#### 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
For calendar plan year 2023 or fiscal plan year beginning 01/01/2023

## **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

2023

This Form is Open to Public Inspection

and ending 12/31/2023

Enter name of individual signing as DFE

A This return/report is for:  \[ \begin{array}{cccccccccccccccccccccccccccccccccccc							
		)	,				
<b>B</b> This r	return/report is:	the first return/report	the final return	report report			
		ar return/report (less than 12 mo	onths)				
<b>C</b> If the	plan is a collectively-barga	ined plan, check here					
	k box if filing under:	Form 5558	automatic exte	<u>-</u>	the DFVC program		
D Check	k box ii iiiiiig under.	special extension (enter description			_ tile bi ve program		
F If this	is a retroactively adopted i	plan permitted by SECURE Act section 2		<b>,</b> [			
Part II		nation—enter all requested information					
	ne of plan	Tation - enter all requested information			1b Three-digit plan		
	ANAGEMENT, INC. WELF	FARE BENEFIT PLAN			number (PN) ▶	501	
					1c Effective date of pla 01/01/2020	an	
		r, if for a single-employer plan)			2b Employer Identifica	ition	
City	or town, state or province,	apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	Number (EIN) 95-3948968		
QTC MA	ANAGEMENT, INC.				2c Plan Sponsor's telephone		
					number 909-978-3928		
	ERLAND CT				2d Business code (see	Э	
SAN DI	MAS, CA 91773				instructions) 541600		
Caution	: A penalty for the late or	incomplete filing of this return/report	t will be assessed u	unless reasonable cause is es	tablished.		
Under pe	enalties of perjury and othe	r penalties set forth in the instructions, I	declare that I have	examined this return/report, inclu	uding accompanying sche		
			07/16/2024	LAURA OCHOA			
SIGN HERE	Filed with authorized/valid						
Signature of plan administrator Date Enter name of individual signing					ng as plan administrator		
S.O.							
SIGN HERE							
	Signature of employer/p	olan sponsor	Date	Enter name of individual signing	ing as employer or plan sponsor		

Date

SIGN HERE

Signature of DFE

	Form 5500 (2023) Page <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor	<b>3b</b> Adr	ministrator's EIN
			ministrator's telephone mber
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	
a C	Sponsor's name Plan Name	4d PN	
5	Total number of participants at the beginning of the plan year	5	2941
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(	(1) Total number of active participants at the beginning of the plan year	6a(1)	2940
a(	(2) Total number of active participants at the end of the plan year	6a(2)	3671
b	Retired or separated participants receiving benefits	6b	5
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	3676
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	
g(	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	6g(1)	
g(		6g(2)	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	0
b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes  If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes  4A 4B 4D 4E 4F 4H 4L	s in the in	
<b>у</b> а	Plan funding arrangement (check all that apply)  (1)	insurance	e contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number of the control of	oer attach	ned. (See instructions)
а	Pension Schedules b General Schedules		
	(1) R (Retirement Plan Information) (1) H (Financial Information	1)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money (2) I (Financial Information	- Small	Plan)
	Purchase Plan Actuarial Information) - signed by the plan (3) A (Insurance Information	n) – Num	ber Attached10
	actuary (4) C (Service Provider Info	rmation)	

(5)

(6)

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

**G** (Financial Transaction Schedules)

(3)

(4)

(5)

 $\textbf{SB} \ \ (\text{Single-Employer Defined Benefit Plan Actuarial}$ 

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

MEP (Multiple-Employer Retirement Plan Information)

Information) - signed by the plan actuary

Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

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 pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2023

This Form is Open to Public

		F			mspection			
For calendar plan year 202	23 or fiscal plar	year beginning 01/01/2023	and	d ending 12/31/2023				
A Name of plan			Вт	hree-digit				
QTC MANAGEMENT, INC. WELFARE BENEFIT PLAN			ţ	olan number (PN)	501			
<b>C</b> Di .		0 (5 5500	D. 5	1 11 20 c N 1	(EIN)			
C Plan sponsor's name a		e 2a of Form 5500	<b>D</b> En	nployer Identification Number	(EIN)			
QTC MANAGEMENT, IN	IC.			95-3948968				
Part I Informat	ion Concer	ning Insurance Contract	Coverage Fees and C	Ommissions Provide info	ormation for each contract			
		. Individual contracts grouped as						
1 Coverage Information:		<u> </u>						
(a) Name of insurance car	rrier							
KAISER FOUNDATION H	EALTH PLAN	NC						
	T .	1	(e) Approximate number of	f Policy or	contract year			
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	persons covered at end of	:				
	code	identification number	policy or contract year	(f) From	(g) To			
94-1340523	00000	124175	601	01/01/2023	12/31/2023			
		ation. Enter the total fees and total	al commissions paid. List in lin	e 3 the agents, brokers, and	other persons in			
descending order of the		mianiana naid	//-	) Total amount of face poid				
(a) Total a	amount of comm	130237	<u> </u>	) Total amount of fees paid	0			
					U			
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons	s).				
	(a) Name a	nd address of the agent, broker,	or other person to whom comm	nissions or fees were paid				
MERCER HEALTH AND E	BENEFITS		ORTH WACKER DRIVE SUITE	1500				
		CHICA	GO, IL 60606					
		Fee	s and other commissions paid					
(b) Amount of sales ar commissions pai		(c) Amount	(d) Pur	200	(e) Organization code			
COMMINICONO PAR	61792	0	(4) 1 (1)	0000	3			
	01732				3			
	(a) N	and address of the court for t		-11				
		nd address of the agent, broker,		nissions or fees were paid				
MERCER HEALTH AND E	BENEFITS		PAYSPHERE CIRCLE AGO, IL 60674					
		33	.00, 12 0001 1					
(b) Amount of soles on	(b) Amount of sales and base Fees and other commissions paid							
(b) Amount of sales and base commissions paid (c) Amount				oose	(e) Organization code			
	35331	0	. ,		3			
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	500.	Sche	edule A (Form 5500) 2023 v. 230707			

Page	2 –	1
------	-----	---

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

#### INNOVA INSURANCE SOLUTIONS

3191 WEST TEMPLE AVENUE SUITE 285 POMONA, CA 91768

(b) Amount of sales and base commissions paid				
33114	0		code 3	
(a) Na	me and address of the agent, broker,	or other person to whom commissions or fees were paid		
	I	ees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	
<b>(a)</b> Nar	me and address of the agent, broker,	or other person to whom commissions or fees were paid		
(b) Amount of sales and base	I	Fees and other commissions paid	<b>(e)</b> Organization	
commissions paid	(c) Amount	(d) Purpose	code	
<b>(a)</b> Nar	me and address of the agent, broker,	or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
<b>(a)</b> Nar	me and address of the agent, broker,	or other person to whom commissions or fees were paid		
(le) Amount of color		Fees and other commissions paid	(e)	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
		(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

Pa	art				(-)		. 1	
		If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individual	ng purposes if such con	tracts are expe	erience-rated as a unit	. Where cont	racts o	cover individual
8	Ben	nefit and contract type (check all applicable boxes)						
	a	X Health (other than dental or vision)	<b>b</b> Dental	С	Vision	d	l Li	fe insurance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unemp	oloyment <b>h</b>	N X PI	rescription drug
	ιĖ	Stop loss (large deductible)	j	· - =	PPO contract	· I	ı∐ını	demnity contract
	. L				11 0 contract	•	. П	John My Contract
	m	Other (specify)						
<b>Q</b> 1	Evno	perience-rated contracts:						
	•	Premiums: (1) Amount received		9a(1)				
	u	(2) Increase (decrease) in amount due but unpaid.		9a(2)				
		(3) Increase (decrease) in unearned premium rese		· · ·				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b							
		(2) Increase (decrease) in claim reserves		:-:				
		(3) Incurred claims (add (1) and (2))				9b(3)		
		(4) Claims charged				9b(4)		
	С	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) 9c(1)(G)				
		(G) Other retention charges				0o/1\/U\		
		(H) Total retention	_			9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These a	_	-		9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)		
		(2) Claim reserves(3) Other reserves				9d(2) 9d(3)		
	е					9a(3)		
10		onexperience-rated contracts:	morade amount entere	a III IIII 0 30(2).	<i>,</i>	30		
. •	а	Total premiums or subscription charges paid to ca	rrier			10a		3387996
	b	If the carrier, service, or other organization incurre						
	~	retention of the contract or policy, other than repor				10b		
	Spe	ecify nature of costs.						
<b>D</b>	L P. C	IV Provision of Information						
	art					V 57	1	
		id the insurance company fail to provide any informa		lete Schedule	A?	Yes X	No	
12	If t	the answer to line 11 is "Yes," specify the information	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

2023

This Form is Open to Public

		pa.oaa to =			mspection			
For calendar plan year 202	23 or fiscal plar	year beginning 01/01/2023	and	ending 12/31/2023	_			
A Name of plan			<b>B</b> Th	ree-digit				
QTC MANAGEMENT, IN	NC. WELFARE	BENEFIT PLAN	pla	an number (PN)	501			
0.5			D =		(=\h\)			
C Plan sponsor's name a		e 2a of Form 5500		oloyer Identification Number	(EIN)			
QTC MANAGEMENT, IN	IC.			95-3948968				
Part I Informat	ion Concer	ning Insurance Contract	Coverage Fees and Co	mmissions Drovido info	rmation for each contract			
		. Individual contracts grouped as						
1 Coverage Information:		<u> </u>		, ,				
1 Coverage information.								
(a) Name of insurance ca	rrier							
KAISER FOUNDATION H	EALTH PLAN	OF GEORGIA INC						
	-		(a) Approximate number of	Doliny or o	ontract year			
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	_	contract year			
	code	identification number	policy or contract year	(f) From	<b>(g)</b> To			
58-1592076	96237	5184	11	01/01/2023	12/31/2023			
		ation. Enter the total fees and total	al commissions paid. List in line	3 the agents, brokers, and o	other persons in			
descending order of the								
(a) Total a	amount of comr		(b)	Total amount of fees paid				
		4717			0			
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons)					
	(a) Name a	nd address of the agent, broker,	or other person to whom commi	ssions or fees were paid				
MERCER HEALTH AND E	BENEFITS	4565 F	PAYSPHERE CIRCLE					
		CHICA	AGO, IL 60674					
					1			
<b>(b)</b> Amount of sales ar			es and other commissions paid					
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code			
	2907	0			3			
		-						
	(a) Name a	nd address of the agent, broker,	<u> </u>					
INNOVA INSURANCE SO	LUTIONS		WEST TEMPLE AVENUE SUITE	285				
		POMC	DNA, CA 91768					
	(b) Amount of sales and base Fees and other commissions paid							
(b) Amount of sales ar commissions pa	(e) Organization code							
COMMINISSIONS PA		(c) Amount	(d) Purpo	J3C	7 , 0			
1810 0					3			
For Paperwork Reductio	n Act Notice,	see the Instructions for Form 5	5500.	Sche	dule A (Form 5500) 2023			
					v. 230707			

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid											
		Food and other commissions paid	(0)								
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> Organization								
commissions paid	(c) Amount	(d) Purpose	code								
(a) Nar	me and address of the agent, broker	, or other person to whom commissions or fees were paid									
		Fees and other commissions paid	(e)								
(b) Amount of sales and base	(c) Amount	(d) Purpose	Organization								
commissions paid	(c) / illioant	(4) 1 41,5000	code								
(a) Nar	me and address of the agent, broker	, 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 paid			couc								
())											
<b>(a)</b> Nar	ne and address of the agent, broker	, 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) Nar	ne and address of the agent, broker	, or other person to whom commissions or fees were paid									
(4)	no and address of the agent, stener	, or said, person, or memoralisms or rose note para									
(b) Amount of calca and base		Fees and other commissions paid	(e)								
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code								

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

P	art							
		If more than one contract covers the same g the information may be combined for reporting employees, the entire group of such individu	ng purposes if such con	tracts are expe	erience-rated as a unit	. Where con	tracts cove	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	X Health (other than dental or vision)	<b>b</b> Dental	С	Vision	c	Life in	surance
	еĪ	Temporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unemp	olovment <b>h</b>	N Presc	ription drug
	. [	Stop loss (large deductible)	j HMO contract	· - =	PPO contract			nity contract
	' L		] [ ] Tilvio contract	ĸ_	11 O contract			Tilly Contract
	m	Other (specify)						
_								
	•	perience-rated contracts:		00/4)				
	a	Premiums: (1) Amount received		9a(1) 9a(2)				
		<ul><li>(2) Increase (decrease) in amount due but unpaid.</li><li>(3) Increase (decrease) in unearned premium rese</li></ul>		· · ·				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b					ou(+)		
	~	(2) Increase (decrease) in claim reserves		:-:				
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		-
	С	Remainder of premium: (1) Retention charges (on						
		(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)		
		(2) Dividends or retroactive rate refunds. (These	amounts were  paid i	n cash, or 🔲 d	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1)	•			9d(1)		
		(2) Claim reserves				9d(2)		
	_	(3) Other reserves				9d(3)		
10		Dividends or retroactive rate refunds due. (Do no	t include amount entere	d in line 9c(2).	)	9e		
10	_	onexperience-rated contracts:				40-		777.40
	а	Total premiums or subscription charges paid to ca				10a		77749
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than report				10b		
	Spe	ecify nature of costs.	,	, ,				
Pa	art	IV Provision of Information						
		id the insurance company fail to provide any informa	ation necessary to comp	lete Schedule	А?	Yes	No	
		the answer to line 11 is "Yes," specify the information		Concadie				
12	II L	the answer to line it is ites, specify the information	in 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

2023

This Form is Open to Public Inspection

pursuant to ERISA section 103(a)(2). Inspection						Inspection		
For calendar plan year 20								
A Name of plan				<b>B</b> Three	e-digit			
QTC MANAGEMENT, IN	NC. WELFAR	E BENEFIT PLAN			number (P	N) 🕨	501	
				'	`	,		
C Plan sponsor's name a	s shown on li	ne 2a of Form 5500		<b>D</b> Emplo	ver Identific	cation Number (	EIN)	
QTC MANAGEMENT, IN					-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						
			(e) Approximate n	umber of		Policy or co	ontract vear	
(b) EIN	(c) NAIC code	(d) Contract or identification number	persons covered a	t end of	(f)	From	<b>(g)</b> To	
94-1340523	60053	45034	policy or contract	•	01/01/20		12/31/2023	
2 Insurance fee and com descending order of the		nation. 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								
		0					0	
3 Persons receiving com		fees. (Complete as many entries						
	(a) Name	and address of the agent, broker	, or other person to who	m commiss	ions or fees	were paid		
(la) A manufact and a size and		Fe	es and other commissio	ns paid				
(b) Amount of sales ar commissions pa		(c) Amount	(d) Purpose				(e) Organization code	
•				(4) - 4.5000			, ,	
	(a) Name	and address of the agent, broker	or other person to who	m commiss	ions or fees	were paid		
	(a) Hamo	and address of the agent, broken	, or other percent to who		10110 01 1000	, word para		
(b) Amount of sales ar	nd hase	Fe	es and other commissio	ns paid		<u> </u>		
commissions pa		(c) Amount		(d) Purpose			(e) Organization code	
	$\exists$							

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Face and other commissions paid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	T		T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	ı		<b>.</b>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
• •	-						
(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					
	<b>y</b> ,	,					
(b) Amount of color and har-		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
	•	•					

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year		6c		
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

F	art	Welfare Benefit Contract Information If more than one contract covers the same gro		e same e	mplo	oyer(s) or members of	the same e	mployee organization	ns(s),
		the information may be combined for reporting employees, the entire group of such individual	purposes if such conf	tracts are	expe	erience-rated as a unit	Where co	ontracts cover individ	luaÌ ´
8	Bone	efit and contract type (check all applicable boxes)	CONTRACTO WITH CACIT C	arrior maj	, 50	troated as a arm for pr	arposos or t	ль торога	
Ü	_	_	Dental		сГ	Vision		<b>d</b> Life insurance	2
	L	=	H		<u> </u>	1	alaymant	h X Prescription of	
	e		<b>=</b>	-	g	<u> </u>	Jioyment		-
	! [	☐ Stop loss (large deductible) j	HMO contract		k	PPO contract		I Indemnity cor	ntract
	m	Other (specify)							
9		erience-rated contracts:		0.41	. 1				
		Premiums: (1) Amount received		9a(1)					
		(2) Increase (decrease) in amount due but unpaid		9a(2)					
		(3) Increase (decrease) in unearned premium reserv		9a(3)			00(4)		
		(4) Earned ((1) + (2) - (3))					9a(4)		
	b	Benefit charges (1) Claims paid(2) Increase (decrease) in claim reserves		9b(1) 9b(2)					
		(3) Incurred claims (add (1) and (2))					9b(3)		
		(4) Claims charged					9b(4)		
	С	Remainder of premium: (1) Retention charges (on a					35(4)		
		(A) Commissions		9c(1)(	A)				
		(B) Administrative service or other fees		9c(1)(					
		(C) Other specific acquisition costs		9c(1)(					
		(D) Other expenses		9c(1)(l	D)				
		(E) Taxes		9c(1)(l	Ε)				
		(F) Charges for risks or other contingencies		9c(1)(l					
		(G) Other retention charges		9c(1)(	G)				
		(H) Total retention	<u></u>		. <u></u>		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These an	nounts were 📗 paid ii	n cash, or	· 📙 (	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits	after	retirement	9d(1)		
		(2) Claim reserves					9d(2)		
		(3) Other reserves					9d(3)		
	е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entere	d in line 9	c(2).	.)	9e		
10	No	nexperience-rated contracts:							
	а	Total premiums or subscription charges paid to carr	er				10a		16368
	b	If the carrier, service, or other organization incurred					405		
	Sne	retention of the contract or policy, other than reported in the policy, other than reported in the return of costs.	d in Part I, line 2 abov	e, report	amo	unt	10b		
	Ope	ony nation of occio.							
Р	art l	IV Provision of Information							
11	Dic	d the insurance company fail to provide any information	on necessary to comp	lete Sche	dule	A?	Yes	X No	
		he answer to line 11 is "Yes," specify the information				<u></u>			
		, , ,							

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.

OMB No. 1210-0110

n.maant to EDICA anotion 400(a)(0)					m is Open to Public Inspection		
For calendar plan year 20	23 or fiscal pla	an year beginning 01/01/2023		and en	ding 12/3	31/2023	
A Name of plan QTC MANAGEMENT, IN	NC. WELFAR	E BENEFIT PLAN		<b>B</b> Three plan	e-digit number (PN	I) <b>•</b>	501
C Plan sponsor's name a	ıs shown on li	ne 2a of Form 5500		<b>D</b> Emplo	yer Identifica	ation Number	(EIN)
QTC MANAGEMENT, IN	IC.			95	-3948968		
		erning Insurance Contract  A. Individual contracts grouped					
1 Coverage Information:							
(a) Name of insurance ca		LOE WASHINGTON					
RAISER FOUNDATION I	-	VOF WASHINGTON	1				
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a				ontract year
(8) 2.11	code identification number policy or contract year			(f)	From	<b>(g)</b> To	
91-0511770	95672	2066200	1	1 01/01/2023			12/31/2023
2 Insurance fee and com descending order of the		nation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents, b	orokers, and o	ther persons in
	•	nmissions paid		<b>(b)</b> To	tal amount o	of fees paid	
126 0					0		
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all	persons).			
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
MERCER HEALTH AND E	BENEFITS	23Ri	AVENUE OF THE AME D FLOOR V YORK, NY 10028	RICAS			
<b>(b)</b> Amount of sales a	nd boso	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	)		(e) Organization code
	126	0					3
	(a) Name	and address of the agent, broke	er, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Face and other commissions paid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	T		T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	ı		<b>.</b>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
• •	-						
(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					
	<b>y</b> ,	,					
(b) Amount of color and har-		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
	•	•					

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year		6c		
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

Р	art		Welfare Benefit Contract Informal If more than one contract covers the same the information may be combined for report employees, the entire group of such individ	group of employees of the ing purposes if such cont	tracts are e	· expe	erience-rated as a uni	t. Where co	ontracts cover	
8	Ben	efit an	d contract type (check all applicable boxes)							
	a	K Hea	alth (other than dental or vision)	<b>b</b> Dental	C	: [	Vision		<b>d</b> Life ins	urance
	е	= Ter	nporary disability (accident and sickness)	f  Long-term disabili	itv <b>o</b>	3 <u> </u>	Supplemental unem	plovment	h X Prescri	otion drua
	i	_	p loss (large deductible)	j HMO contract		, <u> </u>	]	,		ity contract
	m	- Oth	ner (specify)				1			
	L		(0,000)							
9	Expe	erienc	e-rated contracts:							
-			ums: (1) Amount received		9a(1)					
			crease (decrease) in amount due but unpaid		9a(2)					
			crease (decrease) in unearned premium res		9a(3)					
			arned ((1) + (2) - (3))					. 9a(4)		
	-	. ,	fit charges (1) Claims paid		9b(1)					
			crease (decrease) in claim reserves		9b(2)					
		` '	curred claims (add <b>(1)</b> and <b>(2)</b> )					9b(3)		
			aims charged					9b(4)		
	С	` '	ainder of premium: (1) Retention charges (o							
			A) Commissions		9c(1)(A	()				
		(I	B) Administrative service or other fees		9c(1)(B					
		((	C) Other specific acquisition costs		9c(1)(C					
		(1	O) Other expenses		9c(1)(D	)				
		(1	E) Taxes		9c(1)(E	)				
		(1	F) Charges for risks or other contingencies		9c(1)(F)					
		(0	G) Other retention charges		9c(1)(G	i)				
		(1	H) Total retention					9c(1)(H	)	
		(2) D	ividends or retroactive rate refunds. (These	amounts were paid ir	n cash, or	(	credited.)	9c(2)		
	d	Statu	s of policyholder reserves at end of year: (1	) Amount held to provide	benefits af	fter	retirement	9d(1)		
		(2) C	laim reserves					9d(2)		
		(3) O	ther reserves					9d(3)		
	е	Divid	ends or retroactive rate refunds due. (Do no	ot include amount entere	d in line <b>9c</b>	(2).	.)	9e		
10	No	nexpe	erience-rated contracts:							
	а	Total	premiums or subscription charges paid to o	arrier				10a		4215
	b	If the	carrier, service, or other organization incurr	ed any specific costs in o	connection	witl	h the acquisition or			
		reten	tion of the contract or policy, other than repo					10b		
	Spe	cify na	ature of costs.							
Р	art l	IV_	Provision of Information							
11	Dic	the in	nsurance company fail to provide any inform	ation necessary to comp	lete Sched	lule	A?	Yes	X No	<del></del>
12			swer to line 11 is "Yes," specify the informati							

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

		pursuant to E	ERISA section 103(a)(2).			nspection	
For calendar plan year 20	23 or fiscal plan	year beginning 01/01/2023	and e	ending 12/31/2	2023	•	
A Name of plan QTC MANAGEMENT, IN	NC. WELFARE	BENEFIT PLAN		ee-digit In number (PN)	•	501	
	C Plan sponsor's name as shown on line 2a of Form 5500 QTC MANAGEMENT, INC.  D Employer Identification N 95-3948968				n Number (E	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		MPANY OF AMERICA					
/I-) [IN]	(c) NAIC	(d) Contract or	(e) Approximate number of		Policy or co	ntract year	
(b) EIN	code	identification number	persons covered at end of policy or contract year	(f) Fro	om	<b>(g)</b> To	
13-5123390	64246	00353815	3624	01/01/2023		12/31/2023	
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 a	(a) Total amount of commissions paid (b) Total amount of fees paid						
175185 17589							
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons).				
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees wer	re paid		
MERCER HEALTH AND E	BENEFITS		NVESTORS WAY VOOD, MA 02062				
(b) Amount of sales ar	nd hase	Fee	es and other commissions paid				
commissions pa		(c) Amount	<b>(d)</b> Purpo	se		(e) Organization code	
	146280	17589 F	EES			3	
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	sions or fees wer	re paid		
INNOVA INSURANCE SC	INNOVA INSURANCE SOLUTIONS  1930 SOUTH BREA CANYON ROAD SUITE 2 DIAMOND BAR, CA 91765						
(b) Amount of sales ar	nd base	Fee	es and other commissions paid				
commissions pa		(c) Amount	(d) Purpo	se		(e) Organization code	
	28905	0				3	
E B	n Ast Nation	as the Instructions for Form F	500		0-11	l. A (Farm FF00) 2022	

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
		Face and other commissions paid	(0)				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	T		T				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
	ı		<b>.</b>				
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization				
commissions paid	(c) Amount	(d) Purpose	code				
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid					
• •	-						
(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					
	<b>y</b> ,	,					
(b) Amount of color and har-		Fees and other commissions paid	(e)				
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code				
	•	•					

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year		6c		
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

P	art	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 expe	erience-rated as a uni	t. Where cor	ntracts cover indiv	
8	Ben	nefit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision) <b>b</b> X Dental	С	Vision	(	<b>d</b> X Life insuran	ice
	е	Temporary disability (accident and sickness) <b>f</b> Long-term disabili	ity <b>q</b>	Supplemental unem	ployment	h Prescription	ı drug
	i [	Stop loss (large deductible)  j HMO contract	·	PPO contract	. ,	I Indemnity c	-
	m	X Other (specify) ► ACCIDENTAL DEATH AND DISMEMBERMENT	_			_	
	L						
9	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 premium reserve	9a(3)				
		(4) Earned ((1) + (2) - (3))			. 9a(4)		
	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)		
		(4) Claims charged			9b(4)		
	С	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)			<u> </u>	
		(G) Other retention charges	9c(1)(G)		1 2 40 40		
		(H) Total retention	_		9c(1)(H)		
		(2) Dividends or retroactive rate refunds. (These amounts were paid in			9c(2)		
	d				9d(1)		
		(2) Claim reserves			9d(2)		
		(3) Other reserves			9d(3)		
	е		d in line <b>9c(2)</b>	.)	9e		
10	No	lonexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carrier			10a		2259690
	b	, , ,			405		
	Sno	retention of the contract or policy, other than reported in Part I, line 2 abovecify nature of costs.	e, report amo	ount	10b		
P	art l	IV Provision of Information					
		bid the insurance company fail to provide any information necessary to comp	lete Schedule	Α? Π	Yes	X No	
		the answer to line 11 is "Yes," specify the information not provided.	ioto Jonedule				
12	11 (	the answer to line it is ites, specify the information hot 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

2023

This Form is Open to Public

		pa.oaa to =			mspection	
For calendar plan year 202	23 or fiscal plar	year beginning 01/01/2023	and e	ending 12/31/2023		
A Name of plan			<b>B</b> Thr	ee-digit		
QTC MANAGEMENT, IN	NC. WELFARE	BENEFIT PLAN	pla	n number (PN)	501	
<b>C</b> Di .		0 (5 5500	D.5		(EIN)	
C Plan sponsor's name a		e 2a of Form 5500	·	loyer Identification Number	(EIN)	
QTC MANAGEMENT, IN	IC.		\$	95-3948968		
Part I Informat	ion Concer	ning Insurance Contract	: Coverage, Fees, and Co	mmissions Provide info	rmation for each contract	
			s a unit in Parts II and III can be r			
1 Coverage Information:		<u> </u>				
(a) Name of insurance ca	rrier					
VISION SERVICE PLAN						
	1	1	(a) Approximate number of	Policy or o	ontract year	
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate number of persons covered at end of	-	ontract year	
	code	identification number	policy or contract year	(f) From	<b>(g)</b> To	
94-1632821	00000	30054373	3105	01/01/2023	12/31/2023	
		ation. Enter the total fees and total	al commissions paid. List in line	3 the agents, brokers, and o	ther persons in	
descending order of the						
(a) Total a	amount of comr		(b)	Total amount of fees paid		
	30902 0					
3 Persons receiving com	missions and fe	ees. (Complete as many entries	as needed to report all persons).			
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	ssions or fees were paid		
MERCER HEALTH AND E	BENEFITS	4565 F	PAYSPHERE CIRCLE			
		CHICA	AGO, IL 60674			
(b) Amount of sales ar			es and other commissions paid			
commissions pa		(c) Amount	(d) Purpo	se	(e) Organization code	
	28949	0			3	
	(a) Name a	nd address of the agent, broker,	or other person to whom commis	ssions or fees were paid		
INNOVA INSURANCE SO	LUTIONS		N TEMPLE AVENUE, SUITE 285	5		
		РОМС	DNA, CA 91768			
			on and other commissions noist			
(b) Amount of sales ar			es and other commissions paid		(a) Organi	
commissions pa		(c) Amount	(d) Purpo	ose	(e) Organization code	
	1953	0			3	
For Paperwork Reductio	n Act Notice.	see the Instructions for Form 5	5500.	Sche	dule A (Form 5500) 2023	
					v. 230707	

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		<b>.</b>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
• •	-		
(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	
	<b>y</b> ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.		6d		
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

Pa	art I	III Welfare Benefit Contract Information If more than one contract covers the same group the information may be combined for reporting employees, the entire group of such individual	up of employees of the purposes if such cont	racts are expe	erience-rated as a unit	t. Where cont	racts cover individual
8	Bene	efit and contract type (check all applicable boxes)					
	а	Health (other than dental or vision)	Dental	C X	Vision	d	Life insurance
	еĒ	Temporary disability (accident and sickness) <b>f</b>	Long-term disabilit	<u>=</u>	Supplemental unem	plovment <b>h</b>	Prescription drug
	i	Stop loss (large deductible)	HMO contract		PPO contract	ı	Indemnity contract
	m∫	Other (specify)	_ Time contract	□	11 0 contract	•	
	L	Other (specify) F					
9	=yne	erience-rated contracts:					
		Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid		9a(2)			
		(3) Increase (decrease) in unearned premium reserv		9a(3)			
		(4) Earned ((1) + (2) - (3))				9a(4)	
		Benefit charges (1) Claims paid		9b(1)		.,	
		(2) Increase (decrease) in claim reserves		9b(2)			
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)	
		(4) Claims charged				9b(4)	
		Remainder of premium: (1) Retention charges (on a				,	
		(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)	
		(2) Dividends or retroactive rate refunds. (These an	nounts were paid in	cash, or	credited.)	9c(2)	
	d	Status of policyholder reserves at end of year: (1) A	mount held to provide	benefits after	retirement	9d(1)	
		(2) Claim reserves				9d(2)	
		(3) Other reserves				9d(3)	
	е	Dividends or retroactive rate refunds due. (Do not in	nclude amount entered	l in line <b>9c(2)</b> .	)	9e	
10	Nor	nexperience-rated contracts:					
	а	Total premiums or subscription charges paid to carri	er			10a	319011
	b	If the carrier, service, or other organization incurred	any specific costs in c	onnection with	n the acquisition or		
		retention of the contract or policy, other than reporte	d in Part I, line 2 abov	e, report amo	unt	10b	
	Spec	cify nature of costs.					
D.	out I	Drovision of Information					
	art l				П		
		d the insurance company fail to provide any information		ete Schedule	A?	Yes X	No
12	If th	he 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.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						This Form is Open to Public Inspection		
For calendar plan yea	ar 2023 or fiscal p	lan year beginning 01/01/2023		and en	ding 12/3	1/2023		
A Name of plan QTC MANAGEMEN	NT, INC. WELFAR	E BENEFIT PLAN			e-digit number (PN)	) <b>&gt;</b>	501	
C Plan sponsor's na		ine 2a of Form 5500		•	yer Identifica -3948968	tion Number	(EIN)	
		erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Informa	tion:							
(a) Name of insurance C		RTH AMERICA						
<b>(b)</b> EIN	(c) NAIC	` '	(e) Approximate nu persons covered a				contract year	
(5) 2	code	identification number	policy or contract		(f) I	From	<b>(g)</b> To	
23-1503749	65498	LK965300	3671	01/01/2023		12/31/2023		
2 Insurance fee and descending order of		mation. Enter the total fees and total	al commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
44954						0		
3 Persons receiving	commissions and	I fees. (Complete as many entries	as needed to report all	persons).				
		and address of the agent, broker,			ions or fees v	vere paid		
MERCER HEALTH A	ND BENEFITS		PAYSPHERE CIRCLE AGO, IL 60674					
(b) Amount of sal	es and hase	Fee	es and other commission	ns paid				
commission		(c) Amount		(d) Purpose	е		(e) Organization code	
	44954	0					3	
	(a) Name	e and address of the agent, broker,	or other person to whor	n commiss	ions or fees v	vere paid		
	(-)		,					
(b) Amount of sal	es and hase	Fee	es and other commission	ns paid				
commission		(c) Amount	(d) Purpose				(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		<b>.</b>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
••	-		
(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	
	<b>y</b> ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.		6d		
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(C) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

P	art	III Welfare Benefit Contract Informat If more than one contract covers the same guthe information may be combined for reportin employees, the entire group of such individual.	oup of employees of the	tracts are expe	erience-rated as a uni	t. Where cor	ntracts cover ind	
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision		<b>d</b> Life insura	nce
	е	Temporary disability (accident and sickness)	f X Long-term disabili	ity <b>g</b>	Supplemental unem	ployment	h Prescriptio	n drug
	ιĚ	Stop loss (large deductible)	j		PPO contract		I Indemnity	contract
	m		, 🗀					
	L							
9	Expe	perience-rated contracts:						
	a i	Premiums: (1) Amount received		9a(1)			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)		
	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)		
		(4) Claims charged				9b(4)		
	С	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)		
		(2) Dividends or retroactive rate refunds. (These a	mounts were paid in	n cash, or 📗 d	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)		
			include amount entere	d in line <b>9c(2)</b> .	)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		449545
	b	If the carrier, service, or other organization incurre retention of the contract or policy, other than repor				10b		
	Sne	ecify nature of costs.	ieu iii Fait i, iiile 2 abov	e, report amo	unt	100		
P	art	IV Provision of Information						
		id the insurance company fail to provide any informa	tion necessary to comp	lete Schedule	A?X	Yes	No	
				ioto Goriedale	//	. • •		
ıZ	IT 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.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).							This Form is Open to Public Inspection	
For calendar plan year	2023 or fiscal pl	an year beginning 01/01/2023		and en	iding 12/3	1/2023		
A Name of plan QTC MANAGEMENT	Γ, INC. WELFAR	E BENEFIT PLAN			e-digit number (PN	) •	501	
C Plan sponsor's nam		ine 2a of Form 5500			oyer Identifica 3-3948968	tion Number	(EIN)	
		erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Information	on:							
(a) Name of insurance		RTH AMERICA	_					
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or o	contract year	
(b) EIN	code	identification number	policy or contract		(f)	From	<b>(g)</b> To	
23-1503749	65498	VDT0962300	3671		01/01/2023	3	12/31/2023	
2 Insurance fee and c descending order of		mation. Enter the total fees and total.	al commissions paid. Li	st in line 3	the agents, b	orokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
42849						0		
3 Persons receiving of	ommissions and	fees. (Complete as many entries	as needed to report all	persons).				
		and address of the agent, broker,			ions or fees v	were paid		
MERCER HEALTH AN	ID BENEFITS		PAYSPHERE CIRCLE AGO, IL 60674					
(b) Amount of sales	s and base	Fee	s and other commission	ns paid				
commissions		(c) Amount		(d) Purpos	е		(e) Organization code	
	42849	0					3	
	(a) Name	and address of the agent, broker,	or other person to whor	m commiss	ions or fees v	were paid		
	,,		. ,			- 1		
(b) Amount of sale:	s and hase	Fee	s and other commission	ns paid				
commissions		(c) Amount	(d) Purpose		e		(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		<b>.</b>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
••	-		
(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	
	<b>y</b> ,	,	
(b) Amount of color and har-		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier may	be treated	d as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:			1	
•	a	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.		6d		
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
				. 🗖		
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		15	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(F) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

P	art I	Welfare Benefit Contract Informa If more than one contract covers the same   §		e same ei	mplo	yer(s) or members of	the same e	mployee organiza	tions(s),
		the information may be combined for reporti employees, the entire group of such individu	ng purposes if such con	tracts are	expe	erience-rated as a uni	t. Where co	ontracts cover indi	/iduaÌ
8	Bene	fit and contract type (check all applicable boxes)				·		· ·	
	а	Health (other than dental or vision)	<b>b</b> Dental		с□	Vision		<b>d</b> Life insurar	ice
	e X	Temporary disability (accident and sickness)	f Long-term disabili		g∏		olovment	h Prescription	
	i	Stop loss (large deductible)	j HMO contract	-	k∏		p.0,	I Indemnity of	-
	, _		I I I I I I I I I I I I I I I I I I I		<b>к</b> Ц	110 contract			ontract
	m _	Other (specify)							
9	Evne	ience-rated contracts:							
9	•	remiums: (1) Amount received		9a(1)				-	
		Increase (decrease) in amount due but unpaid		9a(2)					
		3) Increase (decrease) in unearned premium res		9a(3)				_	
		4) Earned ((1) + (2) - (3))					9a(4)		
	-	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)		
	(	4) Claims charged					9b(4)		
	C	Remainder of premium: (1) Retention charges (or	n an accrual basis)						
		(A) Commissions		9c(1)(/	A)				
		(B) Administrative service or other fees		9c(1)(I					
		(C) Other specific acquisition costs		9c(1)(0				_	
		(D) Other expenses		9c(1)(I				_	
		(E) Taxes		9c(1)(E				_	
		(F) Charges for risks or other contingencies		9c(1)(i				_	
		(G) Other retention charges					00/1\/L	<b>\</b>	
		(H) Total retention(2) Dividende or retroactive rate refunde. (These	_		_		9c(1)(H)	<b>/</b>	
		(2) Dividends or retroactive rate refunds. (These					9c(2)		
		Status of policyholder reserves at end of year: (1) (2) Claim reserves	·				9d(1)		
		(2) Other reserves(3)					9d(2) 9d(3)		
		Dividends or retroactive rate refunds due. (Do no					90(5) 9e		
10		experience-rated contracts:	include amount entere	<u>a iii iiiic <b>3</b></u>	U(2).	<i>j</i>	36		
		Total premiums or subscription charges paid to ca	arrier				10a		428488
		If the carrier, service, or other organization incurre							
		retention of the contract or policy, other than repo					10b		
		ify nature of costs.							
Р	art I	/ Provision of Information							
11		the insurance company fail to provide any inform	ation necessary to comp	lete Sche	dule	A? X	Yes	□ No	
		e answer to line 11 is "Yes," specify the information			2010		-		
. 4		salished to mile in to 100, opening the miletimate	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.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).						This Form is Open to Public Inspection		
For calendar plan yea	ır 2023 or fiscal pl	an year beginning 01/01/2023		and en	iding 12/3	1/2023		
A Name of plan QTC MANAGEMEN	IT, INC. WELFAR	E BENEFIT PLAN			e-digit number (PN)	) <b>&gt;</b>	501	
C Plan sponsor's na		ine 2a of Form 5500			oyer Identifica -3948968	tion Number	(EIN)	
		erning Insurance Contract A. Individual contracts grouped as						
1 Coverage Informat	ion:							
(a) Name of insurance Co		RTH AMERICA						
<b>(b)</b> EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or o	contract year	
(b) EII1	code	identification number	policy or contract		(f)	From	<b>(g)</b> To	
23-1503749	65498	COA0004005	3671		01/01/2023	3	12/31/2023	
2 Insurance fee and descending order of		mation. Enter the total fees and total.	al commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in	
(a) Total amount of commissions paid (b) Total amount of fees paid								
14885						0		
3 Persons receiving	commissions and	I fees. (Complete as many entries	as needed to report all p	persons).				
<u> </u>		and address of the agent, broker,			ions or fees v	vere paid		
USI INSURANCE SE	RVICES LLC		OX 66119 NIA BEACH, VA 23466			·		
(b) Amount of sale	as and base	Fee	s and other commission	ns paid				
commission		(c) Amount		(d) Purpose	е		(e) Organization code	
	14885	0					3	
	(a) Name	and address of the agent, broker,	or other person to whor	n commiss	ions or fees v	vere naid		
	(2)	and address of the agoing stones,	5. 5 parestructure.			, o, o paid		
(b) Amount of sale	es and base	Fee	s and other commission	ns paid				
commission		(c) Amount	(d) Purpose				(e) Organization code	

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		<b>.</b>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	<b>y</b> ,		
	<del>,</del>		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> 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) Amount of calca and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier mag	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 70	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(F) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

Pa	art	If more than one contract covers the same	group of employees of th					
		the information may be combined for reporemployees, the entire group of such individual.						vidual
8	Ben	nefit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	<b>b</b> Dental	С	Vision	C	Life insurar	nce
	еĪ	Temporary disability (accident and sickness)	f Long-term disabil	ity <b>g</b>	Supplemental unemp	olovment <b>h</b>	n Prescription	n drua
	ιĖ	Stop loss (large deductible)	i HMO contract	· - =	PPO contract		I  Indemnity o	-
	· [		<i>-</i> 🗀	κ	110 contract	'		ontiact
	m	Other (specify) ACCIDENTAL DEATH AN	DISMEMBERMENT					
_								
	•	perience-rated contracts:		00(4)				
		Premiums: (1) Amount received		9a(1)			-	
		(2) Increase (decrease) in amount due but unpai		9a(2) 9a(3)				
		(3) Increase (decrease) in unearned premium re (4) Earned ((1) + (2) - (3))				9a(4)		
						3a( <del>1</del> )		
		(2) Increase (decrease) in claim reserves						
		(3) Incurred claims (add <b>(1)</b> and <b>(2)</b> )				9b(3)		
		(4) Claims charged				9b(4)		
		Remainder of premium: (1) Retention charges (				(-)		
		(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)		
		(2) Dividends or retroactive rate refunds. (These	e amounts were paid i	n cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (	) Amount held to provide	benefits after	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
40		,	ot include amount entere	d in line 9c(2).	.)	9e		
10		onexperience-rated contracts:				40-		400400
		1 0 1				10a		496166
	b	If the carrier, service, or other organization incur retention of the contract or policy, other than rep				10b		
	Spe	ecify nature of costs.	orted iii i art i, iiile 2 abo	ve, report amo	· · · · · · · · · · · · · · · · · · ·	100		
P	art l	IV Provision of Information						
		id the insurance company fail to provide any inforr	nation necessary to comm	olete Schedule	A?X	Yes	No	
				note Solieuule	Δ:	. 00	J '**	
12	if th	the answer to line 11 is "Yes," specify the information	ion 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.

OMB No. 1210-0110

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection					
For calendar plan year 2	023 or fiscal pl	an year beginning 01/01/2023		and en	nding 12/3	1/2023			
A Name of plan QTC MANAGEMENT, INC. WELFARE BENEFIT PLAN					e-digit number (PN)	) •	501		
	C Plan sponsor's name as shown on line 2a of Form 5500 QTC MANAGEMENT, INC.					D Employer Identification Number (EIN) 95-3948968			
on a sepa	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 of LIFE INSURANCE COM		RTH AMERICA			,				
(b) EIN	(c) NAIC	` '	(e) Approximate nu persons covered a				contract year		
(5) 2.11	code	identification number	policy or contract		(f)	From	<b>(g)</b> To		
23-1503749	65498	OK 0819515	3671		07/01/2022	2	06/30/2023		
2 Insurance fee and cor descending order of the		mation. Enter the total fees and total.	al commissions paid. Li	st in line 3	the agents, b	rokers, and	other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid									
27764 0						0			
3 Persons receiving con	mmissions and	fees. (Complete as many entries	as needed to report all	persons).					
<u> </u>		and address of the agent, broker,			sions or fees v	were paid			
USI INSURANCE SERV	ICES LLC		OX 66119 NIA BEACH, VA 23466			·			
(b) Amount of sales	and base	Fee	s and other commission	ns paid					
commissions p		(c) Amount	(d) Purpose			(e) Organization code			
	27764	0					3		
	(a) Name	and address of the agent, broker,	or other person to whor	n commiss	sions or fees v	were paid			
	(a) · ·aiiie	aa aaa	<u> </u>			o.o paia			
(b) Amount of sales	and hase	Fee	s and other commission	ns paid					
commissions p		(c) Amount	(d) Purpose				(e) Organization code		

<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
		Face and other commissions paid	(0)
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Na	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	T		T
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
<b>(a)</b> Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	ı		<b>.</b>
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization
commissions paid	(c) Amount	(d) Purpose	code
(a) Nai	me and address of the agent, broker	r, or other person to whom commissions or fees were paid	
	<b>y</b> ,		
	<del>,</del>		
(b) Amount of sales and base		Fees and other commissions paid	<b>(e)</b> 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	
(-7		, ,	
(h) Amount of calca and have		Fees and other commissions paid	(e)
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	Organization code
	•	•	

_						
F	art	II Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	dual contrac	cts with each carrier mag	y be treated	as a unit for purposes of
4	Curr	ent value of plan's interest under this contract in the general account at year e	nd		4	
		rent value of plan's interest under this contract in separate accounts at year en			5	
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in con				
	<u> </u>	retention of the contract or policy, enter amount.			6d	
		Specify nature of costs				
	е	Type of contract: (1)  individual policies (2)  group deferred	annuity			
	•		amany			
		(3) other (specify)				
	f	If contract purchased, in whole or in part, to distribute benefits from a termina	ating plan, o	check here		
7	Con	tracts With Unallocated Funds (Do not include portions of these contracts main	ntained in s	eparate accounts)		
	а	Type of contract: (1) deposit administration (2) immediate	e participat	ion guarantee		
		(3) guaranteed investment (4) other				
	b	Balance at the end of the previous year			7b	
	C	Additions: (1) Contributions deposited during the year	7c(1)		1 70	
	Ū	(2) Dividends and credits	7c(2)			
		(3) Interest credited during the year	7c(3)			
		(4) Transferred from separate account	7c(4)			
			7c(5)			
		(5) Other (specify below)	70(3)			
	_	(6)Total additions			7c(6)	
	d	Total of balance and additions (add lines 7b and 7c(6))			7d	
	е	Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account	7e(3)			
		(4) Other (specify below)	7e(4)			
		<b>)</b>				
		(F) Total deductions			70/F)	
	£	(5) Total deductions			7e(5)	
	T	Balance at the end of the current year (subtract line 7e(5) from line 7d)			<b>7</b> f	

P	art	III Welfare Benefit Contract Informa If more than one contract covers the same g the information may be combined for reportir employees, the entire group of such individu	roup of employees of thing purposes if such con	tracts are expe	erience-rated as a uni	t. Where cor	ntracts cover individu	
8	Ben	nefit and contract type (check all applicable boxes)	_				_	
	а	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 disabil	ity <b>g</b>	Supplemental unem	ployment	h Prescription dr	ug
	ιĒ	Stop loss (large deductible)	j HMO contract		PPO contract	-	I Indemnity cont	ract
	m		, []e ssasi		1			
	[	_ care (epoon)						
9	Expe	perience-rated contracts:						
		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)		
	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)		
		(4) Claims charged				9b(4)		
	С	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)		1		
		(H) Total retention	<u></u>	<u></u>		9c(1)(H)		
		(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	retirement	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do no	t include amount entere	d in line <b>9c(2)</b> .	)	9e		
10	No	onexperience-rated contracts:						
	а	Total premiums or subscription charges paid to ca	rrier			10a		925482
	b	If the carrier, service, or other organization incurre	ed any specific costs in o	connection with	h the acquisition or			
	_	retention of the contract or policy, other than report	rted in Part I, line 2 abov	e, report amo	unt	10b		
	Spe	ecify nature of costs.						
P	art	IV Provision of Information						
			ation nooceans to see	loto Cobodida	A?X	Yes	No	
		id the insurance company fail to provide any informa		iete Schedule	Α ( ^	162	INU	
12	lf t	the answer to line 11 is "Yes," specify the information	n not provided.					

Part IAnnual Report Identification InformationFor calendar plan year 2023 or fiscal plan year beginning01/01/2023

a multiemployer plan

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

A This return/report is for:

### 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

2023

This Form is Open to Public Inspection

and ending 12/31/2023

employer information in accordance with the form instructions.)

a multiple-employer plan (Filers checking this box must provide participating

		x a single-employer plan	a DFE (specify	y)	,		
<b>B</b> This	return/report is:	the first return/report	the final return	n/report			
	onths)						
C If the	plan is a collectively-barg	gained plan, check here					
<b>D</b> Chec	k box if filing under:	Form 5558	automatic exte	ension	the DFVC program		
		special extension (enter desc	cription)				
<b>E</b> If this	is a retroactively adopted	d plan permitted by SECURE Act se	ection 201, check here	<b>)</b>			
Part II	Basic Plan Infor	mation—enter all requested infor	mation				
	ne of plan IANAGEMENT, INC. WEI	LFARE BENEFIT PLAN			<b>1b</b> Three-digit plan number (PN) ▶	501	
					1c Effective date of plants	an	
<b>2a</b> 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 (see instructions) 541600	Э	
Caution	: A penalty for the late o	or incomplete filing of this return/	report will be assessed	unless reasonable cause is es	tablished.		
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	Laura O-clioa	ι	7/16/2024	Laura Ochoa			
HERE	Signature of plan administrator Date Enter name of individual signing				ng as plan administrator		
SIGN HERE							

Date

Date

Signature of employer/plan sponsor

Signature of DFE

SIGN HERE Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2023) Page <b>2</b>							
3a	Plan administrator's name and address X Same as Plan Sponsor	trator's name and address 🛛 Same as Plan Sponsor				<b>3b</b> Adı	ministrator's EIN
							ministrator's telephone mber
4	If the name and/or EIN of the plan sponsor or the plan name has changed sin enter the plan sponsor's name, EIN, the plan name and the plan number from					4b EIN	N
a c	a Sponsor's name					4d PN	
5	Total number of participants at the beginning of the plan year					5	2941
6	Number of participants as of the end of the plan year unless otherwise stated <b>6a(2), 6b, 6c,</b> and <b>6d</b> ).	d (welfare	plans	com	plete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year					6a(1)	2940
a(	2) Total number of active participants at the end of the plan year					6a(2)	3671
b	Retired or separated participants receiving benefits					6b	5
С	Other retired or separated participants entitled to future benefits					6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.					6d	3676
е	Deceased participants whose beneficiaries are receiving or are entitled to	receive b	enefits	3		6e	
f	Total. Add lines <b>6d</b> and <b>6e</b>					6f	
g(	complete this item,					6g(1)	
g(	2) Number of participants with account balances as of the end of the plan ye complete this item)					6g(2)	
h	Number of participants who terminated employment during the plan year					6h	
7	less than 100% vested					7	
8a	If the plan provides pension benefits, enter the applicable pension feature co		<u> </u>		· ,		instructions:
b	If the plan provides welfare benefits, enter the applicable welfare feature cod 4A 4B 4D 4E 4F 4H 4L						structions:
9a	Plan funding arrangement (check all that apply)  (1)	9b Pla (1)		efit a <mark>√</mark>	arrangement (check all that Insurance	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(2)		Ħ	Code section 412(e)(3)	insurance	e contracts
	(3) Trust	(3)			Trust		
	(4) X General assets of the sponsor	(4)		X	General assets of the sp		
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a		-		•	oer attach	ned. (See instructions)
а	Pension Schedules (1) R (Retirement Plan Information)			Sch	edules  H (Financial Information	.)	
	(1) R (Retirement Plan Information)	(1)		님	I (Financial Information	•	Plan)
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)			A (Insurance Information		,
	Purchase Plan Actuarial Information) - signed by the plan actuary	(3)		<u>^</u>		•	ibei Attached
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(4)			C (Service Provider Info	,	
	Information) - signed by the plan actuary	(5)			D (DFE/Participating Pla		,
	(4) DCG (Individual Plan Information) – Number Attached  (5) MEP (Multiple-Employer Retirement Plan Information)	_ (6)	)	Ц	<b>G</b> (Financial Transaction	n Schedu	lies <i>)</i>

Receipt Confirmation Code