

Form 5500

Annual Return/Report of Employee Benefit Plan

OMB Nos. 1210-0110
1210-0089

2022

This Form is Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

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.**

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

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

Part II Basic Plan Information—enter all requested information

1a Name of plan TOLSA USA	1b Three-digit plan number (PN) ▶	501
	1c Effective date of plan	01/01/2022
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) TOLSA USA INC TOLSA USA INC VICKI THOMPSON 12050 BUCKNUM RD # 1 CASPER, WY 82604-9428	2b Employer Identification Number (EIN)	27-3164662
	2c Plan Sponsor's telephone number	307-224-5114
	2d Business code (see instructions)	212320

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	05/23/2023	VICKI THOMPSON
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

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

Form 5500 (2022)
v. 220413

3a Plan administrator's name and address <input checked="" type="checkbox"/> Same as Plan Sponsor	3b Administrator's EIN 3c Administrator's telephone number																		
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: a Sponsor's name c Plan Name	4b EIN 4d PN																		
5 Total number of participants at the beginning of the plan year	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">5</td> <td style="text-align: right;">12</td> </tr> </table>	5	12																
5	12																		
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1) , 6a(2) , 6b , 6c , and 6d). a(1) Total number of active participants at the beginning of the plan year a(2) Total number of active participants at the end of the plan year b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits..... d Subtotal. Add lines 6a(2) , 6b , and 6c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. f Total. Add lines 6d and 6e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)..... h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.....	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">6a(1)</td> <td style="text-align: right;">12</td> </tr> <tr> <td style="width:10%; text-align: center;">6a(2)</td> <td style="text-align: right;">9</td> </tr> <tr> <td style="width:10%; text-align: center;">6b</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6c</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6d</td> <td style="text-align: right;">9</td> </tr> <tr> <td style="width:10%; text-align: center;">6e</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6f</td> <td style="text-align: right;">9</td> </tr> <tr> <td style="width:10%; text-align: center;">6g</td> <td></td> </tr> <tr> <td style="width:10%; text-align: center;">6h</td> <td></td> </tr> </table>	6a(1)	12	6a(2)	9	6b		6c		6d	9	6e		6f	9	6g		6h	
6a(1)	12																		
6a(2)	9																		
6b																			
6c																			
6d	9																		
6e																			
6f	9																		
6g																			
6h																			
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">7</td> <td></td> </tr> </table>	7																	
7																			
8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A																			

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

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

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

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

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

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code _____

<p>SCHEDULE A (Form 5500)</p> <p>Department of the Treasury Internal Revenue Service</p> <hr/> <p>Department of Labor Employee Benefits Security Administration</p> <hr/> <p>Pension Benefit Guaranty Corporation</p>	<p>Insurance Information</p> <p>This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).</p> <p>▶ File as an attachment to Form 5500.</p> <p>▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</p>	<p>OMB No. 1210-0110</p> <hr/> <p>2022</p> <hr/> <p>This Form is Open to Public Inspection</p>
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For calendar plan year 2022 or fiscal plan year beginning **01/01/2022** and ending **12/31/2022**

<p>A Name of plan TOLSA USA</p>	<p>B Three-digit plan number (PN) ▶</p>	<p>501</p>
<p>C Plan sponsor's name as shown on line 2a of Form 5500 TOLSA USA INC</p>	<p>D Employer Identification Number (EIN) 27-3164662</p>	

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

1 Coverage Information:

(a) Name of insurance carrier
CIGNA HEALTH

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
59-1031071	67369	0067369	11	01/01/2022	12/31/2022

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

(a) Total amount of commissions paid	(b) Total amount of fees paid
	9924

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

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

SERVICE FIRST INSURANCE **235 S. DAVID STE A**
CASPER, WY 82601

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
6033			

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

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

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

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	(c) Amount	(d) Purpose	

Part II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.
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4 Current value of plan's interest under this contract in the general account at year end.....	4	
5 Current value of plan's interest under this contract in separate accounts at year end.....	5	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

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

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

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

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

b Balance at the end of the previous year	7b	
c Additions: (1) Contributions deposited during the year	7c(1)	
	7c(2)	
	7c(3)	
	7c(4)	
	7c(5)	
(6) Total additions.....	7c(6)	
d Total of balance and additions (add lines 7b and 7c(6))	7d	
e Deductions:		
	7e(1)	
	7e(2)	
	7e(3)	
7e(4)		
(5) Total deductions.....	7e(5)	
f Balance at the end of the current year (subtract line 7e(5) from line 7d)	7f	

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

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

9 Experience-rated contracts:

a Premiums: (1) Amount received	9a(1)	72931	
(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)	72931
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)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	
10 Nonexperience-rated contracts:			
a Total premiums or subscription charges paid to carrier		10a	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount		10b	
Specify nature of costs.			

Part IV Provision of Information

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

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

INFORMATION STATES ADMIN FEES INCLUDES COMMISSIONS. I DO NOT HAVE A BREAKDOWN.

SCHEDULE C (Form 5500) <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	Service Provider Information This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA). ▶ File as an attachment to Form 5500.	<small>OMB No. 1210-0110</small> 2022 This Form is Open to Public Inspection.
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For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

A Name of plan <u>TOLSA USA</u>	B Three-digit plan number (PN) ▶	<u>501</u>
C Plan sponsor's name as shown on line 2a of Form 5500 <u>TOLSA USA INC</u>	D Employer Identification Number (EIN) <u>27-3164662</u>	

Part I Service Provider Information (see instructions)

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

1 Information on Persons Receiving Only Eligible Indirect Compensation

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

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

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

CIGNA 500 SANSOME ST.
SAN FRANCISCO, CA 94111

45-2355015

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

CIGNA 150 SOUTH 5TH STE 2300
MINNEAPLOIS, MN 55402

85-0437037

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

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

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

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

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

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

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

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

Part I Service Provider Information (continued)

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

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

Part II Service Providers Who Fail or Refuse to Provide Information

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

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

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

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

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

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

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

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

Explanation:

Cigna

INFORMATION FOR COMPLETING SCHEDULE A ON THE IRS FORM 5500

This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule A, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and Instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.

For Plan Year Beginning: January 01, 2022 and Ending: December 31, 2022
Name of Plan: Tolsa USA Inc.

SCHEDULE A - INSURANCE INFORMATION:

Information Concerning Insurance Contract Coverage, Fees and Commissions

Name of Insurance Carrier: Cigna Health and Life Insurance Company

EIN number	NAIC code	Contract or identification number	Policy or contract year:	
			From	To
59-1031071	87389	00628641	1/1/2022	12/31/2022

Approximate number of persons covered at end of policy or contract year:

Benefit Employee Dependent Spouse Family Child

Insurance fees, benefit advisor fees and commissions paid to agents, brokers, and other persons:

Represents the amount of commission paid during the contract year. This amount is reflective of payments made during the contract year that may be attributable to multiple contract years.

In addition to the commissions and fees reported, Cigna enters into compensation programs under which certain agents and brokers provide our companies with market intelligence, product and service feedback, and other services that enable us to conduct our business more effectively. Qualification for payments and the amount of those payments may be based on new business and persistency results. Unless otherwise noted, this compensation is not allocated to specific policies, is funded from our general overhead, and is not required to be reported on Schedule A. Your agent or broker may also have participated, at our expense, in events we sponsor to inform them on our products and services. Contact your agent / broker for specific information about their participation.

Name and address of the agents, brokers or other persons to whom commissions or fees were paid	Amount of commissions paid	Service/Gen. Agent Fees	Benefit Advisor Fees
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Incentive Compensation Payments based on membership in your plan/or lump sum amount:

Producer **Amount**

Incentive Compensation Payments are funded by the insurer. Contact your agent, broker or consultant for details.

Total premiums* or subscription charges paid to carrier: **\$72,931.79**

State Continuation includes payments made by continuants in amount of **\$0.00** administered by CHLIC and applicable to your account.

The premium reported does not reflect the rebates, if any, under the Patient Protection and Affordable Care Act that may have been paid for any prior plan year. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium /commissions) where applicable.

*Premium may reflect amounts paid for surcharges on provider charges or other assessments imposed under applicable state law.

Cigna

INFORMATION FOR COMPLETING SCHEDULE C ON THE IRS FORM 5500

This is NOT an official form. The information provided on this form is to assist you in completing the official Schedule C, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Refer to the IRS Form 5500 and instructions for more information on filing your IRS Form 5500. The information reflected in this report is accurate and complete based upon information available to Cigna Companies at the time this report is prepared and is certified as being complete and accurate.

For Plan Year Beginning: January 01, 2022 **and Ending:** December 31, 2022
Name of Plan: Tolsa USA Inc.

SCHEDULE C - SERVICE PROVIDER INFORMATION:

Service Provider	EIN#	Administration fees paid to the service provider *
Cigna Health and Life Insurance Company	59-1031071	\$4,497.95

The following amounts were paid to your broker(s) and/or consultant(s) during the plan year:

Commissions: \$6,033.58

Service / Gen. Agent Fees: \$0.00

Incentive Compensation Payments based on membership in your plan/or lump sum amount: \$0.00

Incentive Compensation Payments are funded by the Service Provider. Contact your broker(s)/consultant(s) for details.

*This amount includes administrative service fees for reporting period and other fees paid by the plan, known as "Direct Compensation" as applicable.

If you have a CHLIC administered HRA and/or HSA, the Administrative Service Fees include fees charged by the bank vendor. Includes charges related to Employee Assistance Plan (i.e. administration fee/insurance premium/commissions) where applicable.

Direct Compensation for calendar year 2022 :** \$606.79

**Direct compensation amount does not include compensation received by Express Scripts, Inc. for pharmacy benefit management and related services under direct contracts with you. Express Scripts, Inc. separately reports this information to you for Schedule C reporting.

Direct compensation amount does not include the following compensation received, if any, by affiliated companies:

- Plan benefit payments, if any, made to eviCore
- Utilization management fees paid to eviCore
- Plan benefit payment made to Evernorth Care Solutions, Inc. or Evernorth Behavioral Health, Inc.
- Plan benefit payments made to Cigna HealthCare of Arizona, Inc.(Cigna Medical Group)

The amount of such compensation, if any, with respect to your plan is available upon request.

The Service Provider may have received indirect compensation and eligible indirect compensation associated with your plan. Sources of indirect compensation and eligible indirect compensation will follow if applicable.

Indirect compensation reported does not include any plan participant cost-sharing payments made to the following affiliated companies:

- eviCore
- Evernorth Care Solutions, Inc.
- Evernorth Behavioral Health, Inc.
- Cigna HealthCare of Arizona, Inc. (Cigna Medical Group)

Eligible Indirect Compensation

Service Provider Information for Reporting on Form 5500 Schedule C Part 1, Line 3

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claim Processing | 38 Participant communications | 50 Direct payments from the Plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (If Indicated in ASO Agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation: **\$0 (see formula/estimate provided below)**
- (d) Name and EIN (address) of source of indirect compensation:
Cigna Healthy Rewards Vendors
Amplifon Hearing Healthcare Fifth Street Towers 150 South 5th Street Suite 2300 Minneapolis, MN 55402 EIN # 85-0437037
Fitbit 199 Fremont Street, San Francisco, CA 94105 EIN# 20-8920744
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Volume based marketing fees paid by vendors participating in the Cigna Healthy Rewards program which offers plan participants discounts on various services. Applicable to your plan if you plan participants have a Cigna ID card and access to myCigna.com or other authorized portals.
Eligible Indirect Compensation Formula/Estimate: For calendar year 2022, \$0.01 PMPY (this formula is based upon total compensation received from Healthy Rewards Vendors across Cigna companies entire insured and self-insured book of business.)
Effective Date: **1/1/2022** Cancel Date: **xx/xx/xxxx**
-

Sources of indirect compensation, excluding eligible indirect compensation, to be reported on Schedule C Part 1, Line 3 are as follows:

- (a) Service provider name: **Cigna**
- (b) Service codes:
- | | | |
|---|--------------------------------------|---|
| 12 Claim Processing | 38 Participant communications | 50 Direct payments from the Plan |
| 13 Contract Administrator | 49 Other Services | 56 Non-monetary compensation |
| 31 Named fiduciary - (If Indicated in ASO Agreement) | | 62 Float Revenue |
- (c) Amount of indirect compensation: **\$0 (see formula/estimate provided below)**
- (d) Name and EIN (address) of source of indirect compensation:
Omada Health, Inc., 500 Sansome St., #200, San Francisco, CA 94111 EIN - 45-2355015
- (e) Description of indirect compensation, including any formula used to determine eligibility or amount:
Digital Diabetes Preventive Care Services Provider – Indirect compensation received by Cigna from this provider for services including:
(i) explaining the Omada services to existing and prospective clients; (ii) encouraging at risk individuals who may benefit from the Omada services to utilize Omada's preventive care services, and (iii) facilitating the enrollment of at-risk individuals in the Omada program.
Indirect Compensation Formula/Estimate:
For calendar year 2022, Cigna received indirect compensation from this vendor of approximately \$0.70 per participant. (Determined by dividing total compensation received by the number of participants as of July 1, 2022 in all plans that utilized this vendor (excluding Shared Administration Repricing "SAR")
Effective Date: **1/1/2022** Cancel Date: **xx/xx/xxxx**
-

Cigna

Plan Detail Report

The following information will assist you in completing the Schedule A with respect to your Cigna insurance policy.

For Plan Year Beginning: January 01, 2022

and Ending: December 31, 2022

Name of Plan: Tolsa USA Inc.

Plan #: 00628641

PREMIUMS PLAN DETAIL

<u>BENEFIT</u>	<u>PREMIUMS</u>	<u>ADMIN FEES*</u>	<u>TERMINATION PREMIUM</u>	<u>TERMINATION FEES</u>	<u>STATE CONTINUATION FEES</u>	<u>TOTAL PAID</u>
DENTAL	\$239.64	\$1,980.71	\$0.00	\$0.00	\$0.00	\$2,220.35
MEDICAL	\$72,689.68	\$7,630.35	\$0.00	\$0.00	\$0.00	\$80,320.03
VISION	\$2.47	\$313.68	\$0.00	\$0.00	\$0.00	\$316.15
TOTALS	\$72,931.79	\$9,924.74	\$0.00	\$0.00	\$0.00	\$82,856.53

COMMISSIONS PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL COMM PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
DENTAL	\$613.44	433893	SERVICE FIRST INS
MEDICAL	\$5,278.14	433893	SERVICE FIRST INS
VISION	\$142.00	433893	SERVICE FIRST INS
TOTAL	\$6,033.58		

BENEFIT ADVISOR FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
TOTAL			

SERVICE AND / OR GENERAL AGENT FEE PAID DETAIL

<u>BENEFIT</u>	<u>TOTAL FEES</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
TOTAL			

INCENTIVE COMPENSATION PAYMENTS BASED ON MEMBERSHIP IN YOUR PLAN/OR LUMP SUM AMOUNT

<u>TOTAL PAID</u>	<u>BROKER ACCT#</u>	<u>BROKER NAME</u>
TOTAL		

EXPOSURES DETAIL (Last Month of the Plan Period)

<u>BENEFIT</u>	<u>EMPLOYEE</u>	<u>DEPENDENT</u>	<u>SPOUSE</u>	<u>FAMILY</u>	<u>CHILD</u>
DENTAL	10	0	3	1	0
MEDICAL	10	0	2	0	1
VISION	10	0	3	1	0

*Admin Fees Include Commissions