### UNITED STATES DISTRICT COURT DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, and JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans,

No. 0:24-cv-03043-KMM-DTS

Plaintiffs,

v.

WELLS FARGO & COMPANY, MICHAEL BRANCA, MARK HICKMAN, DREW WINELAND, DAVID GALLOREESE, BEI LING, and DOES 1-20,

Defendants.

# DECLARATION OF RUSSELL L. HIRSCHHORN IN SUPPORT OF DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS THE CLASS ACTION COMPLAINT

- I, Russell L. Hirschhorn, declare as follows:
- I am a member of the law firm Proskauer Rose LLP, counsel for Defendant
   Wells Fargo & Company<sup>1</sup> in the above-captioned action.
  - 2. I submit this declaration in support of Defendant Wells Fargo

& Company's Motion to Dismiss the Class Action Complaint.

<sup>1</sup> The individually named Defendants were voluntarily dismissed from the case pursuant to a joint stipulation. (ECF No. 27.)

- 3. This Declaration is based upon my personal knowledge, and, if called upon to testify, I could and would testify competently thereto.
- 4. Attached hereto as **Exhibit A** is a true and correct copy of excerpts from the Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2019. A complete copy of this document is publicly available at https://efast2-filings-public.s3. amazonaws.com/prd/2020/10/02/20201002153910NAL0006858897001.pdf.
- 5. Attached hereto as **Exhibit B** is a true and correct copy of excerpts from the Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2020. A complete copy of this document is publicly available at https://efast2-filings-public.s3.amazonaws.com/prd/2021/10/11/20211011074906NAL0015578305001.pdf.
- 6. Attached hereto as **Exhibit C** is a true and correct copy of excerpts from the Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2021. A complete copy of this document is publicly available at https://efast2-filings-public.s3. amazonaws.com/prd/2022/09/29/20220929094738NAL0006020625001.pdf.
- 7. Attached hereto as **Exhibit D** is a true and correct copy of excerpts from the Form 5500 for the Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) for the plan year ending December 31, 2022. A complete copy of this document is publicly available at https://efast2-filings-public.s3. amazonaws.com/prd/2023/10/02/20231002105920NAL0022994624001.pdf.

- 8. Attached hereto as **Exhibit E** is a true and correct copy of excerpts from the Form 5500 for the Automatic Data Processing, Inc. Flex 2000 Plan for the plan year ending December 31, 2022. A complete copy of this document is publicly available at https://efast2-filings-public.s3.amazonaws.com/prd/2023/10/15/20231015115605NAL 0073042338004.pdf.
- 9. Attached hereto as **Exhibit F** is a true and correct copy of excerpts from the Form 5500 for the Southwest Carpenters Health and Welfare Trust Fund for the plan year ending December 31, 2022. A complete copy of this document is publicly available at https://efast2-filings-public.s3.amazonaws.com/prd/2023/10/05/20231005075752NAL 0027934528005.pdf.
- 10. Attached hereto as **Exhibit G** is a true and correct copy of excerpts from the Form 5500 for the Charter Communications, Inc. Welfare Benefit Plan for the plan year ending December 31, 2022. A complete copy of this document is publicly available at https://efast2-filings-public.s3.amazonaws.com/prd/2023/06/06/20230606084 838NAL0038577952001.pdf.
- 11. Attached hereto as **Exhibit H** is a true and correct copy of excerpts from the Form 5500 for the Select Medical Corporation Health and Welfare Benefit Plan for the plan year ending December 31, 2022. A complete copy of this document is publicly available at https://efast2-filings-public.s3.amazonaws.com/prd/2023/10/11/2023 1011155927NAL0060988418001.pdf.
- 12. Attached hereto as **Exhibit I** is a true and correct copy of excerpts from the Form 5500 for The Railroad Employees National Health and Welfare Plan for the plan

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year ending December 31, 2022. A complete copy of this document is publicly

available at https://efast2-filings-public.s3.amazonaws.com/prd/2023/10/16/20231016100

027NAL0075267986001.pdf.

I declare under penalty of perjury that the foregoing is true and correct to the best

of my knowledge, information, and belief.

Dated: September 27, 2024

/s/ Russell L. Hirschhorn

Russell L. Hirschhorn

4

# UNITED STATES DISTRICT COURT DISTRICT OF MINNESOTA

SERGIO NAVARRO, THERESA GAMAGE, DAYLE BULLA, and JANE KINSELLA, on their own behalf, on behalf of all others similarly situated, and on behalf of the Wells Fargo & Company Health Plan and its component plans,

No. 0:24-cv-03043-KMM-DTS

Plaintiffs,

v.

WELLS FARGO & COMPANY, MICHAEL BRANCA, MARK HICKMAN, DREW WINELAND, DAVID GALLOREESE, BEI LING, and DOES 1-20,

Defendants.

# INDEX OF EXHIBITS TO DECLARATION OF RUSSELL L. HIRSCHHORN IN SUPPORT OF DEFENDANT WELLS FARGO & COMPANY'S MOTION TO DISMISS THE CLASS ACTION COMPLAINT

<b>EXHIBIT</b>	<u>DESCRIPTION</u>			
A	Wells Fargo & Company Health Plan (for Eligible Active Employees & their Dependents) 2019 Form 5500 (Excerpts)			
B Wells Fargo & Company Health Plan (for Eligible Active Employer & their Dependents) 2020 Form 5500 (Excerpts)				
C Wells Fargo & Company Health Plan (for Eligible Active Employ & their Dependents) 2021 Form 5500 (Excerpts)				
D Wells Fargo & Company Health Plan (for Eligible Active Employ & their Dependents) 2022 Form 5500 (Excerpts)				
Е	Automatic Data Processing, Inc. Flex 2000 Plan 2022 Form 5500 (Excerpts)			

<b>EXHIBIT</b>	<u>DESCRIPTION</u>			
F	Southwest Carpenters Health and Welfare Trust 2022 Form 5500 (Excerpts)			
G Charter Communications, Inc. Welfare Benefit Plan 2022 Form 5500 (Excerpts)				
Н	Select Medical Corporation Health and Welfare Benefit Plan 2022 Form 5500 (Excerpts)			
I	The Railroad Employees National Health and Welfare Plan 2022 Form 5500 (Excerpts)			

# **EXHIBIT A**

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Repetit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2019

This Form is Open to Public

F ension L	Serielli Guaranty Corporation			11113	Inspection	DIIC
Part I	Annual Report Ide	ntification Information				
For calenda	ar plan year 2019 or fiscal	plan year beginning 01/01/2019	and ending 12/31/20	)19		
A This ret	urn/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking the participating employer information in accord			ns.)
		X a single-employer plan	a DFE (specify)			
<b>B</b> This ret	urn/report is:	the first return/report	the final return/report			
		an amended return/report	a short plan year return/report (less than 12	months)	)	
C If the pla	an is a collectively-bargain	ned plan, check here			<b>•</b> [	
<b>D</b> Check b	oox if filing under:	Form 5558	automatic extension	the	e DFVC program	
		special extension (enter description)				
Part II	Basic Plan Informa	ation—enter all requested informatio	on			
1a Name of plan WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR DEPENDENTS)					Three-digit plan number (PN) ▶	537
		(	,	1c Effective date of plan 01/01/2011		
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 41-0449260	
WELLS FARGO & COMPANY					2c Plan Sponsor's telephone number 877-479-3557	
	11-121 GOMERY STREET NCISCO, CA 94104			2d	Business code (see instructions) 551111	)

#### 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.  Signature of plan administrator	10/02/2020 Date	MICHAEL BRANCA  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.  Signature of employer/plan sponsor	10/02/2020 Date	SCOTT KLISMET  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 (2019) v. 190130

# **SCHEDULE C** (Form 5500)

**Service Provider Information** 

This schedule is required to be filed under section 104 of the Employee

OMB No. 1210-0110

2019

Internal Revenue Service	Retirement Income Security Act of 1974 (ERISA).			
Department of Labor Employee Benefits Security Administration	▶ File as an attachment to Form 5500.			Form is Open to Public Inspection.
Pension Benefit Guaranty Corporation  For calendar plan year 2019 or fiscal pla	L an year beginning 01/01/2019	and ending 12/3	31/2019	
A Name of plan	N (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR	B Three-digit plan number (PN)	<b>)</b>	537
C Plan sponsor's name as shown on lii WELLS FARGO & COMPANY	ne 2a of Form 5500	D Employer Identification 41-0449260	on Numbe	r (EIN)
You must complete this Part, in acco or more in total compensation (i.e., m plan during the plan year. If a persor	ormation (see instructions)  rdance with the instructions, to report the information in the control of the cont	n with services rendered to he the plan received the requ	the plan o	r the person's position with the
<ul><li>a Check "Yes" or "No" to indicate whether indirect compensation for which the p</li><li>b If you answered line 1a "Yes," enter</li></ul>	ceiving Only Eligible Indirect Compensations of you are excluding a person from the remainder of plan received the required disclosures (see instructions the name and EIN or address of each person providing sation. Complete as many entries as needed (see in	this Part because they receing for definitions and conditions and the required disclosures for the requ	ns)	Yes No
(b) Enter na	me and EIN or address of person who provided you di	sclosures on eligible indirec	t compens	eation
<b>(b)</b> Enter na	me and EIN or address of person who provided you di	sclosures on eligible indirec	t compens	ation
(-,	, , , , , , , , , , , , , , , , , , , ,	<b>J</b>		
(b) Enter na	me and EIN or address of person who provided you di	sclosures on eligible indirec	t compens	ation
(b) Enter na	me and EIN or address of person who provided you di	sclosures on eligible indirec	t compens	eation

Schedule C	(Form 5500)	2019

Page **3 -** 2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ach person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN o	r address (see instructions)		
EXPRESS	SCRIPTS					
43-142056	33					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	9235645	Yes No	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
DELTA DE			<u>.,</u>			
41-190555	04					
(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	4695298	Yes No X	Yes No		Yes No
		(	<b>a)</b> Enter name and EIN or	address (see instructions)		
CASTLIGI 26-198909	HT HEALTH					
	T	T			T	
(b) Service Code(s)	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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	4462201	Yes No X	Yes No		Yes No

# **SCHEDULE H** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration **Financial Information** 

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2019

This Form is Open to Public

Pension Benefit Guaranty Corporation	, i no ao an attaonnon	10 1 01111 0000.	Inspect	ion
For calendar plan year 2019 or fiscal pla	n year beginning 01/01/2019	and ending 12	2/31/2019	
A Name of plan		<b>B</b> Three	e-digit	
	(FOR ELIGIBLE ACTIVE EMPLOYEES & TH	IEIR plan	number (PN)	537
DEPENDENTS)				
C Plan sponsor's name as shown on lir	ue 2a of Form 5500	<b>D</b> Emplo	yer Identification Number	(EIN)
WELLS FARGO & COMPANY		4	41-0449260	

#### Part I Asset and Liability Statement

Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	3186460	1715918
<b>b</b> Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
C General investments:			
(1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	28339126	9091631
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	31525586	10807549
	Liabilities		·	
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets			
I	Net assets (subtract line 1k from line 1f)	11	31525586	10807549

### Part II Income and Expense Statement

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

Income		(a) Amount	(b) Total
a Contributions:			
(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	1861261473	
(B) Participants	2a(1)(B)	682155159	
(C) Others (including rollovers)	2a(1)(C)		
(2) Noncash contributions	2a(2)		
(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		2543416632
b Earnings on investments:			
(1) Interest:			
(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
(B) U.S. Government securities	2b(1)(B)		
(C) Corporate debt instruments	2b(1)(C)		
(D) Loans (other than to participants)	2b(1)(D)		
(E) Participant loans	2b(1)(E)		
(F) Other	2b(1)(F)		
(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
(2) Dividends: (A) Preferred stock	2b(2)(A)		
(B) Common stock	2b(2)(B)		
(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
(3) Rents	2b(3)		
(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
(B) Other	2b(5)(B)		
(C) Total unrealized appreciation of assets. Add lines 2b(5)(A) and (B)	2b(5)(C)		0

# EXHIBIT B

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2020

This Form is Open to Public Inspection

Tonicion Bonom Guaranty Corporation			mapection		
	dentification Information				
For calendar plan year 2020 or fis	cal plan year beginning 01/01/2020	and ending 12/31/2	020		
A This return/report is for:	a multiemployer plan	a multiple-employer plan (Filers checking t participating employer information in accordance)			
	X a single-employer plan	a DFE (specify)			
<b>B</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 1	2 months)		
C If the plan is a collectively-barg	ained plan, check here				
<b>D</b> Check box if filing under:	X Form 5558	automatic extension	the DFVC program		
	special extension (enter descriptio	n)			
Part II Basic Plan Infor	mation—enter all requested informat	tion			
1a Name of plan			<b>1b</b> Three-digit plan number (PN) ▶ 537		
WELLS FARGO & CO HEALTH	PLAN (FOR ELIGIBLE ACTIVE EMPL	OYEES & THEIR DEPENDENTS)	1c Effective date of plan 01/01/2011		
2a Plan sponsor's name (employ Mailing address (include room City or town, state or province	2b Employer Identification Number (EIN) 41-0449260				
WELLS FARGO & COMPANY  2c Plan Sponsor's telephor number 877-479-3557					
MAC A0101-121 420 MONTGOMERY STREET SAN FRANCISCO, CA 94104	2d Business code (see instructions) 551111				

#### 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.  Signature of plan administrator	10/11/2021 Date	MARK HICKMAN  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.  Signature of employer/plan sponsor	10/10/2021 Date	SCOTT KLISMET  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 (2020) v. 200204

# **SCHEDULE C** (Form 5500)

# **Service Provider Information**

This schedule is required to be filed under section 104 of the Employee

OMB No. 1210-0110

2020

Internal Revenue Service	Retirement Income Security Act of 1974 (ERISA).				
Department of Labor Employee Benefits Security Administration			This Form is Open to Public Inspection.		
Pension Benefit Guaranty Corporation					
For calendar plan year 2020 or fiscal plan	n year beginning 01/01/2020	and ending 12/31	1/2020	T	
A Name of plan		<b>B</b> Three-digit			
WELLS FARGO & CO HEALTH PLAN ( DEPENDENTS)	plan number (PN)	<b>&gt;</b>	537		
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D Employer Identification	on Number	(EIN)	
WELLS FARGO & COMPANY		41-0449260			
Part I Service Provider Infor	mation (see instructions)				
or more in total compensation (i.e., mor plan during the plan year. If a person re	ance with the instructions, to report the information reney or anything else of monetary value) in connection eceived <b>only</b> eligible indirect compensation for which clude that person when completing the remainder of	n with services rendered to the the plan received the require	he plan or t	he person's position with the	
<ul><li>a Check "Yes" or "No" to indicate whether indirect compensation for which the plant</li><li>b If you answered line 1a "Yes," enter the</li></ul>	eiving Only Eligible Indirect Compensate you are excluding a person from the remainder of the received the required disclosures (see instructions ename and EIN or address of each person providing ation. Complete as many entries as needed (see instructions)	nis Part because they receive for definitions and conditions the required disclosures for	s)	Yes X No	
(b) Enter name	and EIN or address of person who provided you dis	closures on eligible indirect	compensat	ion	
(b) Enter name	and EIN or address of person who provided you dis	closures on eligible indirect	compensat	ion	
(b) Enter name	and EIN or address of person who provided you dis	closures on eligible indirect	compensat	ion	
(b) Enter name	and EIN or address of person who provided you dis	closures on eligible indirect	compensat	ion	

answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation in person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
		(	(a) Enter name and EIN o	r address (see instructions)		
EXPRESS	SSCRIPTS					
43-142056	53					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	12219570	Yes No X	Yes No		Yes No
		(	<b>a)</b> Enter name and EIN or	address (see instructions)	,	
DELTA DI 41-190555						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	4708845	Yes No X	Yes No		Yes No
		(	(a) Enter name and EIN or	address (see instructions)		
VSP VISIO	ON CARE					
06-122784	40					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	841149	Yes No X	Yes No		Yes No

# SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

#### **Financial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

OMB No. 1210-0110

2020

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation						
For calendar plan year 2020 or fiscal pla	an year beginning 01/01/2020	and endir	ng 12/31/20	020		
A Name of plan		В	Three-digit	t		
WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR		& THEIR	plan numb	er (PN)	•	537
DEPENDENTS)						
C Plan sponsor's name as shown on lir	ne 2a of Form 5500	D	Employer Id	lentification	Number (E	IN)
WELLS FARGO & COMPANY			41-044	19260		

#### Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. Sec	e instructions.		
Assets		(a) Beginning of Year	(b) End of Year
a Total noninterest-bearing cash	1a	1715918	2893031
<b>b</b> Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
C General investments:  (1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	9091631	7523795
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	1d(1)		
(2) Employer real property	1d(2)		
Buildings and other property used in	plan operation 1e		
Total assets (add all amounts in lines	1a through 1e)	10807549	10416826
Liabili	ies		
Benefit claims payable	1g		
Operating payables	1h		
Acquisition indebtedness	1i		
Other liabilities	1j		
Total liabilities (add all amounts in line	es 1g through1j)	0	0
Net As	sets		
-	1f) <b>1l</b>	10807549	10416826

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	1917011660	
	(B) Participants	2a(1)(B)	695725687	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		2612737347
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets.  Add lines 2b(5)(A) and (B)	2b(5)(C)		0

# **EXHIBIT C**

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

### **Annual Return/Report of Employee Benefit Plan**

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2021

This Form is Open to Public Inspection

			inspection		
Part I Annual Report Id	lentification Information				
For calendar plan year 2021 or fisc	cal plan year beginning 01/01/2021	and ending 12/31/202	21		
A This return/report is for:	s box must attach a list of ance with the form instructions.)				
	🗙 a single-employer plan	a DFE (specify)			
<b>B</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 ı	months)		
C If the plan is a collectively-barga	ained plan, check here		• 🗌		
<b>D</b> Check box if filing under:	X Form 5558	automatic extension	the DFVC program		
	special extension (enter descriptio	n)			
<b>E</b> If this is a retroactively adopted	plan permitted by SECURE Act section	201, check here	· []		
Part II Basic Plan Inform	nation—enter all requested information	on			
1a Name of plan			<b>1b</b> Three-digit plan number (PN) ▶ 537		
WELLS FARGO & CO HEALTH	1c Effective date of plan 01/01/2011				
2a Plan sponsor's name (employed Mailing address (include room City or town, state or province)	2b Employer Identification Number (EIN) 41-0449260				
WELLS FARGO & COMPANY			2c Plan Sponsor's telephone number 877-479-3557		
MAC A0101-121 420 MONTGOMERY STREET SAN FRANCISCO, CA 94104	2d Business code (see instructions) 551111				

#### 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.  Signature of plan administrator	09/29/2022 Date	MARK HICKMAN  Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.  Signature of employer/plan sponsor	09/28/2022 Date	SCOTT KLISMET  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.

# **SCHEDULE C** (Form 5500)

# **Service Provider Information**

This schedule is required to be filed under section 104 of the Employee

OMB No. 1210-0110 2021

Internal Revenue Service Retirement Income Security Act of 1974 (ERISA).				
Department of Labor Employee Benefits Security Administration	Employee Benefits Security Administration File as an attachment to Form 5500.		This Form is Open to Public Inspection.	
Pension Benefit Guaranty Corporation  For calendar plan year 2021 or fisca	l plan year beginning 01/01/2021	and ending 12/31	/2021	
A Name of plan WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & DEPENDENTS)		B Three-digit plan number (PN)	<b>)</b>	537
C Plan sponsor's name as shown of	on line 2a of Form 5500	<b>D</b> Employer Identification	on Number	(EIN)
WELLS FARGO & COMPANY		41-0449260		
Part I Service Provider I	nformation (see instructions)			
or more in total compensation (i.e. plan during the plan year. If a pers	cordance with the instructions, to report the information, money or anything else of monetary value) in connection received <b>only</b> eligible indirect compensation for whice to include that person when completing the remainder of	on with services rendered to the character of the character of the character of the required the required the required the required the required the character of the character	ne plan or t	he person's position with the
Check "Yes" or "No" to indicate whe indirect compensation for which the lift you answered line 1a "Yes," ent	Receiving Only Eligible Indirect Compensate ther you are excluding a person from the remainder of e plan received the required disclosures (see instruction er the name and EIN or address of each person providing pensation. Complete as many entries as needed (see in	this Part because they receive s for definitions and conditions on the required disclosures for	s)	Yes X No
<b>(b)</b> Enter	name and EIN or address of person who provided you d	isclosures on eligible indirect	compensat	ion
<b>(b)</b> Enter	name and EIN or address of person who provided you d	isclosures on eligible indirect	compensat	ion
			<u> </u>	
(b) Enter	name and EIN or address of person who provided you d	isclosures on eligible indirect	compensat	ion
(b) Enter	name and EIN or address of person who provided you d	isclosures on eligible indirect	compensat	ion

Page **3 -** 2

answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
-			(a) Enter name and EIN o	r address (see instructions)		
EXPRESS	SSCRIPTS					
43-142056	63					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	14117839	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
DDMN AS						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	4374463	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
VISION S 06-122784	ERVICE PLAN (VSP)					
(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h)  Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	783786	Yes No 🛚	Yes No		Yes No

# SCHEDULE H (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

#### **Financial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

2021

OMB No. 1210-0110

This Form is Open to Public Inspection

Pension Benefit Guaranty Corporation				Inspection	1
For calendar plan year 2021 or fiscal pla	n year beginning 01/01/2021	and ending	12/31/2021		
A Name of plan		В	Three-digit		
	(FOR ELIGIBLE ACTIVE EMPLOYEES & 1	THEIR	plan number (PN)	•	537
DEPENDENTS)					
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D I	Employer Identification	n Number (E	IN)
WELLS FARGO & COMPANY			41-0449260		

#### Part I Asset and Liability Statement

1 Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i. CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
Total noninterest-bearing cash	1a	2893031	1471388
Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
General investments:  (1) Interest-bearing cash (include money market accounts & certificates	1c(1)		
of deposit)	1c(2)		
(2) U.S. Government securities	10(2)		
(3) Corporate debt instruments (other than employer securities):	1c(3)(A)		
(A) Preferred	1c(3)(B)		
(B) All other	10(0)(D)		
(4) Corporate stocks (other than employer securities):	1c(4)(A)		
(A) Preferred	1c(4)(B)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(6)		
(6) Real estate (other than employer real property)	1c(0)		
(7) Loans (other than to participants)	1c(7)	+	
(8) Participant loans	1c(8)	+	
(9) Value of interest in common/collective trusts	· , ,		
(10) Value of interest in pooled separate accounts	1c(10)	7522705	44200200
(11) Value of interest in master trust investment accounts	1c(11)	7523795	11309280
(12) Value of interest in 103-12 investment entities	1c(12) 1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

1d Employer-related investments:		(a) Beginning of Year	(b) End of Year
(1) Employer securities	. 1d(1)		
(2) Employer real property	1d(2)		
<b>e</b> Buildings and other property used in plan operation	. 1e		
f Total assets (add all amounts in lines 1a through 1e)	. 1f	10416826	12780668
Liabilities			
g Benefit claims payable	. 1g		
h Operating payables	. 1h		
i Acquisition indebtedness	. 1i		
j Other liabilities	. 1j		
k Total liabilities (add all amounts in lines 1g through1j)	. 1k	0	0
Net Assets			
l Net assets (subtract line 1k from line 1f)	. 11	10416826	12780668

# Part II Income and Expense Statement

2 Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	2077321780	
	(B) Participants	2a(1)(B)	692507948	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		2769829728
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets.  Add lines 2b(5)(A) and (B)	2b(5)(C)		0

# **EXHIBIT D**

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

SIGN

**HERE** 

SIGN HERE

# Annual Return/Report of Employee Benefit Plan

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public Inspection

						mopeotion	
Part I		lentification Information					
For caler	dar plan year 2022 or fisc	cal plan year beginning 01/01/2022		and ending 12/31/2022			
A This r	eturn/report is for:	a multiemployer plan		loyer plan (Filers checking this t nployer information in accordan			ns.)
		x a single-employer plan	a DFE (specify	)			,
<b>B</b> This return/report is:				report			
	an amended return/report a short plan year return/report (less than 12 more				onths)	)	
C If the	plan is a collectively-barga	ained plan, check here	 				
<b>D</b> Checl	box if filing under:	X Form 5558	automatic exte	nsion	the	e DFVC program	
	· ·	special extension (enter description	n)				
<b>E</b> If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here				
Part II	Basic Plan Inforr	nation—enter all requested information	n				
1a Nam	•				1b	Three-digit plan	537
WELLS FARGO & CO HEALTH PLAN (FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR DEPENDENTS)				10	number (PN) ▶		
					10	Effective date of pla 01/01/2011	arı
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)				2b Employer Identification Number (EIN) 41-0449260			
WELLS	FARGO & COMPANY				2c	Plan Sponsor's tele number 877-479-3557	phone
420 MO	101-121 NTGOMERY STREET ANCISCO, CA 94104				2d	Business code (see instructions) 551111	•
Caution:	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	Filed with authorized/valid	d electronic signature.	10/02/2023	DREW WINELAND			

Date

Date

Date

10/02/2023

LEE KEEL

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

Signature of plan administrator

Signature of DFE

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Form 5500 (2022) v. 220413

Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

# **Service Provider Information**

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

OMB No. 1210-0110 **2022** 

Department of Labor Employee Benefits Security Administration	oyee Benefits Security Administration File as an attachment to Form 5500.		This Form is Open to Public Inspection.		
Pension Benefit Guaranty Corporation	n voor boginning 104/04/2000	and anding 40/04	/2022	mopeouon.	
For calendar plan year 2022 or fiscal pla	n year beginning 01/01/2022	and ending 12/31	12022		
A Name of plan WELLS FARGO & CO HEALTH PLAN ( DEPENDENTS)	FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR	B Three-digit plan number (PN)	<b>•</b>	537	
C Plan sponsor's name as shown on lin	e 2a of Form 5500	D Employer Identificati	on Numbe	er (EIN)	
WELLS FARGO & COMPANY		41-0449260			
Part I Service Provider Info	rmation (see instructions)				
or more in total compensation (i.e., mo	dance with the instructions, to report the information oney or anything else of monetary value) in connect received <b>only</b> eligible indirect compensation for who nclude that person when completing the remainder	ion with services rendered to ich the plan received the requ	the plan	or the person's position with the	
	eiving Only Eligible Indirect Compens				
a Check "Yes" or "No" to indicate wheth	er you are excluding a person from the remainder o	f this Part because they recei	ved only		
indirect compensation for which the pl	an received the required disclosures (see instruction	ns for definitions and conditio	ns)	Yes X No	
	he name and EIN or address of each person providi sation. Complete as many entries as needed (see i		or the sen	vice providers who	
(b) Enter nam	ne and EIN or address of person who provided you	disclosures on eligible indirec	t compen	sation	
(b) Enter nam	ne and EIN or address of person who provided you	disclosures on eligible indirec	t compen	sation	
(b) Enter nam	ne and EIN or address of person who provided you	disclosures on eligible indirec	t compen	sation	
(b) Enter nam	ne and EIN or address of person who provided you	disclosures on eligible indirec	t compen	sation	

Page **3 -** 2

answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN o	r address (see instructions)		
EXPRESS	SSCRIPTS					
43-142056	53					
(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?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	25639955	Yes No 🗵	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)	l	
DDMN AS 41-185252						
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h)  Did the service provider give you a formula instead of an amount or estimated amount
12 13 50	NONE	3951220	Yes No X	Yes No		Yes No
		(	(a) Enter name and EIN or	address (see instructions)		
VISION S	ERVICE PLAN (VSP)					
06-122784	10					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 50	NONE	542723	Yes No X	Yes No		Yes No

### **SCHEDULE H** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

#### **Financial Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), and section 6058(a) of the Internal Revenue Code (the Code).

2022

OMB No. 1210-0110

This Form is Open to Public

Pension Benefit Guaranty Corporation				Inspection		
For calendar plan year 2022 or fiscal pla	n year beginning 01/01/2022	and endi	ng 12/31/2	2022		
	(FOR ELIGIBLE ACTIVE EMPLOYEES & THEIR	В	Three-digi		•	537
DEPENDENTS)						
C Plan sponsor's name as shown on lin WELLS FARGO & COMPANY	ne 2a of Form 5500	D	Employer lo	dentification 49260	n Number (E	EIN)
	_	•			•	•

### Part I | Asset and Liability Statement

Current value of plan assets and liabilities at the beginning and end of the plan year. Combine the value of plan assets held in more than one trust. Report the value of the plan's interest in a commingled fund containing the assets of more than one plan on a line-by-line basis unless the value is reportable on lines 1c(9) through 1c(14). Do not enter the value of that portion of an insurance contract which guarantees, during this plan year, to pay a specific dollar benefit at a future date. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 1b(1), 1b(2), 1c(8), 1g, 1h, and 1i, CCTs, PSAs, and 103-12 IEs also do not complete lines 1d and 1e. See instructions.

Assets		(a) Beginning of Year	(b) End of Year
Total noninterest-bearing cash	1a	1471388	1886600
Receivables (less allowance for doubtful accounts):			
(1) Employer contributions	1b(1)		
(2) Participant contributions	1b(2)		
(3) Other	1b(3)		
C General investments:  (1) Interest-bearing cash (include money market accounts & certificates of deposit)	1c(1)		
(2) U.S. Government securities	1c(2)		
(3) Corporate debt instruments (other than employer securities):			
(A) Preferred	1c(3)(A)		
(B) All other	1c(3)(B)		
(4) Corporate stocks (other than employer securities):			
(A) Preferred	1c(4)(A)		
(B) Common	1c(4)(B)		
(5) Partnership/joint venture interests	1c(5)		
(6) Real estate (other than employer real property)	1c(6)		
(7) Loans (other than to participants)	1c(7)		
(8) Participant loans	1c(8)		
(9) Value of interest in common/collective trusts	1c(9)		
(10) Value of interest in pooled separate accounts	1c(10)		
(11) Value of interest in master trust investment accounts	1c(11)	11309280	17679129
(12) Value of interest in 103-12 investment entities	1c(12)		
(13) Value of interest in registered investment companies (e.g., mutual funds)	1c(13)		
(14) Value of funds held in insurance company general account (unallocated contracts)	1c(14)		
(15) Other	1c(15)		

Schedule H (Form 5500) 2022

Page 2

1d	Employer-related investments:		(a) Beginning of Year	(b) End of Year
	(1) Employer securities	1d(1)		
	(2) Employer real property	1d(2)		
е	Buildings and other property used in plan operation	1e		
f	Total assets (add all amounts in lines 1a through 1e)	1f	12780668	19565729
	Liabilities			
g	Benefit claims payable	1g		
h	Operating payables	1h		
i	Acquisition indebtedness	1i		
j	Other liabilities	1j		
k	Total liabilities (add all amounts in lines 1g through1j)	1k	0	0
	Net Assets		,	
I	Net assets (subtract line 1k from line 1f)	11	12780668	19565729

### Part II Income and Expense Statement

Plan income, expenses, and changes in net assets for the year. Include all income and expenses of the plan, including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar. MTIAs, CCTs, PSAs, and 103-12 IEs do not complete lines 2a, 2b(1)(E), 2e, 2f, and 2g.

	Income		(a) Amount	(b) Total
а	Contributions:			
	(1) Received or receivable in cash from: (A) Employers	2a(1)(A)	1931456732	
	(B) Participants	2a(1)(B)	650940381	
	(C) Others (including rollovers)	2a(1)(C)		
	(2) Noncash contributions	2a(2)		
	(3) Total contributions. Add lines 2a(1)(A), (B), (C), and line 2a(2)	2a(3)		2582397113
b	Earnings on investments:			
	(1) Interest:			
	(A) Interest-bearing cash (including money market accounts and certificates of deposit)	2b(1)(A)		
	(B) U.S. Government securities	2b(1)(B)		
	(C) Corporate debt instruments	2b(1)(C)		
	(D) Loans (other than to participants)	2b(1)(D)		
	(E) Participant loans	2b(1)(E)		
	(F) Other	2b(1)(F)		
	(G) Total interest. Add lines 2b(1)(A) through (F)	2b(1)(G)		0
	(2) Dividends: (A) Preferred stock	2b(2)(A)		
	(B) Common stock	2b(2)(B)		
	(C) Registered investment company shares (e.g. mutual funds)	2b(2)(C)		
	(D) Total dividends. Add lines 2b(2)(A), (B), and (C)	2b(2)(D)		0
	(3) Rents	2b(3)		
	(4) Net gain (loss) on sale of assets: (A) Aggregate proceeds	2b(4)(A)		
	(B) Aggregate carrying amount (see instructions)	2b(4)(B)		
	(C) Subtract line 2b(4)(B) from line 2b(4)(A) and enter result	2b(4)(C)		0
	(5) Unrealized appreciation (depreciation) of assets: (A) Real estate	2b(5)(A)		
	(B) Other	2b(5)(B)		
	(C) Total unrealized appreciation of assets.  Add lines 2b(5)(A) and (B)	2b(5)(C)		0

# **EXHIBIT E**

#### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

SIGN HERE

SIGN HERE

# **Annual Return/Report of Employee Benefit Plan**

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public Inspection

Part I	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 multiple-employer plan (Filers checking to participating employer information in accordance)				, . · ·			
		X a single-employer plan	a DFE (specify	)			,
<b>B</b> This r	eturn/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-barga	ained plan, check here					
<b>D</b> Check	box if filing under:	X Form 5558	automatic exte	nsion	the	e DFVC program	
	-	special extension (enter description	<u>—</u> า)	_			
<b>E</b> If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here	<b>)</b>			
Part II	Basic Plan Inform	nation—enter all requested informatio	n				
1a Nam	•	IG, INC. FLEX 2000 PLAN			1b	Three-digit plan number (PN) ▶	503
AOTON	IATIO DATAT ROOLOOM	VO, INO. 1 EEX 2000 1 EAN			1c	Effective date of pla 05/01/1977	an
2a Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)					2b Employer Identification Number (EIN) 22-1467904		tion
AUTOMATIC DATA PROCESSING, INC.				number		Plan Sponsor's tele number 973-974-5000	phone
MAIL STOP 433 MAIL STOP			P BOULEVARD DP 433 ND, NJ 07068-1728		2d Business code (see instructions) 518210		
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	Filed with authorized/valid	I electronic signature.	10/13/2023	TANYA GUAZZO			

Date

Date

Date

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

Signature of plan administrator

Signature of DFE

Signature of employer/plan sponsor

Form 5500 (2022) v. 220413

Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 31351 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 31113 a(1) Total number of active participants at the beginning of the plan year ..... 6a(1) 33407 a(2) Total number of active participants at the end of the plan year ..... 6a(2)190 Retired or separated participants receiving benefits 6b Other retired or separated participants entitled to future benefits..... 33597 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item). Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4R 4D 4E 4F 4H 4L 40 9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust General assets of the sponsor (4) General assets of the sponsor (4)Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) **b** General Schedules a Pension Schedules (1) R (Retirement Plan Information) (1)X H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)X (3) A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary X (4)C (Service Provider Information) **D** (DFE/Participating Plan Information) (5)SB (Single-Employer Defined Benefit Plan Actuarial (3) Information) - signed by the plan actuary (6)G (Financial Transaction Schedules)

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

# **Service Provider Information**

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

OMB No. 1210-0110

2022

internal revenue convice	rement meene eccurity rec	01 101 + (L1110/1).	ı		
Department of Labor Employee Benefits Security Administration  File as an attachment to Form 5500.		o Form 5500.	This Form is Open to Public Inspection.		
Pension Benefit Guaranty Corporation			<u> </u>	inspection.	
For calendar plan year 2022 or fiscal plan	year beginning 01/01/2022	and ending 12/31	2022		
A Name of plan		<b>B</b> Three-digit			
AUTOMATIC DATA PROCESSING, INC.	FLEX 2000 PLAN	plan number (PN)	•	503	
C Plan sponsor's name as shown on line	2a of Form 5500	<b>D</b> Employer Identification	on Numbe	er (EIN)	
AUTOMATIC DATA PROCESSING, INC.		22-1467904	22-1467904		
Part I Service Provider Inform	mation (see instructions)				
or more in total compensation (i.e., mor plan during the plan year. If a person re	ance with the instructions, to report the information or anything else of monetary value) in conseceived <b>only</b> eligible indirect compensation folloude that person when completing the remain	nection with services rendered to r which the plan received the requ	the plan of	or the person's position with the	
1 Information on Persons Rece	eiving Only Eligible Indirect Compe	ensation			
a Check "Yes" or "No" to indicate whether	r you are excluding a person from the remaind	ler of this Part because they recei	ved only $\epsilon$	eligible	
indirect compensation for which the pla	n received the required disclosures (see instru	ictions for definitions and condition	าร)	XYes No	
	e name and EIN or address of each person pro ation. Complete as many entries as needed (s		r the serv	vice providers who	
<b>(b)</b> Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirect	compens	sation	
PRUDENTIAL INSURANCE					
22-1211670					
(b) Enter name	and EIN or address of person who provided y	you disclosures on eligible indirec	compens	sation	
(b) Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirect	compens	sation	
(b) Enter name	e and FIN or address of person who provided v	you disclosures on eligible indirect	compens	sation	

Schedule C	(Form	5500)	202
Scriedule C	( - 01111	2200	202

Page **3 -** 2

answered	l "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN o	r address (see instructions)		
EXPRESS	SCRIPTS					
22-346174	10					
(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?	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?
13	MEDICAL ADMINISTRATOR	2908850	Yes No 🛚	Yes No		Yes No
	1		a) Enter name and FIN or	address (see instructions)		
HEALTHY	ROADS INC	•	,	,		
33-078350	)4					
(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?	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?
13	MEDICAL ADMINISTRATOR	2169349	Yes No X	Yes No		Yes No
		(	<b>a)</b> Enter name and EIN or	address (see instructions)		
VIRGIN P	ULSE, INC.			UNTAIN STREET IDENCE, RI 02902		
20-254748	30					
(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?
13	MEDICAL ADMINISTRATOR	790353	Yes No	Yes No	0	Yes No

# **EXHIBIT F**

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**HERE** 

SIGN

**HERE** 

SIGN HERE

## **Annual Return/Report of Employee Benefit Plan**

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

▶ Complete all entries in accordance with the instructions to the Form 5500. OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public Inspection

						mopodion	
Part I	Annual Report Id	lentification Information					
For caler	dar plan year 2022 or fisc	cal plan year beginning 01/01/2022		and ending 12/31/2022			
A This r	eturn/report is for:	X a multiemployer plan		loyer plan (Filers checking this l nployer information in accordan			ns.)
		a single-employer plan	a DFE (specify				,
<b>B</b> This r	eturn/report is:	the first return/report	the final return/	report			
	•	an amended return/report	a short plan ye	ar return/report (less than 12 m	onths)	)	
<b>C</b> If the	plan is a collectively-barg	ained plan, check here			X		
<b>D</b> Check	box if filing under:	X Form 5558	automatic exte	nsion	the	e DFVC program	
		special extension (enter description	٦)				
<b>E</b> If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here				
Part II	Basic Plan Inform	nation—enter all requested informatio	n				
1a Nam	•				1b	Three-digit plan	501
SOUTH	IWEST CARPENTERS H	EALTH AND WELFARE TRUST FUND			10	number (PN) ▶ Effective date of pla	
					10	02/08/1955	<b>1</b> 11
Maili	ng address (include room	er, if for a single-employer plan) , apt., suite no. and street, or P.O. Box) , country, and ZIP or foreign postal code	(if foreign, see instru	ctions)	2b Employer Identification Number (EIN) 95-6042873		tion
		SOUTHWEST CARPENTER'S HEALTH			2c	Plan Sponsor's tele	phone
					number 213-386-8590		•
	JTH FREMONT AVENUE GELES, CA 90071	E			2d	Business code (see instructions) 236200	)
Caution:	A penalty for the late o	r incomplete filing of this return/repor	t will be assessed ւ	ınless reasonable cause is es	tablis	shed.	
		er penalties set forth in the instructions, I ell as the electronic version of this return					
SIGN	Filed with authorized/valid	d electronic signature.	09/21/2023	PETE RODRIGUEZ			

Date

Date

Date

09/21/2023

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

Signature of plan administrator

Signature of DFE

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Form 5500 (2022) v. 220413

Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

CURTIS CONYERS, JR.

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 31701 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 31701 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 32789 a(2) Total number of active participants at the end of the plan year ..... 6a(2)Retired or separated participants receiving benefits ..... 6b Other retired or separated participants entitled to future benefits..... 32789 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item). Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 1299 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4B 4D 4E 4H 9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust General assets of the sponsor (4) General assets of the sponsor (4)Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) **b** General Schedules a Pension Schedules (1)R (Retirement Plan Information) (1) H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)X (3) A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary X (4)C (Service Provider Information) X **D** (DFE/Participating Plan Information) (5)SB (Single-Employer Defined Benefit Plan Actuarial (3) Information) - signed by the plan actuary (6)G (Financial Transaction Schedules)

### **SCHEDULE C** (Form 5500)

Department of the Treasury Internal Revenue Service

### **Service Provider Information**

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

OMB No. 1210-0110

2022

Employee Benefits Security Administration	File as an attachment to Forr	n 5500.	This	Form is Open to Public
Pension Benefit Guaranty Corporation				Inspection.
For calendar plan year 2022 or fiscal plar	year beginning 01/01/2022	and ending 12/31	/2022	
A Name of plan		<b>B</b> Three-digit		
SOUTHWEST CARPENTERS HEALTH	AND WELFARE TRUST FUND	plan number (PN)	•	501
				<u> </u>
C Plan sponsor's name as shown on line	e 2a of Form 5500	D Employer Identification	on Number	· (EIN)
	WEST CARPENTERS HEALTH AND WELFARE	95-6042873		
TRUST				
Part I Service Provider Infor	mation (see instructions)			
or more in total compensation (i.e., more plan during the plan year. If a person	lance with the instructions, to report the information reney or anything else of monetary value) in connection received <b>only</b> eligible indirect compensation for which include that person when completing the remainder of	n with services rendered to h the plan received the requ	the plan or	the person's position with the
	eiving Only Eligible Indirect Compensa			
	er you are excluding a person from the remainder of t	•		· – –
indirect compensation for which the pla	an received the required disclosures (see instructions	for definitions and condition	าร)	XYes No
	ne name and EIN or address of each person providing ation. Complete as many entries as needed (see ins		or the servi	ce providers who
<b>(b)</b> Enter nam	e and EIN or address of person who provided you di	sclosures on eligible indirect	compensa	ation
GOLDMAN SACHS ASSET MANAGEM	ENT			
13-3575636				
(b) Enter nam	e and EIN or address of person who provided you di	sclosures on eligible indirect	compensa	ation
INVESCO CAPITAL MANAGEMENT, LL	С			
58-1709953				
<b>(b)</b> Enter nam	e and EIN or address of person who provided you di	sclosures on eligible indirect	compensa	ation
HEITMAN, LLC				
36-4263867				
<b>(b)</b> Enter nam	e and EIN or address of person who provided you di	sclosures on eligible indirect	compensa	ation
BLACKSTONE INFRASTRUCTURE PA			•	

83-3025827

Schedule C (Form 5500) 2022	

Page <b>3 -</b> 1	Page	3	-	1	
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(1.0., 111011	ey or anything else of	value) in connection v	with services rendered to the	le plan of their position with the	plan during the plan year. (S	ee instructions).
			(a) Enter name and EIN or	address (see instructions)		
ANTHEM	BLUE CROSS					
95-433185	52					
(b) Service Code(s)	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?	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 formula instead o an amount or estimated amount
12 13 15 49 62	NONE	9063939	Yes X No	Yes 🛛 No 🗌	0	Yes X No
			a) Enter name and EIN or	address (see instructions)	-	
95-368719 (b)	94 (c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee	Enter direct compensation paid	Did service provider receive indirect	Did indirect compensation include eligible indirect	Enter total indirect compensation received by	Did the service provider give you
( )	organization, or person known to be a party-in-interest	by the plan. If none, enter -0	compensation? (sources other than plan or plan sponsor)	compensation, for which the plan received the required disclosures?	service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or
12 13	person known to be		other than plan or plan	plan received the required	eligible indirect compensation for which you answered "Yes" to element	formula instead of an amount or
	person known to be a party-in-interest  AFFILIATED	enter -0 5854681	other than plan or plan sponsor)  Yes No X	plan received the required disclosures?	eligible indirect compensation for which you answered "Yes" to element	formula instead of an amount or estimated amount
12 13	person known to be a party-in-interest  AFFILIATED ADMIN. CORP.	enter -0 5854681	other than plan or plan sponsor)  Yes No X	plan received the required disclosures?  Yes No	eligible indirect compensation for which you answered "Yes" to element	formula instead of an amount or estimated amount

Yes No X

Yes No

Yes No

# **EXHIBIT G**

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security
Administration

SIGN HERE

**SIGN HERE** 

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2022

Pensio	in Benefit Guaranty Corporation				Inspection	
Part I	Annual Report Ide	ntification Information			•	
For caler	ndar plan year 2022 or fiscal	plan year beginning 01/01/2022		and ending 12/31/20	)22	
A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.						
		🗙 a single-employer plan	a DFE (specify	)		
<b>B</b> This r	return/report is:	the first return/report	the final return/	report		
	·	an amended return/report	a short plan ye	ar return/report (less than 12	2 months)	
C If the	plan is a collectively-bargain	ned plan, check here			. ▶ 🗍	
<b>D</b> Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the DFVC program	
		special extension (enter description	n)			
<b>E</b> If this	is a retroactively adopted pl	an permitted by SECURE Act section	201, check here		. ▶ 🔲	
Part II	Basic Plan Inform	ation—enter all requested informatio	n			
	ne of plan	NO MELEADE DENEET DI ANI			<b>1b</b> Three-digit plan number (PN) ▶ 507	
CHAR	TER COMMUNICATIONS, II	NC. WELFARE BENEFIT PLAN			1c Effective date of plan 05/01/1994	
Mail City	ing address (include room, a or town, state or province, c	if for a single-employer plan) upt., suite no. and street, or P.O. Box) ountry, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b Employer Identification Number (EIN) 84-1496755	
CHARTER COMMUNICATIONS, INC.					2c Plan Sponsor's telephone number 314-965-0555	
7820 CRESCENT EXECUTIVE DRIVE CHARLOTTE, NC 28217					2d Business code (see instructions) 517000	
Caution	: A penalty for the late or i	ncomplete filing of this return/repor	t will be assessed ւ	ınless reasonable cause is	s established.	
		penalties set forth in the instructions, I as the electronic version of this return				
_						
SIGN HERE	Filed with authorized/valid	electronic signature.	06/06/2023	OLGA LOZADA		
·ILIXL	Signature of plan admini	strator	Date	Enter name of individual si	gning as plan administrator	

Date

Date

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

Signature of employer/plan sponsor

Signature of DFE

Form 5500 (2022) v. 220413

Enter name of individual signing as employer or plan sponsor

Enter name of individual signing as DFE

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 91433 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 90423 a(1) Total number of active participants at the beginning of the plan year ..... 6a(1) 96512 a(2) Total number of active participants at the end of the plan year ..... 6a(2)981 Retired or separated participants receiving benefits ..... 6b 0 Other retired or separated participants entitled to future benefits..... 97493 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item). Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4D 4E 4F 4G 4H 4I 4L **4Q** 9a Plan funding arrangement (check all that apply) **9b** Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust General assets of the sponsor (4) General assets of the sponsor (4)Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) **b** General Schedules a Pension Schedules (1)R (Retirement Plan Information) (1)H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)X (3) A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary X (4)C (Service Provider Information) **D** (DFE/Participating Plan Information) (5)SB (Single-Employer Defined Benefit Plan Actuarial (3) Information) - signed by the plan actuary (6)G (Financial Transaction Schedules)

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

### **Service Provider Information**

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

OMB No. 1210-0110 **2022** 

Department of Labor Employee Benefits Security Administration	▶ File as an attachment to Form 5500.		This Form is Open to Public		
Pension Benefit Guaranty Corporation		Inspection.			
	cal plan year beginning 01/01/2022		1/2022		
A Name of plan		<b>B</b> Three-digit			
CHARTER COMMUNICATIONS,	INC. WELFARE BENEFIT PLAN	plan number (PN)	507		
C Plan sponsor's name as showr	on line 2a of Form 5500	D Employer Identificati	ion Number (EIN)		
CHARTER COMMUNICATIONS,		84-1496755	,		
,		04-14-307-33			
Part I Service Provider	Information (see instructions)				
or more in total compensation ( plan during the plan year. If a p	accordance with the instructions, to report the .e., money or anything else of monetary value erson received <b>only</b> eligible indirect compensed to include that person when completing the	e) in connection with services rendered to sation for which the plan received the requ	the plan or the person's position with the		
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 rece	ived only eligible		
indirect compensation for which	the plan received the required disclosures (s	ee instructions for definitions and condition	ns)		
	enter the name and EIN or address of each permensation. Complete as many entries as n		or the service providers who		
<b>(b)</b> Ent	er name and EIN or address of person who p	rovided you disclosures on eligible indired	et compensation		
<b>(b)</b> Ent	er name and EIN or address of person who p	rovided you disclosures on eligible indired	et compensation		
<b>(b)</b> Ent	er name and EIN or address of person who p	rovided you disclosures on eligible indirec	ct compensation		
			·		
n. v =	1-m 1: 5 :				
( <b>D)</b> Ent	er name and EIN or address of person who p	rovided you disclosures on eligible indired	ct compensation		

CASE 0:24-cv-03043-KMM-DTS	Doc. 32-8	Filed 09/27/24	Page 5 of 5
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;	Schedule C (Form 550	00) 2022		Page <b>3 -</b> 1		
answered	"Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ch person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN or	address (see instructions)		
HEALTHY	'ALLIANCE LIFE INS	СО				
86-025720	)1					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 15 49 62	CLAIMS PROCESSOR	48114130	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
EYEMED						
47-309498	34					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount
12 13 73	CLAIMS PROCESSOR	7170632	Yes No X	Yes No		Yes No

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

EXPRESS SCRIPTS, INC.

#### 22-3461740

(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,	(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?	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?
13 73	CLAIMS PROCESSOR	6248216	Yes No X	Yes No		Yes No

# EXHIBIT H

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public

					Inspection	
Part I	Annual Report Ide	entification Information				
For caler	dar plan year 2022 or fisca	l plan year beginning 01/01/2022		and ending 12/31/2022		
A This return/report is for:  a multiemployer plan  a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)						ons.)
		X a single-employer plan	a DFE (specify	)		
<b>B</b> This r	eturn/report is:	the first return/report	the final return/	•		
		an amended return/report		ar return/report (less than 12 m	onths)	
C If the	plan is a collectively-bargai	ned plan, check here				
<b>D</b> Check	box if filing under:	X Form 5558	automatic exte	nsion	the DFVC program	
		special extension (enter description	n)			
<b>E</b> If this	is a retroactively adopted p	lan permitted by SECURE Act section	201, check here			
Part II	Basic Plan Inform	ation—enter all requested information	n			
1a Nam	e of plan				<b>1b</b> Three-digit plan number (PN) ▶	502
SELEC	T MEDICAL CORPORATION	ON HEALTH AND WELFARE BENEFI	I PLAN		1c Effective date of p 03/01/1998	lan
Maili City	ng address (include room, a or town, state or province, o	, if for a single-employer plan) apt., suite no. and street, or P.O. Box) country, and ZIP or foreign postal code	(if foreign, see instru	octions)	2b Employer Identification Number (EIN) 23-2872718	
SELECT	MEDICAL CORPORATIO	N			2c Plan Sponsor's telephone number 717-972-1100	
4714 GETTYSBURG ROAD MECHANICSBURG, PA 17055			2d Business code (see instructions) 623000			
Caution:	A penalty for the late or i	incomplete filing of this return/repor	t will be assessed ι	ınless reasonable cause is es	stablished.	
		penalties set forth in the instructions, I as the electronic version of this return				
	, 40 1101			,		1

SIGN HERE	Filed with authorized/valid electronic signature.  Signature of plan administrator	10/11/2023 Date	BECKY HEINDEL  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

Form 5500 (2022) Page 2 **3a** Plan administrator's name and address X Same as Plan Sponsor 3b Administrator's EIN 3c Administrator's telephone number 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, 4b EIN enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: а Sponsor's name **4d** PN Plan Name 5 Total number of participants at the beginning of the plan year 32156 5 6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d). 31871 a(1) Total number of active participants at the beginning of the plan year ...... 6a(1) 33622 a(2) Total number of active participants at the end of the plan year ..... 6a(2)106 Retired or separated participants receiving benefits ..... 6b 0 Other retired or separated participants entitled to future benefits..... 33728 Subtotal. Add lines 6a(2), 6b, and 6c. 6d Deceased participants whose beneficiaries are receiving or are entitled to receive benefits. 6e Total. Add lines 6d and 6e. 6f Number of participants with account balances as of the end of the plan year (only defined contribution plans 6g complete this item). Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested... 6h Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) ...... 8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions: **b** If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4R 4D 4E 4F 4H 4L 40 9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1)Insurance (1) Insurance Code section 412(e)(3) insurance contracts (2) Code section 412(e)(3) insurance contracts (2) (3) (3) Trust General assets of the sponsor (4) General assets of the sponsor (4)Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions) **b** General Schedules a Pension Schedules (1)R (Retirement Plan Information) (1)H (Financial Information) (2) I (Financial Information – Small Plan) MB (Multiemployer Defined Benefit Plan and Certain Money (2)X (3) A (Insurance Information) Purchase Plan Actuarial Information) - signed by the plan actuary X (4)C (Service Provider Information) **D** (DFE/Participating Plan Information) (5)SB (Single-Employer Defined Benefit Plan Actuarial (3) Information) - signed by the plan actuary (6)G (Financial Transaction Schedules)

### SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

### **Service Provider Information**

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

OMB No. 1210-0110 **2022** 

mieriai rievenae eernee	redirement moonie ecoanty rec	01 107 + (L111071).			
Department of Labor Employee Benefits Security Administration  File as an attachment to Form 5500.		This Form is Open to Public			
Pension Benefit Guaranty Corporation			Inspection.		
For calendar plan year 2022 or fiscal plan	year beginning 01/01/2022	and ending 12/31	/2022		
A Name of plan		<b>B</b> Three-digit			
SELECT MEDICAL CORPORATION HE	ALTH AND WELFARE BENEFIT PLAN	plan number (PN)	•	502	
C Plan sponsor's name as shown on line	e 2a of Form 5500	<b>D</b> Employer Identification	on Numbe	er (EIN)	
SELECT MEDICAL CORPORATION		23-2872718			
Part I Service Provider Infor	mation (see instructions)				
or more in total compensation (i.e., mo plan during the plan year. If a person r	ance with the instructions, to report the information or anything else of monetary value) in confeceived only eligible indirect compensation for clude that person when completing the remain	nection with services rendered to r which the plan received the requ	the plan	or the person's position with the	
1 Information on Persons Reco	eiving Only Eligible Indirect Compe	ensation			
a Check "Yes" or "No" to indicate whether	er you are excluding a person from the remaind	ler of this Part because they recei	ved only	eligible	
indirect compensation for which the pla	an received the required disclosures (see instru	actions for definitions and condition	ns)	Yes X No	
	e name and EIN or address of each person praction. Complete as many entries as needed (s		or the serv	rice providers who	
(b) Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirec	t compen	sation	
(b) Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirec	t compens	sation	
(b) Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirec	compen	sation	
(b) Enter name	e and EIN or address of person who provided y	you disclosures on eligible indirec	t compens	sation	

Schedule C (Form 5500) 2022	
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Page <b>3</b> -	1
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2. Inform	nation on Other S	Service Providers	s Receiving Direct o	r Indirect Compensation	n. Except for those persons	for whom you
answered	f "Yes" to line 1a above	e, complete as many	entries as needed to list ea	nch person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
			(a) Enter name and EIN o	r address (see instructions)		
HIGHMAF	RK					
23-129472	23					
(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?
13	CLAIMS ADMINISTRATOR	10904418	Yes No X	Yes No		Yes No
			a) Enter name and EIN or	address (see instructions)		
EXPRESS	S SCRIPTS, INC.		a, Enormano ana Envo	addison (ood mendenone)		
22-346174	40					
(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?
13	CLAIMS ADMINISTRATOR	1833984	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

# **EXHIBIT I**

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security
Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

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

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

OMB Nos. 1210-0110 1210-0089

2022

This Form is Open to Public

						inspection	
Part I	Annual Report lo	dentification Information					
For caler	ndar plan year 2022 or fisc	cal plan year beginning 01/01/2022		and ending 12/31/2	022		
<b>A</b> This r	eturn/report is for:	X a multiemployer plan		loyer plan (Filers checking t nployer information in accor			ns.)
		a single-employer plan	a DFE (specify	)			,
<b>B</b> This r	return/report is:	the first return/report	the final return/				
	·	x an amended return/report	a short plan ye	ar return/report (less than 12	2 months)	)	
C If the	plan is a collectively-barg	ained plan, check here			<b>▶</b> 🔀		
<b>D</b> Chec	k box if filing under:	X Form 5558	automatic exte	nsion	the	e DFVC program	
		special extension (enter description	1)				
<b>E</b> If this	is a retroactively adopted	plan permitted by SECURE Act section	201, check here		•		
Part II	Basic Plan Infor	mation—enter all requested information	n				
1a Nam	•	NATIONAL HEALTH AND WELFARE PL	ΔN		1b	Three-digit plan number (PN) ▶	501
IIILIV	AILNOAD LIVII LOTELST	VATIONAL FILALITI AND WELL AND LE			1c	Effective date of pla 03/01/1955	an
Maili City	ing address (include room or town, state or province	er, if for a single-employer plan) n, apt., suite no. and street, or P.O. Box) n, country, and ZIP or foreign postal code	(if foreign, see instru	uctions)	2b	Employer Identifica Number (EIN) 80-0616625	tion
JOINT F	PLAN COMMITTEE				2c	Plan Sponsor's tele number 571-336-7600	phone
	BTH STREET, SOUTH, SI GTON, VA 22202	UITE 750			2d	Business code (see instructions) 482110	•
Caution	A penalty for the late o	r incomplete filing of this return/repor	t will be assessed u	ınless reasonable cause i	s establis	shed.	
		er penalties set forth in the instructions, I ell as the electronic version of this return					
SIGN	Filed with authorized/valid	d electronic signature.	10/11/2023	ARTHUR P. MARATEA			

Date

Date

Date

10/11/2023

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

Filed with authorized/valid electronic signature.

Signature of employer/plan sponsor

Signature of plan administrator

Signature of DFE

**HERE** 

SIGN

**HERE** 

**SIGN HERE** 

> Form 5500 (2022) v. 220413

Enter name of individual signing as plan administrator

Enter name of individual signing as DFE

Enter name of individual signing as employer or plan sponsor

**BRENDAN BRANON** 

	Form 5500 (2022)	Page <b>2</b>		
3a	Plan administrator's name and address X Same as Plan Sponsor		<b>3b</b> Administr	rator's EIN
			3c Administr	ator's telephone
4	If the name and/or EIN of the plan sponsor or the plan name has changed senter the plan sponsor's name, EIN, the plan name and the plan number fro		4b EIN	
а	Sponsor's name	in the last returnineport.	4d PN	
	Plan Name			
5	Total number of participants at the beginning of the plan year		5	213981
6	Number of participants as of the end of the plan year unless otherwise state <b>6a(2)</b> , <b>6b</b> , <b>6c</b> , and <b>6d</b> ).	d (welfare plans complete only lines 6a(1),		
a(	1) Total number of active participants at the beginning of the plan year		6a(1)	75210
a(	2) Total number of active participants at the end of the plan year		6a(2)	74512
b	Retired or separated participants receiving benefits		6b	137111
С	Other retired or separated participants entitled to future benefits		6c	
d	Subtotal. Add lines <b>6a(2)</b> , <b>6b</b> , and <b>6c</b>		6d	211623
е	Deceased participants whose beneficiaries are receiving or are entitled to re	eceive benefits.	6e	
f	Total. Add lines <b>6d</b> and <b>6e</b> .		6f	
g	Number of participants with account balances as of the end of the plan year complete this item)		6g	
h	Number of participants who terminated employment during the plan year wit less than 100% vested	th accrued benefits that were	6h	
7	Enter the total number of employers obligated to contribute to the plan (only		7	41
8a b	If the plan provides pension benefits, enter the applicable pension feature could be pension for the pension feature could be pension for the pension feature could be pension feature could be pension feature could be pension feature featur			
9a	Plan funding arrangement (check all that apply)  (1) X Insurance	9b Plan benefit arrangement (check all the	at apply)	
	(2) Code section 412(e)(3) insurance contracts	(1) X Insurance (2) Code section 412(e)(3)	insurance cont	racts
	(3) X Trust	(3) X Trust		
	(4) General assets of the sponsor	(4) General assets of the s	·	
10	Check all applicable boxes in 10a and 10b to indicate which schedules are a	attached, and, where indicated, enter the numl	ber attached. (	See instructions)
а	Pension Schedules	b General Schedules		
	(1) R (Retirement Plan Information)	(1) 🔀 H (Financial Inform	,	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money	(2)		Plan)
	Purchase Plan Actuarial Information) - signed by the plan	(3) X 1 A (Insurance Infor	rmation)	
	actuary	(4) X C (Service Provid	er Information)	
	(3) SB (Single-Employer Defined Benefit Plan Actuarial	(5) D (DFE/Participat	-	•
	Information) - signed by the plan actuary	(6) G (Financial Trans	saction Schedu	les)

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

### **Service Provider Information**

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

OMB No. 1210-0110 **2022** 

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation	▶ File as an attachment to Form 5500.		This	This Form is Open to Public Inspection.	
For calendar plan year 2022 or fiscal plan	n year beginning 01/01/2022	and ending 12	2/31/2022	•	
A Name of plan	. year 20gg 01/01/2022	B Three-digit	10112022		
THE RAILROAD EMPLOYEES NATION	AL HEALTH AND WELFARE PLAN	plan number (PN	· •	501	
THE TO BELLOND EINE EOTEES WITHOU	ALTERITIONS WELFARET DAY	plan number (FN	<u>,                                      </u>	001	
C Plan sponsor's name as shown on line	e 2a of Form 5500	<b>D</b> Employer Identifi	cation Numbe	er (EIN)	
JOINT PLAN COMMITTEE		80-0616625			
Part I Service Provider Infor	mation (see instructions)				
or more in total compensation (i.e., mo plan during the plan year. If a person	dance with the instructions, to report the information oney or anything else of monetary value) in correceived <b>only</b> eligible indirect compensation for that person when completing the remainstructure.	nnection with services rendere for which the plan received the	d to the plan	or the person's position with the	
1 Information on Persons Rec	eiving Only Eligible Indirect Comp	ensation			
	er you are excluding a person from the remain		eceived only	eligible	
	an received the required disclosures (see inst	•	•		
	· · · · · · · · · · · · · · · · · · ·		,		
	ne name and EIN or address of each person partion. Complete as many entries as needed		es for the serv	vice providers who	
(b) Enter nam	e and EIN or address of person who provided	I you disclosures on eligible ind	irect compens	sation	
UNITEDHEALTHCARE					
36-2739571					
(b) Enter nam	e and EIN or address of person who provided	I you disclosures on eligible ind	irect compens	sation	
HIGHMARK					
56-2526063					
/b) =	and EM anadana of name who would be	Luciu dinalanima amalimiti i dina		a a Mila u	
(D) Enter nam	e and EIN or address of person who provided	you disclosures on eligible ind	irect compens	sation	
AETNA US HEALTHCARE					
06-6033492					
(b) Enter nam	e and EIN or address of person who provided	I you disclosures on eligible ind	irect compens	sation	

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	-		(a) Enter name and FIN or	address (see instructions)		
EXPRES	S SCRIPTS, INC.	<u>'</u>	(a) Enter hame and Envio	address (see instructions)		
22-34617	40					
(b) Service Code(s)	(c) Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 13 99	NONE	4250101	Yes No X	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
TELADO	C HEALTH INC.					
04-37059	70					
(b) Service Code(s)	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?	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?
99	NONE	1384113	Yes No 🛚	Yes No		Yes No
		(	a) Enter name and EIN or	address (see instructions)		
HEALTH	ADVOCATE SOLUTIO	ONS, INC.				
23-30800	19					
(b) Service Code(s)	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?	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?