness)	f∏ı	Long-term disa	ability	аĒ	Supplemental un	employment	h∏	Prescription drug
	iΓ	Stop loss (large deductible)	•	_ =	HMO contract		_	PPO contract	, ,		Indemnity contract
	m			- ш			<u></u>	1			•
<b>9</b> E	Ехре	perience-rated contracts:									
	a i	Premiums: (1) Amount received				9a(1)					
		(2) Increase (decrease) in amount due	but unpaid			9a(2)					
		(3) Increase (decrease) in unearned pro									
		(4) Earned ((1) + (2) - (3))							9a(4)		0
	b	Benefit charges (1) Claims paid									
		(2) Increase (decrease) in claim reserve									
		(3) Incurred claims (add (1) and (2))							9b(3)		0
		(4) Claims charged							9b(4)		
	С	Remainder of premium: (1) Retention of									
	-	(A) Commissions			-	9c(1)(A	()				
		(B) Administrative service or other									
		(C) Other specific acquisition costs				0.14)16	•				
		(D) Other expenses				0-/4\/5	-				
		(E) Taxes				0-/4\/5				_	
		(F) Charges for risks or other contil				0 (4)/5				_	
		(G) Other retention charges									
									0c(1)(H)		0
		(H) Total retention								'	
		(2) Dividends or retroactive rate refund			<u> </u>						
	d	Status of policyholder reserves at end			•						
		(2) Claim reserves									
		(3) Other reserves							9d(3)		
	е	Dividends or retroactive rate refunds d	ue. (Do no	t includ	de amount ente	ered in line 9	(2)	.)	9e		
10	No	onexperience-rated contracts:							_		
	а	Total premiums or subscription charge	s paid to ca	arrier					10a		1769731
	b	If the carrier, service, or other organiza	tion incurre	ed any	specific costs	in connection	wit	h the acquisition or	405		
	Sno	retention of the contract or policy, othe ecify nature of costs.	r than repo	rted in	Part I, line 2 a	bove, report	amc	ount	10b		
Pa	rt l	IV Provision of Information	<u> </u>								
11	Dic	id the insurance company fail to provide	any informa	ation n	ecessary to co	mplete Sche	lule	A?	Yes	X No	)
		the answer to line 11 is "Yes," specify the									
		and another to mile in the reco, opening the	oullC	10 - 1							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information** 

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

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to FRISA section 103(a)(2)

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2).					Inspection				
For calendar plan year 20	022 or fiscal pl	an year beginning 01/01/2022		and en	iding 12/3	1/2022			
A Name of plan				<b>B</b> Thre	e-diait				
QTC MANAGEMENT, II	NC. WELFARE	BENEFIT PLAN			number (PN	<b>1</b> ) •	501		
				•		,			
C Plan sponsor's name	as shown on I	ine 2a of Form 5500		<b>D</b> Emplo	yer Identific	ation Number	(EIN)		
QTC MANAGEMENT, IN	IC.			95-	3948968				
		erning Insurance Contrac							
•		A. Individual contracts grouped	as a unit in Parts II and I	i can be re	ported on a	single Scriedu	ile A.		
1 Coverage Information:									
(a) Name of insurance ca	arrier								
VISION SERVICE PLAN									
VIOIOIV OLIVVIOL I LAIV									
	(c) NAIC	(d) Contract or	(e) Approximate n			Policy or o	ontract year		
<b>(b)</b> EIN	code	identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To		
94-1632821	00000	30054373	2246	2246 01/01/2		2	12/31/2022		
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								
22989 0									
3 Persons receiving con	nmissions and	l fees. (Complete as many entrie	s as needed to report all	nersons)					
U 1 craona receiving cor		and address of the agent, broke			ions or fees	were naid			
INNOVA INCUDANCE	(u) Hame				10110 01 1000	word paid			
INNOVA INSURANCE		1930 STE	S. BREA CANYON ROA	ND .					
			10ND BAR, CA 91765-40	)11					
(b) Amount of sales a	and base	Fe	ees and other commissio	ns paid					
commissions pa		(c) Amount		(d) Purpose	e		(e) Organization code		
	22989						3		
	(a) Nama	and address of the agent, broke	r or other person to who	m commico	ione or food	wore paid			
	(a) Name	and address of the agent, bloke	i, or other person to who	111 COITHINSS	ions or iees	were paid			
(h) Amazzat af aniza	and hose	Fe	ees and other commissio	ns paid					
(b) Amount of sales a commissions page		(c) Amount		(d) Purpose	e		(e) Organization code		
2 2		`,		. , , , , , , ,			(-)		
							ĺ		

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions para			oodc		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(4)		,			
	Т				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
			1-3		
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization		
commissions paid	(O) / Arribuint	(a) i dipose	code		

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Р	art	Welfare Benefit Contract Information If more than one contract covers the same group of employees o the information may be combined for reporting purposes if such o employees, the entire group of such individual contracts with eac	contracts are	expe	erience-rated as a uni	it. Where co	ontracts cove	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision) <b>b</b> Dental		c X	Vision		<b>d</b> Life in	surance
	е	Temporary disability (accident and sickness) <b>f</b> Long-term disa	ability (	g 🗌	Supplemental unem	plovment	h Presci	ription drug
	i	Stop loss (large deductible)  j HMO contract	-	e _ k [	PPO contract			nity contract
	m [			``∟	1110 contract			They contract
	[	Cities (Speedily)						
9	Expe	perience-rated contracts:						
•	•	Premiums: (1) Amount received	9a(1)					
	-	(2) Increase (decrease) in amount due but unpaid						
		(3) Increase (decrease) in unearned premium reserve			-			
		(4) Earned ((1) + (2) - (3))				. 9a(4)		0
	b	Benefit charges (1) Claims paid	9b(1)					
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		0
		(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (on an accrual basis)	·					
		(A) Commissions	9c(1)(A	١)				
		(B) Administrative service or other fees						
		(C) Other specific acquisition costs		-				
		(D) Other expenses						
		(E) Taxes						
		(F) Charges for risks or other contingencies						
		(G) Other retention charges	9c(1)(0	i)				
		(H) Total retention				9c(1)(H)	)	0
		(2) Dividends or retroactive rate refunds. (These amounts were $\ \ \ \ \ $	iid in cash, or	(	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to prov	vide benefits a	ıfter	retirement			
		(2) Claim reserves				9d(2)		
		(3) Other reserves				•		
40		(	ered in line 9	c(2)	<u>.)</u>	9e		
10		onexperience-rated contracts:				40		
	а	Total premiums or subscription charges paid to carrier				10a		218446
	b	If the carrier, service, or other organization incurred any specific costs retention of the contract or policy, other than reported in Part I, line 2 a ecify nature of costs.				10b		
Ρ	art l	IV Provision of Information						
11	Dic	id the insurance company fail to provide any information necessary to co	mplete Sched	dule	A?	Yes	X No	
12	2 If the answer to line 11 is "Yes." specify the information not provided.							

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

#### **Insurance Information**

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

pursuant to ERISA section 103(a)(2).					Inspection			
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022		
A Name of plan QTC MANAGEMENT, IN	C. WELFAR	E BENEFIT PLAN			e-digit number (Pl	N) •	501	
C Plan sponsor's name a QTC MANAGEMENT, IN		line 2a of Form 5500		-	yer Identific 3948968	cation Number (	EIN)	
		erning Insurance Contract A. Individual contracts grouped						
1 Coverage Information:								
(a) Name of insurance ca		RTH AMERICA						
/I.A. EINI	(c) NAIC	(d) Contract or	(e) Approximate no			Policy or co	contract year	
(b) EIN	code	identification number	persons covered a policy or contract		(f) From		<b>(g)</b> To	
23-1503749	65498	LK965300	2658		01/01/2022		12/31/2022	
2 Insurance fee and com- descending order of the		mation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total a	(a) Total amount of commissions paid (b) Total amount of fees paid							
43849 0								
3 Persons receiving com	missions and	d fees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name	e and address of the agent, broke	r, or other person to who	m commissi	ions or fees	were paid		
INNOVA INSURANCE		STE 2	S. BREA CANYON ROA 200 OND BAR, CA 91765-40					
<b>(b)</b> Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code	
	43849						3	
	(a) Name	e and address of the agent, broke	r, or other person to who	m commissi	ions or fees	were paid		
(b) Amount of sales ar	nd base	Fe	ees and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions para			oode		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(4)		,			
	Т				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
			1-3		
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization		
commissions paid	(O) / Arribuint	(a) i dipose	code		

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

P	art I	Welfare Benefit Contract Information If more than one contract covers the same grunder information may be combined for reporting employees, the entire group of such individual	oup of employees of the g purposes if such conti	acts are	exp	erience-rated as a	a unit. Where co	ntracts	cover individual
8	Bene	fit and contract type (check all applicable boxes)							
	а	Health (other than dental or vision)	Dental		С	Vision		d∏∟	ife insurance
	еĪ	Temporary disability (accident and sickness) <b>f</b>	X Long-term disabilit	v	g	Supplemental u	nemplovment	h∏F	rescription drug
	i	Stop loss (large deductible)	HMO contract	-	ے k	PPO contract	,	=	ndemnity contract
	m [	Other (specify)			-`∟	] 1 1 0 001111401		- □ "	radiffinity contract
	···· L	Other (specify)							
a	Evno	rience-rated contracts:							
3		remiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)				_	
		(3) Increase (decrease) in amount due but unpaid		9a(3)					
		(4) Earned ((1) + (2) - (3))	•				9a(4)		0
	_	Benefit charges (1) Claims paid		9b(1)			Ja(+)		
				9b(2)				_	
		(2) Increase (decrease) in claim reserves(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )			_		9b(3)		0
							9b(3)		
		(4) Claims charged					3D(4)		
	С	Remainder of premium: (1) Retention charges (on		00/4\//	۸١			_	
		(A) Commissions		9c(1)(A				_	
		(B) Administrative service or other fees		9c(1)(E				_	
		(C) Other specific acquisition costs		9c(1)([	-			_	
		(D) Other expenses			-			_	
		(E) Taxes		9c(1)(E				_	
		(F) Charges for risks or other contingencies		9c(1)(F				_	
		(G) Other retention charges		9c(1)(0					
		(H) Total retention	_		_		· · · · ·	1	0
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	cash, or	Ш	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	Amount held to provide	benefits a	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not	include amount entered	in line 9	c(2)	.)	9e		
10	No	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to car	rier				10a		438494
	_	If the carrier, service, or other organization incurred retention of the contract or policy, other than report							
		of costs.							
P	art I	Provision of Information					_		
11	Did	the insurance company fail to provide any informat	ion necessary to compl	ete Sche	dule	A?	Yes	X No	
12	If th	e answer to line 11 is "Ves" specify the information	not provided						

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

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

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2022

pursuant to ERISA section 103(a)(2).				Inspection				
For calendar plan year 20	22 or fiscal p	lan year beginning 01/01/2022		and en	ding 12/3	31/2022		
A Name of plan QTC MANAGEMENT, IN	C. WELFARI	E BENEFIT PLAN			Three-digit plan number (PN) 501			
C Plan sponsor's name a QTC MANAGEMENT, IN		ine 2a of Form 5500		D Employer Identification Number (EIN) 95-3948968				
on a separa		erning Insurance Contrac A. Individual contracts grouped a						
1 Coverage Information:							_	
(a) Name of insurance ca		RTH AMERICA						
	(a) NIAIC	(d) Contract or	(e) Approximate nu	umber of		Policy or co	ontract year	
<b>(b)</b> EIN	(c) NAIC code	(d) Contract or identification number	persons covered a policy or contract		(f)	From	<b>(g)</b> To	
23-1503749	65498	VDT962300	1366	1366		2	12/31/2022	
2 Insurance fee and com descending order of the		mation. Enter the total fees and to	tal commissions paid. L	ist in line 3	the agents,	brokers, and ot	her persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
42905 0								
3 Persons receiving com	missions and	I fees. (Complete as many entries	s as needed to report all	persons).				
	(a) Name	e and address of the agent, broker	r, or other person to who	m commissi	ions or fees	were paid		
INNOVA INSURANCE		STE 2	S. BREA CANYON ROA 200 OND BAR, CA 91765-40					
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code	
	42905						3	
	(a) Name							
	(a) Name	and address of the agent, broker	r, or other person to who	m commissi	ions or fees	s were paid		
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid				
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code	

(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
commissions para			oodc		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
(4)		,			
	Т				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization		
commissions paid	(c) Amount	(d) Purpose	code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
Fees and other commissions paid					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
		Fees and other commissions paid	(e)		
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code		
(a) Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid			
	-				
			1-3		
(b) Amount of sales and base	(c) Amount	Fees and other commissions paid  (d) Purpose	(e) Organization		
commissions paid	(O) / Arribuint	(a) i dipose	code		

F	Part	II Investment and Annuity Contract Information			
		Where individual contracts are provided, the entire group of such indivi	dual contracts with each carrier	may be treated as a ur	nit for purposes of
4	Curi	this report.  ent value of plan's interest under this contract in the general account at year e	end	4	
		ent value of plan's interest under this contract in separate accounts at year er			
		tracts With Allocated Funds:		<b>,</b>	
	а	State the basis of premium rates •			
	b	Premiums paid to carrier			
	С	Premiums due but unpaid at the end of the year		6c	
	d	If the carrier, service, or other organization incurred any specific costs in con retention of the contract or policy, enter amount	•	6d	
		Specify nature of costs			
	_				
	е	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 termina	ating plan, check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts mai	ntained in separate accounts)		
	а	Type of contract: (1) $\square$ deposit administration (2) $\square$ immedia	te participation guarantee		
		(3) guaranteed investment (4) dother			
	b	Balance at the end of the previous year		7b	0
	С	Additions: (1) Contributions deposited during the year	7c(1)		
		(2) Dividends and credits	7c(2)		
		(3) Interest credited during the year	7c(3)		
		(4) Transferred from separate account	7c(4)		
		(5) Other (specify below)	7c(5)		
		•			
		(6)Total additions		7c(6)	0
		Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ).		7d	0
	е	Deductions:	70(1)		
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1) 7e(2)		
		(2) Administration charge made by carrier	7e(2)		
		(3) Transferred to separate account	7e(4)		
		(4) Other (specify below)	70(4)		
		,			
		( <del>-)</del>		7.(5)	
	£	(5) Total deductions			0
	ſ	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

Part III  Welfare Benefit Contract Information If more than one contract covers the same group of employees of t the information may be combined for reporting purposes if such cor employees, the entire group of such individual contracts with each	ntracts are experience-rated as	a unit. Where contracts co	
8 Benefit and contract type (check all applicable boxes)	_	_	
a ☐ Health (other than dental or vision) b ☐ Dental	<b>C</b> Vision	<b>d</b> Life	insurance
e  ☐ Temporary disability (accident and sickness) f ☐ Long-term disab	ility <b>g</b> Supplemental u	inemployment <b>h</b> Pres	scription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract	k PPO contract		emnity contract
m ☐ Other (specify) ▶	<u> </u>		
9 Experience-rated contracts:			
a Premiums: (1) Amount received	. 9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ( <b>(1)</b> + <b>(2)</b> - <b>(3)</b> )		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid		, , ,	
(2) Increase (decrease) in claim reserves			
(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )		9b(3)	0
(4) Claims charged		9b(4)	
C Remainder of premium: (1) Retention charges (on an accrual basis)			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees			
(C) Other specific acquisition costs	0 (4)(0)		
(D) Other expenses	0-(4)(D)		
(E) Taxes	0-(4)(5)		
` '	0. (4)(5)		
(F) Charges for risks or other contingencies	0-(4)(0)		
(G) Other retention charges	· · · · · · · · · · · · · · · · · · ·	9c(1)(H)	0
(H) Total retention	_		
(2) Dividends or retroactive rate refunds. (These amounts were paid	<b>—</b>		
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide			
(2) Claim reserves			
(3) Other reserves		9d(3)	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entere	ed in line <b>9c(2)</b> .)	9e	
10 Nonexperience-rated contracts:			
Total premiums or subscription charges paid to carrier		10a	429049
<b>b</b> If the carrier, service, or other organization incurred any specific costs in			
retention of the contract or policy, other than reported in Part I, line 2 abo Specify nature of costs.	ove, report amount	10b	
Part IV Provision of Information			
11 Did the insurance company fail to provide any information necessary to com	plete Schedule A?	Yes X No	
12 If the answer to line 11 is "Yes," specify the information not provided.	p.o.o conoccio / ti		

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public Inspection

						inspection	
Part I		entification Information					
For calenda	ar plan year 2022 or fisca	l plan year beginning 01,	/01/2022	and ending	12/31/2	022	
A This ret	urn/report is for:	a multiemployer plan		a multiple-employer plan (Filers che participating employer information	•		ns.)
		X a single-employer plan		a DFE (specify)			•
<b>B</b> This ret	urn/report is:	the first return/report		the final return/report			
an amended return/report a short plan year return/report (less than 12 mo						ths)	
C If the pla	an is a collectively-bargai	ned plan, check here			▶ 🗍		
<b>D</b> Check b	pox if filing under:	X Form 5558		automatic extension		the DFVC program	
		special extension (enter of	lescription)				
E If this is				, check here			
Part II	Basic Plan Inform	ation—enter all requested in	nformation				
1a Name QTC	'	. WELFARE BENEFIT	PLAN		,	<b>1b</b> Three-digit plan number (PN) ▶	501
					•	1c Effective date of plants 01/01/2020	an
Mailing	g address (include room, a	, if for a single-employer plan apt., suite no. and street, or P country, and ZIP or foreign po	.O. Box)	oreign, see instructions)	2	<b>2b</b> Employer Identifica Number (EIN) 95-3948968	ation
QTC	MANAGEMENT, INC	· .			2	Plan Sponsor's tele number 909-978-392	•
	OVERLAND CT	CA 91773			3	2d Business code (see instructions) 541600	е
SAN	DIMAS	CA 91//3					
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.							

8/10/2023

Date

Date

Brisa Lopez

Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

HERE Signature of DFE Date

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

Brisa Lopez

Signature of plan administrator

Signature of employer/plan sponsor

SIGN HERE

SIGN HERE

**SIGN** 

Form 5500 (2022) Page **2** 

3a Plan administrator's name and address X Same as Plan Sponsor						<b>3b</b> Administrator's EIN	
					3c Adm	inistrator's telephone ber	
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:			4b EIN			
	Sponsor's name Plan Name				4d PN		
5	Total number of participants at the beginning of the plan year				5	2,212	
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare plans	comp	olete only lines 6a(1),			
a(	1) Total number of active participants at the beginning of the plan year				6a(1)	2,210	
a(	2) Total number of active participants at the end of the plan year				6a(2)	2,658	
b	Retired or separated participants receiving benefits				6b	658	
С	Other retired or separated participants entitled to future benefits				6c	0	
d	Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b>				6d	3,316	
е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefits			6e		
f	Total. Add lines <b>6d</b> and <b>6e</b> .				6f		
g	Number of participants with account balances as of the end of the plan year (complete this item)				6g		
h	Number of participants who terminated employment during the plan year with less than 100% vested				6h		
7	Enter the total number of employers obligated to contribute to the plan (only r	multiemployer p	olans	complete this item)	7		
	If the plan provides pension benefits, enter the applicable pension feature code $4A$ $4B$ $4D$ $4E$ $4F$ $4H$ $4L$ Plan funding arrangement (check all that apply)	es from the List	t of PI		s in the ins		
Ja	(1) X Insurance	(1)	X	Insurance	ат арріу)		
	(2) Code section 412(e)(3) insurance contracts	(2)		Code section 412(e)(3)	insurance	contracts	
	(3) Trust	(3)		Trust			
10	(4) X General assets of the sponsor	(4)	X	General assets of the sp		od (Coo instructions)	
	Check all applicable boxes in 10a and 10b to indicate which schedules are at				ber attache	ed. (See instructions)	
а	Pension Schedules	b General	I Sch				
	(1) R (Retirement Plan Information)	(1)	Н	H (Financial Inform	,	or all Diam)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		I (Financial Inform		mali Plan)	
	Purchase Plan Actuarial Information) - signed by the plan	(3)	X	9 <b>A</b> (Insurance Infor	,		
	actuary	(4)	Ц	C (Service Provide		•	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5)		<b>D</b> (DFE/Participati	•	•	
	Information) - signed by the plan actuary	(6)		<b>G</b> (Financial Trans	saction Sc	hedules)	